Christa U. Simons MA, LPC, LLC

81 Conkling Street
Basking Ridge, NJ 07920
Phone: 908-274-1608
Email: christa.u.simons@gmail.com

Informed Consent

Confidentiality and Emergency Situations: Your verbal communication and clinical records are strictly confidential except:

- Information (diagnosis and dates of service) shared with your insurance company to process your claims,
- If you provide information that informs me that you are in danger of harming yourself or others,
- Information that you an/or your child or children report about physical abuse, sexual abuse or elder abuse; then under New Jersey State Law I am obligated to report this to the New Jersey Division of Child Protection and Permanency or the the New Jersey Adult Protective Services,
- When required by court order,
- When you sign a release of information to have specific information shared, and
- Information necessary for case supervision or consultation.

If an emergency situation for which the client or their guardian feels immediate attention is necessary, please call the emergency service in the community (911) for immediate help. We will follow up after those emergency services with standard counseling and support to the client or the client's family.

Coordination of Treatment: It is important that all health care providers work together. As such, we would like your permission to communicate with your providers. Your consent is valid for one year. Please understand that you have the right to revoke authorization, in writing, at any time.

_____ I decline to inform other provider(s)

_____You may inform the following doctors/provider(s)

Name:_____

Address:_____

Phone/Fax:_____

Name:_____

Address:_____

Phone/Fax:_____

Consent for the Treatment of Children or Adolescents (*Must be completed for clients under 18 years of age*)

I/We consent that _____ may be treated by Christa U. Simons MA, LPC, LLC. It is understood that children over the age of 12 have confidentiality protected by the law. This consent to treat expires at the end of treatment or if revoked in writing.

Payments and Cancellations: As a courtesy we will provide you with a bill/receipt for your insurance company. The client is responsible for full payment, which is due at the time of services rendered. Please note, in order to provide a convenient schedule for you and all of our client, if you cancel a booked appointment with less than 24-hours' notice, $50 payment will be due. Thank you for understanding this policy.

Notice of Privacy Practices and Client Rights: I have read and received a copy of the Notice of Privacy Practices and Client Rights document.

By signing below, you indicate that you have read and understood the document, and that any questions you have about this statement have been answered to your satisfaction.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date