Rachel Korenblit, LCSW, LLC

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Welcome to the private practice of Rachel Korenblit, LCSW. It is required that the following information is shared with you to help establish the understanding and trust essential to a therapeutic relationship. Please provide the requested information and read these documents carefully, as they contain important information about the practice, policies, and how your mental health information can be used and disclosed. Please note any questions or concerns that you have—you may discuss these with me at any time. After you sign the enclosed documents, they will constitute a binding agreement between you and your therapist, Rachel Korenblit, LCSW (hereafter referred to in first person). *Only one copy of the forms is needed for couples or families, however all adult family members will need to sign the disclosure statement (those 15 and over).*

PART 1: INFORMED CONSENT

Each client is required to sign the below form. Any child under the age of sixteen (16) years of age must have a parent or legal guardian consent to the mental health services to be provided. Any child sixteen (16) years of age or older may sign the below form and consent to mental health services without the consent of a parent or legal guardian. If the parent or legal guardian is consenting to the mental health services, the required disclosures shall be made to the parent or legal guardian. If the child is consenting to mental health services, the required disclosures shall be made to the child. If a parent or legal guardian is consenting to mental health services for his/her minor child, and the parent or legal guardian is divorced or separated, the parent is required to provide a copy of the Court Order and/or Custody Agreement that grants the parent or legal guardian authority to consent to mental health services. Failure to provide a copy of the Court Order or Custody Agreement will result in immediate termination of therapy.

Participation in therapy can result in a number of benefits, including improving relationships and resolving the concerns that led you to seek help. As a collaborative process, therapy requires your very active effort, honesty, and openness in order to achieve desired changes.

The process of engaging in therapy can result in your experiencing considerable emotional discomfort. Your therapist may challenge your perceptions or propose ways of handling situations that can cause you to feel some distress. Attempting to resolve therapeutic issues may result in changes that were not originally intended. Therapy may also result in decisions about making changes that may be positive for one family member but could be viewed negatively by another. Change will sometimes be easy and swift; other times it will be slow and even frustrating. There is no guarantee that therapy will yield the intended results. At all times, it is your decision whether to pursue the suggestions made by your therapist. It is always your responsibility, not your therapist's, to make decisions regarding relationships such as cohabitation, marriage, divorce, separation, reconciliation, custody, etc.

You are entitled by law to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure. During the course of therapy, I am likely to draw on various therapeutic approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. Within a reasonable period of time after the initiation of treatment, I will be able to offer you some impressions of what your therapy will include. You should also make your own assessment about whether you feel comfortable working with me. If you have any questions about the process of therapy, please let me know.

The most common reason for ending therapy is that a client's concerns have been addressed. You are entitled to end therapy or seek a second opinion from another therapist at any time. Most clients find it helpful to have one or two sessions to bring closure to therapy and discuss the therapeutic process. These sessions can help prevent future problems. Therapy can also end when your challenges lie beyond the limits of your therapist's ability to help. If this becomes apparent to me at any point, I am legally required to refer, terminate, or consult, and will discuss this with you, offer you appropriate referrals, and end treatment.

By signing this document, you affirm your understanding that should you discontinue therapy for more than 60 days without written notice to me, your treatment will be considered "terminated." You may resume therapy any time after the 60-day period by communicating your decision to resume therapy services to me. This document may remain in effect should you resume therapy if one (1) year has not elapsed since your last session. However, you may be asked to re-sign this document or provide additional information to update your client records and/or sign new forms. "Discontinuing therapy" means that you have not had a session with your therapist for at least sixty (60) days.

PART 2: DISCLOSURE STATEMENT (DEGREES, LICENSING, & OTHER CERTIFICATIONS)

Rachel Korenblit, LCSW:
Degrees: Silberman School of Social Work at Hunter College, NY, Masters in Social Work, 2015; Touro College, NY, Bachelor of Arts in Psychology, 2014;
License: Licensed Clinical Social Worker, State of New Jersey #44SC05863000;
Other Certifications: Adelphi University, NY, Postgraduate Certificate Program in Trauma Studies and Treatment, 2016.

New Jersey Social Work Practice Law and Public Safety Guidelines

The information provided by clients during therapy sessions is legally confidential, except as provided in N.J.A.C. § 13:44G-12.3 and except for certain exceptions that are identified in our Confidentiality Form (see Part 4). Pursuant to law, this practice will maintain records for a period of seven years commencing on the date of termination of services or on the date of last contact with the client, whichever is later, unless otherwise provided by law, or in the case of a minor, until age 25.

Notices: (a) Social workers are licensed or certified by the Board of Social Work Examiners, an agency of the Division of Consumer Affairs. You may notify the Board of any complaint relative to the practice conducted by a social worker. The Board's address is Division of Consumer Affairs, Board of Social Work Examiners, Post Office Box 45033, 124 Halsey Street, Newark, New Jersey 07101. (b) Information on professional fees is available to you on request.

PART 3: OFFICE POLICIES

Cancellation and No-Shows: Since your appointments involve the reservation of time specifically for you, and out of respect for your therapist, a minimum of 24 hours notice is required for rescheduling or canceling an appointment, excluding emergency situations. You may be charged up to a full session fee for missed sessions not cancelled with at least 24 hours notice. Repeated cancellations without the required 24 hours notice may result in the termination of therapy. Your therapy sessions may be paid for by the agency you are affiliated with or you are a private pay client. For all private pay clients, repeated cancellations without the required 24 hours notice and no shows may result in the termination of therapy. In addition, repeated late cancelations and no shows will be charged one half the private pay fee. Although I may send clients email, text, or phone call reminders about upcoming appointments, this is done as a courtesy and only if you consent to receive such communications. It remains your sole responsibility to keep track of and attend all scheduled therapy appointments, whether or not you receive the email, text or phone call reminder(s).

Phone Contact: It is my policy to try to return all telephone messages by the following business day, although that may not always be possible. I check my messages a few times a day, though rarely during non-business hours. I may not be available to converse or check messages on weekends, holidays, and when I am out of town. Messages left during these times will be returned in a prompt manner when I return to work. I only provide non-emergency services by scheduled appointment.

Texting/Messaging Policy: Text messaging must be pre-arranged with me. I may not read my text messages in a timely fashion and/or may not receive them. Never leave emergency information on a text message and if, for any reason, you don't hear back from me, please follow up with a phone call. I do not use SMS or social networking sites for communication. These sites are not secure. Please know that by using text messaging, it is impossible to guarantee the confidentiality of the text messages. If you have information that you need to communicate to me, please contact me directly.

Emergency Services: For life threatening emergencies, you are encouraged to go directly to the nearest emergency room.

TeleHealth: The first session you have with me should be in person, although we know that this may not always be the case. I will help you schedule your TeleHealth session and will send you a secure link to the TeleHealth platform (Zoom). You will be required prior to your session to review and sign all informed consent documents and demonstrate proof of identity. The TeleHealth session will require that you ensure you have a secure WIFI or internet connection. You will also need to ensure, ahead of time, that you have a working webcam and audio on your device. You will be given an appointment date and time, as well as directions on how to connect remotely to your session. No recording, photography, or third parties are allowed as a part of this session. By agreeing to participate in a TeleHealth session, you agree to expressly release my practice from any liability associated with unintended cyber security issues and/or difficulties with unsecured communications.

Email Policy: Please use discretion in deciding whether to communicate with me via email. I cannot be held responsible for any information lost in transit or viewed by a third party. Email should *only* be used for brief, general questions (e.g., questions regarding billing or advance scheduling of appointments). Hence, therapeutic issues, emergencies, sensitive personal information, and cancellations should all be communicated to me only over the telephone or in person. Although confidentiality cannot be guaranteed when using email communications, confidentiality will extend to information obtained through email communication.

Social Media Policy: Please do not request me to "like," "follow," "friend" you etc. via any social media site. Any such request will be denied to maintain professional boundaries. Do not use wall postings, @ or # replies, or other means of engaging with me online, if you have an already established client/therapist relationship with me. Engaging in this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. I may have a business Facebook Page, Blog, or other Business Social Media Account. There is no requirement that you "like" or "follow" my account on social media. If you choose to "like," "follow," or post comments on my social media accounts/blog, there is the chance that others will see your name associated with "liking" or "following" me. Any comments you post regarding therapeutic work between us will be deleted as soon as possible after I become aware of such posts. By signing this form, you agree that you will refrain from discussing, commenting, and/or asking therapeutic questions via any social media platform. You agree that if you have a therapeutic comment and/or question that you will contact me through the mode you consented to and not through social media.

Litigation Limitations: If you are involved in divorce/custody litigation, my role is not to make recommendations to the court concerning custody or parenting issues. The court can appoint professionals who have no prior relationship with family members to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interest of your children.

PART 4: CONFIDENTIALITY

> Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a licensed social worker. If the information is legally confidential, I cannot be forced to disclose the information without the client's consent. Information disclosed to a licensed social worker is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of New Jersey without the consent of the person to whom the testimony sought relates. A social worker shall preserve the confidentiality of information obtained from a client in the course of performing social work services for the client, including after the death of a client.

There are exceptions to this general rule of confidentiality. Such situations in which the law requires disclosure include, but are not limited to the following:

1. I am required to report any suspected incident of child abuse or neglect to law enforcement and/or the appropriate agency.
2. I am required to report any suspected abuse or exploitation of an at-risk elder or the imminent risk of abuse of exploitation.
3. Disclosure is required by Federal or state law or regulation, the Board or the Office of the Attorney General during the course of an investigation, or a court of competent jurisdiction pursuant to a judge's order.
4. The client would present a clear and present danger to the health or safety of an individual if the social worker

fails to disclose the information.

5. The social worker is a party defendant to a civil, criminal or disciplinary action arising from the social work services provided, in which case a waiver of the privilege accorded by this section shall be limited to that action.
6. The patient or client is a defendant in a criminal proceeding and the use of the privilege would violate the defendant's right to a compulsory process or the right to present testimony and witnesses on that person's behalf.
7. Your therapist is required to report any suspected threat to national security to federal officials.
8. Disclosure may be required during the course of supervision or consultation.
9. I will advise you of other situations where the law requires disclosure, should the situation arise.

If you see someone you know in the waiting room, please respect their confidentiality by not discussing their attendance of therapy with others.

Considering all the above exclusions, upon your written request I will release information to any agency/person you specify unless I concludes that releasing such information might be harmful. Records will only be released to outside parties when I am authorized to do so, in writing, by every member of the couple/family in treatment legally able to execute a waiver.

HIPAA Notice of Privacy Practices

This form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to your privacy, will be released without permission unless mandated by New Jersey law as described in this form and the "Notice of Privacy Policies and Practices and Compliance with HIPAA Regarding Confidentiality of Client Records and Dissemination of Information."

I am legally required to protect the privacy of your health information called "protected health information," or "PHI" for short. It includes information that can be used to identify you and that I've created or received about your past, present or future health condition, the provision of health care to you or the payment for this health care. I am required to provide you with this notice about my privacy practices. It explains how, when, and why I use any more of your PHI than is necessary to accomplish the purpose of the use or disclosure.

Your Rights: You have the right to: get a copy of or correct your paper or electronic medical record, request confidential communication, ask us to limit the information we share, get a list of those with whom we've shared your information or a copy of this privacy notice, choose someone to act for you, and file a complaint if you believe your privacy rights have been violated.

My Duties: I may use and share your information to: treat you, run my organization, bill for your services, help with public health and safety issues, do research, and comply with laws that may be in place now or in the future.

If you believe your privacy rights have been violated, you may make a complaint by contacting my office, Linda Potere, HIPAA Privacy Officer at (561) 738-1369, the Secretary for the Department of Health and Human Services, or the State of New Jersey Department of Human Services. No individual will be retaliated against for filing a complaint:

The U.S. Department of Health and Human Services: 200 Independence Avenue, S.W., Washington, D.C. 20201, Toll Free: 1-877-696-6775. The State of N.J. Department of Human Services Office of Legal and Regulatory Affairs: P.O. Box 700, Trenton, NJ 08625, 888-347-5345

(For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html)

Consistent with HIPAA guidelines authorization for release and consent for treatment will be automatically revoked one year after the signing date. You acknowledge that you have received Rachel Korenblit, LCSW's Notice of Privacy Policies and Practices and Compliance with HIPAA Regarding Confidentiality of Client Records and Dissemination of Information.

My signature below affirms my informed and voluntary consent to enter therapy (and/or have my child/children enter therapy), and that I have read and understand the nature of confidentiality in therapy as set forth above. I affirm that prior to becoming a client of Rachel Korenblit LCSW LLC, I was given sufficient information to understand the nature of therapy, including the possible risks and benefits. I understand and agree to abide by the office policies and procedures listed above. I have had an opportunity to ask questions and have had my questions answered satisfactorily. I acknowledge that I have read the preceding information. I understand that I have full access to this form online at RachelKorenblitLCSW.com. I acknowledge that if I wish to have a copy of the signed document, I may request one at any time. Such requests shall be submitted in writing. I understand that I can ask questions and raise concerns about the treatment at any time. I also understand that I may terminate therapy at any time by providing written notice to Rachel Korenblit, LCSW LLC. Therapy shall be terminated upon receipt of my written notice.

_____	_____
Printed Name Date	Printed Name Date
_____	_____
Client Signature Date	Client Signature Date
_____	_____
Signature of Guardian(s) if Minor Client(s) Date	Signature of Guardian(s) if Minor Client(s) Date
_____	_____
Clinician Printed Name Date	Clinician Signature Date