Agreement for Individual Therapeutic Consultation

Informed consent for Psychotherapy Services

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I,_______________________________ the client, agree to meet with Kenneth Ovitz LCSW for the purpose of receiving sex addiction treatment. Kenneth Ovitz of Ovitz Psychotherapy Associates, LLC will provide me with treatment services at the following location: 525 Route 73 North, Marlton NJ (Five Greentree Centre, Marlton, NJ 08053). I have read and signed the following materials regarding my therapy, which have been provided to me by this therapist:

1.Informed consent for Psychotherapy Services
2.Acknowledgement of Financial Responsibility
3.Consent for Evaluation
3.Acknowledgement of the Limits of Confidentiality
5.Acknowledgement of Policies pertaining to Electronic Media

_______________________________ _______________

Printed Name of Patient Date

____

Signature of Client/Patient

Consent to Evaluation

I agree to undergo a complete the following instruments at the direction of this third party:

The Sexual Dependency Inventory (SDI)_____Initial

The Post Traumatic Stress Inventory_____Initial

The Money and Work Adaptive Styles Index ____Initial

I understand and agree that the results of this evaluation are to be the sole property of this third party. I agree that I will not hold this third party legally responsible for any events resulting from this evaluation or the records created by it.

<u>I understand that the purpose(s) of this evaluation are:</u>

1.Assess patterns of sexual addiction

2.Assess Intimacy and attachment style

3.Assess impact of trauma on sexual functioning and relationship history

4.Assess Intimacy styles evident in relationship to work and finances.

I agree that a photocopy of this form is acceptable, but that the photocopy must be individually signed by me and a witness. I understand I have the right to receive a copy of this form upon my request.

____ _____________________

Signature of client Date

____

Printed name

I, Kenneth Ovitz LCSW, have discussed the issues above with the client (and/or his or her parent or guardian). My observations of this person's behavior and responses gives me no reason to believe that this person is not fully competent to give informed and willing consent.

____

____

Signature of Kenneth Ovitz LCSW Date

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law

Goals of Treatment

I believe I understand the basic ideas, goals, and methods of this therapy. I have no important questions or concerns that the therapist has not discussed. In my own words, I understand the following:

1. The causes of my problems lie in:

2. The main methods to be used in this therapy are cognitive behavioral, psychodynamic, psychodrama and relapse prevention treatment approaches. Some ancillary techniques such as mindfulness, distraction, grounding and other trauma coping skills will also be taught.

3. During these sessions, we will focus on working toward these goals:

a.

b.

I understand that reaching these goals is not guaranteed.

4. I understand that I will have to do the following things/take the following actions:

a.

b.

With enough knowledge, and without being forced, I enter into treatment with this therapist. I will keep my therapist fully up to date about any changes in my feelings, thoughts, and behaviors. I expect us to work together on any difficulties that occur, and to work them out in my long-term best interest.

After the eighth session, we will evaluate progress and may change parts of this agreement as needed. Our goals may change in nature, order of importance, or definition. If I am not satisfied by our progress toward goals, I will attempt to make change in this agreement, and I may stop treatment after giving this therapist at least 7 days' notice of my intentions and meeting with the therapist for one last time.

Acknowledgement of Financial Responsibility

This agreement shows my commitment to pay for this therapist's services. It also shows this therapist's willingness to use and share his or her knowledge and skills in good faith. I agree to pay $110 per session if my insurance plan does not cover the psychotherapy services I am receiving. I agree to pay before beginning each session. I understand that if I need to cancel an appointment, at least 24 hours notice in advance is required by telephone only (only voicemail accepted: no text or email). Should I miss or cancel my appointment within 24 hours of the appointment date and time, I agree to pay $80 for un-cancelled appointments or those where I fail to give enough notice that I will not attend.The only exceptions are unforeseen or unavoidable situations arising suddenly. I understand and accept that I am fully responsible for this fee, but that my therapist will help me in getting payments from any insurance coverage I have. I understand that this agreement will become part of my record of treatment. I understand that my therapist reserves the right to suspend treatment if balance accrues more than one unpaid sessions.

Signature of Client___________________________________

Date:____

____

Printed Name of Client

I, Kenneth Ovitz LCSW, have discussed the issues above with the client (and/or his or her parent or guardian). My observations of this person's behavior and responses gives me no reason to believe that this person is not fully competent to give informed and willing consent.

____

Signature of Kenneth Ovitz LCSW   Date

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law

Ovitz Psychotherapy Associates, LLC

525 Route 73 North (Suite 104)
(Five Greentree Centre, Suite 104)
Marlton, NJ 08053
917-609-7056

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Privacy is a very important concern for all those who come to this office. It is also complicated, because of the many federal and state laws and our professional ethics. Because the rules are so complicated, some parts of this notice are very detailed, and you probably will have to read them several times to understand them. If you have any questions, our privacy officer will be happy to help you understand our procedures and your rights. His or her name and address are at the end of this notice.

Contents of this notice

A. Introduction: To our clients

B. What we mean by your medical information

C. Privacy and the laws about privacy

D. How your protected health information can be used and shared

1. Uses and disclosures with your consent
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b. For law enforcement purposes and for public health activities
d. Relating to decedents
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4. Uses and disclosures where you have *an opportunity to object*

5. An *accounting* of disclosures we have made

E. Your rights concerning your health information

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A. Introduction: To our clients

This notice will tell you how we handle your medical information. It tells how we use this information here in this office, how we share it with other professionals and organizations, and how you can see it. We want you to know all of this so that you can make the best decisions for yourself and your family. If you have any questions or want to know more about anything in this notice, please ask our privacy officer for more explanations or more details.

B. What we mean by your medical information

Each time you visit us or any doctor's office, hospital, clinic, or other health care provider, information is collected about you and your physical and mental health. It may be information about your past, present, or future health or conditions, or the tests and treatment you got from us or from others, or about payment for health care. The information we collect from you is called **"PHI,"** which stands for **"protected health information."** This information goes into your **medical or health care records** in our office.

In this office, your PHI is likely to include these kinds of information:

✐ Your history: Things that happened to you as a child; your school and work experiences; your marriage and other personal history.

✐ Reasons you came for treatment: Your problems, complaints, symptoms, or needs.

✐ Diagnoses: These are the medical terms for your problems or symptoms.

✐ A treatment plan: This is a list of the treatments and other services that we think will best help you.

✐ Progress notes: Each time you come in, we write down some things about how you are doing, what we notice about you, and what you tell us.

✐ Records we get from others who treated you or evaluated you.✐ Psychological test scores, school records, and other reports.
✐ Information about medications you took or are taking.
✐ Legal matters.

✐ Billing and insurance information
There may also be other kinds of information that go into your health care records

here. We use PHI for many purposes. For example, we may use it:

✐ To plan your care and treatment.

✐ To decide how well our treatments are working for you.

✐ When we talk with other health care professionals who are also treating you, such as your family doctor or the professional who referred you to us.

✐ To show that you actually received services from us, which we billed to you or to your health insurance company.

✐ For teaching and training other health care professionals.
✐ For medical or psychological research.
✐ For public health officials trying to improve health care in this area of the country.✐ To improve the way we do our job by measuring the results of our work.

When you understand what is in your record and what it is used for, you can make better decisions about who, when, and why others should have this information.

Although your health care records in our office are our physical property, the information belongs to you. You can read your records, and if you want a copy we can make one for you (but we may charge you for the costs of copying and mailing, if you want it mailed to you). In some very rare situations, you cannot see all of what is in your records. If you find anything in your records that you think is incorrect or believe that something important is missing, you can ask us to amend (add information to) your

records, although in some rare situations we don't have to agree to do that. If you want, our privacy officer, whose name is at the end of this notice, can explain more about this.

C. Privacy and the laws about privacy

We are required to tell you about privacy because of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requires us to keep your PHI private and to give you this notice about our legal duties and our privacy practices. We will obey the rules described in this notice. If we change our privacy practices, they will apply to all the PHI we keep. We will also post the new notice of privacy practices in our office where everyone can see. You or anyone else can also get a copy from our privacy officer at any time.

D. How your protected health information can be used and shared

Except in some special circumstances, when we use your PHI in this office or disclose it to others, we share only the **minimum necessary** PHI needed for those other people to do their jobs. The law gives you rights to know about your PHI, to know how it is used, and to have a say in how it is shared. So we will tell you more about what we do with your information.

Mainly, we will use and disclose your PHI for routine purposes to provide for your care, and we will explain more about these below. For other uses, we must tell you about them and ask you to sign a written authorization form. However, the law also says that there are some uses and disclosures that don't need your consent or authorization.

1. Uses and disclosures with your consent

After you have read this notice, you will be asked to sign a separate **consent form** to allow us to use and share your PHI. In almost all cases we intend to use your PHI here or share it with other people or organizations to provide treatment to you, arrange for payment for our services, or some other business functions called "health care operations."

In other words, we need information about you and your condition to provide care to you. You have to agree to let us collect the information, use it, and share it to care for you properly. Therefore, you must sign the consent form before we begin to treat you. If you do not agree and consent we cannot treat you.

a. The basic uses and disclosures: For treatment, payment, and health care operations

Next we will tell you more about how your information will be used for treatment, payment, and health care operations.
For treatment. We use your medical information to provide you with psychological treatments or services. These might include individual, family, or group therapy; psychological, educational, or vocational testing; treatment planning; or measuring the benefits of our services.

We may share your PHI with others who provide treatment to you. We are likely to share your information with your personal physician. If you are being treated by a team, we can share some of your PHI with the team members, so that the services you receive will work best together. The other professionals treating you will also enter their findings, the actions they took, and their plans into your medical record, and so we all can decide what treatments work best for you and make up a treatment plan. We may refer

you to other professionals or consultants for services we cannot provide. When we do this, we need to tell them things about you and your conditions. We will get back their findings and opinions, and those will go into your records here. If you receive treatment in the future from other professionals, we can also share your PHI with them. These are some examples so that you can see how we use and disclose your PHI for treatment.

For payment. We may use your information to bill you, your insurance, or others, so we can be paid for the treatments we provide to you. We may contact your insurance company to find out exactly what your insurance covers. We may have to tell them about your diagnoses, what treatments you have received, and the changes we expect in your conditions. We will need to tell them about when we met, your progress, and other similar things.

For health care operations. Using or disclosing your PHI for health care operations goes beyond our care and your payment. For example, we may use your PHI to see where we can make improvements in the care and services we provide. We may be required to supply some information to some government health agencies, so they can study disorders and treatment and make plans for services that are needed. If we do, your name and personal information will be removed from what we send.

b. Other uses and disclosures in health care
Appointment reminders. We may use and disclose your PHI to reschedule or remind you of appointments for treatment or other care. If you want us to call or write to you only at your home or your work, or you prefer some other way to reach you, we usually can arrange that. Just tell us.
Treatment alternatives. We may use and disclose your PHI to tell you about or recommend possible treatments or alternatives that

may be of help to you. *Other benefits and services*. We may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.
Research. We may use or share your PHI to do research to improve treatments —for example, comparing two treatments for the same disorder, to see which works better or faster or costs less. In all cases, your name, address, and other personal information will be removed from the information given to researchers. If they need to know who you are, we will discuss the research project with you, and we will not send any information unless you sign a special authorization form.

Business associates. We hire other businesses to do some jobs for us. In the law, they are called our "business associates." Examples include a copy service to make copies of your health records, and a billing service to figure out, print, and mail our bills. These business associates need to receive some of your PHI to do their jobs properly. To protect your privacy, they have agreed in their contract with us to safeguard your information.

2. Uses and disclosures that require your authorization
   If we want to use your information for any purpose besides those described above, we need your permission on an **authorization form.** We don't expect to need this very often. If you do allow us to use or disclose your PHI, you can cancel that permission in writing at any time. We would then stop using or dis- closing your information for that purpose. Of course, we cannot take back any information we have already disclosed or used with your permission.

3. Uses and disclosures that don't require your consent or authorization The law lets us use and disclose some of your PHI without your consent or authorization in some cases.

Here are some examples of when we might do this.
a. When required by law There are some federal, state, or local laws that require us to disclose PHI:

- We have to report suspected child abuse.

- If you are involved in a law suit or legal proceeding, and we receive a subpoena, discovery request, or other lawful process, we may have to release some of your PHI. We will only do so after trying to tell you about the request, consulting your lawyer, or trying to get a court order to protect the information they requested.

- We have to disclose some information to the government agencies that check on us to see that we are obeying the privacy laws.

b. For law enforcement purposes

We may release medical information if asked to do so by a law enforcement official to investigate a crime or criminal.

c. For public health activities
We may disclose some of your PHI to agencies that investigate diseases or injuries.

d. Relating to descendants
We may disclose PHI to coroners, medical examiners, or funeral directors, and to organizations relating to organ, eye, or tissue donations or transplants.

e. For specific government functions
We may disclose PHI of military personnel and veterans to government benefit programs relating to eligibility and

enrollment. We may disclose your PHI to workers' compensation and disability programs, to correctional facilities if you are an inmate, or to other government agencies for national security reasons.

f. To prevent a serious threat to health or safety

If we come to believe that there is a serious threat to your health or safety, or that of another person or the public, we can disclose some of your PHI. We will only do this to persons who can prevent the danger.

4. Uses and disclosures where you have an opportunity to object
We can share some information about you with your family or close others. We will only share information with those involved in your care and anyone else you choose, such as close friends or clergy. We will ask you which persons you want us to tell, and what information you want us to tell them, about your condition or treatment. You can tell us what you want, and we will honor your wishes as long as it is not against the law.

If it is an emergency, and so we cannot ask if you disagree, we can share information if we believe that it is what you would have wanted and if we believe it will help you if we do share it. If we do share information, in an emergency, we will tell you as soon as we can. If you don't approve we will stop, as long as it is not against the law.

5. An accounting of disclosures we have made
When we disclose your PHI, we may keep some records of whom we sent it to, when we sent it, and what we sent. You can get an accounting (a list) of many of these disclosures.

E. Your rights concerning your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or with payment for your care, such as family members and friends. We don't have to agree to your request, but if we do agree, we will honor it except when it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you. Contact our privacy officer to arrange how to see your records. (See below.)

4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writ- ing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this notice, we will post the new one in our wait- ing area, and you can always get a copy from the privacy officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

You may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

F. If you have questions or problems

If you need more information or have questions about the privacy practices described above, please speak to the privacy officer, whose name and telephone number are listed below. If you have a problem with how your PHI has been handled, or if you believe your privacy rights have been violated, contact the privacy officer. As stated above, you have the right to file a complaint with us and with the Secretary of the U.S. Department of Health and Human Services. We promise that we will not in any way limit your care here or take any actions against you if you complain.

If you have any questions or problems about this notice or our health information privacy policies, please contact our privacy officer, who is and can be reached by phone at 917-609-705 or by e-mail at .

The effective date of this notice is 11/22/2017.

Ovitz Psychotherapy Associates, LLC

525 Route 73 North, Suite 104

(Five Greentree Centre, Suite 104)

Marlton, NJ 08053

917-609-67056

Client Bill of Rights

You have the right to:

- Get respectful treatment that will be helpful to you.
- Have a safe treatment setting, free from sexual, physical, and emotional abuse.
- Report immoral and illegal behavior by a therapist.
- Ask for and get information about the therapist's qualifications, including his or her license, education, training, experience, membership in professional groups, special areas of practice, and limits on practice.

- Have written information, before entering therapy, about fees, method of payment, insurance coverage, number of sessions the therapist thinks will be needed, substitute therapists (in cases of vacation and emergencies), and cancellation policies.

- Refuse audio or video recording of sessions (but you may ask for it if you wish).

- Refuse to answer any question or give any information you choose not to answer or give.

- Know if your therapist will discuss your case with others (for instance, supervisors, consultants, or students).

- Ask that the therapist inform you of your progress.

Acknowledgement of Receipt of Privacy Practice Notice

By signing below, I hereby acknowledge receiving and reviewing Kenneth Ovitz's Notice of Privacy Practices and Limits of Confidentiality.

____ ______

Client's Name (print) Date

____

Kenneth Ovitz L.C.S.W.
Ovitz Psychotherapy Associates, LLC
525 Route 73 North, Suite 104 Marlton, NJ 08053
917-609-7056
kennethovitzlcsw@gmail.com

Policy on Communication between sessions

Holiday, Weekend and Evening Contact

Kenneth Ovitz LCSW will make every effort to return a call, email or text message of a **non-emergency** client message within 24 hours during a scheduled work week. If this call, text or email arrives during a holiday, weekend or evening, Kenneth Ovitz LCSW will return **the non-emergency** client contact during the first working day following the holiday, weekend or evening. For **emergency only** clients (*emergency constitutes imminent danger to self or others*) Kenneth Ovitz LCSW will make every effort to return the call, text or email within 24 hours and ask that if the client is facing a life threatening emergency that they call **911 immediately**. There will be a regular session fee or partial session fee for emergency phone calls and sessions that are in excess of 5 minutes, or more than 1 time per month.

Explanation of Dual Relationships

While a therapeutic relationship can feel psychologically close, it is one that is professional in nature with important boundaries. It is unethical for a therapist to invite you into a business venture, ask you for personal favors, start a social relationship with you, etc. These examples are called, “dual relationships” and can negatively impact clinical boundaries. Although our sessions may be intimate psychologically, it is important to acknowledge that we have a strictly professional relationship. On the rare occasion that your therapist sees a client outside of the office (or you may accidentally run into each other in public), your therapist will be highly discreet and will maintain your confidentiality and will therefore not acknowledge you.

Policy Regarding Internet, Professional, and/or Social Networking Sites

On the topic of Social Media and Internet Sites, our primary concern is your privacy. Please do not follow your therapist on social media of any kind. If there are things from your online life that you wish to share with your therapist, please bring them into your sessions where they can be viewed and explored together, during the therapy hour.

Please do not use messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact your therapist. These sites are not secure and messages may not be read in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with your therapist publicly online if we have an already established client/therapist relationship. Engaging 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. If you need to contact your therapist between sessions, please do so directly via email. See the email section below for more information regarding email interactions.

Email Policy

It is preferred that email only be used to arrange or modify appointments. **Please do not email content related to your therapy sessions unless you and your therapist agree that it is clinically appropriate to do so and the information does not jeopardize your confidentiality. As a general rule, please do not email letters to read, blogs, videos, as email is not completely secure or confidential.** If you choose to communicate by email, be aware that all emails are retained in the logs of your and your therapist's Internet service providers.

While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of Internet service providers. You should also know that any emails received from you and any responses that sent to you become a part of your legal and medical record.

"Friending"

It is a policy that Kenneth Ovitz LCSW will not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when you meet with your therapist to discuss further.

Google Reader and Other Related Forums

Your therapists does not follow current or former clients on Google Reader and does not use Google Reader to share articles. If there are things you want to share with your therapist that you feel are relevant to your treatment, whether they are news items or things you have created, we encourage you to bring these items of interest into our sessions.

Thank you for taking the time to review the Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to your therapist's attention so that we can discuss them.

Your initials indicate that you understand and agree to these boundaries regarding the social media and online policy:
______________ (Initial here)

Physical Contact

Sexual contact is never acceptable in the therapeutic relationship. While it is the aim of therapy to help you to feel comfortable to talk about problem issues some of which includes sex, romance, and explicit language, it is not acceptable to engage in a romantic or sexual relationship with your therapist. Please be aware that you are welcome to and encouraged to discuss problems and issues and you are welcome to use whatever language you choose to do so. It is crucial that the relationship you have with your therapist (Kenneth Ovitz LCSW) is a therapeutic one and therefore please keep your comments directed on you or please discuss problems you are having in doing so. Please know that sometimes sexual comments or references you make may shed light on your beliefs and perceptions. When this happens your therapist will explore your comment professionally and in a non-shaming way within a therapeutic non-sexual relationship.

Illness Policy

When a private practice therapist is consistently exposed to cold and flu viruses in the office and becomes ill as a result, the office closes down, sessions and groups are cancelled, and everyone suffers. In order to maintain good health and create a safe and relatively germ free environment so that your therapist can support all of his clients, we ask that clients who are experiencing any stage of illnesses to respect safety boundaries and to conduct their sessions via phone until they are recovered completely and are not experiencing any signs of illness, fever, rash or cough or contagious symptoms at any stage.

Stage of illness includes: starting to feel flu symptoms, suspect they may be coming down with the flu, dealing with a current cold, head cold, or flu or flu-like symptoms, or are at the end of a flu cycle, currently have the flu, a cough, a cold, pink eye, contagious

rashes, scabies, lice, chicken pox (or a child with chicken pox), or any other potentially contagious illnesses no matter how mild. Your therapist will extend the same respect and consideration if ill.

Please review the following illness agreement and initial:
If I am ill with a head cold, flu, lice, virus, chicken pox, pink eye, scabies, or any other potentially contagious illness at any stage no matter how mild that would potentially expose my therapist or others in the therapy office, I agree to alert my therapist, and either reschedule my session by the 24**-hour cancellation time period**, or agree to conduct my individual therapy session via phone if I am ill, feel as if I am becoming ill, or am at the end of a flu virus. ___________ (Initial here)

I understand that my therapist may, on the rare occasion, ask that my session be conducted via phone if she is ill or recovering from a contagious flu virus. _____________ (Initial here)

I understand that if I choose to show up for my therapy session, couples session or group session at any stage of a contagious flu virus or other illness, my therapist will use discretion, will uphold safety boundaries, and will ask me to leave the office, conduct the session via phone from my car, or another area outside of the clinical office as not to expose himself/herself, colleagues, or other clients to my flu virus at any stage. _____________ (Initial here)

I understand that my fee will apply to all sessions that are not cancelled by 24 hours prior to my scheduled session. On the rare occasion that an emergency or grave illness occurs that does not allow me to give 24 hours notice, special consideration will be extended. Otherwise the session will be conducted via phone and the fee will stand _____________ (Initial here)

_______________________________________ ____

Signature of Client Date

Suicide Policy

If you are suicidal, your therapist will take all reasonable steps to prevent harm to yourself. This may include breaking confidentiality if you pose a serious risk of self-harm to yourself. Your signature indicates that you have read and understand confidentiality and limits to confidentiality:

Client's signature: Date:

Emergency Contact Information

In the event of an emergency, please provide a contact person:

Name____

Relationship__________________________**Phone**_______

______________________________ ________