family connections
WHERE HOPE MEETS POSSIBILITY

Client Rights

Please note your rights as a consumer of Family Connections Services:

1. You have the right to be informed of these rights, and receive a written explanation of these rights.
2. The right to be free from unnecessary or excessive medication (see NJAC 10:37-6.54).
3. The right to be notified of any rules and policies the program has established governing client conduct in the facility.
4. The right to not be subjected to non-standard treatment or procedures, experimental procedures or research, or provider demonstration programs, without written informed consent. If the client has been adjudicated incompetent, authorization for such procedures may be obtained only pursuant to the requirements of NJSA 30:4-24.2(d)2.
5. You have the right to be informed of services available in the program, the names and professional status of the staff providing and/or responsible for your care, fees and related charges for services not covered by insurance.
6. You have the right to receive an explanation of your complete medical/health condition or diagnosis, recommended treatment, progress, treatment options including the option-of no treatment, risk(s) of treatment and expected result(s) of treatment:
    - The Psychiatrist or Director may determine this information may place a client at risk, the explanation shall be provided to a family member, legal guardian, or significant other as available.
    - A release of information to a family member, legal guardian or significant other, along with the reason for not informing the client directly, shall be documented in the client's clinical record
    - All consents to release information shall by signed by client or their parent, guardian or legally authorized representative.
7. You have the right to privileged communications with those who treat you; information you provide may not be disclosed unless you consent.
    - your clinical record shall not be released to anyone outside the program without your written approval to release the information in accordance with the Federal statutes and rules for the Confidentiality of Alcohol and Drug Abuse Client Records, unless the release of information is required and permitted by law, a third-party contract, a peer review, or information needed by DAS for authorized purposes.
    - This program may release data about you for studies containing data only when your identity is protected and masked.
8. You have the right to be informed if the program has authorized other health care or educational institutions to participate in your treatment and have the right to refuse their involvement into your treatment.
9. The right to treatment in the least restrictive setting, free from physical restraints, corporal punishment, and isolation.
10. You have the right to be treated with courtesy, consideration, respect, and with recognition of your dignity, individuality and right to privacy, including but not limited to auditory a11d visual privacy;

11. You have the right to exercise civil and religious liberties, including the right to independent personal decisions.
12. You have the right to not be discriminated against because of age, race, religion, sex, nationality, sexual orientation, disability (including, but not limited to, blind, deaf, hard of hearing), or ability to pay; or to be deprived of any constitutional, civil, and/or legal rights.
13. The right to refuse medication, treatment, and/or decline the recommendation of treatment made by this agency.
    - You will not be discriminated against for taking medications as prescribed.
    - Prescribed medications shall not be withheld for failure to com ply with facility rules or procedures, unless the decision is made to terminate the client; medications may only be withheld when the facility medical staff determines that such action is medically indicated
14. The right to participate in the development of your treatment plan.
15. The right to access and obtain a copy of your record, in accordance with agency policies and applicable federal and state laws: you have a right to add to or request a modification of your treatment record.
16. You have the right to be transferred or discharged only for medical reasons, for your welfare, that of other clients or staff upon the written order of a physician or licensed clinician, or failure to pay required fees as agreed at time of admissions (except as prohibited by sources of third-party payment)
17. Your transfer and/or discharge, and the reason will be documented in your clinical record
18. You will receive 10 day advance notice of such transfer/discharge for non-emergency discharges planned by the treatment program.
19. You have the right to be notified in writing, and to have the opportunity to appeal, an involuntary discharge
20. You have the right to voice grievances or recommend changes in policies and services to program staff, the governing authority; and/or outside representatives of your choice, free from restraint, interference, coercion, discrimination or reprisal

Family Connections retains the right to admit and treat only those clients who are appropriate to the agency's mission, capacity and resources.

Family Connections is a smoke free environment

Resolving Problems

Any problem that may arise between you and your clinician or the agency should be discussed with your clinician. The majority of problems are best resolved this way. However, if you feel this arrangement did not settle the problem you may then call or write the Program Manager who will then discuss the problem with you.

You may also contact the following at any point in time:

1. The Director for Outpatient Services at Family Connections, **973-675-3817**.
2. The Executive Director of Family Connections, **973-323-3439**.
3. The Essex County Mental Health Administrator, Essex County Hospital, 204 Cedar Grove Road, Cedar Grove, NJ 07009, **973-571-2821**.
4. The Division of Mental Health Services, Northern Region, 100 Hamilton Plaza, Suite 615 Box 4 Hudson United Building, Paterson, NJ 07505, **973-977-4397**
5. NJ Protection and Advocacy, Inc. 210 Broad St. Trenton, NJ 08608, **1-800-922-7233** or **609-292-9742**
6. Division of Child Protection and Permanency Essex County 153 Halsey St., 3rd Floor, Newark, NJ 07101, **973-648-7275** or **1-800-792-8610**.
7. Adult Protective Services, 441 Broad St, Newark, NJ 07102, **973-624-2528 ext. 135**.

8. Community Health Law Project; 650 Bloomfield Ave, Bloomfield, NJ 07003, **973-275-1175**.
9. Department of Children and Families Office of Advocacy **1-877-543-7864**.
10. Division of Mental Health Advocacy **609-826-5057.**
11. For Allegations of Non Compliance: Office of the Chief DCF-Office of Oversight and Monitoring; Office of Licensing. P.O. Box 717; Trenton, NJ 08625-0717**, 1-877-667- 9845**.
12. NJ Child Abuse Hotline; **1-877-NJ-ABUSE (1-877-652-2873).**
13. DMHAS Complaint Hotline, **1-877-712-1868**.
14. If you believe you have been discriminated against on the basis of race, creed, national origin, age, handicap or sex, you may present a complaint to: The Federal Office for Civil Rights, 26 Federal Plaza, Room 3311 New York, NY 10278

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Counseling Disclosure

In accordance with the New Jersey Office of the Attorney General, Division of Consumer Affairs State Boards of Marriage and Family Therapy Examiners, Alcohol and Drug Counselor Committee, Professional Counselor Examiners Committee, and Social Work Examiners (hereinafter referred to as "the State licensing body") Statutes and Regulations, Family Connections Inc., has advised me of the following:

In accordance with Regulations 13:34-3.3, 13:34C-3.2(e),13:34C-13.1(g), and 13:44G-3.1, I understand that I may receive counseling services from a staff member who is not a Licensed Clinical Alcohol and Drug Counselor, Licensed Marriage & Family Therapist, Licensed Professional Counselor, or Licensed Clinical Social Worker; however is a Licensed Associate Counselor, Associate Marriage & Family Therapist, Licensed Social Worker in the State of New Jersey, or an intern enrolled in a master's degree program in any of these professions. Furthermore, I understand that this individual shall remain under the clinical supervision of an appropriately licensed/certified supervisor as per Regulations 13:34-3.3(b), 13:34C-6.2(c), 13:34-13.1(g), and 13:44G-8.1(g).

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Fee Agreement

The fee for this intake appointment is:

$

The fee for counseling services for you and your family per session will be:

$

If any family member is scheduled for a psychiatric evaluation or psychological testing, there will be an additional fee and you will be notified in advance.

Once the counseling service is offered, a special time is set aside for you. It is extremely important that you keep your appointment. Missed appointments become wasted time, prevent others from receiving counseling, and add to the cost of the service. If you cannot keep your appointment, please call 24 hours in advance so that your time can be offered to someone else. On-going service cannot be provided for someone who tends to miss appointments.

It is expected that payment be made at the time of each visit. Family Connections does bill appointments that are missed or cancelled without 24 hours notice. Non-payment of fees may result in termination of services.

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Consent to Use and Disclose Health Information

By signing this form, I consent to the use and disclosure of my protected health information (PHI) by my provider, Family Connections, Inc., its staff, and its business associates for the purposes of treatment/services, payment, and health care operations. This is a joint consent form of Family Connections, Inc. and its clinical/direct service staff. This consent will remain in effect for a year following the signature of this consent during which services are being provided by Family Connections, Inc. to you. After a year, this consent will be considered expired, a new Consent will be reviewed with you.

I understand that this information may be needed to:

- Plan my care and treatment;
- Communicate among the various health care professionals within Family Connections, Inc. who are involved in my care;
- Assess the quality of my care and review the care provided to me by my clinicians and their staff;
- Provide information to those paying for my services- specified below;
- Obtain payment from those paying for my services- specified below.

My services are being paid for by:

- ☐ Medicaid
- ☐ Medicare
- ☐ DCPP
- ☐ Grant funding from government (e.g., state, county, etc.)
- ☐ Other

If Other, please specify:

I understand that my signature on this Consent is required in order for me to receive care from my provider.

I also understand that I have the right to revoke this Consent, in writing, at any time, except to the extent that my provider has taken action in reliance upon this Consent.

I further understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, and health care operations of my provider. I realize that my

provider is not required to agree to a restriction that I may request. However, if my provider does agree, the provider must honor the restriction.

My provider agrees to maintain my protected health information in accordance with the practices described in its notice of privacy practices. this notice also describes my rights with respect to the use and disclosure of my protected health information.

I understand that I have a right to review the notice of privacy practices prior to signing this Consent. I acknowledge that I have been provided with a copy of my providers notice of privacy practices and I have been given an opportunity to review the notice of privacy practices prior to signing this Consent. My provider reserves the right at any time to change the privacy practices described in the notice of privacy practices. I understand that I can obtain a copy of the revised notice by accessing the website address www.familyconnectionsnj.org or by requesting one at any future appointment. The notice of privacy practice is also posted in our waiting room.

This consent will remain in effect during the time services are being provided by Family Connections, Inc. for up to a year unless indicated otherwise. In addition, if services are discontinued and start again at a later date, Family Connections will have access to those previous records.

Communication Preferences

Below are my preferences to receive communications from Family Connections. I understand that I may change these preferences at any time.

Communication Authorizations
I consent to receive communications from Family Connections through the following (check all that apply):

- ☐ Phone
- ☐ Voicemail
- ☐ Mail
- ☐ Email (I understand that these email communications are not encrypted. I also understand that Family Connections email addresses will be identified in all email communications)
- ☐ Text (I understand that standard messaging rates may apply)

OK to Identify as Family Connections
OK to identify as Family Connections through the following communications (check all that apply):

- ☐ Phone
- ☐ Voicemail
- ☐ Mail
- ☐ Text
- ☐ Do not identify as Family Connections in any communications (does not apply to email, if consented)

Communication Restrictions
Restrictions, if any, agreed to by the provider regarding the use of and disclosure of health information or method of communications: (please describe in this section)

Integrated Assessment and Treatment Authorization

I authorize the staff at Family Connections, Inc to assess and/or treat:

Client Name _____

Document Date

Integrated Assessment and Treatment Authorization

I have been given a general overview of the services rendered by Family Connections, Inc., and authorize assessment and/or any recommended treatment services that may be offered. I affirm that my participation in assessment and/or treatment is voluntary and that I understand I may refuse services at any time. I agree that participation in assessment services does not guarantee that treatment services will be offered, and does not create a patient/therapist or client relationship.

I understand that with all forms of treatment, there are benefits as well as risks. I acknowledge that no guarantees have been made to me as to the result of my assessment or treatment, and understand that compliance with treatment recommendations is necessary for maximum benefit.

This authorization will remain in effect during the time assessment and treatment services are being provided by Family Connections, Inc.

For clients under the age of 18, the signature of a parent or legal guardian is required.

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Safety Zone Agreement

For Everyone's Safety and Mutual Respect,

Family Connections is a:

Gang-Free
Weapons- Free
Violence-Free
Substance-Free
Zone

Both indoors and outdoors on Family Connections' property, I agree to the following policies:

- No gang-related clothing, attire, accessories, hand signs, gestures, walks, dances or other verbal or physical signals of gang affiliation
- No illegal drugs, alcohol, or prescription medication without a prescription
- No one under the influence of legal or illegal drugs or alcohol
- No weapons
- No physical violence or threats of physical violence

I further agree to explain this policy in advance to anyone who comes with me to Family Connections.

I understand that anyone who violates this policy may be asked to leave the property and that repeat offenders may not be able to get services at Family Connections. I also understand that this policy is for everyone's safety and mutual respect.

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Notice of Privacy Practices

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

If you have any questions about this Privacy Notice, please discuss them with your clinician. If you still have questions, you may also contact our Privacy Officer at 973-675-3817.

I. Introduction

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information we maintain about you and a brief description of how you may exercise these rights. This Notice further states the obligations we have to protect your health information. It is our duty to maintain the privacy of PHI, to abide by the terms of the privacy notice currently in effect and to provide individuals with notice of its legal duties and privacy practices relative to PHI.

"Protected health information" means health information (including identifying information about you) we have collected from you or received from your health care providers, health plans, your employer or a health care clearinghouse. It may include information about your past, present or future physical or mental health or condition, the provision of your health care, and payment for your health care services.

II. How We Will Use and Disclose Your Health Information

We will use and disclose your health information as described in each category listed below. For each category, we will explain what we mean in general, but not describe all specific uses or disclosures of health information.

A. Uses and Disclosures That May Be Made with Your Written Consent

1. **For Treatment.** Upon signing our Treatment Authorization and Consent Form, we may use and disclose your health information within Family Connections. to provide your health care and any related services. For example, we may use and disclose your health information among our staff to coordinate recommended services.
2. **For Payment.** We may use or disclose your health information so that the treatment and services you receive are billed to, and payment is collected from, your health plan or other third party payer. For

example, we may disclose your health information to permit your health plan to take certain actions before your health plan approves or pays for your services. These actions may include:

- making a determination of eligibility or coverage for health insurance;
- reviewing your services to determine if they were medically necessary;
- reviewing your services to determine if they were appropriately authorized or certified in advance of your care; or
- reviewing your services for purposes of utilization review, to ensure the appropriateness of your care, or to justify the charges for your care.

3. **For Health Care Operations.** We may use and disclose health information about you for our operations. These uses and disclosures are necessary to run our organization and make sure that our consumers receive quality care. These activities may include, by way of example, quality assessment and improvement, reviewing the performance or qualifications of our clinicians, training students in clinical activities, licensing, accreditation, and development, and general administrative activities.

We may combine health information of many of our consumers to decide what additional services we should offer, what services are no longer needed, and whether certain new treatments are effective. We may also combine our health information with health information from other providers to compare how we are doing and see where we can make improvements in our services. When we combine our health information with information of other providers, we will remove identifying information so others may use it to study health care or health care delivery without identifying specific clients.

We may also use and disclose your health information to contact you to remind you of your appointment.

B. Uses and Disclosures That May be Made Without Your Consent, Authorization or Opportunity to Object.

1. **Emergencies.** We may use and disclose your health information in an emergency treatment situation. By way of example, we may provide your health information to a paramedic who is transporting you in an ambulance.
2. **As Required by Law.** We will disclose health information about you when required to do so by federal, state or local law.
3. **To Avert a Serious Threat to Safety.** We may use and disclose health information about you when necessary to prevent a serious and imminent threat to your safety or to the safety of the public or

another person. Under these circumstances, we will only disclose health information to someone who is able to help prevent or lessen the threat.

4. **Abuse and Neglect Authorities.** We will report child abuse or neglect and elder abuse as required by law to report such abuse, neglect or domestic violence.
5. **Health Oversight Activities.** We may disclose health information about you to a health oversight agency for activities authorized by law. Oversight agencies include government agencies that oversee the health care system, government benefit programs such as Medicare or Medicaid, other government programs regulating health care, and civil rights laws.
6. **Disclosures in Legal Proceedings.** We may disclose health information about you when we are court ordered to do so by a judge.
7. **Law Enforcement Activities.** We may disclose health information to a law enforcement official for law enforcement purposes when:
    - we report criminal conduct occurring on the premises of our facility; or
    - we determine that the law enforcement purpose is to respond to a threat of an imminently dangerous activity by you against yourself or another person; or
    - the disclosure is otherwise required by law.
8. **Medical Examiners.** We may provide health information to a medical examiner. Medical examiners are appointed by law to assist in identifying deceased persons and to determine the cause of death in certain circumstances.
9. **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official.
10. **Workers' Compensation.** We may disclose health information about you to comply with the state's Workers' Compensation Law, provided we have an Authorization for Release of Information.

III. Uses and Disclosures of Your Health Information with Your Permission.

Uses and disclosures not described in Section II of this Notice of Privacy Practices will generally only be made with your written permission, called an "authorization." You have the right to revoke an authorization at any time. If you revoke your authorization we will not make any further uses or disclosures of your health information under that authorization, unless we have already taken an action relying upon the uses or disclosures you have previously authorized.

IV. Your Rights Regarding Your Health Information.

A. Right to Inspect and Copy.

You have the right to request an opportunity to inspect or copy health information used to make decisions about your care – whether they are decisions about your treatment or payment of your care. You must submit your request in writing with a brief explanation for purpose to your treating counselor or physician. If you request a copy of the information, we may charge a fee for the cost of copying, mailing and supplies associated with your request.

We may deny your request to inspect or copy your health information in certain limited circumstances. In some cases, you will have the right to have the denial reviewed by a licensed health care professional not directly involved in the original decision to deny access. We will inform you in writing if the denial of your request may be reviewed. Once the review is completed, we will honor the decision made by the licensed health care professional reviewer.

B. Right to Amend.

For as long as we keep records about you, you have the right to request us to amend any health information used to make decisions about your care – whether they are decisions about your treatment or payment of your care. To request an amendment, you must submit a written document to our Privacy Officer and tell us why you believe the information is incorrect or inaccurate.

If we deny your request to amend, we will send you a written notice of the denial stating the basis for the denial and offering you the opportunity to provide a written statement disagreeing with the denial. If you do not wish to prepare a written statement of disagreement, you may ask that the requested amendment and our denial be attached to all future disclosures of the health information that is the subject of your request.

If you choose to submit a written statement of disagreement, we have the right to prepare a written rebuttal to your statement of disagreement. In this case, we will attach the written request and the rebuttal (as well as the original request and denial) to all future disclosures of the health information that is the subject of your request.

C. Right to an Accounting of Disclosures.

You have the right to request that we provide you with an accounting of disclosures we have made of your health information. But this list will not include certain disclosures of your health information, by way of example, those we have made for purposes of treatment, payment, and health care operations. To request an accounting of disclosures, you must submit your request in writing to the Privacy Officer.

D. Right to Request Restrictions.

You have the right to request a restriction on the health information we use or disclose about you for treatment, payment or health care operations. You may also ask that any part (or all) of your health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in Section II(B)(2) of this Notice of Privacy Practices.

To request a restriction, you must either include it (with our approval) in the Consent for Use or Disclosure Form or request the restriction in writing addressed to the Privacy Officer.

E. Right to Request Confidential Communications.

There may be circumstances warranting communication with you, for example, rescheduling of an appointment or providing an appointment reminder. You have the right to request that we communicate with you about your health care only in a certain location or through a certain method. For example, you may request that we contact you only at work or by telephone.

To request such a confidential communication, you must make your request in writing to your counselor or doctor treating you. You do not need to give us a reason for the request; but your request must specify how or where you wish to be contacted.

F. Right to a Paper Copy of this Notice.

You have the right to obtain a paper copy of this Notice of Privacy Practices at any time.

V. Confidentiality of Substance Abuse Records

For individuals who have received treatment, diagnosis or referral for treatment from our drug or alcohol abuse programs, the confidentiality of drug or alcohol abuse records is protected by federal law and regulations. As a general rule, we may not tell a person outside the programs that you attend any of these programs, or disclose any information identifying you as an alcohol or drug abuser, unless:

- you authorize the disclosure in writing; or
- the disclosure is permitted by a court order; or
- the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation purposes; or
- you threaten to commit a crime either at the drug abuse or alcohol program or against any person who works for our drug abuse or alcohol programs.

A violation by us of the federal law and regulations governing drug or alcohol abuse is a crime. Suspected violations may be reported to the Unites States Attorney in the district where the violation occurs.

Federal law and regulations governing confidentiality of drug or alcohol abuse permit us to report suspected child abuse or neglect under state law to appropriate state or local authorities.

Please see 42 U.S.C. § 290dd-2 for federal law and 42 C.F.R., Part 2 for federal regulations governing confidentiality of alcohol and drug abuse patient records.

VI. Communication Preferences

For those clients/consumers who have consented to receive emails from Family Connections, please note that FC cannot guarantee the security and confidentiality of an email transmission. If your email is a family address, other family members may see your messages, therefore, please be aware that you e-mail at your own risk. Because of the many internet and e-mail factors beyond our control, we cannot be responsible for misaddressed, misdelivered or interrupted e-mail. FC is not liable for breaches of confidentiality caused by yourself or a third party. Email is best suited for routine matters and simple questions and should not be used for treatment purposes or sensitive information. You should not send us e-mail for urgent or emergency situations or for matters requiring an immediate response.

VII. Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, contact our Compliance Officer. There will be no retaliation against the individual if a complaint is made.

VII. Changes to this Notice

We reserve the right to change the terms of our Notice of Privacy Practices. We also reserve the right to make the revised or changed Notice of Privacy Practices effective for all health information we already have about you as well as any health information we receive in the future. We will post a copy of the current Notice of Privacy Practices at each site where we provide care. You may also obtain a copy of the current Notice of Privacy Practices by accessing our website at www.familyconnectionsnj.org or by asking for one any time you are at our offices.

VIII. Who will follow this Notice

All locations comprising Family Connections. will follow this notice. In addition, these entities site or locations may share health information with each other for treatment, payment or health care operation purposes.

395 S. Center St. Orange, NJ 07050

Consumer Financial Policy

Consumer agrees to pay for all services due in full at the time services are provided by our office.

Consumer Financial Policies:

You are required to present a valid insurance card at every visit and as needed throughout your care. You are responsible to inform FAMILYConnections of changes in your insurance.

You reserve the right to opt out of using contracted insurance and accept full financial responsibility for services rendered. In this circumstance, you are required to complete a waiver and provide payment in full for services at the time you receive the services.

Commercial Insurance Carriers: You are responsible for providing referrals and pre-authorizations if required by your insurance company. We bill in-network insurance carriers for you. Any outstanding balances, co-payments, and deductibles are due prior to checking in for your appointments. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid, fees are due and payable in full from you.

Medicare: Certain providers in our group are Medicare participating providers and we will bill Medicare for you. Any outstanding balances for deductibles, co-insurance, or noncovered services will be due as service is rendered.

Medicaid: Our office is a Medicaid participating provider and we will bill Medicaid for you.

Out-of-Network: If we are out of network with your insurance carrier, you are responsible to pay your fee at the time of service. You may submit your claims to your insurance company for reimbursement.

Payments and Collections:
Consumer balance statements will be sent monthly. Please pay any balances received by statement within 15 days to keep your account in good standing. Requests to setup a payment plan may be addressed to the Manager of Revenue Cycle. Unpaid balances may jeopardize your status as a client and your case may be closed. Our office accepts the following payment methods: cash, personal check. For returned checks, we assess a $25 insufficient funds charge.

If not paid according to terms, the consumer understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, consumer agrees to pay all additional fees assessed in the collection of the debt. These fees include collection agency fees and attorney fees.

The consumer is ultimately responsible for all fees for services. I have read, understood, and agreed to the above financial policy for payments of professional fees.

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Consumer Guide

Thank you for choosing FAMILYConnections. FAMILYConnections is dedicated to helping adults, children, and families who are experiencing difficulty in their lives and struggle with resulting emotional, behavioral and substance use problems, or who may have long-standing psychiatric conditions. This guide is designed to answer some of the more commonly asked questions that arise about therapy/ counseling services, medication, consumer responsibilities, emergency situations, and insurance.

WHAT IS THERAPY?

Therapy (often referred to as psychotherapy, counseling therapy, or counseling) is a treatment that helps people cope with distressing emotions or life circumstances, and make improvements in their lives. Our consumers share their experiences with a caring professional (therapist, counselor, clinician), who helps them understand and manage their reactions to stressful or painful situations. Together, the consumer and therapist work together to develop coping skills and strategize solutions.

Depending on the presenting problem(s) therapy is provided:

- Individually; **and/or**
- with partners or other family members participating some or all of the time, **and/or**
- in groups of people who share similar problems and could benefit from mutual support and problem-solving under the guidance of the therapist.

When problems involve a child or adolescent, some level of family participation is recommended. Our staff regularly consults with each other regarding cases, in order to provide the best possible care.

WHAT CAN YOU EXPECT FROM THERAPY?

1. It will take time to feel completely comfortable talking about your problems.
2. Weekly appointments; approximately 45-60 minutes per individual session.
3. Working together on goals and an understanding of when treatment is completed.
4. Change in some—but not all—of your problems. You can use what you learn in therapy to address future problems.
5. You will be asked to apply the coping strategies you learn during treatment between sessions; and,
6. Confidentiality. No information about you may be given out without your consent unless allowed or required by law.

CONSUMER RESPONSIBILITIES

1. ATTENDANCE

Attending every appointment, on time, is vital to the success of your therapy. Repeated missed or cancelled appointments diminish the effectiveness of therapy and prevent others from receiving services. It is expected that you call 24 hours in advance if you need to re-schedule, or within 24 hours after missing an appointment due to an emergency. ***If you miss two consecutive appointments, or frequently miss or cancel your appointments, your case will be reviewed for closure. Please note that psychiatric services are only available to those clients who consistently attend therapy sessions.***

2. FULL INFORMATION

You have the responsibility to provide, to the best of your ability, accurate and complete information about your presenting problem(s), past medical and psychiatric treatment, medication and other matters relating to your physical and emotional health.

3. PARTICIPATION

You are expected to actively participate in the planning of your treatment and to follow its recommendations. You are responsible for your actions if you refuse to comply with the treatment provided by your clinician or psychiatrist.

4. RESPECT

You are responsible for being considerate of the rights and the property of other consumers and Agency personnel.

MEDICATION

At times, medication can help people manage moderate to severe emotional distress. Please note:

1. Before any medication is prescribed, an evaluation with the medical provider will be conducted and options discussed with you.
2. When medication is deemed appropriate, it is prescribed in small and non-refillable amounts, for limited periods of time, and in the smallest dosage required to help you.
3. It is *not* our policy to prescribe or refill medication over the telephone. This makes it extremely important that you keep your appointments to avoid running out of medication. Consumers are required to attend therapy sessions as scheduled in between psychiatric appointments in order to maintain scheduled in order to continue medication monitoring services.
4. The decision to take a medication is ultimately yours. Our duty is to assist you in making an informed choice and only prescribe medication if it is likely to benefit you.

CALLING YOUR CLINICIAN

Calls should be limited to situations such as communicating a worsening of your condition or reporting an unexpected or severe side effect of a medication. Other concerns can be handled during your session. Appointments may be scheduled with front desk/reception staff.

EMERGENCY SITUATIONS

Should you experience a psychiatric emergency and you are unable to contact your primary clinician, you should call 911 or head directly to the nearest hospital emergency room

OTHER SERVICES

FAMILYConnections has many programs to assist people in improving their lives, and will also refer you to other agencies that may have services that will assist you. Please speak with your clinician if you have needs for other services.

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Understanding Mental Health Advance Directives

Information for Consumers and Families

An Advance Directive is a Wellness Tool

Taking charge of your recovery from the symptoms of a mental illness can be empowering. Executing an Advance Directive will assure that even when your symptoms are severe the choices that are made about treatment are those you want.

Can I change or revoke my AD?

Yes, at any time, either by making a new AD or by telling a member of your treatment team, your proxy, or your doctor or lawyer that you want to change or revoke it. If you have registered the AD with DMHAS, you should also notify DMHAS that you have changed your AD. If you are an inpatient in a psychiatric facility, you can change or revoke your AD if your doctor says you are competent to change your mind at that time.

Will the hospital or agency honor the AD?

The hospital or agency will follow the AD if you have become unable to make decisions. The hospital or agency will attempt to transfer you for treatments if services are not available where you are. If the treatment you want is unavailable even with a transfer, or is not medically sound in your case, or would violate a court order or law, or if it would harm you or someone else, the hospital or agency will not honor the AD. Otherwise, the hospital or agency and your proxy have to follow your AD. Of course, in a life-threatening emergency there may not be time to provide the treatment you have chosen or to contact a proxy, but as soon as the emergency is resolved the hospital or agency will honor the AD.

Who needs a Mental Health Advance Directive (AD)?

Anyone can be rendered unable to make decisions because of a mental illness. Although anyone can develop a mental illness at any time, those most likely to need care when they cannot make decisions for themselves are people already diagnosed with a mental illness. Current and likely future consumers of mental health treatment can give comfort and security to their families and friends, and direct their own treatment no matter what their future decision-making capacity by completing an Advance Directive (AD) when they are capable of making decisions.

Who can execute an AD?

Any competent adult can execute an AD. In New Jersey, that means a person over 18 who does not have a guardian or a minor who has been emancipated by a court order or another event that establishes financial independence from his or her parents.

Is there a special form?

No, any form will do, but a hospital or agency can supply a form if you need one, and a member of the treatment team or a peer advocate can help you complete the form. You can also download a form at the DMHAS website (see back of brochure), sign and date your WRAP in front of a witness, or take a form from one of the other websites that give information about ADs. The requirements are that it is in writing, signed and dated, and there be one witness.

What should be included in an AD?

An AD can provide for a substitute decision-maker, or proxy, who will only be called upon if you become unable, according to at least 2 clinicians, to make a particular decision.

It can also state the person's preferred treatment including:

- religious preferences
- choices of medications
- crisis interventions
- peer support
- dietary preferences
- 12-step programs
- comfort interventions
- safety plans
- people who should or should not be called
- choice of doctor or hospital

It can also say what treatments are not acceptable and under what conditions some might be, in which case the proxy will have to follow the person's wishes as much as possible.

What is a Proxy?

A person appointed by a consumer to make decisions for him/her in the event that he/she becomes incompetent to make those decisions.

Do I have to carry it with me?

No, you can register the AD with the Division of Mental Health and Addiction Services by filling out a simple form and sending a copy to DMHAS. Then you, your proxy, or a mental health professional can get it in an emergency from Centralized Admissions at 609.777.0317. It's also a good idea to give a copy to a relative or friend, and to your chosen proxy.

DMHAS Website for the Advance Directive is:

http://www.state.nj.us/ humanservices/dmhs/ home/forms.html

Available in English or Spanish

New Jersey Division of Mental Health and Addiction Services
222 South Warren Street
PO Box 700
Trenton, NJ 08625-0700
800-382-6717

Other useful resources:

National Resource Center on Psychiatric Advance Directives: www.nrc-pad.org
Temple University Collaborative on Community Inclusion:
http://tucollaborative.org
The Bazelon Center for Mental Health Law: www.bazelon.org
Disability Rights New Jersey:
www.drnj.org

family connections

Charitable Choice Law Notification

Appendix-Part 54a Model Notice of Individuals Receiving Substance Abuse Services

No provider of substance abuse services receiving Federal funds from U. S. Substance Abuse and Mental Health Services Administration, including this organization, may discriminate against you on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in religious practice.

If you object to the religious or non-religious character of this organization, Federal law gives you the right to a referral to another provider of substance abuse services. The referral, and your receipt of alternative services, must occur within a reasonable period of time after you request them. The alternative provider must be accessible to you and have the capacity to provide substance abuse services. The services provided to you by the alternative provider must be of a value not less than the value of the services you would have received from this organization.

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Notice of Confidentiality of Substance Use Treatment Records

Federal laws safeguard your legal and human rights pertaining to alcohol and drug abuse patient records (42 USC. 290dd and 42, USC 290ee-3 and 42 CFR Part 2). No information will be given to anyone without your specific written consent prior to the request for information unless court ordered by a Judge in accordance with specific procedural requirements outlined in confidentiality regulations.

The only exceptions to keeping your information confidential are:

1. In medical emergencies (only to qualified personnel),
2. To qualified personnel for research, audit, or program evaluation. All clients have the right to refuse to participate in research studies without negative consequence,
3. In the event we have knowledge that you may harm yourself and/or others,
4. If we have knowledge or suspicion of child abuse/neglect or elder abuse/neglect, it is mandatory that we report any suspicion to the Division of Youth and Family Service (child abuse/neglect) or for evaluation.
5. In the event of criminal behaviors on our premises.

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HIV Testing/Referral Information

Rapid HIV Counseling and Testing Sites in Essex County

Newark Department of Health & Human Services
Communicable Diseases Prevention & Treatment Center
110 William Street Newark, NJ 07102
973-648-2227

North Jersey AIDS Alliance (NJCRI)
393 Central Avenue, Newark, NJ 07102
973-412-8300

St. Michael's Medical Center
306 Martin Luther King Jr. Blvd.
Newark, NJ 07102
973-877-5525

Newark Community Health Center
101 Ludlow Street, Newark, NJ 07114
973-565-0355

Newark Beth Israel Medical Center Family Treatment Center
166 Lyons Avenue, Newark, NJ 07112
973-926-5197
973-926-8474

UMDNJ-University Hospital, Infectious Disease Practice, Unit 6
150 Bergen Street, Newark, NJ 07101
973-972-9827

Planned Parenthood of Metro New Jersey
606 Central Avenue, East Orange, NJ 07108
973-674-4343

East Orange Health Department
143 New Street, East Orange, NJ 07017
973-266-5454

Satellite Sites of Newark Community Health Center
973-565-0355

Broadway Clinic
741 Broadway, Newark, NJ 07104

East Orange Primary Care
444 William Street East, East Orange, NJ 07108

Irvington Health Center
832 Chancellor Avenue (Level G), Irvington, NJ 07111

Attestation and Consent Release for County of Essex Chapter 51 Grant

I

Hereby attest that I my primary residence is in Essex County, New Jersey and I will provide documents verifying this attestation upon request. I further attest that I do not currently have viable means of paying the full cost of my treatment services at Family Connections, including (but not limited to) Medicaid or commercial insurance plans, which would prohibit of my care under the Chapter 51 Grant.

I understand that this consent is valid for a period up to (1) year following the closure of my file with Family Connections, and that I have the right to revoke my consent before that date. I understand that if I wish to revoke my consent I must notify Family Connections of that intention in writing. I understand that any information disclosed while this consent is in affect is done legally and cannot be challenged as a violation of relevant privacy laws.