

New Brunswick Counseling Center & Burlington Comprehensive Counseling

“Recovery is never out of reach!”



Substance Use Treatment Program Intake Forms

New Brunswick Counseling Center & Burlington Comprehensive Counseling

To better assist you, we kindly ask you to answer the following questions along with the other questionnaires in this packet. After the initial screening questionnaire, there are additional forms that refer to the handbook and our commitment to you during your time with New Brunswick Counseling Center and Burlington Comprehensive Counseling. If you need assistance, please ask the receptionist staff or the staff member that you meet with for the screening.

<p>Name</p> <p>First: _____ Middle Initial: ____ Last: _____</p>								
<p>Contact Information:</p> <p>Phone Number: _____ Email: _____</p>								
<p>Address</p> <p>Street Address:</p> <p>_____</p> <p>City : _____ State, Zip code : _____</p>								
<p>Marital Status</p> <table> <tr> <td><input type="checkbox"/> Common Law</td> <td><input type="checkbox"/> Never Married</td> </tr> <tr> <td><input type="checkbox"/> Divorced</td> <td><input type="checkbox"/> Remarried</td> </tr> <tr> <td><input type="checkbox"/> Living Together/cohabitating</td> <td><input type="checkbox"/> Separated</td> </tr> <tr> <td><input type="checkbox"/> Married</td> <td><input type="checkbox"/> Widowed</td> </tr> </table>	<input type="checkbox"/> Common Law	<input type="checkbox"/> Never Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Remarried	<input type="checkbox"/> Living Together/cohabitating	<input type="checkbox"/> Separated	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed
<input type="checkbox"/> Common Law	<input type="checkbox"/> Never Married							
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<input type="checkbox"/> Living Together/cohabitating	<input type="checkbox"/> Separated							
<input type="checkbox"/> Married	<input type="checkbox"/> Widowed							
<p>Other Major Health Concerns:</p> <p>_____</p>								

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<p>Employment Status</p> <ul style="list-style-type: none"> <input type="checkbox"/> Employed Full Time (35+ hrs/week) <input type="checkbox"/> Employed Part time (<35 hrs/week) <input type="checkbox"/> Disabled <input type="checkbox"/> Homemaker <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Seasonal Employment <input type="checkbox"/> Seeking Employment <input type="checkbox"/> Unemployed 	<p>Housing Status</p> <ul style="list-style-type: none"> <input type="checkbox"/> Housed <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Doubling up (living with others/couch surfing) <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Street (living on street, vehicle, outdoors, encampment) <input type="checkbox"/> Other (reside in hotel/motel)
<p>Military Affiliation</p> <p>Have you or an immediate family member ever served in the U.S. Armed Forces? Yes/No: _____</p> <p>Relation to person serving (if applicable): _____</p> <p>Branch: _____</p> <p>From/To Dates: ___/___/___ to ___/___/___</p>	
<p>Additional accommodation required? <i>(NOTE: This is not a guarantee of provision, however, NBCC/BCC will do their best to accommodate any legally required provisions)</i></p>	

Personal History

What is the reason you are coming in for counseling? Is there something specific, such as a particular event? If so, when did the event occur?

Are you currently in school? If yes, which school?

- No
- Yes: _____

Would you like to sign a release of information so we can coordinate with your school? If yes, please provide contact information.

- No
- Yes:

Do you have a learning disability? If so, what is the disability?

- No
- Yes: _____

Psychiatric History

Have you seen a mental health professional before? If yes, please indicate the timeframe.

- No
- Yes: _____

Would you like to sign a release of information so we can coordinate with this provider?

- No
- Yes

If yes, please provide contact information:

Provider: _____

Agency: _____

Phone: _____

Email: _____

If applicable, list all psychotropic medications you are currently taking. If you take prescription medication, who is your prescribing doctor?

Medication names: _____

Prescribing Doctor: _____

Have you ever been hospitalized for a psychiatric issue? If yes, please describe why.

- No
- Yes
 - Reason for hospitalization:

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Is there anything else you would like your counselor to know?

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CARE MANAGEMENT

NBCC/BCC can provide help or referrals for various needs. Place a check next to anything you would like help with so that we may gather more information to assist you to the best of our ability.

Social Needs		Health Needs	
	Protective Services		Health Education and Prevention
	Financial Assistance		Health Insurance
	Home Aid Services		Screening and Assessment
	Respite Care		Primary Care
	Shelter Services		Acute Care
	Foster Care		Long-Term Care
	Adoption		Dental Care
	Clothing		HIV Referral
	Food		Medication Assistance (Financial)
	Housing Issues	Vocational Needs	
	Utilities Assistance		Career Education
	Socialization		Vocational Assessment
	Recreation (YMCA, boy scouts, etc.)		Job Survival Skills
	Domestic Violence Services		Vocational Skills Training
Educational Needs			Career Counseling
	Psychological Testing		Job Finding and Placement
	Resource Classes	Additional Needs	
	Special Education		Self-Help and Support Groups
	Special Schools		Advocacy

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	Home-Bound Instruction		Transportation
	Residential School		Legal Services/Documentation
	Alternative Programs		Volunteer Programs
	Associates Degree		Continuation of Care
	General Education Development (GED)		Reentry Organization/Halfway House
Behavioral Health Needs		Other Concerns/Relevant Comments	
	Recovery Support		
	Peer Support		
	Group Services		
	Higher Level of Care		
	Inpatient Care		
	Specialized Treatment (Trauma/DBT/Eating Disorders, etc.)		
	Hospitalization		

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Please carefully read and review the following forms. In addition to a signature acknowledgement that you have received these forms, some of them require information on the form itself. Please contact your primary counselor if you have any questions or concerns regarding our policies.

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A. CLIENT RIGHTS

This agency formally endorses the recognition and belief in both the rights and responsibilities of patients as the foundation of the relationship between the patient and the agency. The agency, therefore, adopts the following:

Please note your rights as a consumer of New Brunswick Counseling Center Services:

- 1) The right to be informed of these rights, as evidenced by the client's written acknowledgment or by documentation by staff in the clinical record that the client was offered a written copy of these rights and given a written or verbal explanation of these rights in terms the client could understand.
- 2) The right to be notified of any rules and policies the program has established governing client conduct in the facility;
- 3) The right to be informed of services available in the program, the names and professional status of the staff providing and/or responsible for the client's care, and fees and related charges, including the payment, fee, deposit, and refund policy of the program and any charges for services not covered by sources of third-party payment or the program's basic rate;
- 4) The right to be informed if the program has authorized other health care and educational institutions to participate in his or her treatment, the identity and function of these institutions, and to refuse to allow their participation in his or her treatment;
- 5) The right to receive from his or her physicians or clinical practitioner(s) an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risks(s) of treatment, and expected result(s), in terms that he or she understands;
 - i) If, in the opinion of the medical director or director of substance abuse counseling, this information would be detrimental to the client's health, or if the client is not capable of understanding the information, the explanation shall be provided to a family member, legal guardian or significant other, as available;
 - ii) 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; and
 - iii) All consents to release information shall be signed by client or their parent, guardian or legally authorized representative;
- 6) The right to participate in the planning of his or her care and treatment, and to refuse medication and treatment;

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- i) A client's refusal of medication or treatment shall be documented in the client's clinical record;
- 7) The right to participate in experimental research only when the client gives informed, written consent to such participation, or when a guardian or legally authorized representative gives such consent for an incompetent client in accordance with law, rule and regulation;
- 8) The right to voice grievances or recommend changes in policies and services to program staff, the governing authority, and/or outside representatives of his or her choice either individually or as group, free from restraint, interference, coercion, discrimination, or reprisal;
- 9) The right to be free from mental and physical abuse, exploitation, and from use of restraints;
 - i) A client's ordered medications shall not be withheld for failure to comply with facility rules or procedures, unless the decision is made to terminate the client in N.J.A.C. 10:161B-16.2 accordance with this chapter; medications may only be withheld when the facility medical staff determines that such action is medically indicated;
- 10) The right to confidential treatment of information about the client;
 - i) Information in the client's clinical record shall not be released to anyone outside the program without the client's written approval to release the information in accordance with Federal statutes and rules for the Confidentiality of Alcohol and Drug Abuse Client Records at 42 U.S.C. §§ 290dd-2, and 290ee-2, and 42 CFR Part 2 §§ 2.1 et seq., and the provisions of the Health Insurance Portability and Accountability Act (HIPAA) at 45 CFR Parts 160 and 164, unless the release of the information is required and permitted by law, a third-party payment contract, a peer review, or the information is needed by DHS for statutorily authorized purposes; and
 - ii) The program may release data about the client for studies containing aggregated statistics only when the client's identity is protected and masked;
- 11) The right to be treated with courtesy, consideration, respect, and with recognition of his or her dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy;
 - i) The client's privacy also shall be respected when program staff are discussing the client with others;
- 12) The right to exercise civil and religious liberties, including the right to independent personal decisions;
 - i) No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any client;

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13) 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.

i) Programs shall not discriminate against clients taking medications as prescribed;

14) The right to be transferred or discharged only for medical reasons, for the client's welfare, that of other clients or staff upon the written order of a physician or other licensed clinician, or for failure to pay required fees as agreed at time of admission (except as prohibited by sources of third-party payment);

i) Transfers and discharges, and the reasons therefore, shall be documented in the client's clinical record; and

ii) If a transfer or discharge on a non-emergency basis is planned by the outpatient substance use disorder treatment program, the client and his or her family shall be given at least 10 days advance notice of such transfer or discharge, except as otherwise provided for in N.J.A.C. 10:161B-6.4(c);

15) The right to be notified in writing, and to have the opportunity to appeal, an involuntary discharge; and

16) The right to have access to and obtain a copy of his or her clinical record, in accordance with the program's policies and procedures and applicable Federal and State laws and rules.

New Brunswick Counseling Center retains the right to admit and treat only those clients who are appropriate to the agency's mission, capacity, and resources. Please note that New Brunswick Counseling Center is a smoke-free environment.

Client Signature: _____

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B. CONFIDENTIALITY NOTICE

1. General Information and Legal Protections

Information about your health care, including payment for health care, is protected by two main federal laws:

- The **Health Insurance Portability and Accountability Act (HIPAA)**, and
- The federal **Confidentiality of Substance Use Disorder Patient Records** law, **42 C.F.R. Part 2** (Confidentiality Law").

Under these laws:

- New Brunswick Counseling Center (NBCC) and Burlington Comprehensive Counseling (BCC) **may not disclose** to anyone outside NBCC/BCC that you attend (or have attended) the program.
- We may not disclose any information that identifies you as an alcohol or drug user or disclose other protected health information, **except as permitted** by these laws and regulations.

For individuals who have received diagnosis, treatment, or referral for treatment from our substance use disorder programs, the confidentiality of drug and alcohol records is **strictly protected**. As a general rule, we may not tell anyone outside the program that you attend, nor disclose any information identifying you as an alcohol or drug user, unless:

- a) you authorize the disclosure in writing, or
- b) the disclosure is permitted by a valid court order and applicable law.

Violation of **42 C.F.R. Part 2** or **HIPAA (45 C.F.R. Parts 160 & 164)** is a **crime** and may be punishable by fines and/or incarceration.

2. Written Consent for Disclosure

Before disclosing information about your **current treatment, past treatment, and/or treatment recommendations**, NBCC/BCC generally must obtain your **written consent**.

A valid written consent must specifically include:

1. **What information** is being disclosed.
2. **To whom** the information is being disclosed.
3. The **purpose/nature** of the disclosure.
4. The **time period or expiration date** during which the disclosure is allowed.
5. A statement regarding **re-disclosure** by the person/agency receiving the information (for substance use disorder records, further disclosure is generally prohibited unless permitted by law).

You may **revoke any written consent at any time** by telling us in writing. Once revoked, NBCC/BCC will no longer disclose your protected health information under that consent, except to the extent that action has already been taken in reliance on it.

You **may be denied services** if you refuse to consent to disclosure **needed for treatment, payment, or health care operations**, as permitted by law. You **will not be denied services** if you refuse to consent to disclosure for other, non-essential purposes.

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3. NBCC/BCC Responsibilities and Your Right to File a Grievance

NBCC/BCC are required by law to:

- **Maintain the privacy** of your health and treatment information.
- Provide you with information about our legal duties and privacy practices.

If you believe your privacy rights have been violated:

- You may file a **formal grievance** with a supervisor at either location (New Brunswick or Burlington) and request to speak with the **Clinical Director and/or Executive Director**.
- If your concern is not resolved to your satisfaction, you may contact:
 - The **New Jersey Department of Human Services / Division of Mental Health and Addiction Services (DMHAS)**
 - **CARF International**
 - The **Secretary of the U.S. Department of Health and Human Services**

You will **not be retaliated against** for filing a complaint or grievance.

4. Your Rights Under 42 C.F.R. Part 2 and HIPAA

Under these confidentiality laws and regulations, you have the right to:

- **Request restrictions** on certain uses and disclosures of your health and treatment information (although NBCC/BCC is not always required to agree to all requested restrictions).
- **Request amendments** to health and/or treatment records maintained by NBCC/BCC, with some exceptions.
- **Request and receive an accounting of disclosures** made by NBCC/BCC for up to **six years** prior to the date of your request, as allowed by law.
- **Request copies** of your health and treatment information maintained by NBCC/BCC.
 - Psychotherapy notes and certain other information may be withheld or redacted if it is determined that access would be a serious detriment to you or others, in accordance with applicable law.

You **will be asked** to sign a written consent allowing NBCC/BCC to disclose treatment information to certain referring or monitoring agencies when applicable, such as:

- Parole / Probation
- Recovery Court / Drug Court
- Intoxicated Driver Resource Center (IDRC)
- Department of Children and Families (DCF)
- NJ Work First Substance Abuse Initiative (WSFAI)
- Other referral or oversight entities as appropriate

5. Limitations to Confidentiality (Disclosures Without Your Written Consent)

Under certain circumstances, federal and state laws allow (or require) NBCC/BCC to **disclose information without your written consent**. Some of these circumstances include:

1) Suspected abuse or neglect

- a) NBCC/BCC must notify the Division of Child Protection and Permanency (DCP&P) and/or the appropriate authority (e.g., Adult Protective Services, Elder Abuse Hotline) if there is **suspected child or elder abuse or neglect**.

2) Threats of harm to others

- a) If a consumer makes a **serious threat to harm another person**, we may be required to notify that person and/or law enforcement, in accordance with applicable law (duty to warn/protect).

3) Danger to self or others

- a) If a consumer is determined to be at **imminent risk of harm to self or others**, we may inform someone who can intervene effectively. This may include a family member, law enforcement, the local **Mobile Crisis Screening Center**, or other emergency services, and may result in **psychiatric evaluation or hospitalization**.

4) Medical emergencies

- a) Consumer records/information may be released to medical personnel in a **bona fide medical emergency** to the extent necessary to meet the emergency.

5) Public health and infectious disease reporting

- a) In emergency situations (such as **COVID-19, Tuberculosis, Syphilis, or other reportable conditions**), information may be disclosed:
 - i) To a **public health authority**,
 - ii) To persons at risk of contracting or spreading a disease (when permitted under state law),
 - iii) To family, friends, or others involved in your care, and
 - iv) In cases of **imminent danger**.

6) Court orders and legal requirements

- a) When we receive a **properly executed court order** or as otherwise required by law, we may be compelled to release records. In these cases, we must comply with the order and cannot avoid producing records under existing privileged communication law.

7) Supervision and quality review

- a) Therapists and other staff are required to share relevant information for **clinical supervision, case consultation, and utilization review** to ensure quality and appropriate care.

8) Psychiatric screening and evaluation

- a) If a consumer is psychiatrically evaluated at a **psychiatric screening center** or similar facility, information may be shared with the screening center staff to facilitate evaluation and comply with federal and state law.

9) Qualified Service Organizations / Business Associates

- a) Information may be shared pursuant to a written agreement with a **Qualified Service Organization (QSO) or Business Associate** that provides services (e.g., billing, data management, lab services) and is required to maintain confidentiality under applicable law.

10) Within NBCC/BCC

- a) Information may be shared **among NBCC/BCC personnel** as needed to provide your care, coordinate services, and conduct agency operations.

New Brunswick Counseling Center & Burlington Comprehensive Counseling**11) Research, audits, and evaluations**

- a) Records may be reviewed for **research, state and federal audits, licensing reviews, and certification evaluations**. You may refuse to participate directly in research activities.
- b) When the **Office of Licensing**, Medicaid, or other authorized agencies conduct a review, a consumer's clinical record may be examined.

12) External review bodies

- a) Consumer records may, without their consent, be reviewed by:
 - a) Appropriate **New Jersey State audit teams**
 - b) Professional review or quality improvement staff within the organization
 - c) **Accreditation reviewers** (e.g., CARF)
 - d) **State or county medical examiner** in specific circumstances

13) Deceased consumers

- a) Records of a deceased consumer who received services from NBCC/BCC may be released to the estate's **administrator or executor**.
- b) If there is no administrator or executor, records may be released to the **next of kin** indicated in the consumer record.
- c) A valid written authorization will be obtained from the appropriate next of kin (natural or adoptive parents, siblings, grandparents, family caregiver of record, spouse, or adult children), as required by law.

14) Minors (consumers under age 18)

- a) Release of information about any consumer under the age of 18 that requires authorization will generally be determined by the **consumer's parent or legal guardian**, consistent with state law and confidentiality regulations.

6. Questions and More Information

If you have **any questions** about this Confidentiality Notice, your privacy rights, or any of the information above, **please ask your assigned counselor, nurse, or another NBCC/BCC staff member for an explanation**. You may request a copy of this notice at any time.

Client Signature: _____

C. NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

1. Our Legal Duty to Protect Your Privacy

NBCC/BCC have a **legal duty** to protect the privacy of your **Protected Health Information (PHI)**.

PHI includes any information that can identify you and relates to:

- Your past, present, or future physical or mental health or condition
- The health care services you receive
- Payment for those services

All employees, volunteers, staff, doctors, health professionals, and other personnel are **required by law** to protect the confidentiality of your health information and to follow the practices described in this notice.

We may change our privacy practices at any time. If we do:

- We will update this notice and post it in our lobby.
- You may request a **current copy** at any time from our front desk or by visiting www.nbcounselingcenter.org.

2. How We May Use and Disclose Your PHI

We may use and disclose your PHI for the following purposes:

A. Treatment

We may use and share your PHI to provide, coordinate, or manage your care. For example:

- Your counselor may discuss your care with our medical staff.
- Our medical staff may review your medications and medical history.

Prescription Monitoring Program (PMP):

Upon admission and when clinically necessary, our medical department may check the **State Prescription Monitoring Program (PMP)** and DrFirst to see if you are receiving medications from another provider that may be unsafe with your medication-assisted treatment. If we need to contact your private physician, we will

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ask you to sign a **Release of Information (ROI)** to allow communication between our medical director and your prescriber.

B. Payment

We may use or disclose your PHI so that **services can be billed and paid for**. For example:

- We may send information to your insurance plan to:
 - o Confirm eligibility or coverage
 - o Determine medical necessity
 - o Obtain pre-authorization or certification
 - o Justify charges for care

Payers may include:

- Medicaid
- Medicare
- Commercial/private health insurance
- DCF
- Government grant funders

C. Health Care Operations

We may use and disclose PHI as needed to **run our programs and improve services**, for example:

- Quality assessment and improvement
- Reviewing performance and qualifications of clinicians
- Training of students under supervision
- Licensing, accreditation, and audits
- General administrative activities

We may combine health information from many clients to:

- Decide what services to offer or discontinue
- Evaluate new treatments or programming
- Compare our services with other providers and look for ways to improve

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When we use combined data for these purposes, information that identifies you is **removed whenever possible**.

3. Other Uses and Disclosures Allowed Without Your Written Permission

The law allows (and sometimes requires) us to use or disclose your PHI without your signed authorization in certain situations, including:

A. Emergencies

- In an emergency, we may share your PHI to provide necessary care- for example, with paramedics or emergency room staff.

B. Appointment Reminders

- We may contact you (by phone, mail, or text) to remind you of **appointments**.

C. Research / Program Evaluation

Under strict safeguards and approval processes, we may use or disclose limited PHI for:

- Research or program evaluation (e.g., comparing outcomes of different treatments)

Any research project involving your PHI is subject to a **special approval process**. If a researcher will see your **name, address, or identifiable information**, or if you are being asked to participate in experimental treatment, we will **ask for your specific permission**.

D. Abuse and Neglect

We will report suspected:

- Child abuse or neglect
- Elder or vulnerable adult abuse
- Certain forms of domestic violence

to the appropriate authorities, as required by law.

E. As Required by Law

We will disclose PHI when required by **federal, state, or local law**, including:

- Court orders signed by a judge
- Certain public health reporting
- Other specific legal requirements

F. To Avert a Serious Threat

We may use or disclose PHI when necessary to **prevent or lessen a serious and imminent threat** to your health or safety, or the health and safety of others. We will only share information with someone able to help prevent the threat (e.g., police, crisis team, potential victim).

G. Health Oversight Activities

We may disclose PHI to government agencies that oversee:

- The health care system
- Government benefit programs (e.g., Medicaid/Medicare)
- Licensing and civil rights compliance

H. Legal and Law Enforcement Situations

- **Legal proceedings:** We may disclose PHI if we are ordered to do so by a court.
- **Law enforcement:** We may disclose PHI when:
 - Reporting a crime on our premises, or
 - Responding to an imminent and dangerous situation, or
 - When required by law.

I. Medical Examiners

We may provide PHI to a medical examiner to:

- Identify a deceased person
- Determine cause of death, when required

J. Inmates

If you are an **inmate** or under custody of law enforcement, we may disclose PHI to:

- The correctional institution or
- The law enforcement official

if necessary for your care, safety, or security.

K. Workers' Compensation

We may disclose PHI as needed to:

- Comply with **Workers' Compensation** or similar programs, when we have your signed Authorization for Release of Information.

L. Uses and Disclosures Requiring Your Written Authorization

Any **use or disclosure not described in this notice** will generally **require your written authorization**.

- You have the right to **revoke** an authorization **at any time**, in writing.
- If you revoke, we will stop using or disclosing information under that authorization, except for actions already taken in reliance on it.

4. Health Information Exchange (HIE)

NBCC/BCC may participate in **Health Information Exchanges (HIEs)**, which allow secure electronic sharing of PHI with other authorized providers and health plans for:

- Treatment
- Payment
- Health care operations
- Other purposes allowed by law

PHI shared through an HIE may include:

- Diagnoses, medications, allergies
- Lab results

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- Health plan enrollment and eligibility

It may also include **sensitive information**, such as mental health information, HIV/AIDS-related information, and family planning information.

Participation is voluntary and subject to your right to opt out.

- If you **do not opt out**, NBCC/BCC may share your information with HIEs, as allowed by law.
- If you **opt out**, your information **will not be shared through an HIE**, including in emergencies.
- Opting out does **not stop** sharing of PHI through other secure means permitted by law (such as secure fax).

More information:

- NJ Health Information Network (NJHIN): <https://www.njhi.com/healthcare/new-jersey-health-information-network-njhin/>
- NJ Prescription Monitoring Program (NJMPMP): <https://www.njconsumeraffairs.gov/pmp>

To opt out of HIE data sharing:

- NBCC (New Brunswick): 732-246-4025
- BCC (Burlington): 609-267-3610

5. Your Rights Regarding Your Health Information

You have the following rights:

A. Right to Inspect and Copy

You may request to **inspect or obtain a copy** of PHI used to make decisions about your care or payment.

- Request must be **in writing** to your treating counselor or physician.
- We may charge a **reasonable fee** for copies and mailing.
- In certain cases, we may deny your request; some denials may be reviewed by another licensed professional.

B. Right to Amend

You may request that we **amend (correct)** PHI if you believe it is inaccurate or incomplete.

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- Request must be **in writing**, with an explanation of why you believe it is incorrect.
- If we deny your request, we will provide a **written explanation** and options for:
 - o Submitting a **statement of disagreement**, or
 - o Having your request and our denial attached to future disclosures of that PHI.

C. Right to an Accounting of Disclosures

You may request an **accounting (list)** of certain disclosures of your PHI made by NBCC/BCC (not including disclosures for treatment, payment, or operations).

- Request must be **in writing** to your primary counselor.

D. Right to Request Restrictions

You may request that we **limit** how we use or disclose your PHI for treatment, payment, or operations, and/or not share information with certain family members or others.

- We are **not required** to agree to all requested restrictions.
- If we **agree in writing**, we must follow the restriction unless allowed to change it by law or mutual agreement.

E. Right to Request Confidential Communications

You may request that we **contact you in a specific way or place**, such as:

- Only at work
- Only by mail
- Only at a certain phone number
- Requests must be **in writing** to your counselor or physician.
- You do not need to give a reason, but you must clearly specify **how or where** we should contact you.

F. Email, Text, and Other Communications

If you choose to communicate by email or text:

- We cannot guarantee that email/text is **completely secure or confidential**.
- Shared email accounts may allow others to see your messages.

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- NBCC/BCC are **not liable** for misaddressed, misedelivered, or interrupted messages due to factors beyond our control.
- Email/text should be used only for **routine, non-urgent matters** and **not** for emergencies or clinical treatment.

G. Right to a Paper Copy of This Notice

You may request a **paper copy** of this Notice of Privacy Practices at any time.

6. Consent and Right to Revoke

By signing our consent form, you:

- Authorize NBCC/BCC to **use and disclose your PHI** for treatment, payment, operations, and as described in this notice.
- Acknowledge that you have been **offered or given a copy** of this Notice of Privacy Practices.

Client Signature: _____

D. CLIENT RIGHTS REGARDING HEALTH INFORMATION

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.

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 staff members, front desk personnel, or your primary counselor 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.

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 your primary counselor.

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 healthcare operations. You may also ask that any part (or all) of your health information not be

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disclosed to family members or friends who may be involved in your care or for notification purposes as described in 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 Executive Director.

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 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.

Communication Preferences

For those clients who have consented to receive emails from New Brunswick Counseling Center, please note that we 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, undelivered, or interrupted e-mail. NBCC 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.

Communication Authorizations

Below are my preferences to receive communications from New Brunswick Counseling Center. I understand that I may change these preferences at any time.

I consent to receive communications from New Brunswick Counseling Center through the following (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Phone | <input type="checkbox"/> Email (I understand that email communications are not encrypted and that New Brunswick Counseling Center email addresses will be identified in all email communications) |
| <input type="checkbox"/> Voicemail | <input type="checkbox"/> Mail (I understand that communications will be sent out to the address listed on file) |
| <input type="checkbox"/> Text (I understand that standard messaging rates may apply) | |

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.

Client Signature: _____

E. INTERIM MANAGEMENT ENTITY (IME) CONSENT

I, the client, authorize **New Brunswick Counseling Center (NBCC)**, **Rutgers University Behavioral Health Care (UBHC)** in its capacity as the **Interim Managed Entity (IME)**, and the **New Jersey Department of Human Services / Division of Mental Health and Addiction Services (NJ DHS/DMHAS)** to communicate with and disclose to one another information about my substance use treatment.

Purpose of Disclosure

The purpose of this authorized disclosure is to:

- Provide me with **better, more coordinated care**, and
- Allow for the **evaluation, management, and authorization** of my treatment.

I understand that information will be exchanged verbally and electronically through the **New Jersey Substance Abuse Monitoring System (NJSAMS)**, a secure computer system, and that my information will be maintained within NJSAMS.

Confidentiality and Legal Protections

I understand that my medical records are protected under federal and state law, including:

- **42 C.F.R. Part 2** - Confidentiality of Substance Use Disorder Patient Records, and
- **The Health Insurance Portability and Accountability Act of 1996 (HIPAA)** – 45 C.F.R. Parts 160 & 164.

My records **cannot be disclosed without my written consent** unless otherwise permitted or required by these laws and regulations.

Conditions of Services

I understand that:

- I **may be denied services** if I refuse to consent to a disclosure that is necessary for **treatment, payment, or health care operations**.
- I **will not be denied services** if I refuse to consent to a disclosure for **other purposes** not related to treatment, payment, or health care operations.

I acknowledge that I have been offered or provided a copy of this form.

Description of Information to Be Disclosed / Released

By signing this form, I authorize the disclosure of:

- **All of my health information**, including:
 - Substance use / drug and/or alcohol treatment records
 - Medical records

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- Mental health treatment records
- Records of any other conditions for which I may have received treatment

This authorization includes any information maintained in NJSAMS related to my treatment episode(s).

Term, Expiration, and Revocation

- This signed Consent will **expire one (1) year from my discharge date** from NBCC (or the relevant treatment episode), and will remain in effect until that date, unless revoked earlier.
- A reminder of my rights will be sent out **once per year**. I may also request a copy of this consent at any time from my primary counselor.
- I understand that I may **revoke this consent at any time**, except to the extent that action has already been taken in reliance on this authorization.
- To revoke this consent, I must notify NBCC (or my primary counselor) **in writing**.

Acknowledgment and Signature

By signing below, I acknowledge that:

- I have read (or had read to me) and understand this IME Consent form.
- I have had the opportunity to ask questions, and all questions have been answered to my satisfaction.
- I understand my rights regarding the confidentiality of my substance use and health information and the limits of those rights under applicable law.
- I voluntarily authorize the disclosure and exchange of information as described above.

Client Signature: _____

F. TELEHEALTH CONSENT

Purpose and Overview

New Brunswick Counseling Center (NBCC) and Burlington Comprehensive Counseling (BCC) offer counseling and behavioral health services through telehealth. Telehealth allows clients to receive care using a secure, HIPAA-compliant video platform.

This form outlines your rights, responsibilities, and the conditions under which telehealth services are provided.

Telehealth sessions are conducted through the MyEvolv Telehealth Portal.

You will receive a secure link via email approximately 10 minutes before your scheduled session.

Sessions are 45 minutes in length unless otherwise indicated.

Technology and Access

You will need:

- A reliable internet connection
- A device with audio and video capability (computer, tablet, or smartphone)
- A private space, free from distractions and interruptions

Telehealth sessions are conducted through MyEvolv, a HIPAA-compliant platform that meets federal and state privacy requirements.

If you experience technical issues, your counselor will attempt to reach you by phone to re-establish the session or reschedule.

If connection problems persist, your counselor will follow up with you to explore alternative care options, which may include in-person sessions.

Scheduling and Attendance

Telehealth sessions are held to the same professional standard as in-office sessions.

You are expected to:

- Log in on time
- Be appropriately dressed
- Not be under the influence of drugs or alcohol

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If you do not join your session within 15 minutes of the scheduled start time, your counselor may consider the session a no-show.

Repeated missed appointments may result in:

- Temporary suspension of telehealth privileges, and
- A requirement to resume in-person sessions to continue services.

When Telehealth May Not Be Appropriate

Telehealth may not be suitable for all clients or situations. In consultation with you, your counselor, and clinical supervision, telehealth services may be limited or discontinued if:

- You do not have a safe, private, or stable environment for sessions.
- You experience a psychiatric or medical emergency requiring a higher level of care.
- There are repeated missed appointments, non-engagement, or ongoing technical problems.
- Your provider determines that in-person care is clinically necessary or more appropriate.

If telehealth is discontinued, your counselor will help coordinate an appropriate plan for ongoing care, which may include in-person treatment or referral to another provider.

Confidentiality and Privacy

The confidentiality of all client information is protected by federal and state law, including HIPAA, 42 C.F.R. Part 2, and N.J.A.C. 10:37, as applicable.

MyEvolv Telehealth is a secure platform, but as with all technology, there are potential risks (e.g., unauthorized access, data breaches). NBCC/BCC takes reasonable steps to prevent such occurrences.

You are responsible for:

- Ensuring your physical location provides adequate privacy
- Making sure no unauthorized persons are present during your session unless pre-approved by your counselor

Recording of sessions by clients or staff is strictly prohibited without prior written consent.

Email, Phone, and Other Technology

Email communication through Microsoft Outlook is encrypted and is intended for scheduling and administrative purposes only, not for clinical counseling.

Telehealth sessions cannot be conducted by phone (voice-only) per New Jersey Department of Health regulations, except in emergencies when approved by clinical supervision and consistent with current regulations.

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Text messages may be used for appointment reminders or confirmations only, not for clinical communication or crisis support.

Client Rights and Informed Consent

By agreeing to telehealth services, you acknowledge that:

- You understand that the laws protecting confidentiality (HIPAA, 42 C.F.R. Part 2, and state law) also apply to telehealth.
- You have the right to withhold or withdraw consent for telehealth at any time without affecting your right to future care, though the form of care (e.g., in-person only) may change.
- You understand that outcomes from telehealth cannot be guaranteed, and telehealth may have both benefits and limitations.
- Your provider may modify or discontinue telehealth if it is determined to be unsafe, clinically inappropriate, or not sufficiently private/confidential.
- You agree to notify your counselor of any changes in your contact information, emergency contact, or physical location, particularly prior to or at the start of each telehealth session.

Emergency Procedures During Telehealth Sessions

If you experience a mental health emergency, you agree to take one or more of the following actions immediately:

- Call 988 (National Suicide & Crisis Lifeline)
- Call 911
- Go to the nearest emergency department
- Contact your Emergency Contact Person (ECP) on file

You agree to:

- Provide your current physical address at the start of each telehealth session, and
- Identify:
 - o The nearest hospital/emergency department, and
 - o The nearest police department to your location during the session.

If your counselor determines that telehealth is no longer clinically appropriate or safe, services will be transitioned to in-person care or another appropriate level of care. You will receive follow-up communication to help ensure your safety and continuity of treatment.

Consent Acknowledgement

I have read and understand the information provided above regarding telehealth services at New Brunswick Counseling Center and Burlington Comprehensive Counseling. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction.

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I voluntarily agree to participate in telehealth services through the MyEvolv Telehealth Portal under the terms described in this consent.

Client Signature: _____

G. ADVANCE DIRECTIVE

What is an Advance Directive?

An **advance directive (AD)** is a legal document you can complete to help ensure that your preferences for medical treatment are followed if you become unable to make your own health care decisions.

If you are **under the age of 18**, your legal **next of kin** (usually a parent or legal guardian) will make these decisions for you, and you do not need to complete this section.

Your advance directive only goes into effect **after** a physician has evaluated you and determined that you are unable to understand:

- Your diagnosis
- Your treatment options
- The possible benefits and risks of those options

Types of Advance Directives in New Jersey

New Jersey recognizes two main kinds of advance directives. You may choose to complete **one or both** of these:

1. Proxy Directive (Durable Power of Attorney for Health Care)

A **proxy directive** is a document you use to appoint a person to make health care decisions for you if you become unable to make them yourself.

- This applies whether your inability is **temporary** (for example, due to an accident) or **permanent** (for example, due to a serious illness).
- The person you appoint is called your **health care representative**.
- Your health care representative is responsible for making the same decisions **you would have made** under the circumstances, based on your known wishes and values.
- If they cannot determine what you would want in a specific situation, they should base decisions on **what they believe is in your best interest**.

2. Instruction Directive (Living Will)

An **instruction directive**, often referred to as a **Living Will**, is a document you use to tell your physician and your family:

- The kinds of situations in which you **would or would not want** life-sustaining treatment, and
- Your **beliefs, values, and general care preferences**.

This document guides your physician and family when they must make health care decisions for you, including situations not specifically described in your directive.

Mental Health Advance Directives

A **Mental Health Advance Directive** is a type of advance directive that focuses on **psychiatric care and treatment**.

Anyone can become unable to make decisions because of mental illness. People who are **currently receiving mental health treatment**, or who may need it in the future, can use a Mental Health AD to:

- Direct their **future treatment**
- Give guidance and reassurance to **family and friends**
- Ensure their wishes are known even if they cannot express them later

Who can execute an AD?

- Any **competent adult** can execute an AD.
- In New Jersey, this generally means a person **18 or older** who does **not** have a legal guardian, or a **minor who has been emancipated** (for example, by court order or another event that establishes financial independence).

Can I Change or Revoke My Advance Directive?

Yes. You may change or revoke your AD **at any time** by:

- Creating a **new advance directive**, or
- Informing a member of your treatment team, your proxy, your doctor, or your lawyer that you want to change or revoke it.

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If you have registered your AD with the **Division of Mental Health and Addiction Services (DMHAS)**, you should notify DMHAS if you change or revoke your directive.

If you are an **inpatient in a psychiatric facility**, you can change or revoke your AD if your doctor determines that you are **competent** to do so at that time.

Will Hospitals or Agencies Honor the Advance Directive?

In general, hospitals and agencies will **follow your advance directive** if:

- You have become unable to make decisions, and
- The requested treatment is **available, medically appropriate, and lawful**.

A hospital or agency may not honor an AD if:

- The treatment you request is not available, even with a transfer
- The treatment is **not medically sound** in your case
- The directive would **violate a court order or law**
- The requested action would likely **harm you or someone else**

In a **life-threatening emergency**, there may not be enough time to review your directive or contact your proxy before treatment is given. However, as soon as the emergency is stabilized, the hospital or agency will follow your AD as closely as possible.

Is There a Special Form?

No specific single form is required. However:

- Hospitals and agencies can supply a form and help you complete it.
- A member of your treatment team or a **peer advocate** can assist you.
- You may also download forms from the **DMHAS website** or other reputable sources.

In general, an AD must be:

- **In writing**
- **Signed and dated**
- Witnessed by at least **one person**

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An AD may include:

- The name of a **proxy/health care representative**, and
- Your **specific instructions** and **preferences** for treatment.

You do **not** have to carry your AD with you. You may:

- Register it with **DMHAS** so it can be accessed in an emergency through Centralized Admissions at **609-777-0317**
- Share copies with your **proxy, family**, and your **treatment providers**

Useful Resources

- **DMHAS - Advance Directive Information (English/Spanish)**
www.state.nj.us/humanservices/dmhas/resources/mental/pad/
- **Wellness Recovery Action Plan (WRAP)**
www.wellnessrecoveryactionplan.com
- **New Jersey Psychiatric Advance Directive Registry (NJPAD)**
www.state.nj.us/humanservices/dmhas/resources/mental/pad/
- **New Jersey Division of Mental Health and Addiction Services**
222 South Warren Street, PO Box 700
Trenton, NJ 08625-0700
Phone: **800-382-6717**
- **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

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NBCC/BCC Policy on Advance Directives

It is the policy of NBCC/BCC to **accept advance directives** from clients.

However, within our level of care and scope of practice:

- Staff will **always administer CPR** and
- **Call 911** for Emergency Medical Services in a medical emergency.

If you share your advance directives with us:

- We will **place a copy in your medical record**, and
- We will **provide them to Emergency Medical Services** upon their arrival when appropriate.

Please note: **NBCC/BCC staff always resuscitate** in a medical emergency situation.

Youth Under Age 18

For individuals **under the age of 18**:

- In the event of a **medical or psychiatric emergency on-site**, a **parent or guardian will be contacted immediately**.
- Staff will **not accompany** the youth to the hospital.
- Ideally, the **parent/guardian will meet the youth at the clinic** for transport or will meet them **directly at the hospital**.

How NBCC/BCC Will Address Advance Directives with You

As part of intake or ongoing care:

- Staff may ask whether you **currently have an advance directive**.
- If you **do have one**, you may choose to **provide a copy** to NBCC/BCC so it can be placed in your medical record.
- If you **do not have an advance directive**, you may ask for **more information** or assistance, and staff can refer you to resources and forms.

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You are **not required** to complete an advance directive in order to receive services at NBCC/BCC, but we encourage you to consider your options and discuss any questions with your treatment team.

Client Signature: _____

H. NOTICE OF NON-DISCRIMINATION / CHARITABLE CHOICE

Notice of Non-Discrimination

No provider of substance use services that receives federal funds from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) – including New Brunswick Counseling Center (NBCC) and Burlington Comprehensive Counseling (BCC) – may discriminate against you on the basis of:

- Your religion
- Your religious beliefs
- Your refusal to hold any religious belief
- Your refusal to participate in any religious practice

You cannot be denied services, treated differently, or pressured to participate in religious activities because of your beliefs or lack of beliefs.

Charitable Choice

Under federal Charitable Choice protections:

NBCC and BCC may not require you to take part in religious activities (such as prayer, worship, or religious groups) as a condition of receiving substance use treatment services.

If you object to the religious or non-religious character of NBCC or BCC, federal law gives you the right to request a referral to another provider whose services are more consistent with your preferences.

NBCC and BCC are required to:

- Take your objection seriously, and
- Assist you, within a reasonable period of time, in locating and referring you to an accessible, alternative substance use treatment provider whose services are of equal value, to the extent such services are available.

You will not be penalized or lose eligibility for services because you request such a referral.

Client Signature: _____

I. COUNSELOR CREDENTIAL DISCLOSURE FORM

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”) — New Brunswick Counseling Center (NBCC) and Burlington Comprehensive Counseling (BCC) have 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 Marriage and Family Therapist (LMFT)
- Licensed Professional Counselor (LPC)
- Licensed Clinical Social Worker (LCSW)
- Licensed Clinical Alcohol and Drug Counselor (LCADC)

Instead, my counselor may be one of the following, licensed or credentialed in the State of New Jersey:

- Licensed Associate Counselor (LAC)
- Associate Marriage and Family Therapist (AMFT)
- Licensed Social Worker (LSW)
- Certified Alcohol and Drug Counselor (CADC)
- Counselor in training
- An intern enrolled in a master’s degree program in one of these professions

Furthermore, I understand that:

Any such counselor will remain under the clinical supervision of an appropriately licensed and/or certified supervisor, as required by Regulations 13:34-3.3(b), 13:34C-6.2(c), 13:34C-13.1(g), and 13:44G-8.1(g). Clinical supervisors have access to my treatment records, and the supervising clinician is ultimately responsible for all aspects of my treatment

Client Signature: _____

J. GRIEVANCE PROCEDURE

(Grievances / Complaints / Suggestions)

“Patient” or “client” includes the person receiving services and, if the client is a minor, their parent or legal guardian.

Your Rights

You have the right to complain about your services, treatment decisions, or how you have been treated without fear of retaliation or barriers to services.

You may also make suggestions about agency rules, regulations, or protocols.

If you are being considered for administrative discharge, you may request a “fair hearing” to review the decision, except in cases of violent or threatening behavior.

How to File a Grievance

Step 1 – Talk to Your Counselor or Staff Person

First, bring your concern to the person providing your service (your counselor, nurse, etc.).

They will try to meet with you within 2 business days to discuss your concern and work on a solution.

If you do not feel comfortable speaking with them directly, you may ask to speak with their supervisor instead.

Step 2 – Talk to a Supervisor

If the concern is not resolved with the person providing your service, you may ask to speak with the supervisor.

You can share your grievance verbally or in writing.

The supervisor will:

- Listen to your concerns
- Review relevant information
- Talk with involved staff as needed

A meeting with the supervisor should be offered within 5 business days.

After the meeting, you will receive a verbal response and/or a follow-up letter summarizing the outcome.

In most cases, any negative action related to your grievance will be put on hold until a final decision is made, unless there is a serious health or safety risk.

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Step 3 – Talk to the Program/Department Director

If you are not satisfied with the supervisor's response, you may ask to speak with the Program/Department Director.

The Director will review your grievance, speak with staff involved, and, if requested, meet with you (generally within about two weeks).

You will receive a response explaining the Director's decision.

Step 4 – Talk to the Executive Director & Outside Agencies

If you are still not satisfied after speaking with the Director, you may write to the Executive Director.

The Executive Director will:

- Review your grievance
- Offer to meet with you (usually within about one week of the request)
- Provide you with a final written response

If the matter cannot be resolved within the agency, the Executive Director will give you contact information for outside agencies where you can file a complaint.

External Complaint Resources (Selected)

You may contact any of the following at any time:

Mental Health Complaint Hotlines

Southern Region: 609-777-0763

Northern Region: 973-977-4397

NJ Division of Mental Health and Addiction Services – Ombudsperson

Phone: 609-438-4321

DMHAS Substance Use Treatment Complaint Line

Toll-free: 1-877-712-1868

County Mental Health Administrators

Middlesex County: 732-745-4373

Burlington County: 609-265-5383

Department of Children and Families – Office of Advocacy

Toll-free: 1-877-543-7864

NJ Child Abuse Hotline (24/7)

1-877-NJ-ABUSE (1-877-652-2873)

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Mental Health Association of NJ (Information & Referral)

Toll-free: 1-877-294-HELP (or 1-877-294-4357) or 1-877-285-2844 (local resources)

In an emergency, always call 911 or go to the nearest emergency room.

Client Acknowledgment

I have read and understood the information above about the Grievance Process at NBCC/BCC. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction. A signature will be required at the end of this packet acknowledging the understanding of the Grievance Process.

Client Signature: _____

K. DRUG SCREENING CONSENT

Laboratory Name: Atlantic Diagnostics Laboratory

New Brunswick Counseling Center (NBCC) and Burlington Comprehensive Counseling (BCC) utilize **drug screening** as a routine and required part of Substance Use Disorder (SUD) treatment and our Drug Screening Only Program.

Drug Screening Protocol

- Drug screens are used to **monitor treatment progress** and support clinical decision-making.
- Drug screens are **collected on-site** by a **contracted laboratory** (Atlantic Diagnostics Laboratory) and sent for analysis.
- Drug screens may be **oral fluid** or **urine** and may be collected:
 - At **admission**, and
 - On an ongoing basis (e.g., **weekly, biweekly, or monthly**) as determined by your treatment plan and program requirements.
- **Drug screens are required** in order to participate in NBCC/BCC services.

Refusal Policy

- If you **refuse** to provide a requested drug screen, it will be treated as a **"positive" result** for program purposes.
- **Continued refusal** to provide drug screens may result in **termination from treatment** at this agency.

Drug screening is intended to be **part of your treatment**, not a punishment. It will be conducted in a **professional and respectful manner**.

You should be **prepared to provide a specimen** if and when requested by staff.

Information Shared with the Laboratory

I understand that NBCC/BCC will share the following information with the contracted laboratory **solely for the purposes of testing and claim submission**:

- Name
- Date of Birth

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- Social Security Number
- Medicaid/Medicare/Insurance number (if applicable)
- Diagnostic code(s) and other information necessary for billing and processing

If you are a **Medicaid or Medicare recipient**, the contracted laboratory will submit claims to your **insurance company** for payment of the drug screen services.

Tampering and Manipulation

Any attempt to **tamper with, substitute, or otherwise manipulate** a drug screen specimen or result may result in:

- A clinical review of your case, and
- Possible **termination from the program**, consistent with agency policy.

Release of Results to Outside Entities

Drug screen results are considered **confidential health information** and are protected by **HIPAA** and **42 C.F.R. Part 2** (where applicable).

When required or requested by an **outside provider or referring source**, NBCC/BCC will only release your drug screen results if:

- There is a valid **Release of Information (ROI)** signed by you (or your legal guardian, if applicable), unless otherwise permitted or required by law.

Examples of outside entities that may receive results with your signed authorization include:

- Department of Children and Families (DCF)
- NJ Work First Substance Abuse Initiative (WSFAI)
- Recovery Court / Drug Court
- Probation / Parole
- Other referring agencies or oversight entities

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I understand the information above regarding drug screening at NBCC/BCC, including:

- The purpose and requirements of drug screening
- How and when drug screens are collected and used
- What information is shared with the contracted laboratory
- The consequences of refusal or tampering
- How and when results may be shared with outside entities

Client Signature: _____

L. COMMUNICABLE DISEASE TESTING INFORMATION

(Tuberculosis and Sexually Transmitted Diseases)

New Brunswick Counseling Center (NBCC) and Burlington Comprehensive Counseling (BCC) comply with New Jersey licensing regulations regarding communicable disease screening and reporting.

As required by these regulations:

- NBCC/BCC **offer free testing** for:
 - **Tuberculosis (TB)**
 - **Sexually Transmitted Diseases (STDs)**
- Certain **positive test results must be reported** to the appropriate **local and/or state Health Departments** for follow-up testing, contact tracing where indicated, and offers of appropriate treatment.

Communicable disease screening is part of:

- The **initial admission assessment**, and
- **Subsequent annual physical examinations** during your treatment episode.

NBCC/BCC use a **separate standardized screening tool** to assess your current symptoms, risk factors, and history related to TB and STDs. That tool guides decisions about testing, referrals, and follow-up.

Symptoms to Report to Staff

Please check all that apply and tell a staff member or your medical provider if you are currently experiencing, or have recently experienced, any of the following symptoms **as soon as possible**:

- Persistent cough
- Chills
- Unexpected weight loss
- Fever
- Fatigue or unusual tiredness
- Loss of appetite
- Night sweats
- History of a previous **positive TB test**
- History of a previous **positive STD test**

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These symptoms are used as **clinical screening information only** and will be reviewed by medical staff as part of your assessment and ongoing care.

Masking and Infection Control

To protect the health and safety of all patients, visitors, and staff:

- Any person who is **actively coughing** and/or reporting symptoms suggestive of TB may be asked to:
 - **Wear a protective mask** while in NBCC/BCC facilities, and
 - Cooperate with further medical evaluation and/or testing until their tuberculosis status can be fully evaluated and confirmed.

Additional infection control measures may be implemented as needed based on clinical assessment and public health guidance.

Education and Testing for STDs

- **Education about STDs** (including prevention, safer sex practices, and treatment options) is **available upon request**.
- You may ask to be **referred for STD testing at any time** during your episode of care. Staff will assist you with referrals to appropriate testing sites if testing is not performed on-site.

Confidentiality and Reporting

- Your health information, including any testing and results for TB and STDs, is protected under **HIPAA** and **42 CFR Part 2** when applicable.
- Certain communicable diseases, including TB and specific STDs, are **reportable by law** to the appropriate Health Department.
- Reporting is done in accordance with **New Jersey public health requirements** and is used to support follow-up care, public health surveillance, and prevention.

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If you have any questions about communicable disease testing, reporting, or your rights, please speak with your **primary counselor, nurse, or medical provider**. They can provide more information, written materials, and referrals as needed.

Client Signature: _____

M. HIV INFORMATION AND NOTIFICATION

I understand the following information about HIV (Human Immunodeficiency Virus) and AIDS:

1. Effect on the Immune System

If I become infected with HIV, my immune system will be weakened, and I may have much more difficulty fighting off infections and diseases.

2. Treatment and Prognosis

AIDS (Acquired Immunodeficiency Syndrome) is a serious, potentially fatal condition. However, **modern HIV medications (antiretroviral therapy)** are helping people with HIV/AIDS live **longer, healthier lives**.

3. How HIV Is Transmitted and How to Reduce Risk

- a. HIV can be passed to others through **unprotected sexual activity** and through **sharing needles or other injection equipment**.
- b. I can greatly reduce my risk of infection, and the risk of passing HIV to others, by:
 - i. Practicing **safer sex** (using condoms and other barrier methods), and
 - ii. **Not sharing needles**, syringes, or other drug-use equipment.

4. HIV Testing

- a. I can be tested for HIV by having a sample of my **blood (or other approved specimen)** analyzed for HIV infection.
- b. **New Brunswick Counseling Center (NBCC) and Burlington Comprehensive Counseling (BCC) offer HIV testing on their premises** as part of comprehensive care, when clinically appropriate and available.

5. Importance of Early Testing

It is important to be tested **early** for HIV infection for at least three reasons:

- A) I can be infected and **not know it** (HIV may have no symptoms for a long time).
- B) I can infect others **unless I take steps to protect them**.
- C) If I am infected, I need **early medical care and counseling** to stay as healthy as possible and reduce the risk of transmitting HIV to others.

6. Protection Against Discrimination

If I am HIV-positive (HIV+), or if someone believes or assumes I am HIV+, it is **against the law** to discriminate against me in areas such as:

- a. Housing

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- b. Employment
- c. Credit
- d. Public accommodations
- e. Health or social services

7. Voluntary Nature of HIV Testing

- a. In most situations, HIV testing is **voluntary**.
- b. There are limited exceptions (such as certain individuals convicted of specific crimes, certain minors under state law, or some medical emergencies).
- c. In general, HIV testing can only be performed after I have **given informed consent**.

8. On-Site Testing and Community Referrals

- a. If I choose to have an HIV test, I may be able to receive **HIV testing on-site at NBCC/BCC**, when offered and clinically appropriate.
- b. If on-site testing is not available, or if I prefer, I can be referred to an appropriate local agency where **both pre-test and post-test counseling** will be available, along with information about prevention, treatment, and support.

9. Confidentiality of HIV Information

I understand that my personal HIV information, along with other information maintained by this facility about my treatment, is **confidential** and protected by:

- a. **Federal law (42 C.F.R. Part 2)**, and
- b. **HIPAA** (Health Insurance Portability and Accountability Act), especially as these laws apply to the treatment of substance use disorders and mental health conditions.

Testing Information and Referrals

I have been informed that my **drug use and/or behaviors** may place me at **higher risk** for contracting HIV, and I have been encouraged to have an **HIV antibody test** due to this risk. I have also been informed of the importance of being tested **annually for Tuberculosis (TB) and Hepatitis C**, especially if I have risk factors.

When available and appropriate, **NBCC/BCC may provide HIV testing directly on-site** as part of my care.

In addition, I have been informed that I may also seek HIV testing through the following community resources:

New Brunswick Counseling Center (NBCC) is advising me that I may seek HIV testing through:

New Brunswick Counseling Center & Burlington Comprehensive Counseling

- **Chandler Clinic**

Phone: 732-235-6700 or 732-235-6717

Burlington Comprehensive Counseling (BCC) is advising me that I may seek HIV testing through:

- **Burlington County Health Department**

Phone: 609-265-5548

These agencies can provide HIV testing, counseling, and additional referrals as needed.

Acknowledgment

I, the client, have been given information about HIV, HIV testing, and ways to reduce my risk. I understand that I may contact NBCC/BCC staff at any time to:

- Ask questions about HIV or other communicable diseases, and
- Request assistance with **on-site HIV testing (when available)** or with **referrals** for HIV, TB, and Hepatitis C testing.

Client Signature: _____

N. FINANCIAL POLICY

The client agrees to pay for all services in full at the time services are provided by our office, unless other arrangements are made in advance.

Client Financial Policies

You are required to present a valid insurance card at intake and as needed throughout your care. You are responsible for informing New Brunswick Counseling Center (NBCC) or Burlington Comprehensive Counseling (BCC) of any changes in your insurance (carrier, policy number, coverage, etc.).

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

Commercial Insurance Carriers:

You are responsible for obtaining any referrals and pre-authorizations required by your insurance plan.

We will bill in-network insurance carriers on your behalf.

Any co-payments, co-insurance, deductibles, and outstanding balances are due prior to checking in for your appointments.

Your agreement with your insurance carrier is a private contract between you and the carrier. We do not routinely research why a carrier has not paid or why it has paid less than anticipated.

If your insurance carrier has not paid within a reasonable period or denies coverage, all fees become due and payable in full by you.

Medicare:

Our office is a Medicare participating provider and we will bill Medicare on your behalf.

Any deductibles, co-insurance amounts, or non-covered services are your responsibility and will be due as services are rendered.

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Medicaid:

Our office is a Medicaid participating provider and we will bill Medicaid on your behalf.

You are responsible for informing us of any changes in your Medicaid eligibility or managed care plan.

Any services not covered or denied due to loss of eligibility may become your financial responsibility as allowed by law and plan rules.

Out-of-Network Insurance:

If we are out of network with your insurance carrier, you are responsible for paying your fee at the time of service.

Upon request, you may submit claims to your insurance company for possible reimbursement, subject to your plan's out-of-network benefits.

Payments and Collections

Client balance statements will be sent monthly. Please pay any balance shown on your statement within 15 days to keep your account in good standing.

If you need a payment plan, you may contact the billing department to discuss options.

Unpaid balances may jeopardize your status as a client, and your case may be placed on hold or closed until payment arrangements are made.

Our office accepts the following forms of payment: cash and credit cards (and any other methods you choose to add, e.g., debit, HSA cards).

If your balance is not paid according to the terms of this policy:

- Our office may refer your account to an outside collection agency.
- If your account is turned over for collections, you agree to pay all additional fees incurred in the collection of the debt, including collection agency fees and reasonable attorney's fees, as permitted by law.

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The client is ultimately responsible for all fees for services rendered.

By receiving services, you acknowledge that you have read, understand, and agree to the above financial policy for payment of professional fees.

Cancellation / Missed Appointment Policy

Once a counseling or clinical service is scheduled, a specific time is reserved for you. It is extremely important that you keep your appointment, as missed appointments prevent others from receiving services and increase program costs.

If you cannot keep your appointment, please call at least 24 hours in advance so that your time can be offered to another client.

Ongoing services cannot be provided for clients who frequently miss or cancel appointments without adequate notice.

Missed / Late-Cancelled Appointments

It is expected that payment be made at the time of each visit.

New Brunswick Counseling Center / Burlington Comprehensive Counseling may bill a fee for appointments that are missed or cancelled without 24 hours' notice, except where prohibited by your insurance plan or by law.

Repeated missed appointments and/or non-payment of fees may result in:

- Appointments being placed on same-day or walk-in status only, and/or
- Suspension or termination of services, with appropriate referrals offered.

Client Acknowledgment

I have read and understand the Financial Policy and Cancellation/Missed Appointment Policy of New Brunswick Counseling Center / Burlington Comprehensive Counseling. I agree to abide by these policies and understand that I am ultimately responsible for all fees for services rendered, in accordance with my insurance coverage and applicable laws.

Client Signature: _____

Acknowledgement

This is to acknowledge that I have received and reviewed the contents of the NBCC/BCC intake paperwork. You have the right to a paper copy of this packet and all the forms included. Please let us know if you would like a copy. Additionally, please sign below to indicate that you have reviewed and understand the contents of this packet:

Client Name (Print): _____

Client Signature: _____

Date: _____

OFFICE USE ONLY — Do Not Write Below This Line

Staff Name (Print): _____

Staff Signature: _____

Date: _____

New Brunswick Counseling Center & Burlington Comprehensive Counseling

LOCATIONS, ACTIVITY SCHEDULES, AND TELEPHONE NUMBER

New Brunswick Counseling Center

320 Suydam Street, New Brunswick, NJ 08901

Phone: 732-246-4025

Fax: 732-246-1214

Regular Office Hours*:

Monday-Thursday: 6:00AM-6:00PM

Friday: 6:00AM-1:30PM

Saturday: 6:00AM-9:00 AM (by
appointment)

Sunday & Holidays: Closed

Medication Hours:

Monday-Friday: 6:00AM-12:00 PM

Saturday: 6:00AM-9:00AM

Sunday & Holidays: Closed

Life Threatening Emergency: 911

Suicide and Crisis Hotline: 988

Burlington Comprehensive Counseling

605 High Street, Mt. Holly, NJ 08060

Phone: 609-267-3610

Fax: 609-267-9692

Regular Office Hours*:

Monday – Thursday: 6:00AM-3:00PM

Friday: 6:00-1:30 PM

Saturday: 6:30AM-10:30AM (by
appointment)

Sunday & Holidays: Closed

Medication Hours:

Monday – Friday: 6:00AM-11:00AM

Saturday: 6:30AM-10:00AM (by
appointment)

Sunday & Holidays: Closed

Life Threatening Emergency: 911

Suicide and Crisis Hotline: 988

*Includes individual counseling, group sessions, Intensive Outpatient, HIV counseling, admission assessments, intake screenings, case management, and doctors' appointments.

**NEW BRUNSWICK COUNSELING CENTER AND BURLINGTON
COMPREHENSIVE COUNSELING LEADERSHIP**

Sandra Lutomski, LCSW, LCADC

Chief Executive Director

Dr. Henry Scharf, MD

Medical Director, New Brunswick

Dr. Marshall Lauer, MD

Medical Director, Burlington

Ami Davey, RN

Director of Nursing, New Brunswick

Donna Kensler, RN

Director of Nursing, Burlington

Dr. Allen Blasucci, PsyD, LCADC

Clinical Psychologist & Manager

Lori Sonenblum, LCSW, LCADC

Clinical Director

Adaugo Nwaogwugwu, APN

Psychiatric Advanced Practice Nurse

Paul Abbey, LCSW

Clinical Supervisor

Susan Bosakowski, LCSW

Clinical Supervisor

Stephanie Riordan, LPC, LCADC

Clinical Supervisor

**THANK YOU FOR CHOOSING NEW BRUNSWICK COUNSELING CENTER AND BURLINGTON
COMPREHENSIVE COUNSELING FOR YOUR BEHAVIORAL HEALTH NEEDS!**

