Gwen S. Bloom, LCSW, LLC
3322 Rt. 22 West
Building 4, The Executive Suites – Suite 424
Branchburg, NJ 08876
Ph: 732-501-5917
Email: gwensbloom@gmail.com
Website: www.gwenbloomlcsw.com
License: 44SC051377300 NPI: 1043415599 Tax ID: 811740357

To My Clients:

I would like to welcome you to my office. Making the decision to enter therapy is a significant one, and I am honored that you have chosen me as your provider. My primary concern is that you receive high-quality professional care and that you feel as comfortable as possible here. At any time, if you have questions about your
appointments, my services, or my billing procedures, please be sure to ask for clarification.

The goal is for the therapist to aid the client in facilitating change, not encourage a dependency on the therapist to regulate your emotions. Thus, I find that most crises, or episodes, can be stabilized with, but not limited to, the following:

- A toolbox of behavioral skills
- Gaining insight into patterns of behaviors
- Recognize that your past may have contributed to your issues, but do not have to continue to dictate your existence
- Happiness is mindful moments of experiences
- At any given Ume, you are doing the best you can with the resources you have available

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CONFIDENTIALITY

As a general rule, we will keep the information you share with us in our sessions confidential, unless we have your written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with us in a therapy session. In some situations, we are required by law or by the guidelines of our profession to disclose information whether we have your permission.

Client: NoUfy a trusted adult or parent immediately to ensure safety and to assist with the below. Focus on distracting yourself and utilizing coping skills, *in the middle of a crisis is not the 0me to talk things through.*

- Somerset County residents – Call Psychiatric Emergency Screening Services (PESS) – 908-526-4100. They will provide a Mobile Outreach to you.
- All other counties call 911 or go to the local ER immediately.
- All clients, if in a medical emergency, go to the local ER immediately.

If there is aggression, threats, or violence and self and others' safety is at risk, please contact your local police department to ensure everyone's safety.

I understand that my therapist may not be available to answer the phone in crisis, and if my child or I are in crisis, I will follow the directions above.

____ ____________________

Client's Signature *Date*
(If under 14, the client does not need to sign.)

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CONSUMER FINANCIAL RESPONSIBILITY

The method of payment is by cash, check, Venmo, or Zelle (Privacy). A fee of $35 will be issued for any returned checks.

Rates and Payment
$185 initial consultation – 68-75 minutes\ (90791)
$150 per 45-50 minute session (90837)
$160 per 45-50 minutes for a family session (90847)

I am currently an in-network provider with Aetna, Cigna, Horizon Blue Cross/Blue Shield, United Healthcare, Beacon, and Medicare. My office will submit claims; however, you are responsible for deductibles and copays at each session.

Out-of-network benefits for behavioral health/mental health services. If mental health benefits are available, be sure to ask if your deductible is met, what is the maximum number of sessions covered, and if pre-authorization is required. I do not submit claims for out-of-network insurance coverage. However, I will provide you with a receipt that will have all the necessary information for you to complete and submit your insurance claim (please let me know if you need a statement more frequently).

Missed and Cancelled Appointments
To be effective, therapy needs to take place on a regular basis. The best results occur when appointments are consistently scheduled. Additionally, an appointment Ume reserved for you means that it cannot be used for someone else. Since the scheduling of an appointment involves the reservation of Ume specifically for you, a minimum of 24 hours notice is required for rescheduling or canceling an appointment. A full fee will be charged for sessions missed without notification.

Obviously, there are cases when missing therapy cannot be avoided, and exceptions can and will be made to this policy. Please note that "no-show" appointments cannot be billed to your third-party insurance carrier, and you are responsible for the full payment.

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COUNSELING AGREEMENT / INFORMED CONSENT

I agree and consent to participate in counseling services offered and provided by Gwen Bloom. I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to provide within the scope of the provider's license, certification, and training. I understand that these services may include observation, individual, family, and couples counseling, and, if clinically appropriate, documentation and consultation.

Signing below indicates that you have reviewed the policies described within this packet, including the limits to confidentiality, financial responsibility, cancellation policy, and crisis plan in the case of an emergency. If you have any questions as we progress with therapy, you can ask at any time.

I have read and agree to the office policy statement:

_________________________________ _____________
Client's Signature Date

____
Client's Name (print)

____
Parent's Signature (if the client is under the age of 18)

____
Parent's Name

In case of emergency – contact information

Name: ____________________________
Address:____
Phone: (home)______________ (cell) ______________ (work) ______________

In case of emergency – contact information

Name: ____________________________
Address:____
Phone: (home)______________ (cell) ______________ (work) ______________

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RELEASE OF INFORMATION

I, ____, authorize Gwen Bloom, LCSW, LLC, to release information to and/or receive information from:

Name: ____

Address: ____

____

Phone: ____

Reason for release: ____

This release of information can be used to obtain or release any physical or mental status exams, social or family history information, educational evaluations/reports, ongoing treatment summaries/reports, and any information needed to process a third-party insurance claim.

The purpose for disclosure is to facilitate assessment, treatment, planning, and payment.

I understand that by law, I do not have to release this information. However, I choose to do so voluntarily for the purpose specified above. I further understand that I may cancel this authorization for the release of information at any Ume unless the information has already been sent. The permission to release the above information will expire in one year.

Clients Name: __________________________________ DOB _______________________

Address:____

___________________________________ ___________________
Signature of Client Date Date

___________________________________ ___________________
Signature of Parent/Legal Guardian Date

___________________________________ ___________________
Signature of Witness Date

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PATIENT INFORMATION

Today's Date: ______________

Patients Name: ______________ ______________ ________ S M D

Last First Middle Marital Status

SS#: ________________Home Phone: __________________ Cell: __________________

Date of Birth: ______________ Age :_____________ Sex:__________________

Patient's Address: ____

Email Address: ____________________ Preferred Method of Contact: Text / Email/ Voice Mail

Occupation: ____

Employer Name: ____

Employer Address ____

Employer Phone Number: ____

Doctor's Name and Number: ____

Referred by: ____

INSURANCE INFORMATION

Is the patient covered by insurance ____ Yes ____ No

Insurance Company: ______________________ Policy No. __________________________

Responsible Party: _______________________ Date of Birth: ________________________

Address (if different): ____

Home Number: __________________________ Cell Number: ________________________

Is responsible party a patient here? ___ Yes ___ No

Relations to patient: ____

Occupation: ____

Employer Name: ____

Employer Address ____

Employer Phone Number: ____

WE DO NOT ACCEPT SECONDARY INSURANCE