JEWISH FAMILY SERVICES
1937 West Cornwallis Road, Durham NC 27705
Phone (919) 354-4922 Fax (919) 794-6116
Website: www.shalomdch.org

DEAR NEW CLIENT:

Upon entering therapy people often have many questions. In addition to talking about them, we find it helpful to outline in writing some of the answers to them. Please discuss with your therapist any questions and concerns you have about our procedures.

STAFF AND CREDENTIALS

The clinical staff of JFS includes:

Jennifer Schwartz, MSW, LCSW, Director
Shira Bar-On, MSW, LCSW, Social Worker

MESSAGES

Our phones are answered Monday – Thursday, 9:00a.m. to 5 p.m. and Friday, 9:00 a.m. to 3 p.m. You may leave a confidential message on your therapist's voicemail at any time. If you do not hear back from your therapist the next day please call again—it is possible for a message to get lost in voice mail. Messages are usually not retrieved on nights, holidays or weekends. We **DO NOT** provide emergency services. If a life threatening or other crisis situation arises, please call 9-1-1 or go to your nearest emergency room as soon as possible.

OFFICE HOURS

Monday through Friday by appointment only.

APPOINTMENTS

Your appointment is time set-aside just for you. If you are late, your appointment will still finish at the set time. However, if your therapist is late you will receive your full time or we will arrange to make it up at another time. Individual, couple and family sessions are 50 minutes unless otherwise arranged in advance. If you do not show up for three appointments in a calendar year without notice, we will assume that you are not committed to therapy at this time and consider the relationship with JFS to be terminated.

CANCELLATIONS AND RESCHEDULING

Your therapy time is reserved for you. It is recommended that every client make a commitment to a regular appointment time if at all possible. If for some reason you must cancel an appointment, as much advance notice as possible is appreciated. IF APPOINTMENTS ARE CANCELLED LESS THAN A FULL 24 HOURS IN ADVANCE, YOU WILL BE CHARGED YOUR REGULAR FEE FOR THIS APPOINTMENT. If we can reschedule the appointment, there will still be a charge for the missed appointment if 24-hour notice was not given. Insurance will not pay for missed appointments; therefore it will be your responsibility to pay the full fee.

PAYMENT AND INSURANCE

Our policy is that fees are paid at the beginning of each session. In order to maximize your therapy time, please have your checks made out prior to your session. Checks should be made out to Jewish Family Services. All fees are available on a sliding scale, and should be discussed with your therapist. We will be glad to assist with insurance by completing a standard insurance form for you.

CONFIDENTIALITY

No information about the content of your therapy sessions will be communicated to anyone without your written authorization (insurance forms require your signature and release of information, which is a possible waiver of your confidentiality). The only exceptions to this are cases of child abuse, elder abuse, suicidal, homicidal or life threatening emergencies. Remember that once insurance or third party payments are involved (HMO's, PPO's, Managed Health Care, Insurance) your signature waives your rights to confidentiality, although your therapist still attempts to honor your confidences by sharing the fewest details possible and only when required. There is a legal exception to your rights of confidentiality in certain cases when you file a lawsuit. Please speak further with your therapist about this clarification.

ADDITIONAL QUESTIONS

If you have any questions, concerns or complaints that you cannot resolve with your therapist please call the JFS Director, Jennifer Schwartz. We want your experience with our agency to be helpful and rewarding.

I have read the policies and agree to abide by them.

Client's Signature:_____

Social Worker's Signature:_____

Date:_____

(For Counseling and Case Management Client ONLY)

CLIENTS USING INSURANCE-INSURANCE AUTHORIZATION

I, _____,
hereby authorize payment of medical benefits to Jewish Family Service of Durham-Chapel Hill for services received. I also authorize the release of information necessary to process claims. I understand that: I am responsible for all co-pays, deductibles, and any fees unpaid by insurance for any reason; that Jewish Family Service of Durham-Chapel Hill only bills primary insurance coverage, not for secondary coverage; and that I am responsible for understanding my benefit plan and will inform Jewish Family Service of Durham-Chapel Hill of any changes in my insurance coverage, including the termination of coverage. When insurance coverage terminates or an annual limit is reached I will arrange to pay for services out-of-pocket if I decide to continue counseling.

X_____Date: _____
Client Signature (or Legal Guardian)