THE INSTITUTE FOR CHANGE
(973) 734-0780

MORRISTOWN OFFICE
44 Elm Street
2nd Floor
Morristown, NJ 07960

MONTCLAIR OFFICE
460 Bloomfield Avenue
Suite 211
Montclair, NJ 07042

Mailing Address: IFC, PO Box 289, Caldwell, NJ 07006

PROFESSIONAL POLICIES

Welcome to our practice. We look forward to working with you. Please read this document carefully since it contains important information about our professional services and business policies. If you have any questions, please feel free to discuss them with us.

Payment and Billing Procedures: You are expected to pay for services (full or co-payment as agreed) at the end of each session. If you are covered by health insurance, we can submit claim forms directly to your insurer upon your request. Please make all checks out to The Institute for Change. You may also pay by credit card (processing fee applies) or via Zelle (Our Zelle ID is: ifc.correspondence@gmail.com)

Cancellation Policy: Appointments canceled with less than 24 hours notice will result in a charge reflective of your fee unless you are canceling due to illness or emergency. Your insurance company does not reimburse charges for missed appointments or late cancellations, so you will be responsible for payment of the session. We appreciate your courtesy in providing us with as much notice as possible if canceling or rescheduling an appointment.

Confidentiality: Information shared between a patient and a psychotherapist is confidential and protected by law. Information cannot be disclosed without permission in writing from you or your parent/legal guardian if you are a minor. The exceptions to this rule are as follows:

1. The therapist receives information suggesting that child abuse may have been committed. State law requires notification to the Division of Child Protection and Permanency.
2. The therapist receives information suggesting that the client presents a danger to self or others.
3. Information in the therapist's file is subpoenaed and a judge upholds the subpoena.
4. Information is requested by your insurance company to authorize reimbursement. In this case we provide only what is allowed by law, usually name and address, CPT code (type of service provided), dates of service, fee and diagnosis.

Thank you for following our practice guidelines. We look forward to working with you.
You may either print this form and bring your signed form to your first appointment or we can provide the form to you at our office.

By signing below, I acknowledge that I have read and understood the above policies and agree to follow them.

_____

Printed Name of Patient -OR- Child Patient Date

_____

Signature of Patient -OR- Parent/Legal Guardian Date

_____

Name of therapist seen at IFC