



BETTER BE BLAKE THERAPY

NEW JERSEY PSYCHOTHERAPY INFORMED CONSENT & PRACTICE POLICIES

Adult, Minor, Telehealth, Financial, Communication, Custody & Release-of-Information Forms

Purpose of this packet

This packet documents informed consent for outpatient psychotherapy and acknowledges Better Be Blake Therapy practice policies. It is designed for use in New Jersey and should be reviewed by the practice's attorney/compliance professional before implementation or whenever law, payer requirements, or practice policies change.

Client Information

Client legal name: _____

Preferred name: _____

Date of birth: _____ Pronouns: _____

Address: _____

Phone: _____ Email: _____

Emergency contact: _____ Relationship/phone: _____

Clinician Information

Treating clinician: _____

Credential/license: _____ License/permit no.: _____

Clinical supervisor (if applicable): _____

Supervisor credential/license no.: _____

1. INFORMED CONSENT FOR OUTPATIENT PSYCHOTHERAPY

Nature and Purpose of Services

Psychotherapy is a collaborative professional service intended to address emotional, behavioral, relational, developmental, or mental health concerns. Treatment may include assessment, diagnosis when clinically appropriate, treatment planning, psychoeducation, skill building, and evidence-based psychotherapy. Specific methods, frequency, and goals are individualized and may change as treatment progresses.

Psychotherapy may provide benefits such as improved coping, functioning, relationships, insight, and symptom reduction. It can also involve temporary discomfort, including discussing difficult experiences or emotions. No particular outcome can be guaranteed.

You may ask questions, request treatment-plan changes, seek another provider or second opinion, decline a recommended intervention, or end treatment. Referral or a different level of care may be recommended when clinically indicated.

Confidentiality and Its Limits

Clinical information is generally confidential and is handled in accordance with applicable federal and New Jersey law and professional standards. Information may be disclosed with your written authorization or without authorization when disclosure is required or permitted by law. Examples can include suspected abuse or neglect, certain serious safety threats, valid court orders or other compulsory legal process, health oversight or other legally authorized disclosures, and circumstances necessary for treatment, payment, or healthcare operations as permitted by law.

If you have questions about a particular confidentiality situation, ask your clinician before sharing information. A Notice of Privacy Practices should be provided separately when applicable.

Clinical and administrative records are maintained as required by applicable law and professional standards. With appropriate authorization, care may be coordinated with other providers.

Emergencies

Better Be Blake Therapy is an outpatient practice and does not provide continuous crisis monitoring. Do not use email, text, voicemail, or portal messages for emergencies. If there is immediate danger or a mental health emergency, call 911, call or text 988, or go to the nearest emergency department.

Acknowledgment and Consent

- ☐ I have had the opportunity to ask questions about psychotherapy, its potential benefits and risks, alternatives, confidentiality, and practice expectations.
- ☐ I voluntarily consent to outpatient psychotherapy with Better Be Blake Therapy and understand that consent may be withdrawn, subject to clinically and legally appropriate termination procedures.

2. PRACTICE POLICIES ACKNOWLEDGMENT

The following summarizes the practice policies currently published by Better Be Blake Therapy. The website policy remains subject to lawful updates; material changes affecting your care should be communicated as appropriate.

Attendance & Engagement

Clients are expected to attend at the frequency mutually agreed upon with the clinician. Better Be Blake Therapy states that it does not charge financial penalties for missed appointments, late cancellations, or no-shows. A pattern of two consecutive no-shows/late cancellations, or three no-shows and/or late cancellations within a four-week period, may be treated as significant disruption to treatment. The clinician may modify frequency, recommend a different level of care, place services on hold, or terminate treatment in accordance with clinical, ethical, and professional standards.

Financial Responsibility & Payment

When applicable, the practice submits claims to participating insurers as a courtesy. The client remains responsible for understanding insurance benefits and for patient responsibility amounts such as copayments, deductibles, coinsurance, non-covered services, or other balances. The practice issues monthly statements and currently lists personal check, major credit card, HSA/FSA, Zelle, and Venmo as payment options.

The published policy states that if a balance remains unpaid after three monthly statements and reasonable communication efforts are unsuccessful, the practice may pursue lawful collection efforts, including referral to a third-party collection agency. Clients are encouraged to contact the practice promptly about billing questions or financial hardship.

Communication Between Sessions

Messages are generally returned within one to two business days, though timing may vary. Administrative matters should be directed to administrative channels when possible; clinical updates should go to the treating clinician using approved methods. Electronic communications are not a substitute for therapy or crisis care and may carry privacy/security risks.

Court & Legal Proceedings

Routine psychotherapy is treatment, not a forensic service. The practice does not provide custody evaluations, parenting evaluations, fitness-for-duty evaluations, or other forensic services unless specifically contracted to do so. Clients should not assume a treating clinician will testify, prepare extensive legal reports, participate in depositions, or communicate with attorneys. Legal-service requests are subject to clinician availability, law, ethics, professional judgment, and the practice's established professional rates.

3. TELEHEALTH INFORMED CONSENT

Telehealth Services

Telehealth uses electronic communication technology to provide psychotherapy when clinician and client are not in the same physical location. Telehealth may offer convenience and continuity of care but can involve risks such as technology failure, interruptions, reduced ability to observe some nonverbal information, and privacy/security limitations.

Location, Identity & Safety

At telehealth visits, the clinician may confirm the client's identity, current physical location, and a method for emergency contact. The client agrees to participate from a reasonably private and safe location and not to drive or operate hazardous equipment during a session. The clinician must be legally permitted to provide services where the client is physically located at the time of the session.

Technology & Privacy

The practice and clinician will use reasonable safeguards. The client is responsible for reasonable privacy on the client side, including use of a private space and secure device/network when feasible. If technology fails, the clinician and client may reconnect, switch to an approved backup method when clinically and legally appropriate, reschedule, or arrange in-person care.

Recording

Sessions may not be audio- or video-recorded by either party without advance agreement and any written informed consent required by applicable law and professional rules.

Emergency Planning

Telehealth is not an emergency service. The clinician may use the client's reported location and emergency contact information to facilitate emergency assistance when clinically and legally necessary. In an emergency, call 911, call or text 988, or go to the nearest emergency department.

- ☐ I consent to receive psychotherapy by telehealth when offered and clinically appropriate.
- ☐ I understand that telehealth consent may be oral, written, or digital under New Jersey law when appropriate to the standard of care; this signed form documents my consent for the practice record.

4. MINOR CLIENT / PARENT-GUARDIAN CONSENT

Consent Authority

For minor clients, the practice will determine who has legal authority to consent to treatment based on the client's age, the service requested, applicable New Jersey law, and any custody or court documents. New Jersey law contains circumstances in which a minor may independently consent to certain outpatient mental health services; those situations should be handled according to the governing statute and clinical/legal requirements rather than a blanket parental-consent rule.

Privacy in Child & Adolescent Therapy

Effective therapy often requires an age-appropriate degree of privacy. Parents/caregivers can generally expect information about treatment progress, overall themes, recommendations, and significant safety concerns rather than a detailed account of every session. Confidentiality may be limited when disclosure is required or permitted by law or necessary to address significant safety concerns.

Parent/Caregiver Participation

The clinician may recommend parent consultations, caregiver coaching, joint sessions, family sessions, or coordination with schools or other providers when clinically appropriate. Caregivers are encouraged to provide relevant updates while allowing the clinician to maintain an appropriate therapeutic relationship with the minor.

Authority / Documentation

- ☐ I represent that I have legal authority to consent to this minor's treatment, unless the minor is independently consenting under applicable New Jersey law.
- ☐ I will provide current custody orders, parenting plans, guardianship documents, or other legal restrictions that may affect treatment, scheduling, communication, or access to records.

Minor client name: _____

Parent/guardian name(s): _____

Legal relationship / authority: _____

5. CUSTODY, DIVORCE & CO-PARENTING

ADDENDUM

This addendum is intended for families in which custody, separation, divorce, guardianship, or co-parenting arrangements may affect treatment. Better Be Blake Therapy's role is therapeutic, not forensic, and the child's clinical welfare remains the focus of treatment.

Required Information

- ☐ I have disclosed all known custody, parenting, guardianship, restraining, or court orders relevant to treatment.
- ☐ I will promptly provide updated legal documents if circumstances change.
- ☐ I understand the practice may delay, modify, or discontinue services when unresolved guardian disagreement prevents lawful or clinically appropriate treatment.

Neutrality and Boundaries

Clinicians will not serve as messengers between parents, take sides in custody disputes, gather evidence for litigation, or make custody/parental-fitness determinations as part of ordinary psychotherapy. Requests for records, testimony, attorney communication, reports, or legal participation are handled according to applicable law, ethics, clinical judgment, and practice policy.

Custody Information

Legal custody arrangement: _____

Physical custody arrangement: _____

Other parent/guardian name & contact: _____

Court/case information (if applicable): _____

Documents provided to practice: _____

6. ELECTRONIC COMMUNICATION & EMERGENCY ACKNOWLEDGMENT

Approved Communication

Email, text, voicemail, and portal communications may be used for appropriate administrative or limited clinical communication consistent with practice procedures. These methods may have privacy/security risks and are not guaranteed to be reviewed immediately. Complex clinical matters generally belong in a scheduled session.

Emergency Instructions

DO NOT USE MESSAGES FOR EMERGENCIES

If you or another person may be in immediate danger, call 911. For a mental health crisis, call or text 988 or go to the nearest emergency department. Better Be Blake Therapy cannot guarantee immediate review of voicemail, email, text, or portal messages.

Communication Preferences

- ☐ Voicemail may be left at my listed phone number.
- ☐ Text messages may be used for scheduling/administrative communication.
- ☐ Email may be used for scheduling/administrative communication.
- ☐ I understand that choosing electronic communication does not eliminate privacy/security risks.

Preferred phone: _____

Preferred email: _____

7. AUTHORIZATION FOR RELEASE / EXCHANGE OF INFORMATION

Use this form when the client wants Better Be Blake Therapy to disclose information to, obtain information from, or exchange information with another person or organization. This form should be completed separately for each recipient when practical.

Client name: _____

Date of birth: _____

Person/organization: _____

Address / fax / secure email: _____

Direction of Information

- ☐ Better Be Blake Therapy may disclose information TO the person/organization above.
- ☐ Better Be Blake Therapy may obtain information FROM the person/organization above.
- ☐ Two-way exchange of information is authorized.

Information Authorized

- ☐ Attendance / appointment information
- ☐ Diagnosis / assessment information
- ☐ Treatment plan, goals, and progress
- ☐ Medication / coordination-of-care information
- ☐ Discharge summary
- ☐ Other: _____

Purpose

- ☐ Coordination of care
- ☐ Insurance/payment
- ☐ School/academic coordination
- ☐ Legal/personal request
- ☐ Other: _____

Expiration and Revocation

This authorization expires on the date/event written below, or as otherwise required by applicable law. I understand I may revoke this authorization in writing, except to the extent action has already been taken in reliance on it.

Information disclosed to some recipients may no longer be protected by the same privacy laws. This authorization does not require disclosure beyond what is lawful and clinically appropriate.

Expiration date/event: _____

Client/authorized signer signature

Date

8. FINAL ACKNOWLEDGMENT & SIGNATURE

By signing below, I acknowledge that I received or had access to the applicable informed-consent and practice-policy information in this packet; I had the opportunity to ask questions; and, where applicable, I consent to outpatient psychotherapy and telehealth and acknowledge the minor/parent, custody, attendance, financial, communication, emergency, and court/legal provisions described above. This signature is intended to serve as my acknowledgment for the packet as a whole.

- ☐ I consent to outpatient psychotherapy as described in this packet.
- ☐ I acknowledge the attendance, financial, communication, emergency, and court/legal policies.
- ☐ If I use telehealth, I consent to telehealth as described in this packet.
- ☐ If treatment involves a minor, I acknowledge the minor/parent and custody provisions applicable to the case.
- ☐ I understand that a separate Notice of Privacy Practices and any other required notices/authorizations may also apply.

For a minor client, the parent/legal guardian or other person legally authorized to consent should sign in the authorized-signer line below. The client may also sign when clinically or legally appropriate.

_____	_____
Client name (print)	Date of birth

_____	_____
Client / authorized signer signature	Date

_____	_____
Authorized signer name & relationship (if applicable)	Relationship / authority

_____	_____
Clinician signature	Date

Practice Use Only

Packet reviewed by: _____

Date reviewed: _____

Additional forms/notices provided: _____

Notes / exceptions: _____

Source & Compliance Notes

Practice-policy source: Better Be Blake Therapy, "Policies & Procedures," reviewed October 6, 2026. New Jersey compliance references used in drafting include the NJ Professional Counselor Examiners Committee statutes/regulations page and New Jersey telemedicine/telehealth law. This template is not a substitute for legal advice and should be reviewed by qualified New Jersey counsel/compliance personnel before use.