E R I N G I L B E R T , M S W
226 West 26th Street, 8th floor #7, NY, NY 10001
www.egtherapy.com / erin@egtherapy.com
T. 646.580.7025

Client Information/ Adult #1

Name: _____

Address: _____

_____

Date of Birth: _____

Email Address: _____

Home Telephone: _____ **Work Telephone:** _____

Mobile Telephone: _____

Please circle preferred telephone number.

Is it ok for therapist to leave a message at the preferred number if necessary?	Yes / No
Is it ok for therapist to text you on your mobile if necessary?	Yes / No
Is it ok for therapist to email you if necessary?	Yes / No

Emergency Contact Person: _____

Relationship to Client: _____

Telephone #1: _____

Telephone #2: _____

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Acknowledgement of Receipt of Service Agreement

I have read the Service Agreement and consent for myself or my child to receive psychotherapy services under the terms outlined.

Signature of Client or Representative: _____

Printed Name of Client or Representative: _____

If Not Client, Relationship to Client: _____

Date: _____

Copy given to client or his or her representative: YES / NO

Acknowledgement of Receipt of Notice of Privacy Practices

This form is acknowledgement that you (the client or the client's personal representative), _____ have received a copy of the Notice of Privacy Practices (NPP). When I use the term "you" below, it will mean the client (or your child, relative or other person if you have written his or her name above).

By signing this form, you are acknowledging that I have provided you with a copy of the NPP. The NPP explains in more detail your rights and how I can share and use your information.

In the future, I may change how I use and share your information and so may change my NPP. If I change it, you are able to request a copy.

Signature of Client or Representative: _____

Printed Name of Client or Representative: _____

If Not Client, Relationship to Client: _____

Date: _____

Copy given to client or his or her representative: YES / NO

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Client Information/ Adult #2

Name: _____

Address: _____

_____

Date of Birth: _____

Email Address: _____

Home Telephone: _____ **Work Telephone:** _____

Mobile Telephone: _____

Please circle preferred telephone number.

Is it ok for therapist to leave a message at the preferred number if necessary?	Yes / No
Is it ok for therapist to text you on your mobile if necessary?	Yes / No
Is it ok for therapist to email you if necessary?	Yes / No

Emergency Contact Person: _____

Relationship to Client: _____

Telephone #1: _____

Telephone #2: _____

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Date: _____

Copy given to client or his or her representative: YES / NO

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Gottman Marathon Couples Therapy Service Agreement

WHAT IS IT?

Marathon couples therapy is an intensive form of couples therapy that takes place over several hours in one day or several days, and gives you and your partner the opportunity to explore issues in a more focused way than allowed in weekly sessions. A great benefit of Marathon couples therapy is that changes in the relationship may be experienced more quickly since it is such an in-depth experience.

The framework for Marathon couples therapy is provided by the Gottman Method. This strengths-based approach to improving relationships is based on John and Julie Gottman's extensive research with both healthy and struggling couples. For more information about the Gottman Method, please visit https://www.gottman.com/about/the-gottman-method/, or pick up one of John and Julie Gottman's many books.

IS IT A GOOD FIT FOR MY PARTNER AND ME?

If you and your partner are having trouble resolving the same old conflicts, or you can't seem to connect anymore, or (insert your particular problem here!), it's an opportune moment to explore what's happening. Marathon couples therapy is a great fit for you if you would like to dive deeply into these issues but have limited time on a weekly basis.

WHAT TO EXPECT?

Now that you have decided to invest in Marathon couples therapy, here's what else you need to know.

BEFOREHAND: An assessment process is an important aspect of any couples therapy informed by the Gottman Method. The following steps can occur before the Marathon couples therapy experience or during that experience depending upon your situation.

- **Consultation**: The consultation includes time for you to explain what brings you to therapy. You and your partner will answer a variety of questions about yourselves and your relationship. Next steps in the process will be reviewed.
- **Gottman Relationship Checkup**: Around this time, the Gottman Relationship Checkup, a computerized survey filled out by you and your partner, should be completed and will be reviewed either in a later session or in the Marathon couples therapy experience.
- **Individual Interviews**: You and your partner each will meet for an individual interview to concentrate on individual issues and concerns, and how these may impact the couple.

DURING MARATHON COUPLES THERAPY: We will begin by discussing the results of the Gottman Relationship Checkup. Following that, we'll have freedom to explore a variety of issues, though likely we'll use the Gottman Method to focus upon one or two issues. Our conversations will provide us with opportunities to work on conflict resolution, deepening friendship, finding

shared meaning, and improving communication. You will both practice and take home the skills needed to improve the health of your relationship.

SCHEDULE: The following is an example of a schedule for a 5 hour session. Short breaks may be taken as needed.
Part one: 10-12:30pm. Lunch break: 12:30-1:30pm. Part two: 1:30-3:30pm.

PROFESSIONAL FEES: My fee for Marathon couples therapy will be agreed upon in advance of the experience. Payment of 50% is due 48 hours in advance of the session in order to secure the time, paid via cash, check, Venmo or Zelle. Credit card payments are not accepted at this time. Additional fees may be charged for professional time outside of this (e.g., telephone consultations beyond 15 minutes), which will be pro-rated according to an hourly fee for services.

USING YOUR INSURANCE: I currently am a participating provider on BCBS's and Magnacare's insurance panels, and am considered out of network on all other plans. However, I will do my best to provide insight into how to access out-of-network insurance coverage. Insurance plans will not provide full coverage for a Marathon couples experience but may provide reimbursement of the equivalent for a 45 minute session.

CLINICAL INDEPENDENCE: While I have taken training in the Gottman Method Couples therapy, I am completely independent in providing you with clinical services and I alone am fully responsible for those services. The Gottman Institute or its agents have no responsibility for the services you receive.

CONFIDENTIALITY: The psychotherapy services I provide constitute confidential and privileged communication. Information regarding these services is kept in a secure location. Information stored or transmitted electronically is password-protected and secure to the extent that current technology permits, though please note that as email, video, cell phone and cordless phone communications can be accessed by unauthorized people, the privacy and confidentiality of such communication can be compromised. Please alert me if you would like to avoid or limit in any way the use of any or all of the above-mentioned communication devices.

Information about treatment may only be released with patient/responsible adult written authorization, unless otherwise mandated by law, namely, suspected child, elder, or spousal abuse, dangerousness to others or self, certain legal proceedings, and conditions of the Patriot Act. Information also may be released should assistance be required to collect payment when such payment is past due. The confidentiality of information released to another person or agency (for example, to another therapist or to an insurance company) cannot be guaranteed; I cannot be held liable if the other person or agency re-releases the information without your authorization. You will receive a copy of my Healthcare Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices.

EMERGENCY PROCEDURES: I am not in the office every day and therefore cannot respond immediately to crisis situations. If you think you are having a mental or physical health emergency, you need to call 911 and/or go to the emergency room of the nearest hospital. If you need to contact me between sessions, please call me and follow the recorded instructions. If you do not

receive a return call within 24 hours, assume mechanical failure of the voice mail system and call again. Do not use email to contact me for an emergency.

CANCELLATION: Please call to reschedule or cancel at least 48 hours in advance of your Marathon couples therapy appointment time or 50% of the full fee will be charged for a missed appointment without such notification. If you use email to cancel your appointment, please also call me as well so that I can be certain that I have received your message. For weekly sessions, 24 hour notice is requested, or your full fee will be charged. Again, for weekly sessions, if you do not show up for a scheduled session and provide no notice, your reserved time slot may be made available for other patients. If you do not show for two scheduled sessions and provide no notice, I will assume you would like to end treatment and I will send you a letter or an email alerting you of the closure. Frequent no-shows may result in termination from treatment and notice will be provided to you in advance of such an action.

COMPLAINTS AND CONCERNS: You are encouraged to discuss concerns about any aspect of our work together with me at any time.

ENDING THERAPY: If I determine that I am unable to help you reach your therapeutic goals either during the first few meetings or at any point during therapy, I will give you a referral. If you request it and authorize it in writing, I will talk to the psychotherapist of your choice in order to help with the transition. You have the right to terminate therapy at any time.

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Permission for Digitally Recording Therapy Sessions

THERAPIST'S EXPLANATION: As a primary tool in Gottman Method Couples Therapy, and in order to augment your therapy work, I use video feedback as part of therapy sessions. This means that I may ask to video you during specific dialogues or exercises, or during entire sessions. We will play back these videos in sessions to help you see patterns of behavior between the two of you and help you to process conflicts. By viewing the videos in sessions, it will allow us to "stop action" and process how you might approach a conflict in more productive way. It also allows you to witness your progress as your relationship becomes more satisfying to both of you.

In addition to in-session use, I may wish to use videos to receive consultation from Drs. John or Julie Gottman or an independently practicing clinician who has received training from The Gottman Institute, and to provide such training. This may occur during the time of treatment or thereafter for purposes of peer review, education and quality assurance. During this process, your name will be kept confidential. In addition, all matters discussed in consultations will remain completely confidential within the Gottman Institute Staff. The videos are not part of your clinical record and will be used for no other purpose without your written permission and they will be erased when they are no longer needed for these purposes.

These videos are my property and will remain solely in my possession during the course of your therapy. Copies may be sent to the Gottman Institute for the purposes notes above. Should you wish to review these videos for any reason, we will arrange a session to do so. These materials will remain at all times in locked facilities and/ or on secure computers or devices.

CLIENT'S AGREEMENT: I understand and accept the conditions of this statement and give my permission to have my therapy sessions videotaped or digitally recorded. I understand I may revoke this permission in writing at any time but until I do so it shall remain in full force and effect until the purposes stated above are completed.

Client _____ Date _____
(signature)

Client _____ Date _____
(signature)

Therapist _____ Date _____
(signature)

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT ME.

I am committed to keeping your personal health information private and secure. I protect your personal health information by maintaining safeguards that meet or exceed applicable state law and the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). If you are a parent or guardian of a dependent under my care, this notice applies to your dependent's health records and references to "You" in this notice refer to you in your capacity as parent or guardian. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change my practices and the terms of this Notice at any time, and to make the new notice effective for all protected health information that I maintain. Upon request, I will provide you with any revised Notice of Privacy Practices.

Uses and Disclosures of Personal Health Information

I will not use or disclose your health information without your authorization, except as described in this notice. When you become my patient, you will be asked to sign a consent form allowing us to provide clinical services to you, use your personal information for treatment, payment, and health care operations. For example:

- Treatment. I will use your information to create a case record, determine the best course of treatment, coordinate your care, consult with other professionals as necessary, or make referrals.
- Payment. I will use your information to determine eligibility under health plans, manage billing and claims procedures, and collect payment from you or third-party payers if applicable.
- Health care operations. I will use your information to assess the care and outcomes of treatment and to improve the quality of my services.

I may also use your personal health information where required or permitted by law. These situations include:

- Emergencies. In an emergency, I may use or disclose health information to notify a family member, personal representative, or person responsible for your care, to determine your location and condition.
- As required by law. I may notify authorities of alleged abuse or neglect; risk or threat of harm to self or others; information required for public health, law enforcement, or national security purposes; information in response to a subpoena, judicial order, or similar legal process; information required by agencies responsible for oversight or regulation of health care providers; information pertaining to my compliance with HIPAA requirements.
- Research. I may disclose your protected health information without key pieces of identifying information to researchers if an institutional review board or privacy board has approved the research protocols to ensure protection of your privacy.
- Appointment Reminders and Alternative Treatments. I may use your information to contact you about an upcoming appointment or inform you about treatment alternatives.
- Business Associates. There are some jobs that I may hire other businesses to do for me. Examples include insurance billing services, auditors and attorneys, some of whom may need to receive some of your personal

health information to do their jobs properly.

In all other situations, I will use or disclose your health information only with your written authorization. If you sign an authorization, you have the right to revoke the authorization to prevent future uses and disclosures.

Your Rights as Patient

You have the following rights with respect to your protected health information:

- Restrictions. You may request restrictions on how I use or disclose your health information; your request will be considered but I am not legally obligated to agree to your requested restriction.
- Confidentiality. You may request that your health information be communicated to you in a confidential manner, such as sending mail to an address other than your home.
- Access. You may inspect and copy your protected health information or request a summary of your health information; if you request copies of your records or a summary, you may be charged reasonable fees for these services.
- Amendment. If you believe information in my records is incorrect, you may request an amendment to your health information.
- Accounting of Disclosures. You have the right to receive an accounting of disclosures of your protected health information.

My Duties

I have the following obligations with respect to your privacy and this notice:

- I am required by law to maintain the privacy of protected health information and to provide my patients with notice of my privacy practices.
- I am required to abide by the terms of this notice while it is in effect.
- I reserve the right to change the terms of this privacy notice and make the revised notice applicable to all health records maintained by my office. If I change my privacy notice, you always have the right to request an updated copy.

Complaints

If you believe your privacy rights have been violated in any way, you may file a complaint in writing with me. I will attempt to resolve your complaint promptly. You also have the right to file a complaint with the Secretary of the U.S. Department of Health and Human Services. I will not retaliate against you for filing a complaint under any circumstances.

Effective Date

This notice is effective August 28, 2008.

Questions

Any questions or concerns relating to your privacy rights should be directed to me.