KAREN J. LANDSMAN, Ph.D.
License # 35S100406700
(973) 895-2442
268 Green Village Road
Green Village, New Jersey 07935
68 Essex Street, Suite 1A
Millburn, New Jersey 07041

Date of Initial Visit: _____

Child's/Teen's Name: _____

Date of Birth: _____ Age: _____

Complete Address: _____

_____

Grade: _____ School: _____

Phone (home): _____ (cell): _____

Email: _____

Presenting Problem: _____

Marital Status of Parents: _____

Mother's Name: _____ Age: _____

Occupation: _____ Highest Education: _____

Employer: _____ Office Phone: _____

Father's Name: _____ Age: _____

Occupation: _____ Highest Education: _____

Employer: _____ Office Phone: _____

Emergency Contact: _____

Phone:_____

Persons in the Home	Age	Relationship
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

Referral Source: _____

Medical Status:
Child's Height and Weight: _____

Pediatrician's Name: _____

Psychiatrist's Name: _____

Current Medications: _____

Past Medications: _____

Previous Therapy: _____

Please list current or past medical/mental health conditions:

Diagnosis	**Age Diagnosed**	**By Whom**

Does your child have frequent physical complaints? Please describe:

_____

_____

Please describe any concerns about your child's sleep:

_____

_____

Please describe any concerns about your child's eating habits

_____

_____

Academic History:
Describe any concern about academic performance or behavior at school:

_____

_____

Are there any concerns about the child's school attendance?

_____

_____

Please list any special education services or outside support your child receives (e.g., OT, Speech, Gifted, 504 Plan, IEP):

_____

_____

Has your child had psychological/psychoeducational testing in or out of the school?

_____

_____

Social/Behavioral History:
What are your child's strengths?

_____

_____

List hobbies or free-time activities:

_____

_____

Please share concerns about your child's behavior at home:

_____

_____

Please describe concerns related to your child's social interactions and making friends:

_____

_____

Developmental History:
Were there any medical problems during pregnancy or delivery?

_____

_____

Were there any medical problems during the child's first year?

_____

_____

Please describe how your child exhibited anxiety as a young child:

_____

_____

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Consent to Treatment

I, _____, give my permission and consent to Karen J. Landsman, Ph.D., to provide psychotherapeutic treatment to me and/or _____, who is/are my child/children.

I understand that Dr. Landsman does not provide emergency services and I have been informed who to call in an emergency or during weekend and evening hours. I understand that I need to provide 24 hours' notice for cancellations; otherwise, I will be charged for the session. Payment in full is due at time of services rendered. I understand that Karen J. Landsman, Ph.D. is an out-of-network provider and my insurance company may or may not cover some services (such as services without procedural codes, exceeding the limit on the number of office visits, marital sessions, telephone sessions, VOIP/broadband telephony, or missed sessions) with Karen J. Landsman, Ph.D. I acknowledge it is my responsibility to contact my insurance company to understand my limits and to request reimbursement from my insurance company. Further, I accept responsibility for payment in full for all services rendered with Karen J. Landsman, Ph.D., whether or not my insurance company reimburses me. Your contract with your health insurance company requires that I provide it with information relevant to the services I provide to you. I am required to provide a clinical diagnosis. Sometimes I may be required to provide additional clinical information such as treatment plans or summaries, or copies of your clinical record. By signing this agreement, you agree that I can provide requested information to your carrier.

Sessions may consist of the following types of session modalities: face-to-face office sessions, telephone sessions, VOIP/broadband/similar telephony, telepsychology, home visits, or on-site visits/fieldwork. Research shows that cognitive-behavioral treatment for anxiety disorders may be delivered effectively through each of these modalities. I understand that services are applied as appropriate to address needs. Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as audio/video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. Risks to confidentiality: Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.
There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies. You should be aware that I cannot guarantee the confidentiality of any information communicated by email. Therefore, I will not discuss any clinical information by email and prefer that you do not, either. Also, I do not regularly check my email, nor do I respond to emails, so these methods should not be used unless specifically requested by the therapist (e.g., submission of evaluation forms).
Confidentiality: I will make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

Emergencies and Technology: Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan, as needed, when engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

I understand that cell/telephones, emails and texts are not a guaranteed secure nature of communication. Telephonic services may impact the therapeutic relationship due to the physical distance of the communication. I understand that my health care provider and I may participate in telemedicine visits. My health care provider has explained to me how technology will be used and will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine visit if it is felt that the connections are not adequate for the situation. I have had the alternatives to a telemedicine visit explained to me. I understand that billing will occur from the provider. I have been informed and understand the benefits, risks, and practical alternatives. I have read or had this form read and/or explained to me and I fully understand its contents including the risks and benefits.

Confidentiality will be maintained except for the following situations:

1. When the therapist is legally responsible to report incidents of child abuse, neglect, and molestation.
2. When records are subpoenaed.
3. When the therapist determines it necessary to protect the client from harming themselves or others.

_____ _____

Signature of parent or guardian Date

_____ _____

Signature of child if 14 or older Date

NOTICE OF HIPAA'S PRIVACY PRACTICES AND PROCEDURES

I acknowledge Karen J. Landsman's Notice of Privacy Practices for HIPAA regulations.

_____ _____

Signature of parent or guardian Date

_____ _____

Signature of child if 14 or older Date

Authorization for release of confidential information and medical records

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.
I authorize my psychologist, Karen J. Landsman, Ph.D., to release and/or obtain from

_____
_____
_____

copies of medical treatment or other information pertaining to my treatment for the purpose of therapy or

_____
information to be released is limited to
_____ dates, diagnosis, and treatment summary
_____ no restrictions apply
_____ other _____
I am requesting my psychologist to release this information for the following reasons: ("for treatment purposes" is all that is required if you are my patient and you do not desire to state a specific purpose.)

_____
This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).

_____
You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.
I understand that the confidentiality of these records is protected by federal and state law and that they cannot be released except as indicated above without my written consent unless special circumstances as authorized by laws governing release of information are applicable.
Your contract with your health insurance company requires that I provide it with information relevant to the services I provide to you. I am required to provide a clinical diagnosis. Sometimes I may be required to provide additional clinical information such as treatment plans or summaries, or copies of your clinical record. By signing this agreement, you agree that I can provide requested information to your carrier.
I understand that this authorization will remain valid throughout the duration of my treatment and that I may withdraw my consent at any time (except for action already taken) by written request.
I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of parent or guardian Date

_____ _____
Signature of child if 14 or older Date

_____ _____
Karen Landsman, Ph.D., Lic. #35S100406700 Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.