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

Name:_____Date:_____

Complete Address: _____
_____

Age:_____ Date of Birth:_____

Phone:_____ home _____cell

Phone:_____ office

Occupation:_____Education:_____

Emergency Contact:

_____
Phone:_____

Marital Status:_____

Spouse's name _____ Spouse's Occupation_____

Children_____ At home_____

Referral Source _____

Previous Therapy_____

Medications_____

I authorize Karen J. Landsman, Ph.D., (License # 35S100406700) to charge my credit card on a recurring basis for services with her. I accept responsibility for payment in full for all services with Karen J. Landsman, Ph.D.

_____
Signature

KAREN J. LANDSMAN, Ph.D.
License # 35S100406700

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Green Village, New Jersey 07935

68 Essex Street, Suite 1A
Millburn, New Jersey 07041

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, 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.

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 _____Date

NOTICE OF HIPAA'S PRIVACY PRACTICES AND PROCEDURES

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

_____ _____ _____
Signature Date Print Name

Authorization for release of confidential information and medical records

Authorization Form

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

_____

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: ("at the request of the individual" 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 _____Date

_____Signature of parent or guardian if person is under 14 or declared legally incompetent. _____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.