Stepping Stones Psychological Services of Princeton, LLC
Child/Adolescent Intake Form

Today's Date:_____

Child's Name:_____ DOB:_____

Child's Nickname (if any):_____

Gender: Male Female Other_____

Address:
_____
(Street/Apartment) (City) (State) (Zip)

Home Phone: (_____)_____ Cell Phone: (_____)_____

E-mail Address:_____

Current School:_____ Grade:_____

Religion: _____ Ethnicity: _____

Parent Information:

Parent #1 Name:_____ Age:_____

Address: *(Write "Same" if same as child's address)*

_____
(Street/Apartment) (City) (State) (Zip)

Home Phone: (_____)_____Work Phone: (_____)_____

Cell Phone: (_____)_____Other Phone: (_____)_____

E-mail
Address:_____

Occupation/Place of
Business:_____

Highest Level of Education Achieved & Date of
Completion:_____

Religion:_____Ethnicity:_____

Parent #2 Name:_____ Age: _____

Address: *(Write "Same" if same as child's address)*

_____
(Street/Apartment) (City) (State) (Zip)

Home Phone: (_____)_____ Work Phone: (_____)_____

Cell Phone: (_____)_____ Other Phone: (_____)_____

E-mail
Address:_____

Occupation/Place of
Business:_____

Highest Level of Education Achieved & Date of
Completion:_____

Religion:_____Ethnicity:_____

Parents are (circle one):

Married Separated Divorced (date_____) Never Married Widowed

Who has legal guardianship of your child?
_____

Who does your child currently live with? (Please include all people living in the household and their relationship to your child.)
_____
_____
_____
_____

Siblings

	Name	Gender	Age
1.			
2.			
3.			
4.			

Is there any family history of substance abuse, physical or emotional abuse, or psychological disorders?

_____

_____

_____

Please list and describe any previous therapy and/or psychological evaluations/assessments that your child has had: (Include the type of service, date of service/s, and outcome)

_____

_____

_____

_____

_____

_____

_____

Has your child ever received special education services? If yes, please describe.

_____

_____

_____

_____

_____

_____

What is the main reason you are seeking psychological services for your child?

_____

_____

_____

_____

_____

_____

Medical History:

What is the name of your child's medical doctor?_____

Address: _____ Phone:_____

Date of your child's last physical examination:_____

Does your child have any significant medical problems or history of medical problems? Please identify any such problems and describe current health status. (Include any medications.)

_____

_____

Stepping Stones Psychological Services of Princeton, LLC
122 Commons Way
Princeton, NJ 08540
908-907-0693

Laura Berness, Ph.D.
NJ License # 5057

Client-Therapist Service Agreement (updated 2.19.21)

Fees and Payment

Initial evaluations are approximately 1 hour in length. The standard fee for the initial evaluation session is $240.

Regular sessions are forty-five (45) minutes in length. Fees are determined based on this time period, and variations from this time will be billed on a pro-rated basis. The standard fee for a forty-five minute session is $225.

School visits or other onsite consultations are billed on a pro-rated basis in 15-minute increments according to the established full-session rate. You will be billed for the time required for your doctor to travel to and from the off-site location.

Telephone sessions: If necessary, telephone sessions may also be scheduled or used to reschedule a missed appointment. Telephone sessions are billed on a pro-rated basis in 15 minute increments according to the established full-session rate.

Telephone consultations: You may need to speak to your doctor briefly at times. However, if telephone calls exceed 10 minutes, calls will be billed on a pro-rated basis in 15-minute increments according to the established full-session rate.

Payment is due at each session. You may pay by credit card, cash, or check (made payable to Stepping Stones Psychological Services of Princeton, LLC). If you wish to pay by check, please do so at the beginning of the session so that we may utilize the full session time to address your clinical concerns. Failure to pay for two consecutive sessions may result in suspension of therapy until payment is made.

Returned checks will result in an additional $25 fee charged to the patient.

Insurance

Please note that Stepping Stones Psychological Services of Princeton, LLC does not participate with insurance companies. All services are considered "out of network". Please note that patients have direct financial responsibility to Stepping Stones Psychological Services of Princeton, LLC.

"Reimbursable diagnoses": Please be aware that not all psychological disorders or services (such as attending school meetings) are considered "reimbursable" by all insurance companies. It is illegal to alter a diagnosis simply to fit insurance company guidelines.

Insurance Reimbursement: All patients are strongly encouraged to contact their insurance company prior to starting services so that they fully understand the reimbursement that they can expect to received from their insurance company. Depending on your insurance plan, insurance companies may provide no out of network coverage or may agree to pay a percentage of what is deemed "reasonable and customary". Patients should clarify with their insurance companies what this amount is for therapy services received from a licensed clinical psychologist. A receipt will be provided so that patients can submit this to their insurance companies for reimbursement.

Protected Health Information: Communication with insurance companies for the purpose of reimbursement requires that the doctor release Protected Health Information. In order for the doctor to communicate with insurance companies, the patient or guardian must sign a release form explicitly permitting this communication, as specified in federal HIPAA regulations designed to protect patient confidentiality. No Protected Health Information will be released to insurance companies without a signed release of information explicitly permitting such an action. Please see accompanying form outlining further details of Protected Health Information and HIPAA guidelines.

Cancellation Policy

Once treatment has begun, consistency and regularity of sessions will contribute to your reaching your therapeutic goals. Your doctor reserves specific time for you.

Twenty-four (24) hour notice is required for all cancellations. The patient's full fee will be charged if less time is allowed.

Termination of Services

If you do not contact the therapist for a follow up appointment, then it will be assumed that you no longer wish to continue therapy services. Please note that if you decide to resume therapy, there is no guarantee of the therapist having an immediate opening.

Emergencies

In the event of an emergency, the patient should go to the nearest ER or call 911.

Doctor Availability

Your doctor will not answer calls while in session and there may be an unavoidable wait before a telephone call is returned. Please refer to the office emergency policy or any specific policy put into place by your doctor in the event that you need immediate care.

CONSUMER ISSUES

As a consumer of psychological services, you retain the following rights:

1. The right to know the training and qualifications of your doctor such as: degrees, licenses, specialized training.

2. The right to know and to participate in setting the goals of therapy.

3. The right to know the progress made toward these goals during the course of therapy.

4. The right to know and to participate in the establishment of the treatment plan.

5. The right, as a competent adult, to refuse treatment for yourself or your child.

6. The right to terminate therapy or refuse to participate in research, at any time, without prejudice.

7. The right to obtain a second opinion from a qualified professional.

8. The right to give feedback, at any time, to your doctor.

9. The right to know the rationale for treatment decisions.

10. The right to complete confidentiality [except in circumstances when express written permission is given by the patient or parent, or if: (1) the patient threatens to harm him/herself, (2) the patient threatens to harm another and identifies that individual, (3) there is suspicion of child abuse at any time.]

NOTE FOR MINORS: If the client is under eighteen year of age, please be aware that the law may provide parents with the right to examine the treatment records. If the client desires to keep part or all of therapist-client conversations private from the parent(s), and the therapist believes it to be clinically advantageous to do so, he or she will verbally request an agreement from the parent(s) to allow for the therapist and the client to speak confidentially.

This list is meant to inform, but is by no means exhaustive. You also have the right to investigate with qualified sources any further rights you may have. In New Jersey, licensed professionals are monitored by the State Board of Psychological Examiners and must adhere to the ethical guidelines established by the Board. Professional societies, such as the American Psychological Association also provide guidelines of conduct for psychologists. You are encouraged to resolve any issues directly with your doctor. However, the above organizations are available to you in the event that a resolution is not reached to your satisfaction.

Stepping Stones Psychological Services of Princeton, LLC
122 Commons Way
Princeton, NJ 08540
908-907-0693

AGREEMENT

I have read and understood the above statement of Consumer Issues and the Client-Therapist Service Agreement. I understand the Emergency Policy to call 911 or go to the nearest hospital in the event of an emergency. I accept the fees set by the office as stated in the policy above and understand that Stepping Stones Psychological Services, LLC is an out of network provider. Additionally, I am aware that securing reimbursement for psychological services is my responsibility and Stepping Stones Psychological Services of Princeton, LLC does not guarantee reimbursement of any services rendered. I am aware that I will be charged the full session fee in the event that I cancel my session within twenty-four (24) hours of my session day and time.

I agree to all conditions and to psychological services.

NAME of Client:_____

Signature of Client (if 14 or older) _____

Signature of Parent #1: _____

Signature of Parent #2 (if needed):_____

DATE:_____

Stepping Stones Psychological Services of Princeton, LLC
122 Commons Way
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908-907-0693

Consent to Contact Form

Client's Name: _____

Parent/Guardian (if client is under age 18): _____

Phone Numbers:

Home:_____

Consent to Leave a Message? YES NO

Cell:_____

Consent to Leave a Message? YES NO

Work:_____

Consent to Leave a Message? YES NO

Mail:

Consent to send mail? YES NO

Address:

_____

(street) (city) (state) (zip)

Please note that email is not a secure form of communication and thus its confidentiality can never be guaranteed.

Client's Signature (if client is 14 or older): _____

Parent/Guardian's Signature (if client is under 18): _____

Date: _____

Stepping Stones Psychological Services of Princeton, LLC
122 Commons Way
Princeton, NJ 08540

EMAIL AND TEXT POLICY

I understand that Stepping Stones Psychological Services of Princeton, LLC/Dr. Laura Berness offer no guarantee of privacy of email communication that I send.
-Other people may have access to email accounts
-If I or you accidentally type an email address, private clinical information could be sent to a stranger
-Employees at the company that provides email service can access messages
-Email communication can be intercepted by unscrupulous people through spyware or other hacking methods

Stepping Stones Psychological Services of Princeton, LLC/Dr. Laura Berness also offer no guarantee that email will be read or responded to in a timely manner. If I need to speak with someone before my next scheduled appointment, I should use the phone number (908-907-0693). I also can communicate via regular mail sent to the office address.

Due to the risks above, Stepping Stones Psychological Services of Princeton, LLC/Dr. Laura Berness has specifically warned me NOT to use email for sensitive clinical information. Sensitive clinical information includes, but is not limited to, names, symptoms, diagnoses, and the fact that I or my child is the client. If I choose to send email communication despite these warnings, I assume full responsibility for the risks, and I will not hold Stepping Stones Psychological Services of Princeton, LLC/Dr. Laura Berness liable for any possible breach in confidentiality or failure to respond in a timely manner.

TEXTS: Please note that Dr. Berness will not respond to text messages due to confidentiality concerns. I understand that I should not attempt to communicate via text.

My signature below indicates that I have read the information in this document and agree to abide by it.

Client Name: _____

Parent/Guardian (if minor): _____

Signature of Client or Parent/Guardian:_____

Date:_____

Stepping Stones Psychological Services of Princeton, LLC

Notice of Policies and Practices to Protect the Privacy of Your Health Information

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

1. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Your provider may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are definitions:

a. *"PHI"* refers to information in your health record that could identify you.

b. "Treatment, Payment, and Health Care Operations"

- *Treatment* is when your provider provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when your provider consults with another health care provider, such as your family physician or another psychologist
- *Payment* is when your provider obtains reimbursement for your healthcare. Examples of payment are when your provider discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- *Health Care Operations* are activities that relate to the performance and operation of this practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

c. *"Use"* applies only to activities within this practice such as releasing, transferring, or providing access to information about you to other parties.

d. *"Disclosure"* applies to activities outside of this practice such as releasing, transferring, or providing access to information about you to other parties.

2. Uses and Disclosures Requiring Authorization

Your provider may disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission that permits specific disclosures. In those instances when the provider is asked for information for purposes outside of treatment, payment and health care operations, the provider will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) the provider has relied on that authorization; or (2) if that authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

Please note that your psychologist may elect to keep a second set of records called "Psychotherapy Notes". These Notes are for the psychologist's use only and are designed to assist in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations and how they impact therapy. They also contain particularly sensitive information that you may reveal to your psychologist that is not required to be included in your PHI. They

may also include information from others provided to me confidentially. These Psychotherapy Notes are kept separate from your PHI. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else. In very rare circumstances, your Psychotherapy Notes may be released to third party payers with your explicit Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

3. Uses and Disclosures with Neither Consent nor Authorization

Your provider may use or disclose PHI without your consent in the following circumstances:

- **Child Abuse**: If your provider has reasonable cause to believe that a child is being subject to abuse, then your provider must report this immediately to the New Jersey Division of Youth and Family Services.
- **Adult and Domestic Abuse**: If your provider reasonably believes that a vulnerable adult is the subject of abuse, neglect, or exploitation, your provider may report the information to the county adult protective services provider.
- **Health Oversight**: If the New Jersey State Board of Psychological Examiners issues a subpoena, your provider may be compelled to testify before the Board and produce your relevant records and papers.
- **Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about the professional services that your provider has provided you and/or the records thereof, such information is privileged under state law, and your provider must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. Your provider must inform you in advance if this is the case.
- **Serious Threat to Health or Safety:** If you communicate to your provider a threat of imminent serious physical violence against a readily identifiable victim or yourself or the public, and your provider believes you intend to carry out that threat, your provider must take steps to warn and protect. Your provider must also take such steps if he/she believes you intend to carry out such violence, even if you have not made a specific verbal threat. The steps taken to warn and protect may include arranging for you to be admitted to a psychiatric unit of a hospital or other health care facility, advising the police of your threat and the identity of the intended victim, warning the intended victim or his/her parents if the victim is under 18, and warning your parents if you are under 18.

4. Patients' Rights and Psychologists' Duties

Patients' Rights:

- **Right to Request Restrictions**: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, your provider is not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want your family member to know that you are seeing a

psychologist. Upon your request, your provider can send your bills to another address.)

- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI in your provider's mental health and billing records used to make decisions about you as long as the PHI is maintained in the record. Your provider may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, your provider will discuss with you the details of the request and denial process.
- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your provider may deny your request. On your request, your provider will discuss with you the details of amendment process.
- **Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, your provider will discuss with you the details of the accounting process.
- **Right to a Paper Copy:** You have the right to obtain a paper copy of the notice from your provider upon request, even if you have agreed to receive the notice electronically.

Psychologists' Duties:

- Your provider is required by law to maintain the privacy of PHI and to provide you with a notice of his/her legal duties and privacy practices with respect to PHI.
- Your provider reserves the right to change the privacy policies and practices described in this notice. Unless your provider notifies you of such changes, however, your provider is required to abide by the terms currently in effect.
- If your provider revises his/her policies and procedures, and you are an active patient, your provider will inform you of the changes in policy in person. If you have discontinued services, your provider will provide you with a revised notice upon request.

5. Questions and Complaints

If you have any questions about this notice, disagree with a decision your provider makes about access to your records, or have other concerns about your privacy rights, you may contact Dr. Laura Berness at 908-907-0693. If you believe that your privacy rights have been violated and wish to file a complaint with me/my office, you may send your written complaint to Stepping Stones Psychological Services of Princeton, Attn: Laura Berness, PhD, 122 Commons Way, Princeton, NJ 08540.

You may also send a written complain to the Secretary of the U.S. Department of Health and Human Services. The appropriate address can be provided to you upon request.

You have specific rights under the Privacy Rule. Your provider will not retaliate against you for exercising your right to file a complaint.

6. Effective Date, Restrictions, and Changes to Privacy Policy.

This policy went into effect January 1, 2015. Your provider reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that your provider maintains. Your provider will provide you with a revised written notice of any changes.

Stepping Stones Psychological Services of Princeton, LLC
122 Commons Way
Princeton, NJ 08540
908-907-0693

HIPAA Acknowledgement
(Please keep a copy of this form for yourself.)

By your signature below, you indicate that you have received and read the HIPAA document entitled **Notice of Policies and Practices to Protect the Privacy of Your Health Information**.

_____ _____
Signature of Patient if 14 years old or older Date

_____ _____
Print your name above Date of Birth

_____ _____
Signature of Parent/Guardian if under 18 years Date

_____ _____
Signature of other Parent/Guardian if Joint Custody Date

Stepping Stones Psychological Services of Princeton, LLC
122 Commons Way
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908-907-0693

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below:

Client Name | Date of Birth | Social Security Number

Address (Street, City, State, Zip Code) | Telephone Number

The following individual or organization is authorized to make the disclosure:
_____ Stepping Stones Psychological Services of Princeton, LLC

This information may be disclosed to and used by the following individual or organization (please specify):
Pediatrician: _____

Treatment dates | Purpose of Request

The following information is to be disclosed: (please check)

Yes	No		Yes	No	
_____	_____	DSM-V Diagnosis	_____	_____	Treatment Summary
_____	_____	Medication Records	_____	_____	Psychological Assessment Reports
_____	_____	Collateral Data (e.g., school reports)	_____	_____	Specific Interventions
_____	_____	Psychotherapy Notes	_____	_____	Complete Record
_____	_____	Other _____			

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

If I do not specify an expiration date, event or condition, this authorization will expire in 12 months.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, I may be denied enrollment in the research study. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. If I have questions about disclosure of my health information, I can contact Stepping Stones Psychological Services LLC at 908-907-0693.

Signature of Client or Legal Representative/s (both parents if required) | Date

If Signed by Legal Representative, Relationship to Client

Signature of Minor Client if 14 years of age or older (his/her failure to sign voids this consent)

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I hereby authorize use or disclosure of the named individual's health information as described below:

Client Name | Date of Birth | Social Security Number

Address (Street, City, State, Zip Code) | Telephone Number

The following individual or organization is authorized to make the disclosure:
_____ Stepping Stones Psychological Services of Princeton, LLC

This information may be disclosed to and used by the following individual or organization (please specify):
Insurance Company: _____

Treatment dates | Purpose of Request

The following information is to be disclosed: (please check)

Yes	No		Yes	No	
_____	_____	DSM-V Diagnosis	_____	_____	Treatment Summary
_____	_____	Medication Records	_____	_____	Psychological Assessment Reports
_____	_____	Collateral Data (e.g., school reports)	_____	_____	Specific Interventions
_____	_____	Psychotherapy Notes	_____	_____	Complete Record
_____	_____	Other _____			

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