Danielle Kupperman, LCSW
child & adolescent therapist

www.breatheandbloomtherapy.com

973.809.4599
danielle@breatheandbloomtherapy.com

47 Crescent Road
Livingston, NJ 07039

Welcome to Breathe & Bloom Therapy

Please carefully read through the following letters and forms:

INFORMED CONSENT FOR TREATMENT
PRACTICE POLICIES
NOTICE OF PRIVACY PRACTICES
INTAKE

Please sign where applicable, and bring during your initial visit…even better if you can return earlier.

A few things to note…

The office is out of my home. Please park on the street and walk down the driveway.
You may enter the office through the front door.

When I am working with your child, please wait in your car. When the session is over, I will supervise your child until they reach you.

I do have a very friendly dog. He will not be in the office during our time, but you may hear him bark outside as you arrive. If you or your child have any fear of dogs, please let me know ahead of time.

Thank you, and if you have any questions prior to our first session, please let me know.
I look forward to working with you and your child.

Danielle Kupperman, LCSW

INFORMED CONSENT
AND AGREEMENT FOR TREATMENT OF MINOR

GENERAL INFO

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by signing at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. Establishing a therapeutic alliance outside of the home can facilitate open and appropriate expression of strong feelings such as guilt, grief, sadness and anger, provide an emotionally neutral setting in which children can explore these feelings, help children understand, accept, and cope with whatever difficulty they may be experiencing, and offer feedback and recommendations to a child's caregivers based on knowledge of the child's specific emotional needs and developmental capacities.

The outcome of treatment depends largely on the clients willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that behavior or circumstance will change, however, I can promise to support you and do my very best.

The usefulness of therapy may be limited when the therapy itself becomes simply another matter of dispute between parent and child or between parents. With this in mind, and in order to best help your child, I strongly recommend that your child and each of the child's caregivers (e.g., parents or stepparents) mutually accept the following as requisites to participation in therapy:

1. As your child's psychotherapist, it is my primary responsibility to respond to your child's emotional needs. This includes, but is not limited to, contact with your child and each of his or her caregivers, and gathering information relevant to understanding your child's welfare and circumstances as perceived by important others (e.g., pediatrician, teachers). In some cases, this may include a recommendation that you consult with a physician, should matters of your child's physical health be relevant to this therapy.
2. I ask that all caregivers remain in frequent communication regarding this child's welfare and emotional well-being. Open communication about his or her emotional state and behavior is critical. In this regard, I invite you to initiate open exchange with me as your child's therapist.
3. I ask that caregivers recognize and, as necessary, reaffirm to the child, that I am the child's helper. This may include encouragement for the child that is reluctant or anxious about therapy, or support and optimism regarding change. Also, I have found that use of therapy as a consequence or punishment is usually not helpful.
4. This psychotherapy will not yield recommendations about custody. In general, I recommend that parties who are disputing custody strongly consider participation in alternative forms of negotiation and conflict resolution, including mediation and custody evaluation, rather than try to settle a custody dispute in court.

Termination

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source. Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

CONFIDENTIALITY & PRIVACY

Breathe & Bloom Therapy is committed to maintaining the confidentiality of our clients. We do not share or disclose personal information or data about our clients to any other party except as requested by the client in writing, with the exception the following situations:

-Suspected child abuse or dependent adult or elder abuse, for which we are required by law to report this to the appropriate authorities immediately.

-If a client is threatening serious bodily harm to another person/s, we must notify the police and inform the intended victim.

-If a client intends to harm him or herself, we will make every effort to enlist their cooperation in insuring their safety. If they do not cooperate, we will take further measures without their permission that are provided to us by law in order to ensure their safety.

With treatment of a minor, caregivers may be legally entitled to some information about therapy. I will discuss with the minor and caregivers what information is appropriate for to receive and which issues are more appropriately kept confidential.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Your signature, below, signifies that you have read and accept these points.

_____ _____ _____

parent/guardian signature parent/guardian signature date

Danielle Kupperman, LCSW

www.breatheandbloomtherapy.com

PRACTICE POLICIES

APPOINTMENTS & CANCELLATIONS

The standard meeting time for psychotherapy is 50 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to change the 50-minute session needs to be discussed with the therapist in order for time to be scheduled in advance.

Please remember to cancel or reschedule 24 hours in advance. You will be responsible for the entire fee if cancellation is less than 24 hours. Cancellations and re-scheduled sessions will be subject to a full charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

FEES

We understand that therapy can be a big time and financial commitment. Our goal is to help you get the help you need and meet your goals in an efficient and timely manner so that you can live your desired outcome as quickly as possible.

As therapists with many years of experience helping children and teens transform, we have established fees that are commensurate with our experience and consistent with other mental, health providers in our area. Fees vary by service.

Payment for services is expected at time of appointment it the form of cash, check, Venmo, or Credit Card. For your convenience, if you choose to pay by credit card, we will keep your card on file and have the right to charge without notice. You will be provided with a statement services/superbill at the end of the month to submit to your insurance carrier.

INSURANCE

We are an out-of-network provider for insurance companies. If your insurance plan provides out-of-network mental health coverage for you and your enrolled family members, you can expect to receive reimbursement for our services, once you have satisfied your deductible. We are happy to help you navigate this system to ensure you receive the payments you are entitled to.

It is recommended that you check with your insurance provider to find out the exact coverage included in your plan. Here are some helpful codes you can give for the services we provide:

CPT Code 90791: Initial Assessment/Evaluation
CPT Code 90832: Psychotherapy, 30 minutes
CPT Code 90834: Psychotherapy, 45 minutes
CPT Code 90837: Psychotherapy, 60 minutes
CPT Code 90847: Family Therapy with Patient Present, 50 minutes
CPT Code 90846: Family Therapy without Patient Present, 50 minutes
CPT Code 90853: Group Psychotherapy

Here are some helpful questions to ask your insurance company regarding your plan:
What is my/our coverage for out-of-network mental health services (using the CPT Codes above)?
Do I have an annual deductible?
How much of my annual deductible has already been met?
Are there any limits or requirements in order to receive reimbursement?

_____	_____	_____
parent/guardian signature	parent/guardian signature	date

NOTICE OF PRIVACY POLICY

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

Make sure that protected health information ("PHI") that identifies you is kept private.

Give you this notice of my legal duties and privacy practices with respect to health information.

Follow the terms of the notice that is currently in effect.

I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION

Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is: a. For my use in treating you. b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy. c. For my use in defending myself in legal proceedings instituted by you. d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA. e. Required by law and the use or disclosure is limited to the requirements of such law. f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes. g. Required by a coroner who is performing duties authorized by law. h. Required to help avert a serious threat to the health and safety of others.

Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

For health oversight activities, including audits and investigations.

For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

For law enforcement purposes, including reporting crimes occurring on my premises.

To coroners or medical examiners, when such individuals are performing duties authorized by law.

For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT

Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI

The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certainPHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no"if I believe it would affect your health care.

The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a healthcare item or a health care service that you have paid for out-of-pocket in full.

The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.

The Right to Get a List of the Disclosures I Have Made.You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee foreach additional request.

The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

I have read and understand the forgoing notice and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____ _____

parent/guardian signature parent/guardian signature date

Danielle Kupperman, LCSW

www.breatheandbloomtherapy.com

INTAKE

Please fill out this intake form as best you can. We will review it together during our initial consult. All information contained in this document is confidential.

CLIENT/MINOR INFORMATION

Child's Name:			
Date of Birth:	Age:	Gender M F NB	Preferred pronouns:
Home Address:			
City/State/Zip Code:			

CONTACT INFORMATION OF RESPONSIBLE PARTY

Parent/Guardian:	Parent/Guardian:
Relationship:	Relationship:
Phone: May I leave a message? Y / N	Phone: May I leave a message? Y / N
Email: May I contact you here? Y / N	Email: May I contact you here? Y / N
What is the best way to reach you?	
Child currently lives with?	
Emergency Contact: Relationship to Child:	Emergency Contact Phone Number:

INSURANCE COMPANY INFORMATION

Name of Carrier	Policy Number	Group Number
Carrier Address		

Referred by:

Insurance Co. Internet search Word of mouth Advertisement Other

DESCRIPTION OF PRESENTING PROBLEM

Who suggested that you seek psychotherapy for your child?

Myself My child Primary Care School Other _____

Please provide a brief description of why you decided to seek psychotherapy..

How long has this been a significant problem for your child?

Have you sought psychotherapy for this concern, or any other concerns, before? Y / N

If applicable, please describe any changes that may have contributed to this problem.
(for example-family death, divorce, move)

Do you have reason to suspect your child has been abused
(emotionally, sexually and/or physically): Y / N
please explain

Has your child experienced a significant trauma? Y / N
please explain

Are there times when the presenting problem is especially challenging or better?
(for example, day/night, school, home)

How does the presenting problem mostly effect your child? (check all that apply)

Going to school	Sleeping	Completing homework
Staying in school	Socially	Transition between activities
Eating	Daily Activities	Mood
Spending time with mom	Spending time with dad	Interaction with siblings

Behavior / Mood Observations: (check all that apply)

Fighting/argumentative	Poor grades	Aggressive
Disorganized	Frequent meltdowns	Withdrawn
School refusal/phobia	Depressed/Sad	Lacking energy
Difficulty making friends	Happy	Suicidal/ideations
Late homework	Friendly	Anxious/Worried
Inattentive	Angry	Agreeable
Hyperactive	Argumentative	
Other		

FAMILY HISTORY

Current parent marital status: Single Married Separated Divorced Remarried

Other children such as siblings/half siblings/step siblings: (please include names and ages)

Anyone else live in the house?

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family shown symptoms of or been diagnosed with a mental health condition? Please mark each as yes or no. If yes, please indicate family member effected.

Autism Spectrum	Y / N	_____
Attention Deficit	Y / N	_____
Depression	Y / N	_____
Anxiety Disorder	Y / N	_____
Bipolar Disorder	Y / N	_____
Panic Attacks	Y / N	_____
Alcohol/Substance Abuse	Y / N	_____
Eating Disorder	Y / N	_____
Learning Disability	Y / N	_____
Trauma History	Y / N	_____
Domestic Violence	Y / N	_____
Obesity	Y / N	_____
Obsessive Compulsive Behavior	Y / N	_____
Schizophrenia	Y / N	_____
Other		

CLIENT HISTORY

MEDICAL/DEVELOPMENTAL HISTORY

Please indicate if birth was: normal complicated

Were developmental milestones reached within typical timeframes?
Please describe

Any behavior, such as head banging, rocking, etc., during infancy/toddlerhood? Y / N
If yes, please explain:

Did/Does your child have difficulty separating from their primary caregiver? Y / N
If yes, please explain:

Has your child had any severe, long-term illnesses or accidents? Y / N
If yes, please explain:

Does your child have any allergies? Y / N

Does your child have any medical conditions or physical disabilities? Y / N
If yes, please explain

Has your child ever received or is currently receiving any other
mental health services? Y / N

Has your child ever been prescribed psychiatric medication? Y / N
If yes, please list:

Has your child ever been hospitalized for mental health issues? Y / N
If yes, please explain:

Any other medical and/or developmental concerns to share?

SLEEP HABITS

Does your child settle down to sleep? Y / N

Does your child sleep through the night without interruptions? Y / N

Does your child experience nightmares, night terrors, Y / N
sleep walking, and/or talks in their sleep?

Is your child a restless sleeper? Y / N

Does your child snore? Y / N

Any other concerns related rot sleep to share?

APPETITE

Does your child eat a well balanced diet? Y / N

Is your child a picky eater? Y / N
List any foods or food textures that your child will not eat

Any other concerns related to appetite to share?

EDUCATIONAL HISTORY

Current school and grade

Did your child go to preschool? Y / N
If yes, were there any concerns with behavior/friendships? Please explain

Name of any past schools

How does your child academically perform in school?
Please explain:

Does your child have an IEP? Y / N
If yes, what is the classification?

Does your child have a 504? Y / N
If yes, please describe

Any other concerns related to school or educational history to share?

SOCIAL HISTORY/FUNCTIONING

Describe your child's relationships with peers and/or siblings.

What are your child's strengths?

Describe your child's recreational interests.

Please describe anything else you think I should know about your child.

What are your goals for therapy/what would you like to accomplish?

_____ _____

Signature of Responsible Party Date