DR. STACEY BERARDINO
Ph.D. Clinical and Forensic Psychologist

California License PSY 17545
(949) 235-4874

Laguna Hills Office:
23421 South Pointe Drive #130
Laguna Hills, CA 92653
Mailing Address:
26895 Aliso Creek Road, Suite B #627
Aliso Viejo, CA 92656

CONFIRMATION OF APPOINTMENT

You are scheduled for an appointment with Dr. Berardino on _____. Please fill out the following forms and bring them to the first session. This will save time during the introductory session. All of the enclosed information will be discussed with your therapist/evaluator.

You will be billed for the hourly rate described in the Office Policies and Procedures Form. Fees will be due at the time services are rendered. Cancellations must occur at least 24 hours in advance, to avoid being charged for the session. Client Signature (or parent/guardian of client): _____

Please arrive promptly to the office address of:

Laguna Hills Office:

23421 South Pointe Drive #130
Laguna Hills, CA 92653

Please fill out, sign, and date the following enclosed documents:

-Client Information Form
-Office Policies and Procedures
-Confirmation of Appointment

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Office Policies and Procedures

Please sing and date this form agreeing that you understand the following office policies. Your therapist/evaluator will be happy to answer any questions you might have.

1. **Cancellations**: Your therapist will need a minimum of 24 hours notice if you need to cancel or change a session. If you do not cancel within 24 hours, you will be charged for the entire cost of the visit (Co-pay and amount paid by insurance, if applicable.) The cancellation fee **will not** be billed to your insurance.
2. **Fees**: The fee for a Comprehensive Initial Assessment (your first session) is $185. The fee for a 50-minute psychotherapy or psychological testing session is $150. (Please note that psychological testing is charged on a per hour basis and may include face-to-face time, scoring, analysis, and a written report.) Reduction in fees is considered in some cases. Payment is to be made in full at the beginning of each session in the form of cash or personal check.
3. **Payment**: Payment is to be made at the beginning of each session to Dr. Stacey Berardino, Ph.D. Billing will be provided by office staff or the doctor.
4. **Returned Checks**: The Office will require a $20 fee (in addition to the original amount) for any returned checks.
5. **Insurance:** This office is a "Fee for Service" practice. The office will bill Blue Cross and/or Blue Shield insurance companies. If you are covered by Blue Cross or Blue Shield and your account is billed through a third-party, we will need to collect the full payment for your visit. You will then be reimbursed after we receive payment from the third-party billing service. If you are covered by other insurance companies which cover mental health services, the office will supply you with a suitable receipt and it will be the client's responsibility to submit claim forms for reimbursement. **It is your responsibility to know your insurance plan and its limits. Therefore, it is advisable for you to check with your insurance company for any applicable deductibles and/or co-payments you may have.**
6. **Phone Sessions**: Phone sessions are charged at the same rate as individual counseling. If you need to speak to your therapist outside of your sessions and your phone conversation is longer than 10 min. your therapist will need to charge you for this time. Most insurance plans DO NOT cover phone sessions.
7. **Administrative Fee**: Administrative fees of $30-50 are applied for various services (i.e., photocopies of chart records to third parties, disability paperwork requests, etc.)
8. **Confidentiality**: If you are an adult, anything you say or do in the context of psychotherapy is confidential with these exceptions:
    a. If you are behaving in a way that poses a threat to the life of another person, confidentiality must be broken. We are bound by law to contact the person(s) involved as well as the police to warn them of possible harm or danger.
    b. If you are using confidentiality as a means of avoiding legal punishment, confidentiality must be broken. Psychotherapists may not aide or abet in committing a crime. The Patriot Act 2001: Health information may be disclosed to authorize federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.
    c. If your therapist believes a client is in danger of harming herself/himself or is gravely disabled the counselor can break confidentiality in order to protect the client from harm.
    d. If the therapist suspects any instance of child, elder or dependent adult abuse, he/she is legally required to report this to the proper authorities.

e. Cases may be discussed with other therapists (names will remain confidential) for the purpose of benefitting the therapeutic process.
f. Office staff conducts billing and other various tasks such as scheduling appointments, etc.

9. **Appointments-**We strive to provide each patient with superior service. We will do everything possible to provide convenient appointment times. However, we do not guarantee you or your family member will be provided with the same day and time each week.
10. **Emergency-**If you or your family member (who is receiving treatment) is having an emergency or is having a mental health crisis you are to call "911" or proceed to your nearest emergency room. Dr. Berardino and her staff are not liable for any missed patient phone calls or messages.
11. **Denied Claims-**Any claims, billed to insurance, that return "denied" or "no payment" are the responsibility of the client. Cash payment for "denied" or "no payment" claims are due within 30 days. If payment is not made within 30 days, the claim will be turned over to collections.

A Release of Information Form signed by you is required before we will send records to or request records from other health care providers. The exception is in the case of a delinquent account. Financial information can be forwarded to a collection agency.

Your signature confirms you have read and understand the following office policies and procedures.

Date: _____ Client Signature (or parent/guardian of client) _____

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

LEGAL DUTY

Federal and state law requires the maintenance of privacy with regard to your mental health and health information. It is required to disseminate this notice about privacy practices, legal duties and your rights concerning your health information. This notice will take effect until replaced.

Dr. Berardino reserves the right to change privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Dr. Berardino reserves the right to make the changes in privacy practices and the new terms of our Notice effective for all health information that are maintained, including health information created or received before changes were made. A new notice will be issued and made available if such changes are made.

You may request a copy of the Notice at any time. For more information about privacy practices, or to request an additional copy, please contact Dr. Berardino by using the information listed at the end of the notice.

USES AND DISCLOSURES OF HEALTH IFNROMATION

Health information for treatment, payment, and healthcare operation are used and disclosed. For example:

Treatment: Dr. Berardino may disclose treatment information with your permission/request.

Payment: Dr. Berardino or her staff may use and disclose your health information to obtain payment for services provided.

Healthcare Operations: Dr. Berardino may use and disclose your health information in connection with healthcare operations such as quality assessment, review of cases. In cases of supervision from other practitioners, individual identifying data are removed to protect the confidentiality of the client.

Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any reason. If you give us an authorization, you may revoke it in writing t any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for

any reason except those described in this Notice. We may only disclose information about your health to your family and friends with permission.

Psychological Testing: Psychological testing evaluations are made available to clients. However raw psychological test data are reserved for those with professional qualifications to read such, as declared in the American Psychological Association's Ethical Guidelines (APA). However, raw data, with permission are able to be disclosed to other professionals. In addition, a summary, or evaluation will be made available to the patient upon request.

Allowed Breaches of Confidentiality: Confidentiality may be breached in certain instances. If the patient discloses that he/she intends to harm self, or involuntary hospitalization is required for Danger to Self, Danger to Others, or Gravely Disabled, then confidentiality may be breached. In addition, if the client discloses that he/she intends to harm an identifiable victim or victims, and then confidentiality will be breached to local law authorities. If the patient discloses that he/she is involved in harming a child, sexual or physical, or the instance is reportable to Child protective Services, then confidentiality will be breached. If the patient discloses that he/she is involved in harm to an alder, and the instance is reportable again to local authorities, then confidentiality will be breached. If the patient discloses that he/she was sexually assaulted or abused as a child, and the perpetrator continues to have access to children, then a report may be made to the proper authorities. Health information may be disclosed to avoid a serious threat to your health or safety or the health or safety of others.

Required by Law: If the law (a judge) requires Dr. Berardino to disclose health information, Dr. Berardino must abide by the law. However, an attempt will be made prior to offer a treatment summary or letter, in order to protect the patient. In addition, health information could be disclosed with regard to national security issues required by law.

Evaluations: Psychological evaluations will be made available to the receiving parties with the patient's designated consent. The patient must consent to the evaluation if he/she is not obtaining services himself/herself, and will be distributed as permission is given.

Appointment Reminders: Health information may be disclosed to provide you with appointment reminders (i.e., voicemail messages, postcards, letters, or email).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. As stated earlier, raw psychological testing data is reserved for trained professionals. A summary of you test results, as well as verbal/written feedback can be provided. In addition, a summary of treatment progress will be made available upon request. A reasonable cost based fee may be assessed for items which require photocopying.
Disclosure Accounting: You have the right to receive a list of instances in which we disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last six year, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency)

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure in your health information or to have us communicate with you by alternative means, you may complain to us using the contact information listed at the end of this Notice.

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You may also contact the California Board of Psychology at:
California Board of Psychology
1422 Howe Avenue, Suite 22
Sacramento, CA 95625
(916) 263-2699

____ I or my Authorized Representative, acknowledge receipt of the Notice of Privacy Practices and Patient Rights.

___ I authorize the office to email appointment reminders at the following email(s):

_____

___ I authorize the office to contact me by phone, and to leave voice messages regarding your appointment times and / or state the name of the office or doctor; at the following numbers.

_____
(Phone Number)

_____
(Name of Client, Parent or Legal Guardian, Legal Representative)

_____ _____
(Signature) (Date)

_____ _____
(Witness) (Date)

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TREATMENT CONSENT

I affirm that I am a legal adult 18 years of age or older:

_____
(Name)

I hereby authorize: **Stacey D. Berardino, Ph.D.** to provide psychological treatment and/or evaluation services between the periods of _____ and _____.

_____
(Name)

_____ _____
(Signature) (Date)

_____ _____
(Witness) (Date)

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TREATMENT CONSENT FOR MINOR

I affirm that I am the parent or legal guardian for:
_____ and that I am an adult legally authorized to make
(Name)
medical and/or mental health treatment decisions.

I hereby authorize: **Stacey D. Berardino, Ph.D.** to provide psychological treatment and/or evaluation services for: _____ between the periods of
(Minor's name)

_____ and _____.

_____
(Name of Parent or Guardian)

_____ _____
(Signature) (Date)

_____ _____
(Minor Signature/Optional) (Date)

_____ _____
(Witness) (Date)

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CLIENT INFORMATION FORM

Please Note: If you are using insurance we will need a copy of your insurance card.

TODAY'S DATE: _____-_____-_____

LAST NAME: _____ FIRST NAME:_____ MI: _____

DATE OF BIRTH: _____-_____-_____ GENDER: _____ MARITAL STATUS: ____

ETHNICITY: _____ RELIGION: _____ PATIENT UNDER 18? _____

STREET: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE/CELL PHONE: _____

NAME OF REGULAR PHYSICIAN: _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: _____

PATIENT'S SOCIAL SECURITY NUMBER: _____-_____-_____

IF PATIENT IS UNDER 18, PARENT'S SSN#: _____-_____-_____

IF PATIENT IS UNDER 18, ARE YOU HIS/HER LEGAL GUARDIAN? _____

REFERRAL SOURCE

WHO REFERRED YOU TO THE OFFICE: _____

FAMILY MEMBERS AT HOME

NAME	DATE OF BIRTH	RELATIONSHIP

_____ _____ _____

_____ _____ _____

_____ _____ _____

INSURANCE DATA

PRIMARY INSURANCE COMPANY: _____

NAME OF INSURED: _____

NAME OF RESPONSIBLE PARTY: _____

RELATIONSHIP OF RESPONSIBLE PARTY TO PATIENT: _____

EMPLOYER AND ADDRESS: _____

LANDLORD: _____ PHONE #: _____

CONTACT INFORMATION

SPOUSE'S NAME AND ADDRESS (IF DIFFERENT): _____

SPOUSE'S EMPLOYER: _____

RELATIVE NOT LIVING WITH YOU: _____ PHONE #: _____

FRIEND NOT LIVING WITH YOU: _____ PHONE#: _____

NAME OF EMERGENCY CONTACT: _____ PHONE#: _____

HAVE YOU EVER BEEN INVOLVED IN A LAWSUIT WITH A PROFESSIONAL

PARTY? IF SO, PLEASE EXPLAIN: _____

FINANCIAL RESPONSIBILITY

WHO IS RESPONSIBLE FOR PAYMENT OF SERVICES? _____

I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS), I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I HAVE READ ALL THE INFORMATION ON THESE SHEETS AND HAVE COMPLETED ALL OF

THE ANSWERS THAT APPLY TO ME. I CERTIFY THIS INOFMRATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY DR. BERARDINO OF ANY CHANGES IN THE ABOVE INFORMATION, INCLUDING MY ADDRESS, EMPLOYMENT, AND INSURANCE STATUS.

_____ _____

(Signature of Patient or Parent, if Patient is Minor) (Date)