

Port Jefferson Psychological & Vocational, P.C.
Davis Professional Park
5225-46 Route 347
Port Jefferson Station, New York 11776
(631) 928-4635

SARAH C. LONG, PSY.D.
CLINICAL PSYCHOLOGIST
NYS LIC #019381

DARYL P. DI DIO, PH.D., ABPP
DIPLOMATE IN CLINICAL PSYCHOLOGY
NYS LIC # 005285
FL LIC # PY 00048

PATRICK MCCAULEY, PSY.D.
RONDA SCHWARTZ, R-LCSW., J.D.
TERESA MAGUIRE, R-LCSW

MARSHA SHERMAN, PH.D.
COLLEEN KALMAN, LCSW
ELIZABETH CAIN, LCSW

INDIVIDUAL PATIENT INFORMATION

Patient Information:

Today's Date: _____

Full Name: _____ Preferred Name/Nickname: _____

Age: _____ Date of Birth: _____ Gender: _____ Race/Ethnicity: _____

Address: _____
STREET CITY/STATE ZIP CODE

Home Telephone: _____ Work Telephone: _____

Cell Phone: _____ S.S.#: _____ Marital Status: _____

Education: _____ Occupation: _____

Present Employer's Name & Address: _____

Spouse/Responsible Parent: _____ Relationship: _____

Age: _____ Date of Birth: _____ Gender: _____ Race/Ethnicity: _____

Address: _____
STREET CITY/STATE ZIP CODE

Home Telephone: _____ Work Telephone: _____

Cell Phone: _____ S.S.#: _____ Marital Status: _____

Education: _____ Occupation: _____

List the members of your family and all others in your home:

NAME(S)	AGE	BIRTH DATE	RELATIONSHIP	OCCUPATION
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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EMERGENCY CONTACT: _____ Relationship: _____

Home #: _____ Work #: _____ Cell Phone: _____

MEDICAL INFORMATION

Who suggested you contact us? _____

Briefly describe your reason for seeking treatment: _____

When were you last examined by a physician? _____

List any health problems for which you currently receive treatment: _____

List any medications you are currently taking: _____

Have you ever received psychological or psychiatric help or counseling of any kind before? _____

If yes, please explain: _____

Please circle any of the following problems which pertain to you:

NERVOUSNESS	DEPRESSION	MAKING DECISIONS	DIVORCE
CAREER CHOICES	TIREDDNESS	INFERIORITY FEELINGS	FRIENDS
FINANCES	DRUG USE	HEALTH PROBLEMS	SLEEP
ANGER	SELF-CONTROL	BEING A PARENT	HEADACHES
STRESS	WORK	BOWEL TROUBLE	AMBITION
SEPARATION	LEGAL MATTERS	SUICIDAL THOUGHTS	LONELINESS
FEARS	INSOMNIA	SOCIAL DIFICULTY	ENERGY
ALCOHOL USE	CONCENTRATION	EDUCATION	MARRIAGE
UNHAPPINESS	WORRY	NIGHTMARES	MEMORY
RELAXATION	MY THOUGHTS	SHYNESS	OTHER

Is there anything else you feel we should know?

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PLEASE LIST OTHER PROVIDERS YOU SEE

Your Primary Care Physician	Your Psychiatrist (if you have one)
Name:	Name:
Address:	Address:
Phone #:	Phone #:
Fax #:	Fax #:
Your Neurologist (if you have one)	Other Provider
Name:	Name:
Address:	Address:
Phone #:	Phone #:
Fax #:	Fax #:

PERMISSION FOR EXCHANGING CONFIDENTIAL INFORMATION WITH OTHER TREATMENT PROVIDERS

This form when completed and signed by you, authorizes your clinician at Port Jefferson Psychological & Vocational, P.C. to obtain and/or release protected information from your clinical record to the treatment providers you designate for the purposes of coordination of care. Coordination of care can provide far more effective treatment. We encourage you to provide permission for this contact.

Primary Care Physician Psychiatrist Neurologist Dr. _____

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.

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 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 Patient/Parent

Date

I DO NOT want my provider to contact my other doctors.

Primary Care Physician Psychiatrist Neurologist Dr. _____

Signature of Patient/Parent

Date

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****THIS MUST BE FULLY COMPLETED****

INSURANCE INFORMATION

PRIMARY:

Insurance Co. Name: _____

Mailing Address: _____
STREET CITY/STATE ZIP CODE

Phone # _____

Policy/Group #: _____ Member I D#: _____

Policy Holder: _____
NAME DATE OF BIRTH

Address: _____
STREET CITY/STATE ZIP CODE

SS#: _____ Phone: _____ Relationship: _____

Employer: _____
NAME ADDRESS

SECONDARY: FOR MEDICARE ONLY

Insurance Co. Name: _____

Mailing Address: _____
STREET CITY/STATE ZIP CODE

Phone # _____

Policy/Group #: _____ Member I D#: _____

Policy Holder: _____
NAME DATE OF BIRTH

Address: _____
STREET CITY/STATE ZIP CODE

SS#: _____ Phone: _____ Relationship: _____

Employer: _____
NAME ADDRESS

It this related to an automobile or work-related accident? Yes No

CLINICIAN - PATIENT SERVICES AGREEMENT

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), the federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. The law requires that we obtain your signature acknowledging that we have provided you with this information. When you sign this document, it will also represent an agreement between us.

PSYCHOLOGICAL SERVICES

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy.

Signature of Patient/Responsible Party

Date

APPOINTMENTS

We normally conduct an initial evaluation that will last from 1 to 3 sessions. If psychotherapy is begun, we will usually schedule one 45-minute per week at a time we agree on. **Once an appointment is scheduled, you will be expected to keep it unless you provide 24 hours advance notice of cancellation or we both agree that you were unable to attend due to circumstances beyond your control. All unauthorized Missed Appointments cancelled within the 24-hour period will be charged a fee of \$50. All unauthorized Missed Appointments without cancelation will be charged a fee of \$75. If your insurance plan does not allow for a Missed Appointment fee and there is a Missed Appointment, we may not be able to accommodate your treatment at this office.** It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

Signature of Patient/Responsible Party

Date

PROFESSIONAL FEES

Psychological Services Fees for psychotherapy sessions are to be determined by Port Jefferson Psychological & Vocational, P.C. and may change from time to time. Other services include report writing, telephone conversations lasting longer than 5 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us will also incur fees. If you become involved in legal proceedings that require our participation, you will be expected to pay for all of our professional time, including preparation and transportation costs, even if we are called to testify by another party. Because of the difficulty of legal involvement, we charge \$350 per hour for preparation and \$3,000 per day for our attendance at any legal proceedings.

Please note: there will be a charge for all returned checks & interest on past due accounts.

Signature of Patient/Responsible Party

Date

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a Licensed Mental Health Practitioner. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA.

There are some situations where we are permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services that we provided you, such information is protected by the Doctor-patient privilege law. We cannot provide any information without your written authorization, or a court order.
- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.
- If we are providing treatment for conditions directly related to a worker's compensation claim, we may have to submit such records, upon appropriate request, to Chairman of the Worker's Compensation Board on such forms and at such times as the chairman may require.
- If you would like to use medical insurance benefits to pay for the cost of treatment, we may disclose information in order to receive payment. The disclosure may be up to and including your whole treatment record.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment.

- If we receive information in our professional capacity from a child or the parents or guardian or other custodian of a child that that gives us reasonable cause to suspect that a child is an abused or neglected child, the law requires that we report to the appropriate governmental agency.
- If a patient communicates an immediate threat of serious physical harm to an identifiable victim, we may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.
- If a patient communicates an immediate threat of serious physical harm to themselves, we may be required to take action. This action may include contacting the police or seeking hospitalization for the patient.

Please note that Port Jefferson Psychological is a group practice and as a result, clinical information may be shared between the clinicians in the practice to ensure continuity of coverage.

Signature of Patient/Responsible Party

Date

THE SAFE ACT (S 9.46)

Mental Health Professionals are required to report when reasonable professional judgment determines a patient is likely to engage in contact that would result in serious harm to self or others. The report is made as soon as is practical to the Division or Criminal Justice Services. Only a patient’s name and other NON-CLINICAL identifying information shall be released which may only be used for determining whether a license issued pursuant to section 400.00 of the penal law should be suspended or revoked, or for determining whether a person is ineligible for a license issued pursuant to section 400.00 of the penal law, or is no longer permitted under state or federal law to possess a firearm.

The decision of a Mental Health Professional to disclose or not to disclose in accordance with this section, when made reasonable and in good faith, shall not be the basis for any civil or criminal liability of such Mental Health Professional.

Signature of Patient/Responsible Party

Date

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to us confidentially by others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. In most circumstances, we are allowed to charge a copying fee of 75 cents per page (and for certain other expenses).

Signature of Patient/Responsible Party

Date

MINORS & PARENTS

New York law gives children of any age the right to independently consent to and receive mental health treatment without parental consent if they request it and we determine that such services are necessary and requiring parental consent would have a detrimental effect on the course of the child’s treatment. In that situation, information about that treatment cannot be disclosed to anyone without the child’s agreement. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

Signature of Patient/Responsible Party

Date

