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

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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: _____

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: _____

Emergency Contact #1: _____ Relationship: _____

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

Emergency Contact #2: _____ Relationship: _____

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

Nearest Medical Hospital: _____

Nearest Police Department: _____

Who suggested you contact us? _____

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

NAME(S) AGE BIRTH DATE RELATIONSHIP OCCUPATION

_____

_____

_____

_____

_____

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	TIREDNESS	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
FEAR	INSOMNIA	SOCIAL DIFFICULTY	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

Is 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 minimum $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

TELEHEALTH REQUIREMENTS

For telehealth sessions, doxy.me is used as an online communication tool allowing for face-to-face video that is HIPAA compliant. For more information about doxy.me security and privacy, please contact doxy.me. This website, doxy.me, requires the use of a browser but does not require any software download. Any internet-based communication is not 100% guaranteed to be secure/confidential. I agree that my therapist and Port Jefferson Psychological & Vocational, P.C. should not be held responsible if any outside party gains access to the video feed.

Please be online at least five minutes prior to session, alone, in a quiet room, with the door closed. For best picture and audio quality, a hardwired connection (via LAN cable) rather than a wireless one should be used if possible. Headphones add additional security and audio quality. Confidentiality should be treated like an in-office session: no outside distractions, turn off cell phones, close other programs on your computer, and be on time.

In a crisis or emergency situation that needs immediate attention, (especially if there is the threat or intent of serious harm to myself or someone else), I will dial 911, or go to a mental health hospital/Emergency Room.

For all video sessions, anyone participating must be visible on the screen. For individual sessions, this is the patient only. For family/parent sessions, this is only those members who will be involved in the session. For sessions with a minor – anyone under 18 years of age - a parent/responsible adult must be available in your location.

I understand that my therapist may decide to terminate telehealth services if they deem it inappropriate for me to continue treatment through video sessions. In this case, they may provide in-person care or make a referral to another provider or clinic, if necessary.

_____ _____

Signature of Patient/Responsible Party Date

IN PERSON REQUIREMENTS

For in person sessions, you are expected to be in good health, free from symptoms of a contagious illness. If any member of your household has symptoms of an illness, you will wear a surgical or N/KN-95 mask over your nose and mouth in all areas of the office, or switch to telehealth. An inherent risk of exposure to illness, including COVID-19, RSV, Influenza, etc., exists in any public place where people are present. According to the Centers for Disease Control and Prevention, senior citizens, people with underlying medical conditions, and people who are unvaccinated are especially vulnerable to illnesses. By coming to the office, you voluntarily assume all risks related to exposure to illnesses. This risk may increase if you travel by public transportation, cab, or ridesharing service.

_____ _____

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

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 Processional.

_____ _____

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

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. [If such legal action is necessary, its costs will be included in the claim.]

_____ _____

Signature of Patient/Responsible Party Date

HEALTH SAVINGS ACCOUNTS/FLEXIBLE SPENDING ACCOUNTS

As we do not currently accept credit or debit cards, we may not be able to accept a direct payment from any health-related account that requires a card be run. In the event that you wish to use such an account to pay for deductibles, co-pays, and co-insurance payments you will be responsible for providing payment at the time of your visit and submitting for reimbursement from the company. We will provide you with a receipt for your payment that you can use to submit for reimbursement.

_____ _____

Signature of Patient/Responsible Party Date

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it will often provide some coverage for mental health treatment. When possible, we will fill out forms and provide you with assistance to receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. It may be necessary to seek approval for more therapy after a certain number of sessions.

You should also be aware that your contract with your health insurance company requires that we provide them with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. This information will become part of the insurance company files and will probably be stored in a computer. We will provide you with a copy of any report we submit, if you request it. By signing you agree that we can provide requested information to your carrier.

It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above [unless prohibited by contract].

_____ _____

Signature of Patient/Responsible Party Date