CENTER FOR SOLUTIONS

1758 Union Street, Niskayuna, New York 12309

Patient Intake Sheet

First Name____________________ Middle Initial______ Last Name______________________________

Address______________________________ City____________________ State_______ Zipcode________

Home phone____________________ Cell phone____________________ Preferred phone____________

Where would you like to receive confirmation calls? Home phone______ Cell phone_____ Via text_____

Patient's Date of Birth___/___/__________ Patient' Social Security Number _______/_____/________

Patient's Marital Status: Minor____ Single____ Married____ Divorced____ Separated______

Person to contact in case of emergency: ____
Name, Phone number and relationship to patient

Patient's email address:____

Does patient attend school? If so, name of school?______________________________________

Does student have an IEP at school?____

Primary Care Physician:____
Name, Address and Phone number

If taking any medications, please list name of medication, Dosage and Prescribing Doctor's Name:

____

____

Name and Phone Number of preferred Phamacy:____

Insurance:

Name of Insurance:______________________ Subsriber:________________________________

Subscribers relationship to patient______________

Group NO. ______________________ Subscriber's SSN: ______________________

I.D.NO.________________________ Subscriber's DOB: ______________________

Secondary Insurance:

Name of Insurance: ______________________

Name of Insurance:______________________ Subsriber:________________________________

Subscribers relationship to patient______________

Group NO. ______________________ Subscriber's SSN: ______________________

I.D.NO.________________________ Subscriber's DOB: ______________________

Patient is here to see :

____ Tammy LeBlanc, NP-P ____Lynn Asvestas, LMHC ____ Wende W Tedesco, LCSW-R ___Jennifer Sampson, LCSW-R

Today's Date:________________ Patient's signature: ______________________________________

If patient is a minor, parent/guardian signature: ______________________________________

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PERMISSION TO EXCHANGE INFORMATION

I, ______________________________ authorize **CENTER FOR SOLUTIONS**, and/or

______________________________ to share information about my diagnosis and treatment plan
(Name of Mental Health Practitioner)

with ____.
(Name of Primary Care Physician, Address, Phone Number)

The purpose of this disclosure is to coordinate treatment with my Primary Care Physician.

I understand that my Mental Health Practitioner will notify my Primary Care Physician of my medications. It is important for my Primary Care Physician to know about my medications to avoid potential drug interactions and duplicate prescriptions.

For Alcoholism and Substance Abuse Treatment:
I understand that this disclosure is bound by Title 42 of the Federal Regulations governing the confidentiality of alcohol and substance abuse patient records and will not be disclosed to anyone other than the person designated above without my additional authorization.

This authorization will remain valid for one year. I understand that I may revoke this authorization in writing at any time.

Date: ______________________

____
Patient/Guardian Signature

____
Print Name

Date: ______________________

____
Witness

____
Print Name

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NOTICE OF PRIVACY PRACTICES

This Notice contains important information about our professional services and business policies. It also summarizes information about the Health Insurance Portability and Accountability Act (HIPAA), a Federal law that provides expanded privacy protection and patient rights with regard to the use and disclosure of Protected Health Information (PHI).

Professional Records – The laws and standards of our profession require that we keep Protected Health Information about you in your clinical record. We may use this information to conduction normal health care operations, such as quality assessments and provider certifications. 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 request in writing to examine and/or receive a copy of your clinical record. In many circumstances, we are allowed to charge a copying fee of 75 cents per page. If your provider refuses your request for access to your clinical record, you have a right to review, that your provider will discuss with you upon your request.

Billing and Insurance Payments – We are required to provide your insurance company with information relevant to the services provided. We are required to provide a clinical diagnosis. We may be required to provide additional clinical information such as treatment plans or summaries, or copies of your clinical record. Your provider will make every effort to release only the minimum information about you that is necessary for the purpose requested.

Minors and Parents/Guardians – Patients under the age of eighteen (18) years (who are not emancipated) and their parents/guardians should be aware that the law may allow parents/guardians to examine their child's treatment records. Even when parental consent is given, children over the age of twelve (12) have the right to control access to their treatment records. While privacy in psychotherapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment, particularly with younger children. Before giving parents any information, the provider will discuss the matter with the child, if possible, and do his/her best to resolve any of the child's objections.

Revocation – I understand that I may revoke this consent in writing at any time, except to the extent that my provider has taken action relying on this consent.

Date: ______________________________ ______________________________

Patient Name

____

Patient/Parent/Guardian Signature

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FINANCIAL AGREEMENT

I authorize my provider to bill my insurance company for services rendered. I hereby assign the benefits I am entitled to receive under the terms of my insurance plan to be paid directly to my provider.

My provider will bill my insurance company based upon the information that I give to my provider. However, if my insurance company indicates that I do not have coverage or I am not eligible for services, I will be responsible for payment of the bill. I will notify my provider immediately if my insurance changes or is terminated for any reason. I understand that my provider is not a Medicaid provider.

I understand that I am responsible for making my co-pay at the time of my appointment. I understand that I will be billed an additional Fifteen ($15) Dollars for any co-pay not paid at the time of my appointment.

I understand that I will be charged Thirty ($30) Dollars for any check I give to my provider that is returned by my bank for any reason.

I understand that I will be charged Sixty ($60) Dollars for not giving a 24 hour cancellation notice or for any missed appointments.

I understand that if I miss more than two appointments without a 24 hour prior notice to my provider I will be discharged from services.

I understand that sometimes my provider may be required to create documents or reports for my benefit. I understand that my provider may charge me a fee for creating those documents based upon the extent and complexity of the documents. My provider will discuss with me the fee for those documents in advance.

Date ____________________ ____________________

Patient Signature

____

Parent/Guardian Signature

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LIMITS OF CONFIDENTIALITY

In the course of professional relationships, the mental health practitioner may be called upon to discuss information relating to the case or to transfer records. The limits of confidentiality between the patient and the practitioner are broadly included in the following principles:

1. No information about the patient will be transferred to anyone else without the expressed permission of the patient. This must be done in writing, and may include verbal permission.

2. If the patient is a minor, every effort will be made to gain the minor's permission first and then the permission of the parent or guardian.

3. If issues of sexual abuse of the patient emerge, it is the responsibility of the practitioner to convince the patient to report the abuse in the manner specified by State statute, or, in the event that the patient refuses, to make the report over the patient's objection.

4. It is possible that at future times, various organizations (the State Bar, graduate schools, high-security government agencies and so forth) may request information concerning the services rendered. This information will be provided only with the written consent of the patient.

5. No electronic recording of any interviews or contacts will be made without specific written consent of the patient.

______________________________ ____________________

Patient Name Date

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AUTHORIZATION TO PROVIDE SERVICES TO MINORS

I, ______________________________ have legal authority to authorize
(Name of parent/guardian)

______________________________, to receive mental health care services at
(Name and date of birth of patient)

Center for Solutions, 1758 Union Street, Niskayuna, New York, 12309.

I agree to be present, and, when requested, to participate in the treatment process.

I understand that information given to and obtained by the provider will become a part of my child's clinical record and may be protected by the Health Information Portability and Accountability Act.

Dated: ____________________ ______________________________
Signature of Parent/Guardian