Osika & Scarano
PSYCHOLOGICAL SERVICES, P.C.

Five Pine Street
Glens Falls, NY 12801

8 Williams St.
Elizabethtown, NY 12932

400 Rella Blvd. Suite #165
Suffern, NY 10901

Thomas S. Osika, Ph.D.
Gina Scarano-Osika, Ph.D
Angela Pietrantoni, Psy.D.
Cairenn Spooner, LCSW-R
Tacey Shannon, LMSW,

Telephone (518) 745-0079 Fax (518) 745-4291 E-Mail: Dr.Osika@ymail.com

Welcome to our Psychology Practice!

We have been trained in a highly specialized method of brief psychotherapy. What that means for you is that in most cases, some progress is visible by the 5th to 6th session. Although you may not feel better after the 1st or even 2nd session, by session # 3 and 4 you should feel that your provider has a good grasp on what you need. Remaining sessions should isolate the triggers of target behaviors so that over time, you feel more in control and content. We pride ourselves on building this practice based on this model of psychotherapy. It really works!

Having said this, psychotherapy is also about chemistry and how well the provider "clicks" with the client. Sometimes, even the most well-intentioned providers don't click with certain clients. At Osika and Scarano we make it an office policy that client satisfaction is the primary goal. So if you feel that insufficient progress is being made or you just don't "click" with your provider, just ask for a change in provider when scheduling your next appointment. For provider training purposes, we would appreciate it if you could please call Dr. Thomas Osika or Dr. Gina Scarano-Osika regarding the reasons for this change request.

Our office is an official training site for Post Doctoral Psychologists and Social Workers. If you are assigned to a provider other than Dr. Gina or Dr. Tom Osika, your provider is most likely a Social Worker or post-doctoral fellow. Please know that these students are closely supervised by Dr. Gina Scarano-Osika. For example, not only does the treatment plan have to be approved by Dr. Gina, each and every session is reviewed with Dr. Gina Scarano-Osika. If you are assigned to a student and have concerns about your treatment, please call Dr. Gina Scarano-Osika at 744-7978.

We would like you to know a few administrative things about our office.

- Please pay your co-pay to your therapist before your session begins. There is a $10.00 fee for not paying your co-pay at the time of service.
- All of our billing and scheduling personnel work from home and can be reached by leaving a message on their respective voicemails. Anne is in the billing department and she can be reached at 538-0161. Theresa and Lisa schedule/reschedule appointments. They can be reached at 745-0079.
- If you need to pick up or drop off protected health information, please make arrangements with Sheryl between the hours of 9:00 am and noon.

We thank you for choosing our practice to meet your needs and hope your journey is rich with personal growth. We look forward to your initial meeting on _____.

With Warm Regards
Thomas and Gina Osika

OSIKA & SCARANO
PSYCHOLOGICAL SERVICES, PC

Telephone (518) 745-0079 **Fax (518) 745-4291** **E-Mail: Dr.Osika@ymail.com**

INTAKE FORM (Bring with you to scheduled appointment)

PATIENT INFORMATION Date of Birth _____ Age: _____
Patient's Name _____ Sex: ☐ M ☐ F

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ SS#_____

Referring Physician _____ Primary Physician_____ Referred to this office by: _____

If patient is a minor, PLEASE FILL IN THE FOLLOWING:

Biological Father's Name _____ DOB: _____ **SS#** _____

Address _____ City _____ State _____ Zip _____

Home Phone #: _____ Cell Phone #: _____

Biological Mother's Name _____ DOB: _____ SS# _____

Address _____ City _____ State _____ Zip _____

Home Phone #: _____ Cell Phone #: _____

Legal Guardian Name _____ DOB: _____ SS# _____

Relationship to Patient: _____ Guardian SS#: _____

Address _____ City _____ State _____ Zip _____

Home Phone #: _____ Cell Phone #: _____

Primary Insurance: _____ Employer:_____

Subscriber ID#:_____ Group #: _____ Co-pay Amount: _____

Subscriber SS#: _____ Subscriber's DOB: _____

Subscriber's Name _____

Secondary Insurance _____ Employer: _____

Subscriber ID#: _____ Group #: _____ Co-pay Amount:_____

Subscriber's SS#: _____ Subscriber's DOB:_____

Subscriber's Name _____

Psychologist Use Only: Diagnosis _____ (Numerical Codes only)

Guarantor, Insured's or Authorized Person's Signature:
I authorize payment of the medical benefits to Osika & Scarano Psychological Services, PC and understand that I am responsible for all balances not covered by my insurance company, such as co-payments, co-insurance, deductibles and non-coverage of benefits. I understand that my co-payment is due at the time of service and if this account becomes delinquent, it may be turned over to a collection agency and the fact that I received treatment in this office will become public record. I understand that there is a $50.00 no show charge if I do not cancel appointments 24 hours in advance. If I do not pay my co-pay at the time of my service date a $10 late fee will be charged. On any balance 6 months overdue, 18% APR and a $50 collection fee will be added.

Parent or Guardian Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

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DEMOGRAPHICS

Patient's Name: _____Age: _____

Reason for Referral: _____

_____

Referral Source: _____

Current Medications: _____

Name: _____ Prescribing Physician: _____

Physician Address: _____

Name: _____ Prescribing Physician: _____

Physician Address: _____

Name:_____ Prescribing Physician:_____

Physician Address: _____

Primary Care Physician: _____

Address: _____

Phone: _____

Has the patient been in mental health treatment within the past six months (circle) YES NO

If Yes, with whom _____
Which agency_____

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Authorization for Treatment of a Minor

I, _____, hereby certify that I am the parent/legal guardian

of the minor child _____, D:O:B: _____, and that

I have the authority to give consent for his/her mental health treatment. I request and permit that said child shall receive treatment at the above agency and I therefore accept financial responsibility. If there is a change in this consent I must give 30 days written notice.

I also understand that if I have SOLE LEGAL CUSTODY of the child/patient, I need to provide this office with proof of such a custody arrangement within 14 days of first being seen.

Parent/Guardian: _____

Witness: _____

Date: _____

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STATUS OF LEGAL CUSTODY

If the patient to be seen is under the age of 18, please complete the following. If the patient to be seen is over the age of 18 you are finished completing this packet.

Are the patient's biological or birth parents unmarried or divorced or in the process of a divorce? _____YES _____No

If you answered "no", go to next page.

Do you have JOINT LEGAL OR SOLE LEGAL custody of the child (please circle)?

_____

In the case of children with custodial and non-custodial parents, it is SOMETIMES in the child's best interest to notify EACH parent that the child is being brought to treatment. This holds true because during the course of treatment 1) the other non-custodial parent may want to offer information that would otherwise not be received if left out of treatment, 2) the child or yourself may want to address issues with the other non-custodial parent so that they can act more in the child's best interest, or 3) the therapist may want to address issues with the non-custodial so that they can act more in the child's best interest. What follows is a form letter that we prefer (but do not have to) send to non-custodial parents. Please note that only this form letter will be sent which is free of personal and sensitive material. In cases of sole legal custody you have the right not to consent (to contacting the other biological parent). For parents with joint legal custody no release of information is needed to consult with the other biological parent who has joint legal custody.

_____

Dear _____:

Your child, _____ was recently seen at my office for an intake appointment to begin mental health treatment. As a standard part of treatment and because it is your right to know, I prefer to involve both parents, despite the fact that the child's other biological parent made the first appointment. Please call 745-0079 to schedule an appointment at your earliest convenience. Your involvement in your child's treatment is highly recommended and can only help. I hope to hear from you soon.

Sincerely,
Gina Scarano-Osika, Ph.D.
Thomas Osika, Ph.D.

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CONSENT TO RELEASE INFORMATION TO NON-CUSTODIAL PARENT WITHOUT JOINT LEGAL CUSTODY

(to be signed by the custodial parent ONLY IF the custodial parent has SOLE legal custody.)

DOCUMENTATION OF SOLE LEGAL CUSTODY MUST BE PROVIDED AT THE FIRST SESSION

I, _____, am the biological parent of _____
Parent Name Child Name

and hereby authorize the release of information to _____. The
Non-custodial Parent

Non-Custodial parent's address is_____ and

his/her phone number is _____. I understand that I need to

discuss with Dr. Osika/Dr. Scarano the limits of information to be released.

Signed _____ Date _____
Parent

Signed_____ Date _____
Dr. Osika/Dr. Scarano-Osika

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INFORMED CONSENT TO CHILD, FAMILY, OR COUPLES PSYCHOTHERAPY

This form documents that we, _____, give our consent to Osika and Scarano Psychological services, P.C. (the "psychologist") to provide psychotherapeutic treatment to us and/or our child. We understand that sometimes it is necessary to conduct family therapy as part of the treatment for our child.

While we expect benefits from this treatment, we fully understand that no particular outcome can be guaranteed. We understand that we are free to discontinue treatment at any time but that it would be best to discuss with the psychologist any plans to end therapy before doing so.

I have fully discussed with the psychologist what is involved in psychotherapy and I understand and agree to the policies about scheduling, fees and missed appointments.

- ***I understand that I am fully financially responsible for treatment, which, if I have health insurance, includes any portion of the psychologist's fee that are not reimbursed by our insurance.***
- ***I understand that the frequency of our sessions will be 1-4 x PER MONTH and that I am fully responsible for payment of all deductibles and co-payments.***
- ***I understand that payment will be due at the time services are rendered.***
- ***I understand that I will be charged $50.00 for any canceled sessions if I do not give the psychologist at least 24 BUSINESS HOUR notice. For example, if I call on 2 pm Sunday to cancel a Monday appointment I will be billed $50.00 (Insurers don't pay for canceled sessions).***
- ***I understand that there will be a $10.00 charge for not paying my co-pay at the time services are rendered.***
- ***I understand that if my bill for services is 30 days past due, I will need to pay the full amount within two weeks in order to avoid interest at the rate of 18%. If payment cannot be made, then I understand that no further appointments will be provided and/or I may be given a referral to see another provider.***
- ***I understand that if my bill is not paid in full within 6 months of the unpaid date of service, in addition to an 18% APR a $50.00 collection fee will be added.***

Our discussion about therapy has included the psychologist's evaluation and diagnostic formulation of our problems, methods of treatment, goals, length of treatment, and information about record-keeping. We have been informed about and understand the extent of treatment, its foreseeable benefits and risks, and possible alternative methods of treatment. We understand that therapy can sometimes cause upsetting feelings to emerge, that we may feel worse temporarily before feeling better, and that we may experience distress caused by changes we may decide to make in our life as a result of therapy.

Many providers at Osika and Scarano receive supervision by Dr. Tom and Dr. Gina (the supervisors). We understand that during supervision the patient's name, diagnosis and treatment plan are shared with the supervisors. We also understand that during the course of treatment, pertinent information is shared with the supervisors. As always, all providers abide by privacy policies and HIPPA.

We understand that the psychologist cannot provide emergency service. If an emergency arises we will call the beeper numbers as follows: Dr.'s Scarano and Osika 744-7978. In any case, we understand that in any emergency, we may call 911 or go to the nearest hospital emergency room. We understand that Glens Falls Hospital has an Emergency Mental Health Staff and they can be reached at 761-5325.

We have received a HIPPA Notice of Privacy Practices from the psychologist. We understand that information about psychotherapy is almost always kept confidential by the psychologist and not revealed to others unless we give our consent. There are a few exceptions as noted in the HIPPA Notice of Privacy Practices. Details about certain of those exceptions follow:

1. The psychologist is required by law to report suspected child abuse or neglect to the authorities.
2. If we tell the psychologist that we intend to harm another person, the psychologist must try to protect that person, including by telling the police or the person or other health care providers. Similarly, if we threaten to harm ourselves, or our life or health is in any immediate danger, the psychologist will try to protect us, including by telling others such as my relatives or the police or other health care providers, who can assist in protecting or assisting us.
3. As per Section 9.46 of the Mental Health Hygeine Law, the psychologist is mandated to report (at https://nysafe.omh.ny.gov) patients who are at imminent risk of harming themselves or others. Such a report could have direct implications as to whether or not I could possess a firearm.
4. If we are involved in certain court proceedings the psychologist may be required by law to reveal information about our treatment. These situations include child custody disputes, cases where a therapy patient's psychological condition is an issue, lawsuits or formal complaints against the psychologist, civil commitment hearings, and court-related treatment.
5. If our health insurance or managed care plan will be reimbursing us or paying the psychologist directly, they will require that we waive confidentiality and that the psychologist give them information about our treatment.
6. The psychologist may consult with other psychotherapists about our treatment, but in doing so will not reveal our names or other information that might identify us. Further, when the psychologist is away or unavailable, another psychotherapist might

answer calls and so will need to have some information about our treatment.

7. If our account with the psychologist becomes overdue and we do not pay the amount due or work out a payment plan, the psychologist will reveal a limited amount of information about our treatment in taking legal measure to be paid. This information will include our names, social security number, address, dates and type of treatment and the amount due.

In all of the situations described above we understand that the psychologist will try to discuss the situation with us, or notify us, before any confidential information is revealed, and will reveal only the least amount of information that is necessary.

We understand that, except in exceptional circumstances, the psychologist cannot keep secrets from other family members who are involved in the therapy because this might harm the person who does not know.

We agree that each of us has and shall continue to have the right to information about our individual, family, and/or conjoint treatment sessions, and to the treatment records of the psychologist regarding our individual, family, and/or conjoint treatment sessions. We each agree that the psychologist may release such information or record to either or all of us without any additional authorization(s) from the other(s). We understand that each of us will <u>not</u>, however, have any right of access to information or records regarding individual treatment sessions of other family members.

We agree that if marriage or parenting problems lead to legal disputes over child custody or visitation, neither of us will ask or require that the psychologist testify regarding custody or visitation. Because to do so would hurt the child's treatment. The psychologist's role is therapeutic and not evaluative. We understand that these legal disputes are best answered by a third party forensic professional.

If a custody or visitation proceeding does occur, we agree that the psychologist's role will be limited to providing information to a mental health professional appointed to perform a forensic evaluation, the attorneys, law guardian, and/or the judge involved in the legal proceeding. The psychologist will provide these either as required by law or upon our authorization. Because of these limitations, the psychologist also will not be able to give any opinion regarding custody, visitation or any other legal issue.

We understand that we have rights to information about what takes place in the child's therapy, to information about the child's progress in therapy, to information about any dangers the child might present to self or others, and upon request, to obtain copies of the child's treatment record (with certain qualifications and exceptions). We understand that it is sometimes best not to ask for specific information about what was said in therapy sessions because this might break the trust between the child and the psychologist, especially for children over the age of 12.

The psychologist has explained to us that children with two parents have the best chance to benefit from therapy if both parents are involved and cooperate with each other and the psychologist. It is best if both the child's parents are consenting to therapy:

- Each of us agrees that he or she will not end the child's therapy without the agreement of the other parent, and that if we disagree about the child's continuing in therapy, we will try to come to an agreement, by counseling if necessary, before ending the child's therapy.
- We each agree to cooperate with the treatment plan of the psychologist for the child and understand that without mutual cooperation, the psychologist may not be able to act in the child's best interests and may have to end therapy.

- We agree that each of us has and shall continue to have the right to information about the child's treatment and to the treatment records of the psychologist regarding the child, and agree that the psychologist may release information or records to either of us without any additional authorization of the other.

If we and/or the child are participating in a managed care plan, we have discussed with the psychologist our financial responsibility for any co-payments and the plan's limits on the number of therapy sessions. If we and/or the child are not participating in a managed care program, we understand that we are fully financially responsible for treatment, including any portion of the fees not reimbursed by health insurance. The psychologist has also discussed options for continuation of treatment when managed care or health insurance benefits end.

We have the right to be notified of a data breach. We have the right to ask for an electronic copy of my medical record. We have the right to opt out of fundraising communications from us. Uses and disclosures of my medical information cannot be sold or used for marketing purposes without my authorization. All patients who pay in full out of pocket for services (i.e. do not bill their insurance) can instruct us to not share information about your treatment with your health plan.

We understand that we have a right to ask the psychologist about the psychologist's training and qualifications. If we ever desire to file a complaint about the psychologist's professional conduct, we understand we can call the NYS Psychology Licensing Board within the Department of Education at 474-3866. Complaints to the licensing board can also be made if you feel your provider or any staff member of Osika and Scarano violates your patient rights or discriminates against you based on gender, race, sexual orientation, national origin or color. If (the licensing board finds that) an employee of Osika and Scarano has violated this non-discrimination policy, appropriate disciplinary action, ranging from counseling to termination, will be taken against the employee who violated the policy.

By signing below, we are indicating that we have read and understand this agreement, that we give consent to the psychologist's treatment for ourselves and/or our child, and that we have the proper legal status to give consent to therapy for our child.

Parent or Guardian Signature: _____ Date: _____
(of parent or spouse)

Parent or Guardian Signature: _____ Date: _____
(of parent or spouse)

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IMPORTANT NOTICE:

I agree to call my insurance company, prior to my first visit, and obtain the following information. I understand that if I do not come to the first session with all of this information that the provider will need to take time out of the first session to call my insurance company and complete this form. I understand that this information is critical, in order to minimize my out-of-pocket expenses. I understand that I am fully responsible for updating this form on a yearly basis and when my insurance changes. Failure to give us immediate notice of any change in insurance can result in large out-of-packet expenses, which I will be fully liable to pay in full.

1. Name of Insurance Company _____
(as it appears on the card)
Name of the insurance representative who you got this information from _____

_____

Date I called: _____

2. Co-pay amount _____

3. Is there a Deductible? _____

4. Referral from Primary Care Physician Needed? _____

5. Outpatient Treatment Report (OTR) needed?_____
If yes, after how many sessions? _____

6. Prior Authorization need? Yes or No If yes, complete the following.
6 a. Authorization Number: _____
6 b. What is the maximum number of visits allowed under this authorization _____
6 c. Is it a calendar year (e.g. 01/01/09 to 01/01/10) _____
If no, give the dates that the authorization is valid from _____ to _____

By signing below I am agreeing to pay in full any outstanding balance that results from incomplete or inaccurate information.

_____ _____
Patient or Parent Signature Date

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PLACE THIS SIGNED & DATED FORM IN ALL CHARTS

TO CONTACT US

This is our contact information as referred to above:

Our Privacy Officers are: Dr. Thomas "Osika and Dr. Gina Scarano-Osika

Our mailing address is: Five Pine Street
Glens Falls, NY 12801

Telephone: (518) 745-0079

Fax: (518) 745-4291

ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that I have received, read, and understood this Notice of Privacy effective April 14, 2003, and that any questions I have about it have been answered.

_____ _____
Signature Date

_____
Print Name

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RELEASE OF INFORMATION/AUTHORIZATION FORM FOR PRIMARY CARE PHYSICIAN

1. I authorize my healthcare practitioner, _____ at Osika & Scarano Psychological Services, P.C., and/or administrative and clinical staff to disclose my protected health information, as specified below, to the persons indicated below who will receive the information:

   Primary Care Physician: _____

   _____

   _____

2. I am hereby authorizing the disclosure of the following protected health information:
   DIAGNOSTIC EXAMINATION AND TREATMENT PLAN

3. This protected health information is being used or disclosed for the following purposes:
   To collaborate regarding the treatment plan and diagnosis

4. This authorization shall be in force and affect until one (1) year after the date below at which time this authorization to disclose protected health information shall expire.
5. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to my healthcare practitioner, at Osika & Scarano Psychological Services, P.C., 5 Pine Street Glens Falls. I understand that a revocation is not effective to the extent that my healthcare practitioner has relied on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
6. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by HIPPA or any other federal or state law.
7. My healthcare practitioner will not condition my treatment on whether I provide an authorization for disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____
Signature of Parent or Guardian Date

_____
Print Name of Patient

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PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

We, _____, assume that we may contact you by telephone at your home and at your work, and in writing at your home, unless you instruct us otherwise.

Under HIPAA, you have the right to request that communications with you be confidential and by means of your selection. We will approve your request if in our opinion it is reasonable. Once we agree to your request, we are obligated to honor it, except if an emergency arises.

I wish to be contacted as follows (check all that apply):

□ At my home telephone number:_____
___ You can leave messages with detailed information
___ Leave message with a call-back number only
___ Call only at specified times of day:_____

□ At my work telephone number:_____
___ You can leave messages with detailed information
___ Leave message with call-back number only
___ Call only at specified times of day:_____

□ At my cell phone number:_____
___ You can leave messages with detailed information
___ Leave message with call-back number only
___ Call only at specified times of day:_____

□ In writing at:
___ My home address
___ My work address
___ My fax number(s):_____
___My email address:_____

□ Other (specify):_____

If any means of contacting you will place you in danger, please specify:_____
_____

_____ _____
Signature of Patient Date

_____

PSYCHOSOCIAL HISTORY
CHILDREN AND ADOLESCENTS

Name:_____

Parents First &Last Name:_____

Date of Birth:_____

Date of First Session:_____

Who referred your child to this office?_____
Why?_____
Primary Care Physician:_____

In order to better meet your needs during sessions, it is beneficial for the therapist to know some general social history. Please answer the following questions. The more truthful you are, the more beneficial treatment can be for you. For children & teens the questions should be answered as if the child is filling out the form.

Directions: With an "X", please designate which statements are "TRUE" for you.

_____When I was born, my birth mother was a teen or unmarried

_____I was conceived from a sexual assault

_____ My birth parents remain married

_____ My birth parents separated when I was ____ years of age

_____One or both of my birth parents re-married

_____ I was adopted.

Directions: Fill in the blank spaces

I have _____ birth siblings (same parents) of which I am the _____ born.

I have _____ half-siblings (share only one birth parent)

I have _____ step siblings (children of a step-parent)

Preg: WNL no substances
Perinatal stressors or illnesses
Pre-natal stressors or illnesses
Labor: WNL
Weight: WNL
Illnesses first year: none
Developmental Milestones: WNL
Physical Development: WNL
Psychological Development: WNL
Social Development: WNL
Intellectual Development: WNL
Academic Development: WNL

Directions: With an "X", please designate which statements are "TRUE" of you.

____At least one of my childhood mentors (e.g., birth parents, step-parents, grandparents, foster parents) were addicted or overused ALCOHOL.
If "YES", Who? _____

____At least one of my childhood mentors (e.g., birth parents, step-parents, grandparents, foster parents) used ILLEGAL DRUGS.

If "YES" Who? _____

____At least one of my childhood mentors (e.g., birth parents, step-parents, grandparents, foster parents) were PHYSICALLY VIOLENT with each other.

If "YES", Who? _____

____At least one of my childhood mentors (e.g., birth parents, step-parents, grandparents, foster parents) were VERBALLY ABUSIVE with each other.

If "YES", Who? _____
What were their abusive statements/names:_____

_____

____I have been a victim of CHILDHOOD PHYSICAL ABUSE (e.g., at least red marks or bruising)

If "YES", By Whom?_____

____I have been a victim of CHILDHOOD SEXUAL ABUSE (e.g. intercourse OR fondling OR giving OR receiving oral sex)

If "YES", By Whom?_____

____I have been a victim or stranger of date rape.

Directions: With and "X" please designate which statements are "TRUE" of you.

I am in _____grade at _____School.

_____I am in Special Education Classes
If yes, describe_____

_____ I don't give my full effort on homework.

_____ I am frequently tardy or truant from school.

Directions: Fill in the blanks

I have been in _____ physically abusive relationships.

I have been in _____ verbally abusive relationship.

I have had _____ serious relationships end negatively. Describe: _____
Number

_____

_____

_____

_____

_____

Medical illnesses that I currently have: _____

_____

I have had _____periods of unconsciousness in my lifetime.

Prescription Medications that I take daily: _____

_____

_____

I am allergic to these medications:_____

Number of cigarettes I smoke daily:_____

Amount of caffeine I drink daily (coffee, tea, cola): _____8 oz servings.

Number of 8 oz servings of alcohol I drink weekly:_____

Prescription pain meds I have used in the past six months:_____

Illegal drugs I have used in my lifetime: _____

Illegal drugs I have used in the past 6 months:_____

I have a firearm in my home: yes no

Directions: With an "X", please designate which statements are "TRUE" of you in the past 6 months. Leave the space blank if the statement does not apply.

____ I have visual memories of abusive childhood events

____ I have nightmares of previous abuse/assualts

____ I cry easily

____ I lose my temper at little things

____I disobey my parents alot

____I blame others

____I have been stealing

____ I have destroyed things when angry

____ I hurt others when angry

____ I have set fires

____ I have run away from home

____ I have been illegally absent from school

____I am sexually active

____ I feel depressed most days

____ I feel irritable most days

____ I worry about things I don't think will happen

____ I have difficulty falling asleep

____ I get too little sleep

____I have trouble staying asleep

------ My appetite has decreased

____I feel tired most days

____ I require more than 10 hours of sleep

____ I have a difficult time concentrating

_____I feel out of control when I overeat.

____ I avoid some foods (e.g., fatty or high in sugar).

____ I am unhappy with my weight and body shape.

____ I've had thoughts of killing myself in the past

____ I have wanted to die in the past.

____ I have had a planned method of killing myself

____ I have hurt myself on purpose by cutting, burning or bruising myself.

____ I have tried to kill myself in the past

If "Yes", When_____

How_____

____ I have been hospitalized for psychiatric reasons

If "YES" Where?_____

When? _____

_____I have been placed on psychiatric medications in the past.
If yes, which ones_____

_____I am currently taking psychiatric medications.
If yes, which medications and how much_____

_____ I have seen a mental health professional for outpatient treatment in the past.
Describe previous treatment provider's interventions:_____
_____

_____ Did treatment help you in the past

_____ Members of my family have mental illness.
If yes, which illnesses:_____
_____

(Patient Stop Here and skip next page)

Mental Status Examination:

Patient came to interview with_____. Parent was cooperative and understood her/his privacy rights under HIPPA. Parent was appropriately concerned about patient.
Insight: WNL DENIAL
Empathy: ADEQUATE
Judgment: ADEQUATE

Patient is a _____year old Caucasian _____ who appeared stated age. Patient was weighed upon intake and they stood _____feet tall and weighed _____ giving them a Body Mass Index of _____. Patient was _____motivated for therapy and was cooperative.
Mood
DFA
DSA
Appetite
Psychosis: None
Insight: WNL

Judgment: WNL
Patient Denied SI/HI

DIAGNOSTIC IMPRESSIONS:

I:

II:

III: Write medical illnesses here.

TREATMENT GOALS:

Patient will be seen for individual therapy. Object Relational, Cognitive-Behavioral, brief time-limited and Family Systems Interventions will be utilized in order to meet the following goals within 10-15 sessions.

A release of information will be signed in order for treatment to be coordinated with patient's pediatrician/family physician and to discuss the utilization of psychiatric medications.

_____

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PSYCHOLOGICAL SERVICES, P.C.

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The Power of Nutrition on Immunity
Depression, Irritability, Attention, and Appetite Control

The bridge between mood/behavioral disorders and all autoimmune diseases is Vitamin D which controls both the immune system and psychiatric centers of the brain. Unlike in years past, 80% of patients presenting for treatment at our office have some type of autoimmune illness (e.g., fibromyalgia, diabetes, IBS, Crohns Disease). As we request that patients receive Vitamin D testing during the course of their psychological treatment, about 95%of those tested are deficient.

Vitamin D is essential to the creation of mood stabilizing hormones such as serotonin. In the case of autoimmune diseases, Vitamin D helps the immune system attack the correct intruder. When Vitamin D is deficient, not only is the person susceptible to chronic illness (e.g. recurrent mononucleosis) but muscles and connective tissue (fibromyalgia), the thyroid (Hashimotos Disease), the pancreas(diabetes), or the digestive tract (IBS and Crohn's) can be the unfortunate targets. More and more, patients in our office are Vitamin D deficient and also have some autoimmune ailment.

Please email Lisa at Dr.Osika@ymail.com to view the symposium by lead Vitamin D researcher from Boston University Medical Center, Dr. Holick.

Since Vitamin D deficiencies can trigger both physical and psychiatric symptoms having to do with anxiety, depression, weight control, attention, and irritability, as clinical psychologists, it behooves us to remain updated on the latest research regarding Vitamin D, nutrition, and the immune system. Although NYS law restricts our ability to dispense nutritional supplements, we can make nutritional and supplemental recommendations for you to discuss with your primary care physician.

What do I do first? Since Vitamin D testing is not part of an annual CBC, ask your doctor to run a Vitamin D test. If you are deficient or even at the low end of normal, consider a liquid and organic Vitamin D supplement to improve absorption. Have your doctor re-test you every 6-12 months to be sure you maintain yourself on an adequate daily dose.

Why are we so Vitamin D deficient? Theories abound about why Vitamin D deficiencies have spiked in the last decade. Chronic stress depletes Vitamin D. Living in cold climates restricts sunlight which is a source of Vitamin D.

Ten Nutritional Tips
to Improve Mood, Appetite Control, Immunity and Attention

The following foods can help maximize your levels of Vitamin D and empower your body to launch its internal defense system to improve your overall feelings of physical and mental wellness.

1) **Citrus Juice:** The gallbladder metabolizes fats and Vitamin D just happens to be a fat soluble vitamin. To improve Vitamin D absorption, the gall bladder may need to be flushed. Grapefruit and lemon juice contains limonoids and flavonoids which reduce the incidence of cancer and can repair damaged DNA. Since some high blood pressure medications prohibit the ingestion of grapefruit, 100% organic lemonade, limes or apple juice are alternatives which also contain limonoids. These may be more palatable for children as well. Grapefruit and lemon juice in the am helps the gallbladder produce adiponectin, a hormone which helps metabolize fats and improves Vitamin D absorption. Ask your doctor about grapefruit seed/pectin supplements; but be sure they are free of soy and corn fillers.

2) Chiobanni Yogurt: contains probiotics and is free of corn and soy fillers. This is an excellent way to boost immunity and get added Vitamin D. Probiotics boost the immune system and Vitamin D by destroying bad bacteria in the intestine.

3) Organic Green Teas: can help the digestive system flush itself of pesticides and toxins. Yogi has a line of green teas infused with fruits which can boost the immune system at the same time.

4) Raw and Organic Honey: is loaded with probiotics but should not be heated. Add it to peanut butter sandwiches or cooled green tea.

5) Fermented and Raw Vegetables: such as sauerkraut, KimChi, and pickles, contain probiotics which can cleanse the digestive track. These can only be purchased at an organic or whole foods store.

6) Stoneyfield Organic Milk with DHA and Omega Three's: if the gallbladder is dysfunctional, the fatty sheath in the brain can deteriorate(myelin)causing attention and short term memory deficits. Stoneyfield has a line of organic milks that are infused with DHA, an essential Omega-3 fatty acid. This can help replenish the myelin. . DON'T buy the chocolate variety since all brands of chocolate milk (both organic and non-organic) contain carrageenan, a thickener made out of toxic red algae.

7) Flax Seed Oil or Flour: is the source of an essential Omega-3 fatty acid which has powerful immune boosting effects. It can be purchased as a flax seed to be put in salads, or in the milled form to be used as a flour substitute, or an oil in place of butter or oil when baking. Flax seed/oil helps replenish myelin and is high in fiber, which helps the probiotics flourish.

8) Ke-Vita Probiotic Sparkling Fruit Drinks: contain live cultures of probiotics, the good bacteria. These immune boosting bugs keep the intestinal track in balance.

9) Kefir: is rich in probiotics and can be purchased as a milk product or frozen pop (see Lifeway products).

10) Eat Organic and foods free of genetically modified organisms (GMO). GMO foods are genetically modified to sustain high levels of pesticides. Vitamin D will suffer if your body is overloaded with toxins and pesticides. Eating organic and non GMO foods is one way to minimize this cascade. Visit nonGMOproject.org for more information. Avoiding corn and soy derivatives (e.g., corn/soy oils, flours, lecithin, and high fructose corn syrup) can be helpful if eating organic/non-GMO is too expensive. Also, focus on incorporating organic and non-GMO grains, carbs, cereals, snacks, pasta and breads first since they appear to cause the most depletion in Vitamin D. Although time consuming, homemade baked goods are a nutritionally sound way to give your kids sweets, as long as you use non GMO flour, flax oil, and unprocessed cocoa.

We hope that your journey to mental and physical wellness is both empowering and enlightening.

Professionally,

Dr.'s Tom and Gina Osika

"ALL PATIENTS LEAVE THE OFFICE WITH THIS DOUBLE SIDES FORM."

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

The following is the Notice of Privacy Practices of_____ HIPPA is a federal law that requires us to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy policies with respect to your protected health information. We are required by law to abide by the terms of the Notice of Privacy Practices.

Your Protected Health Information

Your "protected health information" (PHI) broadly includes any health information, oral, written or recorded, that is created or received by us, other healthcare providers, and health insurance companies or plans, that contains data, such as your name, address, social security number, and other information, that could be used to identify you as the individual patient who is associated with the health information.

Uses or Disclosures of Your Protected Health Information

Generally, we may not "use" or "disclose" your PHI without your permission, and must use or disclose your PHI in accordance with the terms of your permission. "Use" refers generally to activities within our office. "Disclosure" refers generally to activities involving parties outside of our office. The following are the circumstances under which we are permitted or required to use or disclose your PHI. In all cases, we are required to limit such uses or disclosures to the minimal amount of PHI that is reasonably required.

Without your Written Authorization

Without your written authorization, we may use within our office, or disclose to those outside our office, your PHI in order to provide you with the treatment you request, to collect payment for our services, and to conduct other related health care operations as follows:

Treatment activities include: (a) use with our office by our professional staff for the provisions, coordination, or management of your health care at our office; and (b) our contacting you to provide appointment reminders or information about treatment alternative or other health-related services that may be of interest to you.

Payment activities include: (a) if you initially consent to treatment using the benefits of your contract with your health insurance plan, we will disclose to your health plans or plan administrators, or their appointed agents, PHI for such plans or administrators to determine coverage. For their medical necessity reviews, for their appropriateness of care reviews, for their utilization review activities, and the adjudication of health benefit claims; (b) disclosures for billing for which we may utilize the services of outside billing companies and claims processing companies with which we have Business Associate Agreements that protect the privacy of your PHI; and (c) disclosures to attorneys, courts, collection agencies and consumer reporting agencies, of information as necessary for the collection of our unpaid fees, provided that we notify you in writing prior to our making collection efforts that require disclosure of you PHI.

Health care operations include: (a) use within our office for training of our professional staff and for internal quality control and auditing functions (b) use within our office the general administrative activities such as filing, typing, etc.: and (c) disclosures to our attorney, accountant, bookkeeper and similar consultants to our healthcare operations, provided that we shall have entered into Business Associate Agreements with such consultants for the protection of your PHI.

PLEASE NOT THAT UNLESS YOU REQUEST OTHERWISE, AND WE AGREE TO YOUR REQUEST, WE WILL USE OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION FOR TREATMENT ACTIVITIES, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS AS SPECIFIED ABOVE, WITHOUT WRITTEN AUTHORIZATION FROM YOU.

As Required By Law

We may use or disclose your PHI to the extent that such use or disclosure is required by law. Examples of instances in which we are required to disclose your PHI include: (a) disclosures regarding reports of child abuse or neglect, including reporting to social service or child protective services agencies, (b) health oversight activities including audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (c) judicial and administrative proceedings in response to an order of a court of administrative tribunal, or other lawful process, (d) to the extent necessary to protect you or others from a serious imminent risk of danger presented by you; (e) for worker's compensation claims, and (f) as required by the Secretary of Health and Human Services to investigate or determine our compliance with federal regulations, including those regarding government programs providing public benefits.

All Other Situations, With Your Specific Written Authorization

Except as otherwise permitted or required as described above, we may not use or disclose your PHI without your written authorization. Further, we are required to use or disclose your PHI consistent with the terms of your authorization. You may revoke your authorization to use or disclose any PHI at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Special Handling of Psychotherapy Notes

"Psychotherapy Notes" are defined as records of communication during individual or family counseling which may be maintained in addition to and separate from medical or healthcare records. Psychotherapy Notes are only releases with your specific written authorization except in limited instances, including: (a) if you sue us or place a complaint, we may use Psychotherapy Notes in our defense; (b) to the United States Department of Health and Human Services in an investigation of our compliance with HIPPA; (c) to health oversight agencies for a lawful purpose related to oversight of our practice; and (d) to the extent necessary to protect you or others from a serious imminent risk of danger presented by you. Health insurers may not condition treatment, payment, enrollment, or eligibility for benefits on obtaining authorization to review or no reviewing, Psychotherapy Notes.

Your Rights With Respect to Your Health Information

Under HIPPA, you have certain rights with respect to your PHI. The following is an overview of your rights and our duties with respect to enforcing those rights.

Right to Request Restriction On Use Or Disclosure

You have the right to request restriction on certain uses and disclosures of your PHI. While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your protected healthcare information in violation of such restriction,

except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law. We require that all requests for restrictions be in writing and that you state a reason for the request.

Right To Receive Confidential Communications by Alternative Means and at Alternative Locations

We must permit you to request and must accommodate reasonable requests by you to receive communications of PHI from us by alternative means or at alternative locations. We will ask you how you wish us to communicate with you.

Right To Inspect and Copy Your Protected Health Information

You have the right of access in order to inspect, and to obtain a copy of your PHI, except for (a) personal notes and observations of the treating provider, (b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, (c) health information maintained by us to the extent to which the provision of access to you is at our discretion, and we exercise our professional judgment to deny you access, and (d) health information maintained by us to the extent to which the provision of access to you would be prohibited by law.

We require written requests for copies of your PHI; they should be sent to our Privacy Officer at the mailing address below. If you request a copy of your PHI, we will charge a fee for copying. We reserve the right to deny you access to the copies of all or certain PHI as permitted or requested by law. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the basis for denial, a statement of your rights, and a description of how you may file an appeal or complaint.

Right To Amend Your Protected Health Information

You have the right to request that we amend your PHI, for as long as your medical record is maintained by us. We have the right to deny your request for amendment. We require that you submit written requests and provide a reason to support the requested amendment.

If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us and/or the Secretary of the U.S. Department of Health and Human Services (DHHS). If we accept your request for amendment, we will make reasonable efforts to provide the amendment within a reasonable time to persons identified by you as having received PHI of your prior to amendment and persons that we know have the PHI that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendments shall be sent to our Privacy Officer at the mailing address below.

Right To Receive An Accounting Of Disclosures Of You Protected Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your PHI for which you have not provided an authorization, that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of such disclosures for a period of time less than six (6) years from the date of the request. We require that you request an accounting in writing on a form that we will provide to you.

The accounting of disclosures will include the date of each disclosure, the name and, if known, the address of the entity or persons who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, instead of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. We are not required to provide accountings of disclosures for the following purposes: (a) treatment, payment, and the healthcare operations, (b) disclosures pursuant to you authorization, (c) disclosures to you, (d) to other healthcare providers involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve the right to temporarily suspend you right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting with in the same twelve (12) month period. All requests for an accounting shall be sent to our Privacy Officer at the mailing address below.

Complaints

You may file a complaint with us and the Secretary of DHHS if you believe your privacy rights have been violated. Please submit any complaint to us in writing by mail to our Privacy Officer at the mailing address below. A complaint must name the subject of the complaint and describe the acts of omissions believed to be in violations of the applicable requirements of HIPPA or this Notice of Privacy Practices. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew of should have known that the act of omission complained or occurred. You will not be retaliated against for filing any complaint.

Amendments to this Notice of Privacy Practices

We reserve the right to revise or amend this Notice of Privacy Practices at any time. These revisions or amendments may be made effective for all PHI we maintain even if created or received prior to the effective date of the revision or amendment. Upon your written request, we will provide you with notice of any revisions or amendments to this Notice of Privacy Practices, or changers in the law affecting this Notice of Privacy Practices, by mail or electronically with 60 days of receipt or your request.

Ongoing Access to Notice of Privacy Practices

We will provide you with a copy of the most recent version of this Notice of Privacy Practices at any time upon your written request sent to our Privacy Officer at the mailing address below. For any other request or for further information regarding the privacy of your PHI, and for information regarding the filing of a complaint, please contact us at the address, telephone number, or e-mail address listed below.

To Contact Us

This is our contact information referred to above.

Our Privacy Officer is: Dr. Osika and Dr. Scarano-Osika. Our mailing address is: 5 Pine St. Glens Falls, NY 12801

Our Telephone number is: (518) 745-0079 Our Fax number is: (518) 745-4291 Our email address is: N/A_____

Osika & Scarano

PSYCHOLOGICAL SERVICES, P.C.

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Cairenn Spooner, LCSW-R

Telephone (518) 745-0079 **Fax (518) 745-4291** **E-Mail: Dr.Osika@ymail.com**

Record of Disclosures of PHI/EPHI

Date	Disclosure To Whom Address or Fax Number	(1)	Description Disclosure Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type: T=Treatment Record; P=Payment Information; HO=Healthcare Operation
(3) Enter how disclosure is made: F=fax; T=telephone; E=electronic; M=mail; O=other

DIRECTIONS TO 5 PINE STREET, GLENS FALLS

FROM THE NORTH (Lake George, Bolton, Stony Creek, Thurman, Warrensburg)

- **Take I-87 South**(or Rte 9L So. to Route 9 South to I-87) (or Rte 9N South to I-97 south)
- **Take Exit 18** (Glens Falls/Corinth)
- **Turn left** off Exit 18 onto Corinth Rd going toward Glens Falls
  Note: There is a Pine St about ¼ mile east off of Exit 18. This is NOT the correct Pine St.
- **Continue straight** on Broad St at V-intersection if front of Stewart's. (Do not veer right).
- **Turn left** onto Pine St when you near the 10 story white building. A Verizon building will be on your left. If you have gotten to Stewart's you have gone too far. Our building will be on your right with off-street parking behind the building.

FROM THE EAST (Hudson Falls)

- **Take Route 254** (River St.) going toward Glens Falls.
- **Continue straight** onto Warren St. and follow into downtown.
- **At Centennial Circle** in downtown, take second exit onto Glen St./Rte. 9 No.
  Turn left onto Pine St. when you near the 10 story while building. A Verizon building will be on your left. If you have gotten to Stewart's you have gone too far. Our building will be on your right with off-street parking behind the building.

FROM THE NORTHEAST (Putnam, Dresden, Whitehall, Fort Ann, Kingsbury)

- **Take Route 22** South toward Whitehall.
- **Take Route 4 South** into Hudson Falls**.**
- **Follow directions from Hudson Falls** listed above.

FROM THE NORTHWEST (Hampton, Granville, Hartford)

- **Take Route 22A South.**
- **Take Route 148 West** out of West Granville.
- **Take Route 40 South** out of Hartford.
- **Take Route 196 West** into Hudson Falls.
- **Follow directions from Hudson Falls** listed above.

FROM THE SOUTHEAST (Fort Edward, Hebron, Cambridge, Argyle, Greenwich)

- **Take Route 40 north** to Argyle.
- **Take Route 197 West** into Fort Edward.
- **Take Route 4 North** into Hudson Falls.
- **Follow directions from Hudson Falls** listed above.

FROM THE SOUTHEAST (White creek, Salem, Jackson)

- **Take Route 22 North** into Greenwich Junction.
- **Take Route 29 West.**
- **Take Route 338 North** into South Argyle.
- **Take route 40 North into Argyle.**
- **Follow directions from Argyle** listed above.

Directions to 8 Williams Street, Elizabethtown Office

From the North (Plattsburgh area)
Get on 87-S for about 37.5 miles
Take Exit 31 in Westport
Turn right onto NY 9N toward Elizabethtown/Westport for 4.2 miles
Turn left onto NY-9N/US 9S/Court Street
Take second left onto Williams Street
Office building is on the right.

From the south (Moriah/Mineville area)
Take Fisher Hill/Lincoln Pond Rd for 14.5 miles
Turn left on NY-9N for .5 miles
Take second left onto Williams Street
Office building is on the right.

From the south (Ticonderoga area)
Take NY- 22N for 7 miles
Turn right onto NY-22-N/NY-9N N for 26 miles
Turn left on NY-9N for .5 miles
Take second left onto Williams Street
Office building is on the right.

From the south (Lake George area)
Follow I-87 N to Exit 31.
Turn left onto NY 9N toward Elizabethtown/Westport for 4.2 miles
Turn left onto NY 9-N/Court St.
Take second left onto Williams Street
Office building is on the right.

From the west (Saranac Lake area)
Take NY-86 E/Lake Flower Ave for 6 miles
Make slight right onto Old Military Rd for 3.5 miles
Continue onto NY-73 E for 14.5 miles
Turn left onto NY-9N S for 10 miles
Turn left on NY-9N for .5 miles
Take second right onto Williams Street
Office building is on the right.