

Adult

Osika & Scarano Psychological Services, P.C.

8 Williams Street
Elizabethtown, NY 12932

5 Pine Street
Glens Falls, NY 12801

432 Franklin Street
Schenectady, NY 12305

Telephone (518) 745-0079 Fax (518) 745-4291 www.OSPsychServices.com

INTAKE FORM (Bring with you to scheduled appointment)

PATIENT INFORMATION

Date of Birth _____ Age: _____

Patient's Name _____ Marital Status: S M D W Sex: M F

Address _____ City _____ State _____ Zip _____

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

SS# _____ Occupation _____

Employer _____ Address _____

Referring Physician _____ Primary Physician _____

Referred to this office by: _____

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 \$10.00 late fee will be charged. On any balance 6 months overdue, 18% APR and a \$50.00 collection fee will be added.

Patient Signature: _____ Date: _____

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INFORMED CONSENT TO INDIVIDUAL AND GROUP PSYCHOTHERAPY

This form documents that I, _____, give my consent to Osika & Scarano Psychological services, P.C. (the “psychologist”) to provide psychotherapeutic treatment to me.

While I expect benefits from this treatment, I fully understand that no particular outcome can be guaranteed. I understand that I am 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 HOURS 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 180 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 my problems, and method of treatment, goals and length of treatment, and information about record-keeping. I have been informed about and understand the extent of treatment, its foreseeable benefits and risks, and possible alternative methods of treatment. I understand that therapy can sometimes cause upsetting feelings to emerge, that I may feel worse temporarily before feeling better, and that I may experience distress caused by changes I may decide to make in my life as a result of therapy.

Many providers at Osika & 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 HIPAA.

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

I have received a HIPAA Notice of Privacy Practices from the psychologist. I understand that information about psychotherapy is almost always kept confidential by the psychologist and not revealed to others unless I give my consent. There are a few exceptions as noted in the HIPAA 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 I tell the psychologist that I 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 I threaten to harm myself, or my life or health is in any immediate danger, the psychologist will try to protect me, including by telling others such as my relatives or the police or other health care providers, who can assist in protecting or assisting me.
3. As per Section 9.46 of the Mental Health Hygiene 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 I am involved in certain court proceedings the psychologist may be required by law to reveal information about my 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 my health insurance or managed care plan will be reimbursing me or paying the psychologist directly, they will require that I waive confidentiality and that the psychologist give them information about my treatment.
6. The psychologist may consult with other psychotherapists about my treatment, but in doing so will not reveal my name or other information that might identify me. Further, when the psychologist is away or unavailable, another psychotherapist might answer calls and so will need to have some information about my treatment.
7. If my account with the psychologist becomes overdue and I do not pay the amount due or work out a payment plan, the psychologist will reveal a limited amount of information about my treatment in taking legal measure to be paid. This information will include my name, social security number, address, dates and type of treatment and the amount due.

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

I have the right to be notified of a data breach. I have the right to ask for an electronic copy of my medical record. I have the right to opt out of fundraising communications from us.

Uses and disclosures of your medical information cannot be sold or used for marketing purposes without your 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.

If I am participating in a managed care plan, I have discussed with the psychologist my financial responsibility for any co-payments and the plan's limits, if any, on the number of therapy sessions. I have discussed with the psychologist my options for continuation of treatment when my managed care benefits end. If I am not participating in a managed care program, I understand that I am fully financially responsible for treatment.

I understand that I have a right to ask the psychologist about the psychologist's training and qualifications and about where to file complaints about the professional conduct.

I understand that under HIPAA, I have the right to request that communications with the psychologists' office be confidential and by means of my selection. I understand that the Dr.'s office will approve my request if it is reasonable and made in writing. Once agreed upon, the Dr.'s office is obligated to honor it, except if an emergency arises.

I allow the administrative and professional staff at Osika & Scarano Psychological Services to contact me by telephone at my home and at my work, and in writing at my home, unless I instruct them otherwise. Phone messages will be left with minimal information; the Dr.'s name and call back number. Any requests I have for alternative means of, or limits to my communication with your staff (e.g., specific times of day to call) will be made in writing.

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 474-3817. Complaints to the licensing board can also be made if you feel your provider or any staff member of Osika & 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.

I look forward to our initial meeting on_____.

By signing below, I am indicating that I have read and understand this form and that I give my consent to treatment.

Patient Signature:_____ Date: _____

Print Name

TELEMEDICINE INFORMED CONSENT FORM

I, _____ (patient) hereby consent to engaging in telemedicine with _____ (psychotherapist) as part of my psychotherapy. I understand that “telemedicine” includes the practice of health care delivery, diagnosis, consultation, and treatment using interactive audio-video communications. I also understand that, with my signed consent, telemedicine may involve the electronic communication of my medical/mental healthcare information to other health care practitioners. The rights stated supplement those rights I have generally as a patient of the psychotherapist.

I understand that I have the following rights with respect to telemedicine:

I have the right to withhold or withdraw consent to telemedicine treatment at any time.

The laws that protect the confidentiality of my medical/healthcare information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are mandatory exceptions to confidentiality, including reporting child abuse and the imminent risk of danger to self or others. If I put my mental state at issue in certain legal proceedings, then the psychotherapist may be compelled to release otherwise confidential information about my evaluation and treatment.

I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that the transmission of my medical information could be disrupted or distorted by technical failures or unauthorized persons, and that the electronic communication of my medical information could be accessed by unauthorized persons.

I understand that telemedicine based services and care may not be as complete or effective as face-to-face services. I also understand that if my psychotherapist believes I would be better served by in-person psychotherapeutic services, I will be referred to a psychotherapist who can provide such services in my area. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

As with all medical records, I understand that I have a right to access my medical information and copies of medical records of telemedicine treatment in accordance with New York State law.

(Optional: if I am temporarily to be outside of New York State at any time during my telemedicine treatment, then I also hereby represent that I am a permanent resident of New York State. I understand that the psychotherapist is licensed in New York State, and that I have recourse to the professional licensing board and courts of New York State should I have any grievance against the psychotherapist.)

I have read and understand the information provided above. I have discussed it with the psychotherapist, and all of my questions have been answered to my satisfaction. My signature below indicates my informed consent to treatment.

Patient Signature

Date

Osika & Scarano Psychological Services, P.C.

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FEES

For **routine outpatient visits** to our office, we bill your insurance. You are responsible for your copay and deductible (which varies with each plan).

If you **do not have insurance**, please complete the Sliding Fee Scale Packet. In addition, we work closely with a specialist from Fidelis Care and an enrollment specialist from Adirondack Health Institute. Both can help you find a health insurance plan that is affordable for you. We will be more than happy to make a referral for you.

If your insurance does not cover **evaluations for court, probation, etc.**, it will be billed at \$300. This includes fees for your sessions and writing of the report.

If your insurance does not cover **achievement testing required to make a diagnosis of a Learning Disability**, you have 3 options:

- 1) Call your insurance company and ask if they would agree to pay for 2 hours of achievement testing
- 2) Ask your child's school to complete the achievement testing
- 3) Have our office complete the testing and agree to pay over a six-month period of time.
 - a. If you choose our office to complete the testing, we will administer the Wechsler Individual Achievement Scale. Administration of the WIAT will take about 2 hours and the charge is \$60 per hour. A six-month payment plan can be agreed upon in writing at this time.

Unfortunately, most insurance plans do not allow providers to bill for **report writing**. Scoring and writing psychological reports is a daunting task and typically takes 1-3 hours of work. This, again, is billed at a rate of \$60 per hour. A six-month payment plan can be agreed upon if needed. Medicaid does allow clinicians to bill for report writing.

Unless you have a specific insurance, there will be a \$50 **No Show or Late Cancellation Fee**. We respectfully ask that you give us at least a 24-hour notice prior to cancelling your appointment. However, we understand life happens: you are sick, your car breaks down, or you got called into work. Please keep in mind that No Shows (unless you have a specific insurance) will always be billed, and frequent late cancellations will be billed.

By signing below, you state that you understand and agree to our fee policy.

Client Signature (parent if minor)

Date

Name (printed)

Osika & Scarano
PSYCHOLOGICAL SERVICES, P.C.

8 Williams Street
Elizabethtown, NY 12932

Thomas Osika, Ph.D.

Tacey Shannon, LCSW
Erica Zolinas, LMSW

5 Pine Street
Glens Falls, NY 12801

Gina Scarano-Osika, Ph.D.

Amber Shores, LMHC
Christie Seiler, Psy.D.

432 Franklin Street
Schenectady, NY 12305

Melissa Lehrbach, LMHC
Tekla Rydzewski, MFT-MA

Telephone (518) 745-0079

Fax (518) 745-4291

www.OSPsychServices.com

**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 HIPAA 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 patient

Date

Print Name of Patient

DOB:

(Provide a copy of this form to the patient)

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Refusal to Sign ROI for PCP

ONLY SIGN THIS FORM IF YOU REFUSED TO SIGN THE PREVIOUS PAGE

According to HIPAA, you have the right to refuse giving consent for your provider at Osika and Scarano (O and S) to coordinate care with your PCP. According to your insurance company, however, they require documentation of this refusal and an explanation as to why.

Please put an "x" next to all of the follow reasons why you feel that coordination of care with your PCP is not necessary at this time.

I need to discuss very personal issues that I do not want shared with my PCP

I may consider signing a release at a later date as I gain trust in my provider at O and S

I may consider signing a release at a later date as I discuss the things I do and don't want released to my PCP

I just don't feel it is necessary at this time

Other Explain: _____

Patient Signature

Date

Printed Patient Name

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PSYCHOLOGICAL SERVICES, P.C.

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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

Text message me

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

Print Name

Date

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PSYCHOLOGICAL SERVICES, P.C.

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Authorization for the Transmission of ePHI
(Electronic Private Health Information)

I have requested that my PHI be transmitted electronically (via email or texting), which I understand is NOT HIPAA Compliant. Since transmitting ePHI is NOT standard procedure at Osika and Scarano, you need to authorize us to send and receive such information electronically. By signing below, you authorize us to send and receive your PHI electronically.

I understand that although the electronic devices and e-mail at Osika and Scarano are password protected, the privacy of my PHI may be breeched by forces beyond our control (e.g. hacking, stolen devices). I understand I should delete any correspondence with our office from my e-mail and phone as soon as possible, which is a standard and customary procedure by all staff at Osika and Scarano. Once signed, this waiver will be in effect until the office is notified in writing.

Patient (Print)

Date

Patient or Parent Signature

Osika & Scarano Psychological Services, P.C.

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Thomas Osika, Ph.D.

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Christie Seiler, Psy.D.

Melissa Lehrbach, LMHC
Tekla Rydzewski, MFT-MA

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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: 5 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

Osika & Scarano Psychological Services, P.C.

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IMPORTANT NOTICE:

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 immediate notice of any change in insurance can result in large out-of-pocket 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)? Yes or No

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

Print Name

OSIKA & SCARANO PSYCHOLOGICAL SERVICES, PC
INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

Our office is strongly encouraging telehealth visits during the COVID pandemic. If, for some reason you need a face-to-face session, you and your provider will have a discussion as to why.

We are requiring all patients to read, initial and sign this document, regardless of whether we have planned a face-to-face session. This document contains important information about how to safely have a face-to-face session in light of the COVID-19 public health crisis. Please read this carefully and let your provider know if you have any questions. When you sign this document, it will be an official agreement between you and our practice.

Refusal to Meet Face-to-Face

If there is a resurgence of the pandemic or if other health concerns arise, your provider may refuse your request for a face-to-face session. If you have concerns about meeting through telehealth, you will talk to your provider about it first and try to address any issues. You understand that, if your provider believes it is necessary, they may determine that you return to telehealth for everyone's well-being. If you insist on face-to-face sessions, you may request a change in provider if your provider continues to refuse.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, our families, my other staff, and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our termination of the option for face-to-face sessions. Initial each to indicate that you understand. I agree to these actions if I ever have a face-to-face session:

- You will only have your in-person appointment if you are symptom free. ____
- You will take your temperature before coming to each appointment. If it is elevated (100° Fahrenheit or higher), or if you have other symptoms of the coronavirus (e.g., dry cough, flu-like symptoms), you agree to cancel the appointment, or to proceed using telehealth. If you wish to cancel for this reason, we won't charge you our normal cancellation fee. Ask your provider if you'd like to use our point-and-shoot thermometer at the office. ____
- You will wait in your car or outside until no earlier than 5 minutes before our appointment time. ____
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. ____
- You will adhere to the safe distancing precautions we have set up in the waiting room and service rooms. For example, you won't move chairs or sit where seating is prohibited. ____
- You will wear a mask in all areas of the office. (Our staff will also.) ____
- You will keep a distance of 6 feet and there will be no physical contact (e.g., no shaking hands) with any member of our staff. ____

- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. ____
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. ____
- You will take steps between appointments to minimize your exposure to COVID. ____
- If you have a job that exposes you to other people who are infected, you will immediately let us know. ____
- If your commute, or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and my staff] know. ____
- If a resident of your home tests positive for the infection, you will immediately let us know, and we will then begin or resume treatment via telehealth. ____

We may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick

You understand that we are committed to keeping you, me, our staff, and all of our families safe from the spread of this virus. If you show up for an appointment and we believe you have a fever or other symptoms, or believe you have been exposed, we will have to require you to leave the office immediately. Our providers reserve the right to take your temperature. If you are asked to leave the office, we can follow up with services by telehealth as appropriate. If your provider tests positive for the coronavirus, we will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, we may be required to notify local health authorities that you have been in the office. If we have to report this, we will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that we may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

Patient/Client

Date

Psychologist

OSIKA and SCARANO PSYCHOLOGICAL SERVICES, PC
Office Safety Precautions in Effect During the Pandemic

My office is taking the following precautions to protect our patients and help slow the spread of the coronavirus.

- Office seating in the waiting room and in therapy/testing rooms has been arranged for appropriate physical distancing.
- My staff and I wear masks.
- My staff maintains safe distancing.
- Restroom soap dispensers are maintained and everyone is encouraged to wash their hands.
- Hand sanitizer that contains at least 60% alcohol is available in the therapy/testing rooms, the waiting room and at the reception counter.
- We schedule very few face-to-face appointments in order to minimize the number of people in the waiting room.
- We ask all patients to wait in their cars or outside until no earlier than 5 minutes before their appointment times.
- Credit card pads, pens and other areas that are commonly touched are thoroughly sanitized after each use.
- Physical contact is not permitted.
- Tissues and trash bins are easily accessed. Trash is disposed of on a frequent basis.
- Common areas are thoroughly disinfected at the end of each day.
- Providers have to attest daily that they are symptom free, do not have a temperature, have not travelled outside of the state within the past 2 weeks and know of no known exposure to COVID.

PSYCHOSOCIAL HISTORY ADULTS

Name: _____

Date of Birth: _____

Date of First Session: _____

Who referred you to this office? _____

Why? _____

Primary Care Physician: _____

In order to better meet your needs during sessions, it is beneficial for the leaders to know some general social history. Please answer the following questions. The more truthful you are, the more beneficial treatment can be for you.

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(ed) married on my 18th birthday

My birth parents separated when I was _____ years of age

One or both of my birth parents re-married prior to my 18th birthday

My birth parents never married

I was adopted.

Directions: Fill in the blank

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

I have _____ half-siblings (share only one birthparent)

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

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 of stranger or date rape.

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

I received my GED

I dropped out of High School in _____ grade.

I graduated from High School

I graduated from College

Directions: Fill in the blanks

I currently work at _____ on a _____ time basis.
full or part

I am currently living with _____.

I have _____ children ages _____.

I have been in _____ physically abusive relationships as an adult.

I have been in _____ verbally abusive relationships as an adult.

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: _____

I weigh approximately _____ lbs.

I am _____ feet _____ inches tall

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 been arrested _____ times since the age of 18, offenses include: _____

I have firearms in my home: yes no

If yes, are firearms locked in a secure location? 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/assaults

I feel depressed most days

I feel irritable most days

I feel anxious most days

I have explosive bouts of anger

My family would say that I get way too angry over very little things

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

My appetite has decreased

I feel tired most days

I have a hard time falling asleep

I get too little sleep

I have had periods of time when I get no sleep for multiple nights in a row

I have trouble staying asleep

I require more than 10 hours of sleep

I have a difficult time concentrating

I've had thoughts of killing myself in the past

First time was when I was _____ years old

I recently thought of killing myself

When _____

I have wanted to die in the past

First time was when I was _____ years old

I recently wanted to die

When _____

I have had a planned method of suicide.

What was the method _____

I have hurt myself on purpose by cutting, bruising or burning myself in the past.

First time I was _____ years old

I struggle with behaviors I can't control (e.g. spending, aggression, gambling, pornography)

I sometimes can't stop eating when I am full.

I sometimes ignore my feelings of hunger.

I have trouble maintaining weight loss.

When I diet, I eat less than 1300 calories per day.

I make myself vomit to get rid of calories.

I take diet pills.

I have stopped getting my menstrual cycle in the past for no explainable reason

My lowest weight in my life was unhealthy

My highest weight in my life was unhealthy

I feel out of control when I overeat.

I sometimes eat alone because I am ashamed

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

I am unhappy with my weight and body shape.

If I overeat, I eat quickly

When I overeat, I go to extremes that other people don't

I have been hospitalized overnight for psychiatric reasons

If “YES” how many times _____

Which hospitals? _____

When? _____

I have been placed on psychiatric medications in the past.

If yes, which ones _____

Who prescribed them? _____

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. If yes, how

long in terms of months, years, or number of Sessions

Did treatment help you in the past? **yes** **no**

Members of my family have mental illnesses.

If yes, which illnesses _____
