Osika & Scarano Psychological Services, P.C.

125 Broad Street, One Broad Street Plaza, Glens Falls, NY 12801
430 Franklin Street, Schenectady, NY 12305
phone: 518.745.0079 fax: 518.935.9700 www.OSPsychServices.com

Intake Form

Do you want a one-time evaluation for legal reasons, or ongoing therapy?
If ongoing therapy, do you want face-to-face sessions (which may delay scheduling)?

Patient Information:

Patient Legal Name: Date of Birth: Age:
Patient Chosen Name (if different from legal name):
Sex Assigned at Birth: Sexual Orientation:
Gender (if different from sex assigned at birth): Preferred Pronouns:

Address: City: State: Zip Code:
Home Phone #: Cell Phone #:

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

Biological Father: Date of Birth: Social Security #:
Address: City: State: Zip Code:
Home Phone #: Cell Phone #:

Biological Mother: Date of Birth: Social Security #:
Address: City: State: Zip Code:
Home Phone #: Cell Phone #:

Legal Guardian: Date of Birth: Social Security #:
Relationship to Patient: Email:
Address: City: State: Zip Code:
Home Phone #: Cell Phone #:

Primary Insurance: Employer:
Subscriber Name: Gender Marker on Insurance:
Subscriber SS#: Subscriber DOB:
Subscriber ID#: Group #: Co-pay Amount:

Secondary Insurance: Employer:
Subscriber Name: Gender Marker on Insurance:
Subscriber SS#: Subscriber DOB:
Subscriber ID#: Group #: Co-pay Amount:

Please attach photos or scans of your insurance card: Front:

I do not have and cannot acquire images of my insurance card at this time. (It is important that we have these images on file, so please do your best to provide them to us here. Back:

Psychologist Use Only: Diagnosis: (numerical codes only)

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Signature of Guarantor

Signature of guarantor, insured party, or authorized person's signature certifies that:

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.

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

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Authorization for Treatment of a Minor

I, hereby certify that I am the parent and/or legal guardian of the minor child, , with date of birth , 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 Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

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Status of Legal Custody

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

Yes No

(If you answered "no," please go to the next page.)

Do you have JOINT LEGAL or SOLE LEGAL custody of the child?

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.

3) The therapist may want to address issues with the non-custodial parent so that they can act more in the child's best interest.

What follows is a form letter that we prefer to (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 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 518-745-0079 to schedule an appointment at your earliest convenience. Your involvement is your child's treatment is highly recommended, and can only help. I hope to hear from you soon.

Sincerely,

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

Osika & Scarano Psychological Services, P.C.

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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 , and hereby authorize the release of information to .

The non-custodial parent's address is , and his/her phone number is .

I understand that I need to discuss with Dr. Osika and/or Dr. Scarano-Osika the limits of information to be released.

Parent/Guardian Signature:_____ Date:_____

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Informed Consent to Child, Family, or Couples Psychotherapy

This form documents that we, , give our consent to our provider at Osika & 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.

Your therapist may be a student intern or limited permit holder who is permitted to practice psychotherapy only under supervision, and who will provide you with the name and contact number of his/her supervisor. You may contact their supervisor at any point regarding any issues that might arise between you and the student psychotherapist. If your provider is a student, they will let you know upon their introduction at the very first session.

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.

We 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.

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

We understand that the psychologist cannot provide emergency service. If an emergency arises, we will call the beeper numbers as follows: Drs. Scarano and Osika, 518-744-7978. 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 518-761-5325.

We have received a HIPAA 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 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 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 lives or health are in any immediate danger, the psychologist will try to protect us, including by telling others such as our 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 Hygiene Law, the psychologist is mandated to report (at https://nvsafe.omh.nv.gov) patients who are at imminent risk of harming themselves or others. Such a report could have direct implications as to whether or not we 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 my 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 measures to be paid. This information will include our names, social security numbers, address(es), 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 records to either or all of us without any additional authorization(s) from the other(s). We understand that each of us will not, 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, nor 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 a third-party forensic professional best answers these legal disputes.

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 consent 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(s).

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 our medical records. We have the right to opt out of fundraising communications from us. Uses and disclosures of our medical information cannot be sold, or used for marketing purposes, without our authorization. If we pay in full out-of-pocket for services (i.e., we do not bill our insurance), we have the right to instruct the psychologist not to share information about our treatment with our 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 518-474-3817. Complaints to the licensing board can also be made if we feel our provider, or any staff member of Osika and Scarano Psychological Services, P.C., 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 Psychological Services, P.C., has violated this non-discrimination policy, appropriate disciplinary action, ranging from counseling to termination, will be taken against the employee who violated the policy.

Patients (or parents) may audio record sessions, but only with our express written permission. Any violation of this policy will result in our beginning a treatment termination process.

If you are in crisis after hours or on weekends, please text URGENT to both 518-744-7978 and 518-791-5904. Also, please call the Suicide Crisis Line at 988.

If you need a refill on your medication as prescribed by New Hope, please text 518-744-7978 and state your name, date of birth, the name of your prescriber, and the medications you need refilled. Please do this 72 hours in advance of your last dose.

By signing below, we indicate 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/Guardian Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

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Telemedicine Informed Consent Form

I, (parent or guardian) 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.

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

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Fees

For **routine outpatient visits** to our office, we bill your insurance. You are responsible for your co-pay 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.

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

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Release of Information / Authorization Form

1. I authorize my healthcare practitioner and staff at Osika & Scarano Psychological Services, P.C., to disclose and receive my protected health information, as specified below, with the persons indicated below:

   Primary Care Physician:

   Others:

   New Hope Psychology and Nurse Practitioner-Psychiatry Services, PLLC

2. I hereby authorize the disclosure and receipt of the following protected health information:
   Examinations, treatment plans, and progress notes.
3. This protected health information is being used, disclosed, or received for the following purposes:
   To collaborate regarding diagnosis and treatment of the patient.
4. This authorization shall be in force and effect 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., 125 Broad Street, One Broad Street Plaza, Glens Falls, NY 12801. I understand that a revocation is not effective to the extent that my healthcare practitioner has relief 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.

Patient/Guardian Signature:_____ Date:_____

Print Name: Date of Birth:

According to HIPAA, you have the right to refuse to give consent for your provider at Osika & Scarano to coordinate care with your Primary Care Physician (PCP). However, your insurance company requires documentation of this refusal, and an explanation of the reason.

Check here **only** if you **refuse** to give consent.

Please check any of the following reasons why you feel 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 Osika & Scarano.

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 (specify):

Patient/Guardian Signature:_____ Date:_____

Print Name: Date of Birth:

Hixny

Hixny Electronic Data Access Consent Form

Osika & Scarano Psychological Services, PC

In this Consent Form, you can choose whether to allow Osika & Scarano Psychological Services, PC to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Osika & Scarano Psychological Services, PC to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, Osika & Scarano Psychological Services, PC staff involved in my care may see and get access to all of my medical records through Hixny."

If you check the **"I DENY CONSENT"** box below, you are saying "No, Osika & Scarano Psychological Services, PC may not be given access to my medical records through Hixny for any purpose."

Hixny is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services.

Please carefully read the information on both pages of this form before making your decision.
You have two choices:

- ☐ **I GIVE CONSENT for Osika & Scarano Psychological Services, PC to access ALL of** my medical records through Hixny in connection with providing me any health care services, including emergency care.
- ☐ **I DENY CONSENT for Osika & Scarano Psychological Services, PC to access** my medical records through Hixny for any purpose, *even in a medical emergency*. Unless you check this box, New York State law allows medical providers treating you in an emergency to get access to your medical records, including records that are available through Hixny.

_____ _____ _____

Print Name of Patient | Date of Birth | Date

_____ _____

Signature of Patient or Patient's Legal Representative | Print Name of Legal Representative (if applicable)

_____

Relationship of Legal Representative to Patient (if applicable)

Details about patient information in Hixny and the consent process:

How Your Information Will Be Used

Your electronic health information will be used by Osika & Scarano Psychological Services, PC only to:

- Provide you with medical treatment and related services
- Check whether you have health insurance and what it covers
- Evaluate and improve the quality of medical care

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

What Types of Information About You Are Included

If you give consent, Osika & Scarano Psychological Services, PC may access ALL of your electronic health information available through Hixny. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- Alcohol or drug use problems*
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

***If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, such as medications and dosages, lab test results, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social support, and health insurance claims history.**

Where Health Information About You Comes From

Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Hixny. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

Who May Access Information About You, If You Give Consent

Only these people may access information about you: doctors and other health care providers who serve on Osika & Scarano Psychological Services, PC medical staff who are involved in your medical care; health care providers who are covering or on call for Osika & Scarano Psychological Services, PC 's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

Penalties for Improper Access to or Use of Your Information

There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Osika & Scarano Psychological Services, PC at: (518) 744-7302; or call Hixny at (518) 640-0021; or call the NYS Department of Health at 518-474-4987.

Re-disclosure of Information

Any electronic health information about you may be re-disclosed by Osika & Scarano Psychological Services, PC to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Hixny and persons who access this information through the Hixny must comply with these requirements.

Effective Period

This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

Withdrawing Your Consent

You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Osika & Scarano Psychological Services, PC's. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 640-0021.

NOTE: Organizations that access your health information through Hixny while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

Copy of Form

You are entitled to get a copy of this Consent Form after you sign it**.**

Osika & Scarano Psychological Services, P.C.

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Patient Request for Confidential Communications

We, Osika & Scarano Psychological Services, P.C., 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 a 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 a 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:

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Osika & Scarano Psychological Services, P.C.

125 Broad Street, One Broad Street Plaza, Glens Falls, NY 12801
430 Franklin Street, Schenectady, NY 12305

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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 breached by forces beyond our control (e.g., hacking, stolen devices, et al.). 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.

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Check here if you decline to authorize the transmission of your ePHI at this time.

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Contact Us / Notice of Privacy

Our contact information:

Privacy Officers: Dr. Thomas Osika and Dr. Gina Scarano-Osika

Mailing Address: 125 Broad Street, One Broad Street Plaza, 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 4, 2003, and that any questions I have about it have been answered.

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

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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 insurance representative from whom you got this information:

   Date you called:
2. Co-pay amount:
3. Is there a deductible? Yes No
4. Referral from Primary Care Physician needed? Yes No
5. Outpatient Treatment Report (OTR) needed? Yes No

   After how many sessions?

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

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

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Psychosocial History

Please briefly explain the goals you seek to accomplish in therapy:

Childhood

Have you ever been adopted or places into foster care as a child?	Yes	No
Were you ever exposed to alcoholism or substance abuse as a child?	Yes	No
Were you ever physically or sexually abused as a child?	Yes	No

Education

What grade are you in?

Do/did you receive Special Education services as a child?	Yes	No

Medical

What psychiatric medications do you take daily?

Do you have chronic pain or medical illnesses?	Yes	No
Are you allergic to any prescription medication?	Yes	No

Substance Abuse

Do you drink more than 7 servings of alcohol per week?	Yes	No
Do you smoke cannabis or use illegal drugs?	Yes	No

Legal

Have you ever been arrested?	Yes	No
Have you ever refused to go to school or been placed on PINS?	Yes	No

Social

Do you feel safe in your home? Yes No

Mental Health

Have you ever had an eating disorder or binge eaten? Yes No

How many times have you been hospitalized for psychiatric reasons?

How many different therapists or counselors have you seen in your lifetime?

Have you ever thought about wanting to die or take your own life? Yes No

How many times have you intentionally harmed yourself?

How many total hours do you sleep in a typical day, including naps?

Thank you for taking the time to complete this New Patient Packet. We look forward to working with you.