Aziz A Soomro Physician PC
d/b/a Chappaqua Behavioral Medicine
1 South Greeley Avenue, Suite 302
Chappaqua, NY 10514
Tel: (914) 238-1699
Fax: (914) 238-1695

Patient Intake Forms

Kindly print and fill in the following forms legibly before you see the doctor. All the sections must be completed other than section(s) marked as "for official use only"

Please arrive 30 minutes before your scheduled intake/ initial evaluation appointment.

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Patient Information

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Social Security: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Marital Status (circle one): Single Married Divorced Widow/er Other

Primary Care Physician and Number: _____

Referral Source: _____

Emergency Contact Name and Number: _____

Insurance Information (PRIMARY)

Insurance Coverage/Company: _____

Insurance Company Address: _____

Responsible Party: _____

Primary Card Holder Name: _____

Primary Card Holder Address: _____

Primary Card Holder Date of Birth: _____

Primary Card Holder Social Security Number: _____

Insurance Information (SECONDARY)

Insurance Coverage/Company: _____

Insurance Company Address: _____

Responsible Party: _____

Primary Card Holder Name: _____

Primary Card Holder Address: _____

Primary Card Holder Date of Birth: _____

Primary Card Holder Social Security Number: _____

I authorize the release of any medical information necessary to process this claim:

X _____
Patient/Parent or Legal Guardian Signature Date

I authorize the payment of medical benefits to Aziz A. Soomro Physician, PC for services related to this claim:

X _____
Patient/Parent or Legal Guardian Signature Date

I hereby acknowledge that I have received a copy of the notice of Privacy Practices:

X_____
Patient/Parent or Legal Guardian Signature

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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

The following is the Notice of Privacy Practices of Aziz A. Soomro Physician PC, d/b/a Chappaqua Behavioral Medicine.

HIPAA 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 this 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 that 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 require or request, to collect payment for our services, and to conduct other related health care operations as follows:

Treatment activities include: (a) use within our office by our professional staff for the provision, coordination, or management of your health care at our office; and (b) our contacting you to provide appointment reminders or information about treatment alternatives 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 for 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 your 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 for general administrative 40

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 NOTE 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 or 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 acted 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 communications during individual or family counseling which may be maintained in addition to and separate from medical or healthcare records. Psychotherapy Notes are only released 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 HIPAA; (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 on reviewing, Psychotherapy Notes.

Your Rights With Respect to Your Protected Health Information:
Under HIPAA, 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 Restrictions On Use Or Disclosure:
You have the right to request restrictions 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 41

emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law. If you have paid for our services in full yourself, out-of-pocket, then we must comply with your request to restrict those disclosures of your PHI that would otherwise be made for payment or healthcare operations, that are unnecessary because of your manner of payment. We require that all requests for restrictions be in writing and that you state a reason for the request. We will respond in writing to all requests within 30 days or receipt.

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. We must agree to your request if you inform us that certain of means of communicating with you will place you in danger.

Right To Inspect and Copy Your Protected Health Information, Including In Electronic Format:
You have the right of access in order to inspect, and to obtain a copy of your PHI, including any PHI maintained in electronic format, 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-Security Officer at the mailing address below. If you request a copy of your PHI, we will charge a fee for copying, or for electronic records, for labor. We reserve the right to deny you access to and copies of all or certain PHI as permitted or required 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 yours 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-Security Officer at the mailing address below.

Right To Receive An Accounting Of Disclosures Of Your PHI And Electronic Health Records:
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 42

disclosure 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 person 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 healthcare operations, (b) disclosures pursuant to your 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 4/14/2003. We reserve the right to temporarily suspend your 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 within that same twelve (12) month period. All requests for an accounting shall be sent to our Privacy-Security Officer at the mailing address below.
If we maintain any PHI in electronic form, then you may also request and receive an accounting of any disclosures of your electronic health records made for purposes of treatment, payment and health operations during the prior three (3) year period. Upon request, one list will be provided for free every twelve (12) months.

Complaints:
You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. Please submit any complaint to us in writing by mail to our Privacy-Security Officer at the mailing address below. A complaint must name the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA 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 or should have known that the act or omission complained of 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 changes in the law affecting this Notice of Privacy Practices, by mail or electronically within 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-Security Officer at the mailing address below. For any other requests 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 above.

To Contact Us:
This is our contact information referred to above.
Our Privacy-Security Officer is: Aziz A Soomro MD . Our mailing address is: 1 South Greeley Ave Suite 302 Chappaqua NY 10514. Our telephone number is:(914)238-1699. Our fax number is (914)238-1695.

Acknowledgment of Receipt of Notice of Privacy Practices of Aziz A Soomro Physician PC d/b/a Chappaqua Behavioral Medicine:

I hereby acknowledge that I have received the Notice of Privacy Practices of the above practice.

_____ _____
Patient Signature: Date:

_____
Print Name

Office Use Only:
Acknowledgment of Receipt of Notice of Privacy Practices was not obtained from patient

Name of the Patient:_____due to:
____ Patient refusal
____ Patient lack of understanding
____ Emergency
____Other: specify: _____

_____

Patient ____was ____was not offered, ____did _____did not accept a copy of written Notice of Privacy Practices:

Staff Signature:_____

Staff Name :_____

Date:_____

PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

We, Aziz A Soomro Physician PC, d/b/a Chappaqua Behavioral Medicine, 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

_____
Print Name
Approved:

_____ _____
Signature of Healthcare Practitioner Date

Print Name: _____

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Credit Card Authorization Form

I hereby authorize *Aziz A. Soomro Physician, P.C. d/b/a Chappaqua Behavioral Medicine* to charge my credit card listed below for mental health services rendered. I acknowledge that payment will be issued from my credit/debit account and that reversal of any charges from this card will be applied as an outstanding balance on my account and will be considered delinquent after a reversal has taken place.

CARD TYPE: **Visa** **MasterCard** **Discover** **American Express**
(circle one)

CARD NUMBER:

_____

SECURITY CODE: _____EXPIRATION DATE: _____/_____

CARD ACCOUNT HOLDER:

_____

ZIPCODE: _____AMOUNT: $_____

AUTHORIZED SIGNATURE: _____

☐ **Check this box if you would like to allow this office to retain your credit card information on file**

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This is an agreement between Aziz Soomro Physician PC as creditor, and the Patient/Debtor named on this form.

In this agreement, the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Aziz Soomro Physician PC. By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by us in writing, the patient due balance on your statement is due and payable when the statement is issued, and becomes past due if not paid in 30 days.

Required Payments: Any **co-payments** required by an insurance company must be paid at time of service. Because this is an insurance requirement we are asked to collect the patient's copay at the visit so we do not have to bill for the service; if co-payment is not received a **$10.00 non-payment of copay fee** will be charged. **Deductibles will be collected** at the beginning of your carrier's calendar year. Any out-of-pocket expenses, (items not covered by your insurance carrier such as a co-insurance amounts and **non-covered services**) are due upon receipt of your statement.

Payment Options: You may pay by cash, check, or credit card. **Payment for all self-pay/private insurance** patients is due the date treatment is rendered.

Insurance: You authorize us to communicate with your insurance company and to provide all information necessary including the medical and/or psychiatric diagnosis and the records for any treatment or examination rendered to you to the insurance company for the purpose of billing claims and insurance appeals. You agree to pay the portion of the charges not covered by your insurance company. If your insurance company requires a referral, you are responsible for obtaining it. Failure to obtain the referral may result in a lower payment from the insurance carrier. **If mental health benefits have been denied or exhausted, the patient is responsible for all fees associated with the services rendered at the time of visit.**

DIVORCE: In case of divorce or separation, the parent authorizing treatment for the child in the office will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is authorizing parent's responsibility to collect from the other parent.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we refer your account to a collection agency, you agree to pay all of the collection agency costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees, which we incur, plus all court costs. In case of suit, you agree the venue shall be in Westchester County, NY.

Returned Checks: There is a fee (currently $35) for any checks returned by the bank.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that your child received treatment at our office may become matter of public record in accordance with HIPPA regulations.

Transferring Records: You will need to fill out a HIPAA release form if you want to have copies of your records sent to another doctor or organization. If you are requesting records to be transferred from another doctor to us, you authorize us to receive all relevant information, including mental health history, HIV status and payment history.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and this agreement will be in full force and effect.

_____

Patient's Signature/Responsible Party Name (printed)

_____

Signature of Responsible Party Signe/Date

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EMERGENCY/URGENT AND OFF HOURS COVERAGE

Our office hours are from 8 AM to 8 PM Monday through Thursday, then Friday 8 AM to 5 PM and Saturday 9 AM to 5 PM. Messages are checked during the listed office hours. You can leave non-urgent, non-emergency messages with date, time and telephone number and we will get back to you within 24 hours. If you do not hear from us within 24 hours you can call our answering service at (914) 524-8116.

During after-hours or weekends, or if you need to reach us for any urgent issues, please call our 24 hour answering service at (914) 524-8116. If you are having an emergency, please call 911 or go to the nearest emergency room.

The above coverage has clearly been explained to me by my Provider. I understand and acknowledge:

_____

Patient/Parent or Legal Guardian **Date**

_____

Practitioner/Date

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INFORMED CONSENT TO COUPLE OR FAMILY PSYCHOTHERAPY

This form documents that we, _____ _____, give our consent to _____ (the "psychotherapist") to provide psychotherapeutic treatment to us.

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 psychotherapist any plans to end therapy before doing so.

We have fully discussed with the psychotherapist what is involved in psychotherapy and we understand and agree to the policies about scheduling, fees and missed appointments. Our discussion about therapy has included the psychotherapist's evaluation and diagnostic formulation of our problems, the 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.

We understand that the psychotherapist cannot provide emergency service. The psychotherapist has told us whom to call if an emergency arises and the psychotherapist is unavailable.

We understand that information about psychotherapy is almost always kept confidential by the psychotherapist and not revealed to others unless we give our consent. There are a few exceptions as follows:

- The psychotherapist is required by law to report suspected child abuse or neglect to the proper authorities. The psychotherapist is also mandated to report to the authorities' patients who are at imminent risk of harming themselves or others for the purpose of those authorities checking to see whether such patients are owners of firearms, and if they are, or apply to be, then limiting and possibly removing their ability to possess them.

- If one of us tells the psychotherapist of an intention to harm another person, the psychotherapist must try to protect that person, including by telling the police or the person or other health care providers. Similarly, if one of us threatens to harm ourselves, or our life or health is in any immediate danger, the psychotherapist will try to protect us, including by telling others such as relatives or the police or other health care providers, who can assist in protecting us.

- If we are involved in certain court proceedings the psychotherapist may be required by law to reveal information about our treatment. These situations include child custody disputes, cases where a patient's psychological condition is an issue, lawsuits or formal complaints against the psychotherapist, civil commitment hearings, and court-ordered treatment.

- If our health insurance or managed care plan will be reimbursing us or paying the psychotherapist directly, they will require that we waive confidentiality and that the psychotherapist give them information about our treatment.

- The psychotherapist may consult with other psychotherapists about our treatment, but in doing so will not reveal our names or other information that might identify us unless specific consent to do so is obtained. Further, when the psychotherapist is away or unavailable, another psychotherapist might answer calls and so will need to have some information about our treatment.

- If our account with the psychotherapist becomes overdue and we do not work out a payment plan, the psychotherapist will have to reveal a limited amount of information about our treatment in taking legal measures to be paid. This would 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 psychotherapist will try to discuss the situation with 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 psychotherapist 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 and conjoint treatment sessions, and to the treatment records of the psychotherapist regarding our individual and conjoint treatment sessions. We each agree that the psychotherapist may release such information or records to either or all of us without any additional authorization(s) of 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 psychotherapist testify regarding custody or visitation. If a custody or visitation proceeding does occur, we agree that the psychotherapist's role will be limited to providing to a mental health professional appointed to perform a forensic evaluation, and/or to the attorneys, law guardian, if any, and the judge involved in the legal proceeding, written information regarding, and/or the record of, our treatment; the psychotherapist will provide these either as required by law or upon our authorization.

If we are participating in a managed care plan, we have discussed with the psychotherapist our financial responsibility for any co-payment, and the plan's limits on the number of therapy sessions. We have discussed with the psychotherapist our options for continuation of treatment when our managed care benefits end. If we 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 our health insurance.

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

By signing below we are indicating that we have read and understood this form and that we give our consent to treatment.

Signature:_____ Date: _____

Signature:_____

Signature:_____

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INFORMED CONSENT TO GROUP PSYCHOTHERAPY

This form documents that I,_____,
give my consent to _____ (the "psychotherapist") to provide group 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 psychotherapist any plans to end therapy before doing so.

I have fully discussed with the psychotherapist what is involved in group 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 psychotherapist's fees that are not reimbursed by my insurance. I understand that the frequency of group sessions will be _____, that I am fully responsible for all deductibles and co-payments if I have health insurance, that the frequency of billing will be _____ and that payment will be due at the session that immediately follows my receipt of a bill, and that I will be personally responsible for payment in full for any canceled session if I do not give the psychotherapist at least _____hours advance notice of the cancellation (please note that insurers don't pay for canceled sessions).

Our discussion about therapy has included the psychotherapist's evaluation and diagnostic formulation of my problems, the 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.

I understand that the psychotherapist cannot provide emergency service. The psychotherapist has told me whom to call if an emergency arises and the psychotherapist is unavailable. I understand that in any emergency, I may call 911 or go to the nearest hospital emergency room.

I understand that information about psychotherapy is almost always kept confidential by the psychotherapist and not revealed to others unless I give my consent. There are a few exceptions as follows:

1. The psychotherapist is required by law to report suspected child abuse or neglect to the proper authorities. The psychotherapist is also mandated to report to the authorities patients who are at imminent risk of harming themselves or others for the purpose of those authorities checking to see whether such patients are owners of firearms, and if they are, or apply to be, then limiting and possibly removing their ability to possess them.

2. If I tell the psychotherapist I intend to harm another person, the psychotherapist 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 psychotherapist 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. If I am involved in certain court proceedings the psychotherapist 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 psychotherapist, civil commitment hearings, and court-ordered treatment.

4. If my health insurance or managed care plan will be reimbursing me or paying the psychotherapist directly, they will require that I waive confidentiality and that the psychotherapist give them certain information about my treatment.

5. The psychotherapist may consult with other therapists about my treatment, but in doing so will not reveal my name or other information that might identify me. Further, when the psychotherapist is away or unavailable, another therapist might answer calls and so will need to have some information about my treatment.

6. If my account with the psychotherapist becomes overdue and I do not work out a payment plan, the psychotherapist will have to reveal a limited amount of information about my treatment in taking legal measures to be paid. This would 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 psychotherapist will try to discuss the situation with me before any confidential information is revealed, and will reveal only the least amount of information that is necessary.

I understand that the psychotherapist cannot assure me that other group members will keep confidential what is said in the group therapy sessions. I assume that risk and understand that the psychotherapist cannot be held responsible for other group members revealing confidential information. There are rules, however, that are meant to protect confidentiality. These rules, which I agree to follow, are:

Only first names will be used at group sessions.

1. I will not socialize with other group members outside of sessions.

2. I will not discuss any information about a group member except with other group members during therapy sessions.

3. There will be no visitors at, or recordings of, group sessions allowed.

4. For breaking any of these rules, I can be expelled from the group or required by the group to pay a fine of $_____ to the person(s) I hurt by breaking a rule, and understand I could even be subject to a lawsuit by that person.

If I am participating in a managed care plan, I have discussed with the psychotherapist my financial responsibility for any deductible or co-payments, or both, and the plan's limits on the number of therapy sessions. I have discussed with the psychotherapist my options for continuation of treatment when my managed care benefits end.

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

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

Signature:_____ Date:_____
(of patient or person authorized to consent for patient)

Aziz A Soomro Physician PC
d/b/a Chappaqua Behavioral Medicine
1 South Greeley Avenue, Suite 302
Chappaqua, NY 10514
Tel: (914) 238-1699 Fax: (914) 238-1695

INFORMED CONSENT TO INDIVIDUAL PSYCHOTHERAPY

This form documents that I,_____, give my consent to _____(the "psychotherapist") 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 psychotherapist any plans to end therapy before doing so.

I have fully discussed with the psychotherapist 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 psychotherapist's fees that are not reimbursed by my insurance. I understand that the frequency of my sessions will be _____, that I am fully responsible for payment of all deductibles and co-payments if I have health insurance, that the frequency of billing will be _____ and that payment will be due at the session that immediately follows my receipt of a bill, and that I will be personally responsible for payment in full for any canceled session if I do not give the psychotherapist at least _____ hours advance notice of the cancellation (please note that insurers don't pay for canceled sessions).

Our discussion about therapy has included the psychotherapist's evaluation and diagnostic formulation of my problems, the 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.

I understand that the psychotherapist cannot provide emergency service. The psychotherapist has told me whom to call if an emergency arises and the psychotherapist is unavailable. In any case, I understand that in any emergency, I may call 911 or go the nearest hospital emergency room

I understand that information about psychotherapy is almost always kept confidential by the psychotherapist and not revealed to others unless I give my consent. There are a few exceptions as follows:

- The psychotherapist is required by law to report suspected child abuse or neglect to the proper authorities. The psychotherapist is also mandated to report to the authorities patients who are at imminent risk of harming themselves or others for the purpose of those authorities checking to see whether such patients are owners of firearms, and if they are, or apply to be, then limiting and possibly removing their ability to possess them.

- If I tell the psychotherapist that I intend to harm another person, the psychotherapist 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 psychotherapist 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.

- If I am involved in certain court proceedings the psychotherapist 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 psychotherapist, civil commitment hearings, and court-related treatment.

- If my health insurance or managed care plan will be reimbursing me or paying the psychotherapist directly, they will require that I waive confidentiality and that the psychotherapist give them information about my treatment.

- The psychotherapist 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 psychotherapist is away or unavailable, another psychotherapist might answer calls and so will need to have some information about my treatment.

- If my account with the psychotherapist becomes overdue and I do not pay the amount due or work out a payment plan, the psychotherapist will reveal a limited amount of information about my treatment in taking legal measures 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 psychotherapist 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.

If I am participating in a managed care plan, I have discussed with the psychotherapist the plan's limits, if any, on the number of therapy sessions. I have discussed with the psychotherapist my options for continuation of treatment when my managed care benefits end.

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

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

_____ _____

Signature: of patient or person authorized to consent for patient Date:

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Informed Consent for Psychiatric Medications

PURPOSE OF THE FORM: THIS FORM DOCUMENTS THAT YOU AND I HAVE DISCUSSED YOUR MEDICATION(S) TO YOUR SATISFACTION.

I have recommended the following medication(s). I have either told you about the medication(s) or given you written information or both. You are entitled to know the following information before deciding whether to take the medication(s):

1. What your condition or diagnosis is.
2. What symptoms the medication(s) should reduce and how likely the medications are to work.
3. What your chances are of getting better without the medication(s).
4. What other reasonable treatments are available.
5. The name, dosage, frequency, route of administration and duration of prescribed medications.
6. Side effects of the medications known to commonly occur.
7. Any special instructions about taking the medications.

Medications	Daily Dose

- **By signing this form, you indicate the medications have been explained to you to your satisfaction.**
- **Even after signing, you can still refuse any medication or withdraw your agreement completely at any time.**
- **You will receive a copy of this consent form.**

Please check one of the following:

❑ I have had the opportunity to receive information about my medications from you, and I consent to this treatment. I understand I can ask questions about my medicines at any time. (INFORMED CONSENT).

❑ I have had the opportunity to discuss information about the medications with you, and I **refuse** to consent to the medications recommended. I understand that you will continue to offer me the chance to take medicine, and information about it, but that I may still continue to refuse the medicine. (INFORMED REFUSAL).

❑ The patient verbally consents to the recommended medications, but refuses to sign because:

_____

Continued attempts to obtain signature: Initials_____ Date_____ Initials_____ Date_____

Patient Signature:_____ **Date** _____

Prescriber Name (Print): _____ **Date** _____

Psychiatrist Signature: _____ **Date** _____

Witness (if patient unable or unwilling to sign): _____ **Date** _____

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Intake/ Evaluation System

Welcome and thank you for giving us the opportunity to help you/your child. We would like to take the time to explain our intake and evaluation process. This process involves two steps. Today, you/your child will be seen by a licensed clinician; then, you/your child will be evaluated by a psychiatrist at the next available date and time (or vice versa). After this process we will discuss you/your child's clinical condition with our treatment team. We will then share our initial treatment team's impression and recommendations with you. If we believe we can help you/your child we will offer to take you/your child into treatment as our patient. If we believe you/your child need(s) a different level or type of care than what we can provide we will refer you/your child to other appropriate services.

You understand and acknowledge that we cannot offer you/your child treatment until the entire intake and evaluation process has been completed, and that in starting the intake and evaluation process we cannot guarantee that we will offer you/your child treatment once the process is completed. Please acknowledge by signing below that you have read about and understand our intake and evaluation process.

_____ _____

Patient/ Guardian/ Parents Date

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DECLARATION OF AGREEMENT REGARDING RESCHEDULED, MISSED OR CANCELLED APPOINTMENTS

I understand and agree to the following:

1. If I am unable to keep a scheduled appointment, it is my responsibility to contact the office at (914) 238-1699 during business hours in order to notify the office at least **72 hours** prior to the scheduled appointment (except in the case of an emergency).

2. I agree that I will be billed for the full appointment fee in the event that I miss an appointment without giving the office advanced notice (no show fee). I also understand that insurance will not pay for missed appointments.

3. I agree that I will be billed for the full appointment fee in the event that I fail to cancel or reschedule an appointment at least 72 hours prior to the scheduled appointment.

_____

Patient/Parent/Date

_____

Practitioner/Date

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OFFICE POLICIES

WE EXPECT ALL CURRENT PATIENTS TO BE HERE 15 MINUTES BEFORE THEIR SCHEDULED APPOINTMENTS SO THAT FRONT DESK STAFF MAY CHECK YOU IN AS WELL AS COLLECT COPAYS AND BALANCES.
WE DO NOT ALLOW AUDIO OR VIDEO RECORDING OF SESSIONS WITH YOUR CLINICIANS

WE ARE UNABLE TO OFFER OR PROVIDE SERVICES RELATED AND/ OR FOR LEGAL PURPOSES DISABILITY (I.E. LONG TERM, SHORT TERM, AND SOCIAL SECURITY), DIVORCE AND/OR CUSTODY ISSUES, WORKER'S COMPENSATION, LAWSUITS/ LEGAL MATTERS

COPAYMENTS ARE DUE AT THE TIME OF SERVICE. IF THIS REQUIREMENT IS NOT MET, YOUR APPOINTMENT WILL NEED TO BE RESCHEDULED.

A VALID, CURRENT INSURANCE CARD IS NEEDED ON FILE. IF THIS REQUIREMENT IS NOT MET, YOUR APPOINTMENT WILL NEED TO BE RESCHEDULED.

PLEASE BE AWARE THAT ANY PATIENT UNDER AGE OF 18 YEARS MAY NOT BEEN SEEN UNLESS A PARENT OR LEGAL GUARDIAN IS PRESENT.

IN ORDER TO BETTER COORDINATE CARE, PATIENTS RECEIVING PSYCHOTHERAPY AND
MEDICATION MUST RECEIVE BOTH INTERVENTIONS AT OUR OFFICE.

IN ORDER TO OBTAIN A PRESCRIPTION/REFILL YOU MUST SCHEDULE AN APPOINTMENT TO SEE THE DOCTOR. HOWEVER A 72 HOUR ADVANCE NOTICE IS REQUIRED FOR PHARMACY/ MEDICATION REQUESTS.

REQUESTS FOR RELEASE OF MEDICAL RECORDS WILL TAKE A MINIMUM OF 5 BUSINESS DAYS TO BE PROCESSED.

HERE AT CHAPPAQUA BEHAVIORAL MEDICINE, WE ARE AWARE THAT EMERGENCY SITUATIONS CAN ARISE. IN AN EMERGENCY SITUATION, WE DO OUR BEST TO ASSIST OUR PATIENTS DURING BUSINESS HOURS. HOWEVER, IF YOU ARE EVER IN CRISIS, PLEASE CALL 911 OR CONTACT YOUR NEAREST EMERGENCY ROOM.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I UNDERSTAND AND ACCEPT THE STATED OFFICE POLICIES.

_____ _____
SIGNATURE OF PATIENT/ PARENT/ GUARDIAN DATE

_____
PRINT PATIENT/ PARENTS/ GUARDIAN'S NAME

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TELEMEDICINE INFORMED CONSENT FORM

I_____hereby consent to engaging in telemedicine with Chappaqua Behavioral Medicine as part of my treatment. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, 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 Chappaqua Behavioral Medicine.

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 treatment 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 clinician 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 interrupted 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 clinician believes I would be better served by in-person treatment services, I will be referred to a clinician who can provide such services in my area. I understand that there are potential risks and benefits associated with any form of treatment, and that despite my efforts and the efforts of my clinician, 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.

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

_____ _____
Patient Signature Date

_____ _____
Clinician Signature Date

Aziz A. Soomro M.D.
Chappaqua Behavioral Medicine
1 South Greeley Ave Suite 302
Chappaqua NY 10514
Tel 914-238-1699 Fax 914-238-1695

General Consent for Treatment

Authorization for Medical Treatment: I hereby authorize the physicians, nurse practitioners, therapists and professional staff, assisted by the employees of Aziz A. Soomro Physician P.C. D/B/A Chappaqua Behavioral Medicine, to provide treatment to me or the above named patient. I acknowledge that no guarantees or assurances have been made to me concerning the results or findings intended from treatment or evaluation at Aziz A. Soomro Physician P.C. D/B/A Chappaqua Behavioral Medicine.

Release of Medical Information: I hereby authorize and direct Aziz A. Soomro Physician P.C. D/B/A Chappaqua Behavioral Medicine to release such medical information from my medical records as is necessary to complete forms for continued care, payment by insurance carriers, health care plans and third party payers.

Assignment of Benefits, Guarantee of Payment Notice: I hereby assign to Aziz A. Soomro Physician P.C. D/B/A Chappaqua Behavioral Medicine any and all rights, title and interest that I have in any insurance proceeds or benefits payable to me or on my behalf for serviced rendered to me by Aziz A. Soomro Physician P.C. D/B/A Chappaqua Behavioral Medicine, whether such services are considered in- or – out-of-network with respect to any third party payer. I therefore hereby authorize and direct my insurance carrier and/or health care plan to make payment of any and all such amounts directly to Aziz A. Soomro Physician P.C. D/B/A Chappaqua Behavioral Medicine, rather than to myself or any other insured. I acknowledge that as a member of a health care plan, I may be responsible to notify my primary care physician or obtain pre-certification for services. I understand that I am financially responsible to Aziz A. Soomro Physician P.C. D/B/A Chappaqua Behavioral Medicine for all charges, including those not paid by insurance or health care plans for services not authorized as specified in my benefit package, incurred by me or on my behalf.

Acknowledgement of Receipt of Notice of Privacy Practice: By signing below, I acknowledge receipt of the Notice of Privacy Practices, which outlines how health information about me may be used or disclosed.

Telepsychiatry: I have been given basic information regarding the use of Telephsychiatry and consent to participate in services utilizing this technology. If I am under the age of 18 such information was shared with and consent is obtained from my parent or guardian. I understand I have the right to refuse to participate in Telepsychiatry services, in which case evaluations will not be withheld, but will be conducted in-person by appropriate clinicians. I also understand that upon my refusal of such services I will be apprised of the alternatives to Telepsychiatry services, including any delays in service, need to travel, or risks associated with not having the services

provided by Telepsychiatry. Furthermore, I am made aware that each Telepsychiatry session shall not be recorded without my consent.

___ I do not wish to participate in Telepsychiatry

Gene Testing: I have been given basic information regarding Gene Testing and the consent to participate in services utilizing this technology. If I am under the age of 18 such information was shared with and consent is obtained from my parent or guardian. I understand I have the right to refuse to participate in Gene Testing services, in which case evaluations will not be withheld. I also understand that upon my refusal of such services I will be apprised of the alternatives to Gene Testing services, or risks associated with not having the services provided by Gene Testing.

__ I do not wish to participate in Gene Testing

Release of Liability for Personal Property: I understand and agree that personal property should not be brought into the office of and understand and agree that Aziz A. Soomro Physician P.C. D/B/A Chappaqua Behavioral Medicine shall not be liable for loss of damage to personal property.

I understand and agree that the staff of Aziz A. Soomro Physician P.C. D/B/A Chappaqua Behavioral Medicine will not be responsible for supervision of children left unattended by a parent or guardian in the waiting room during an appointment.

Signature:_____ Date: _____

Patient or Legal Authorized Representative	Telephone Consent is Granted by:
Signed: _____	Signed:_____
Signed: _____	Signed:_____
Witness: _____	Witness:_____
Date: _____	Date:_____