Adult

Osika & Scarano
Psychological Services, P.C.

8 Williams Street
Elizabethtown, NY 12932

5 Pine Street
Glens Falls, NY 12801

432 Franklin Street
Schenectady, NY 12305

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

INTAKE FORM (Bring with you to scheduled appointment)

PATIENT INFORMATION Date of Birth_____Age:_____

Patient's Name_____Marital Status: ☐S ☐M ☐D ☐W Sex: ☐M ☐F

Address_____City_____State_____Zip_____

Home Phone #_____Cell Phone#_____Work Phone # _____

SS#_____Occupation_____

Employer_____Address_____

Referring Physician_____Primary Physician_____

Referred to this office by: _____

Primary Insurance:_____Employer:_____

Subscriber ID#:_____Group #:_____Co-pay Amount: _____

Subscriber SS#:_____Subscriber's DOB: _____

Subscriber's Name _____

Secondary **Insurance**_____Employer:_____

Subscriber ID#:_____Group #:_____Co-pay Amount:_____

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

Subscriber's Name _____

Psychologist **Use Only**: Diagnosis_____(Numerical Codes only)

Guarantor, Insured's or Authorized Person's Signature:

I authorize payment of the medical benefits to Osika & Scarano Psychological Services, PC and understand that I am responsible for all balances not covered by my insurance company, such as co-payments, co-insurance, deductibles and non-coverage of benefits. I understand that my co-payment is due at the time of service and if this account becomes delinquent, it may be turned over to a collection agency and the fact that I received treatment in this office will become public record. I understand that there is a $50.00 no show charge if I do not cancel appointments 24 hours in advance. If I do not pay my co-pay at the time of my service date a $10.00 late fee will be charged. On any balance 6 months overdue, 18% APR and a $50.00 collection fee will be added.

Patient Signature:_____Date: _____

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INFORMED CONSENT TO INDIVIDUAL AND GROUP PSYCHOTHERAPY

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

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

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

- ***I understand that I am fully financially responsible for treatment, which, if I have health insurance, includes any portion of the psychologist's fee that are not reimbursed by our insurance.***
- ***I understand that the frequency of our sessions will be <u>1-4 x PER MONTH</u> and that I am fully responsible for payment of all deductibles and co-payments.***
- ***I understand that payment will be due at the time services are rendered.***
- ***I understand that I will be charged $50.00 for any canceled sessions if I do not give the psychologist at least <u>24 BUSINESS HOURS</u> notice. For example, if I call on 2 pm Sunday to cancel a Monday appointment I will be billed $50.00 (Insurers don't pay for canceled sessions).***
- ***I understand that there will be a $10.00 charge for not paying my co-pay at the time services are rendered.***
- **I understand that if my bill for services is 180 days past due, I will need to pay the full amount within two weeks in order to avoid interest at the rate of 18%. If payment cannot be made, then I understand that no further appointments will be provided and/or I may be given a referral to see another provider.**
- **I understand that if my bill is not paid in full within 6 months of the unpaid date of service, in addition to an 18% APR a $50.00 collection fee will be added.**

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

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

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

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

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

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

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

Uses and disclosures of your medical information cannot be sold or used for marketing purposes without your authorization. All patients who pay in full out of pocket for services (i.e. do not bill their insurance) can instruct us to not share information about your treatment with your health plan.

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

I understand that I have a right to ask the psychologist about the psychologist's training and

qualifications and about where to file complaints about the professional conduct.

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

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

We understand that we have a right to ask the psychologist about the psychologist's training and qualifications. If we ever desire to file a complaint about the psychologist's professional conduct, we understand we can call the NYS Psychology Licensing Board within the Department of Education at 474-3817. Complaints to the licensing board can also be made if you feel your provider or any staff member of Osika & Scarano violates your patient rights or discriminates against you based on gender, race, sexual orientation, national origin or color. If (the licensing board finds that) an employee of Osika and Scarano has violated this non-discrimination policy, appropriate disciplinary action, ranging from counseling to termination, will be taken against the employee who violated the policy.

I look forward to our initial meeting on_____.

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

Patient Signature:_____ Date: _____

_____

Print Name

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FEES

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

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

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

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

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

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

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

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

_____ _____

Client Signature (parent if minor) Date

_____

Name (printed)

Osika & Scarano

PSYCHOLOGICAL SERVICES, P.C.

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432 Franklin Street
Schenectady, NY 12305

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

Tacey Shannon, LCSW | Amber Shores, LMHC | Melissa Lehrbach, LMHC

Erica Zolinas, LMSW | Christie Seiler, Psy.D. | Tekla Rydzewski, MFT-MA

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RELEASE OF INFORMATION/AUTHORIZATION FORMFOR PRIMARY CARE PHYSICIAN

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

   Primary Care Physician: _____

   _____

   _____

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

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

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

_____ _____

Signature of patient Date

_____

Print Name of Patient **DOB:**

(Provide a copy of this form to the patient)

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Refusal to Sign ROI for PCP

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

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

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

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

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

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

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

_____ Other Explain: _____

_____ _____
Patient Signature Date

_____
Printed Patient Name

Osika & Scarano

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PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

We,_____, assume that we may contact you by telephone at your home and at your work, and in writing atyour 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. Wewill approve your request if in our opinion it is reasonable. Once we agree to your request, we are obligated to honor it, except if an emergency arises.

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

☐ At my home telephone number:_____
- ____You can leave messages with detailed information
- ____Leave message with a call-back number only
- ____Call only at specified times of day:_____

☐ At my work telephone number:_____
- ____You can leave messages with detailed information
- ____Leave message with call-back number only
- ____Call only at specified times of day:_____

☐ At my cell phone number:_____
- ____You can leave messages with detailed information
- ____Leave message with call-back number only
- ____Text message me
- ____Call only at specified times of day:_____

☐ In writing at:
- ____My home address
- ____My work address
- ____My fax number(s):_____
- ____My email address:_____

☐ Other (specify):_____

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

_____ _____ _____

Signature of Patient Print Name Date

Osika & Scarano

PSYCHOLOGICAL SERVICES, P.C.

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Authorization for the Transmission of ePHI

(Electronic Private Health Information)

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

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

_____ _____

Patient (Print) Date

_____

Patient or Parent Signature

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PLACE THIS SIGNED & DATED FORM IN ALL CHARTS TO

CONTACT US

This is our contact information as referred to above:

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

Our mailing address is: 5 Pine Street
Glens Falls, NY 12801

Telephone: (518) 745-0079

Fax: (518) 745-4291

ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that I have received, read, and understood this Notice of Privacy effective April14, 2003, and that any questions I have about it have been answered.

_____ _____

Signature Date

_____

Print Name

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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-packet expenses, which I will be fully liable to pay in full.

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

Date I called: _____

2. Co-pay amount _____

3. Is there a Deductible? _____

4. Referral from Primary Care Physician Needed? _____

5. Outpatient Treatment Report (OTR) needed? _____

If yes, after how many sessions? _____

6. Prior Authorization need? Yes or No If yes, complete the following:

6 a. Authorization Number: _____

6 b. What is the maximum number of visits allowed under this authorization? _____

6 c. Is it a calendar year (e.g. 01/01/09 to 01/01/10) _____

If no, give the dates that the authorization is valid from _____ to _____

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

_____ _____

Patient or Parent Signature Date

_____

Print Name

PSYCHOSOCIAL HISTORY ADULTS

Name:_____

Date of Birth:_____

Date of First Session:_____

Who referred you to this office?_____

Why?_____

Primary Care Physician:_____

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

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

_____**When I was born, my birth mother was a teen or unmarried**

_____**I was conceived from a sexual assault**

_____**My birth parents remain(ed) married on my 18th birthday**

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

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

_____**My birth parents never married**

_____**I was adopted.**

Directions: Fill in the blank

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

I have_____**half-siblings (share only one birthparent)**

I have_____**step siblings (children of a step-parent)**

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

____ **At least one of my childhood mentors (e.g., birth parents, step-parents, grandparents, foster parents) were addicted or overused ALCOHOL.**

If "YES", Who? _____

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

If "YES" Who? _____

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

If "YES", Who? _____

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

If "YES", Who? _____

What were their abusiveStatements/names:_____

_____

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

bruising) If "YES", By Whom?_____

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

If "YES", By Whom?_____

____I have been a victim of stranger or date rape.

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

____I received my GED

_____I dropped out of High School in_____grade.

____I graduated from High School

____I graduated from College

Directions: Fill in the blanks

I currently work at_____on a_____time basis.

Full or part

I am currently living with_____.

I have_____children ages_____.

I have been in_____ physically abusive relationships as an adult.

I have been in_____ verbally abusive relationships as an adult.

_____

_____

Medical illnesses that I currently have:_____

_____

I have had_____periods of unconsciousness in my lifetime

Prescription Medications that I takedaily: _____

_____

_____

I am allergic to these medications:_____

I weigh approximately_____lbs.

I am____feet_____inches tall

Number of cigarettes I smokedaily:_____

Amount of caffeine I drink daily (coffee, t e a , cola):_____8 oz servings. Number of 8 oz

servings of alcohol I drinkweekly:_____

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

Illegal drugs I have used in my lifetime:_____

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

I have been arrested_____ times since the age of 18, offenses include: _____

I have firearms in my home: yes no

If yes, are firearms locked in a secure location? yes no

_____

Directions: With an "X", please designate which statements are "TRUE" of you in the past 6 months.

Leave the space blank if the statement does not apply.

____I have visual memories of abusive childhood events.

____I have nightmares of previous abuse/assaults

____I feel depressed most days

____I feel irritable most days

____I feel anxious most days

------- I have explosive bouts of anger

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

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

--------My appetite has decreased

____I feel tired most days

____I have a hard time falling asleep

_____I get too little sleep

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

____I have trouble staying asleep

____I require more than 10 hours of sleep

_____I have a difficult time concentrating

____I've had thoughts of killing myself in the past

First time was when I was_____years old

_____I recently thought of killing myself

When _____

------- I have wanted to die in the past

First time was when I was_____years old

------- I recently wanted to die

When _____

_____I have had a planned method of suicide.

What was the method _____

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

First time I was_____years old

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

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

_____I sometimes ignore my feelings of hunger.

_____I have trouble maintaining weight loss.

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

_____I make myself vomit to get rid of calories.

_____I take diet pills.

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

_____My lowest weight in my life was unhealthy

_____My highest weight in my life was unhealthy

_____I feel out of control when I overeat.

_____I sometimes eat alone because I am ashamed

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

_____I am unhappy with my weight and body shape.

_____If I overeat, I eat quickly

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

_____I have been hospitalized overnight for psychiatric reasons

If "YES" how many times _____

Which hospitals?_____

When? _____

_____I have been placed on psychiatric medications in the past.

If yes, which ones_____

Who prescribed them?_____

_____I am currently taking psychiatric medications.

If yes, which medications and how much_____

_____

_____I have seen a mental health professional for outpatient treatment in the past. If yes, how

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

_____

_____Did treatment help you in the past? Yes or No

_____Members of my family have mental illnesses.

If yes, which illnesses_____

_____

_____

(Patient please stop here)

<u>Mental Status Examination</u>:

Patient is a____year old_____who appeared stated age. Patient was weighed upon intake. They stood _____feet tall and weighed_____giving them a Body Mass I n d e x of_____. Patient was _____motivated for therapy but_____
And was cooperative.
Mood
DFA
EMA
Appetite
Psychosis: None
Insight: WNL
Judgment: WNL
Pt Denied SI/HI

DSM-V DIAGNOSTIC IMPRESSIONS:

1)

2)

3)

4)

5)

TREATMENT GOALS:

Patient will be seen for individual therapy. Object-relational, cognitive-behavioral, brief time limited and family systems interventions will be utilized in order to meet the follow goals within 10 to 15 sessions:

Psychoeducation will be provided to the patient about the following topics

_____Date rape

_____STD's

_____Sexism

_____Racism

_____Pedophilia

_____Domestic Violence

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