The Psychological Health Collaborative, PLLC
1025 Northern Boulevard Suite 214 Roslyn, New York 11576

Adult Background Form

Today's Date:_____

Name: _____ DOB:_____

Address: Sex: Male Female

_____
(Street/Apartment) *(City)* *(State)* *(Zip)*

Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____)_____ Other Phone: (_____)_____

*Please indicate where we may leave you a voicemail with an asterisk**

E-mail Address:_____

Occupation/Place of Business:_____

Highest Level of Education Achieved & Date of Completion:_____

Religion: _____ Ethnicity: _____

With whom do you reside? Please indicate relation: spouse, children, parents, room-mate, etc. _____
(This information is requested in the event that your doctor must call you at home. No information will be given to anyone regarding your appointments without your written permission. Please specify with whom and at what phone number we may leave a message:
_____)

Referral Source:

Doctor_____
(Name) (Address) (Phone)
Friend or relative_____
Other (please specify)_____

In Case of Emergency Contact:

Name: _____ Relationship to you: _____
Phone Number(s): _____

Marital Status (circle one):

Never Married Married (Date: _____) Separated
Engaged Divorced (Date: _____) Widow(er)
Spouse's Name: _____

The Psychological Health Collaborative, PLLC
1025 Northern Boulevard Suite 214 Roslyn, New York 11576

Children

Name Date of Birth Where Resides

_____

_____

_____

_____

_____

_____

Please describe any known health problems, medical problems, medical issues, past hospitalizations, surgeries, developmental problems, etc. for yourself:

_____

_____

_____

_____

_____

_____

_____

Please describe any significant mental or physical health issues of family members (parents, siblings, grandparents, aunts, uncles, children, spouse, etc.)

_____

_____

_____

_____

_____

_____

The Psychological Health Collaborative, PLLC
1025 Northern Boulevard Suite 214 Roslyn, New York 11576

Current/Previous Psychological Evaluations and Treatments:

Name of Doctor, Agency, Hospital, etc.	City, State	Date(s)	Briefly explain services provided and outcome

Additional information not previously mentioned:

_____

_____

_____

_____

_____

_____

_____

_____

The Psychological Health Collaborative, PLLC
1025 Northern Boulevard Suite 214 Roslyn, New York 11576

PRACTICE POLICY STATEMENT

Fees and Payment

Initial evaluations are approximately 1 hour in length. The standard fee for the initial evaluation session is $310.

Regular sessions are forty-five (45) minutes in length. Fees are determined based on this time period. Variations from this time will be billed on a pro-rated basis. The standard fee for a forty-five minute session is $210.

School visits or other onsite consultations are billed on a pro-rated basis in 15-minute increments according to the established full-session rate. You will be billed for the time required for your doctor to travel to and from the off-site location.

Telephone sessions: Although less desirable than face-to-face meetings, telephone sessions may be scheduled when it is not possible to conduct a face-to-face meeting. Telephone sessions are billed on a pro-rated basis in 15 minute increments according to the established full-session rate. Patients incur all telephone charges.

Telephone consultations: You may need to speak to your doctor briefly at times. However, if telephone calls exceed 10 minutes, calls will be billed on a pro-rated basis in 15-minute increments according to the established full-session rate.

Fees are set at the beginning of therapy and based on: (1) the standard charge of the doctor, and (2) the patient's ability to pay. Insurance plan coverage is considered part of the patient's ability to pay. Once determined, this fee forms the basis for all regular psychotherapy billings. "Cost of living" increases may be levied, but this will not be done within the first year of treatment and will not be done without first informing the patient that an increase is planned.

Payment is due at each session. You may pay by cash, most major credit cards, or check (made payable to Paola Conte, PhD). If you wish to pay by check, please do so at the beginning of the session so that we may utilize the full session time to address your clinical concerns. If you wish to pay on a monthly basis, please do so in advance. Failure to pay for two consecutive sessions may result in suspension of therapy until payment is made. Credit card information provided at the initiation of therapy will be used to secure payment if none is made within the requested time period.

Returned checks will result in an additional $35 fee charged to the patient.

I have read and understood the aforementioned practice policies regarding payment and fees. I accept the fees set by the office as stated in the policy

above. I am aware that I will be charged the full session fee in the event that I cancel my session within forty-eight (48) hours of my session day and time.

Name (Print):_____

_____

Signature & Date:_____

_____

Insurance

"Reimbursable diagnoses": Please be aware that not all psychological disorders are considered "reimbursable" by all insurance companies. It is illegal to alter a diagnosis simply to fit insurance company guidelines.

Insurance forms: Receipts of payments will be emailed following each session. It is fraudulent to submit forms for reimbursement prior to receipt of payment.

Protected Health Information: Communication with insurance companies for the purpose of reimbursement requires that the doctor release Protected Health Information. In order that the doctor may communicate with insurance companies, the patient or guardian must sign a release form explicitly permitting this communication, as specified in federal HIPAA regulations designed to protect patient confidentiality. No Protected Health Information will be released to insurance companies without a signed release of information explicitly permitting such an action. Please see accompanying form outlining further details of Protected Health Information and HIPAA guidelines.

Cancellation Policy

Once treatment has begun, consistency and regularity of sessions will contribute to your reaching your therapeutic goals. Your doctor reserves specific time for you.

Forty-eight (48) hour notice is required for all cancellations. The patient's full fee will be charged if less time is allowed.

Credit card information will be collected at the time of the initial appointment. If less than forty-eight hour notice is given for a cancelled appointment, your credit card will automatically be charged the session fee.

Emergencies

In the event of an emergency, the patient should go to the nearest emergency room.

The Psychological Health Collaborative, PLLC
1025 Northern Boulevard Suite 214 Roslyn, New York 11576

Doctor Availability

Your doctor will not answer calls while in session and there may be an unavoidable wait before a telephone call is returned. Please refer to the office emergency policy or any specific policy put into place by your doctor in the event that you need immediate care.

I have read and understood the policies surrounding insurance, cancellations, emergencies and availability.

Name (Print):_____

_____

Signature & Date:_____

_____

The Psychological Health Collaborative, PLLC
1025 Northern Boulevard Suite 214 Roslyn, New York 11576

CONSUMER ISSUES

As a consumer of psychological services, you retain the following rights:

1. The right to know the training and qualifications of your doctor such as: degrees, licenses, specialized trainings.

2. The right to know and to participate in setting the goals of therapy.

3. The right to know the progress made toward these goals during the course of therapy.

4. The right to know and to participate in the establishment of the treatment plan.

5. The right, as a competent adult, to refuse treatment for yourself or your child.

6. The right to terminate therapy or refuse to participate in research, at any time, without prejudice.

7. The right to obtain a second opinion from a qualified professional.

8. The right to give feedback, at any time, to your doctor.

9. The right to know the rationale for treatment decisions.

10. The right to complete confidentiality [except in circumstances when express written permission is given by the patient or parent, or if: (1) the patient threatens to harm him/herself, (2) the patient threatens to harm another and identifies that individual, (3) there is suspicion of child abuse at any time.]

This list is meant to inform, but is by no means exhaustive. You also have the right to investigate with qualified sources any further rights you may have. In New York, licensed professionals are monitored by the State Board of Psychological Examiners and must adhere to the ethical guidelines established by the Board. Professional societies, such as the American Psychological Association also provide guidelines of conduct for psychologists.

You are encouraged to resolve any issues directly with your doctor. However, the above organizations are available to you in the event that a resolution is not reached to your satisfaction.

The Psychological Health Collaborative, PLLC
1025 Northern Boulevard Suite 214 Roslyn, New York 11576

I have read and understood the stated consumer issues and acknowledge my right to resolve any issues directly with my doctor.

Name (Print):_____

_____

Signature & Date:_____

_____

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below:

_____

Patient Name | Date of Birth | Social Security Number

_____

Address (Street, City, State, Zip Code) | Telephone Number

The following individual or organization is authorized to make the disclosure:

_____ Paola Conte, PhD
_____ Other, please specify: _____

This information may be disclosed to and used by the following individual or organization:

_____ Paola Conte, PhD
_____ Other, please specify: _____

_____

Treatment dates | Purpose of Request

The following information is to be disclosed: (please check)

Yes	No		Yes	No	
_____	_____	DSM-IV Diagnosis	_____	_____	Treatment Summary
_____	_____	Medication Records	_____	_____	Psychological Assessment Reports
_____	_____	Collateral Data (e.g., school reports)	_____	_____	Specific Interventions
_____	_____	Psychotherapy Notes	_____	_____	Complete Record
_____	_____	Other _____			

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____

If I do not specify an expiration date, event or condition, this authorization will expire in six months.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, I may be denied enrollment in the research study. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. If I have questions about disclosure of my health information, I can contact Emily Klass, PhD at 516-466-2537.

Signature of Patient or Legal Representative Date

If Signed by Legal Representative, Relationship to Patient

The Psychological Health Collaborative, PLLC
1025 Northern Boulevard Suite 214 Roslyn, New York 11576

MAJOR CREDIT CARD INFORMATION

Name on card:_____

Billing Address:_____

_____

Type of Credit Card (Circle one): Visa Master Card Amex

Credit Card Number:_____

Expiration Date (Month/Year):_____

Security Code (3-digit code on back near signature):_____

- **I understand that my credit card information is being obtained by Emily Klass, PHD and will be utilized for the purpose of securing payment if I:**

  (1) fail to pay for scheduled sessions

  (2) cancel a session with less than 48-hour notice

  (3) choose this method of payment for sessions

- **I will notify Dr. Conte should the payment/credit card information change.**

Name (Print):_____
_____

Signature & Date:_____
_____