PATIENT INFORMATION FORM

NAME: _____ **DOB**: _____
LAST FIRST MI

ADDRESS: _____ **Apartment #** _____

CITY: _____ **STATE**: _____ **ZIP**: _____

PHONE: Home: _____ Cell: _____ Work: _____

EMAIL: _____ **SEX**: ❑ M ❑ F

Marital Status: ❑ Single ❑ Married ❑ Other **Employment Status**: ❑ Employed ❑ Student ❑ Retired

EMERGENCY CONTACT*:* _____ **RELATIONSHIP***:* _____

PHONE: _____ **E-MAIL** _____

PHARMACY INFORMATION

Name_____ Address_____ Phone_____

Do you use a mail-away pharmacy? NO❑ YES ❑ Name_____ Phone_____

INSURANCE INFORMATION – (NOTE: INSURANCE CARD MUST BE PRESENTED)

Name of primary insurance company: _____
(WE DO NOT ACCEPT MEDICAID, HMO OR WORKMANS COMP)

POLICY OWNER: _____ **RELATIONSHIP TO PATIENT**: _____

DATE OF BIRTH: _____ **POLICY NUMBER**: _____

SECONDARY INSURANCE COMPANY: _____ **POLICY #**_____

PLEASE STATE THE REASON YOU CAME TO THIS FACILITY (CHECK ALL THAT APPLY)

❑Anxiety ❑Family Problems ❑Depression ❑Relationship Problems ❑Mood Swing ❑Substance Abuse ❑Other

Please give a brief description: _____

_____

I hereby assign to you, my health care provider, where appropriate and approved by you and your carrier, all medical benefits to which I am entitled.

1) **I agree to pay all and *any deductible, co-payments or co-insurance according to my insurance policy at each visit. Co-payments will not be billed. They must be paid* at the time of visit. A $5.00 fee will be charged.**
2) I hereby authorize said assignee to release all information to secure payment.
3) I understand that I am financially responsible for all charges whether or not paid by said insurance and that payments are due at the time services are rendered.
4) **I understand there will be $50 FEE for all appointments missed or cancelled without PROPER notice. 72 HRS FOR THERAPY AND 24 HRS FOR MD.**
5) I understand that **no prescriptions** will be called in from this office. It is my responsibility to discuss my medication with my doctor and make sure I will have enough to last until my next visit.

I CERTIFY THAT I HAVE READ THE ABOVE AND FULLY UNDERSTAND AND AGREE TO THE TERMS

Signature: _____ Date: _____

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CLINICIAL MANAGEMENT CONSULTANTS

Adult Intake Questionnaire

Instructions: Please answer the following questions to the best of your ability. If you are unsure about a question, please discuss it with the mental health professional.

Patient Name: _____ Age: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Highest level of Education Completed:
☐ Some High School ☐ High School ☐ Associate's Degree ☐ Bachelor's Degree ☐ Post-Graduate Degree

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Receiving Disability ☐ Retired ☐ Student

Current Occupation: _____

Children: ☐ Yes ☐ No How Many: _____ Sibling(s) ☐ Yes ☐ No How Many: _____

If you have sibling(s), where in the birth order do you fall? ☐ Oldest ☐ Middle ☐ Youngest

Name of Primary Physician: _____

Address: _____

Phone: _____ Date of last blood test: _____

Please list all medical conditions *(such as diabetes, heart disease, etc.)*: _____

_____

Please list all medications & dosages you are currently taking for your medical conditions including psychiatric medications:

Medication	Dosage	Prescribing MD	Reason for prescription	Helpful: Yes/No

Please list all psychiatric medications & dosages which you have previously taken:

Medication	Dosage	Prescribing MD	Reason for prescription	Helpful: Yes/No

Please list any allergies: _____

Please list any surgeries in the last five years: _____

_____

Have you recently been hospitalized: ☐ Yes ☐ No

If yes, please list the reason(s) for hospitalization: _____

_____

Please explain any general health changes in the past year: _____

_____

Are you, or do you think you could be pregnant: ☐ Yes ☐ No ☐ N/A

Symptoms check list. Please check all that apply:
☐ Sleeping problems ☐ Overeating ☐ Poor concentration ☐ Loss of appetite ☐ Anxiety ☐ Depression
☐ Not enjoying things ☐ Racing thoughts ☐ Panic attacks ☐ Excessive worrying ☐ Obsessive behaviors
☐ Uncomfortable in social situations ☐ Drug and or alcohol abuse ☐ Compulsive behavior

Have you previously *or are* presently seeing a therapist/counselor/psychiatrist: ☐ Yes ☐ No
If yes, please write name and treatment dates:

_____

_____

_____

Do any biological relatives have any history of psychiatric or emotional problems: ☐ Yes ☐ No
If yes, which family member(s), and what types of problems: _____

_____

Have you ever made a suicide attempt: ☐ Yes ☐ No
If yes, when did this occur? How did you hurt yourself? Were you hospitalized?

_____

_____

Any history of Trauma (physical, emotional, verbal, other)? _____
If so, please explain: _____

_____

Was your childhood happy: ☐ Yes ☐ No
If no, please explain: _____

_____

Is your mother ☐ Living ☐ Deceased
Is your father ☐ Living ☐ Deceased
Are your Parents? ☐ Married ☐ Divorced ☐ Separated ☐ Remarried

Did you ever leave a school you were enrolled in prior to completion: ☐ Yes ☐ No
If yes, please explain: _____

_____

Did you ever receive any special education services (ex: tutoring, IEP, etc.): ☐ Yes ☐ No
If yes, please explain: _____

Were you ever in trouble with the police or other authorities: ☐ Yes ☐ No
If yes, how old were you, describe the incident(s): _____

_____

_____

During your childhood, did you experience any of the following (Please check all that apply):
☐ Learning Difficulties ☐ Conduct Problems ☐ Sleep Walking ☐ Depression ☐ Separation Anxiety ☐ Fears
☐ School Phobia ☐ Night Terrors ☐ Stuttering ☐ Bullying ☐ Hyperactivity ☐ Attention Deficit

Have you ever had a period of time lasting two days where you felt or behaved extremely euphoric (an intense state of happiness and/or overwhelming sense of contentment): ☐ Yes ☐ No

Do you have regular periods of feeling irritable or angry: ☐ Yes ☐ No

Do you experience these feelings on a regular basis: ☐ Yes ☐ No

Have you ever had difficulty managing money such as overcharging, credit card debt, or inability to properly budget your money: ☐ Yes ☐ No
Please explain: _____

_____

Have you ever had the feeling that you have special powers or ability(ies) (like reading other thoughts, predicting the future, conversing with God-not just praying): ☐ Yes ☐ No
If yes, please describe: _____

_____

Have you ever felt that other people could read your mind or hear your thoughts: ☐ Yes ☐ No
If yes, please describe: _____

_____

Have you ever heard voices or seen things that others could not: ☐ Yes ☐ No
If yes, please describe: _____

In the past few months have you worried about having a serious illness: ☐ Yes ☐ No

When you have aches and pains, do you worry it's a serious illness: ☐ Yes ☐ No

Have you ever had concerns with some defect in your appearance: ☐ Yes ☐ No

Have you ever had an eating disorder: ☐ Yes ☐ No

Do you worry a lot about your weight: ☐ Yes ☐ No

Do you eat huge amounts of food at one time: ☐ Yes ☐ No

Have you ever had difficulty resisting the impulse to gamble: ☐ Yes ☐ No

Have gambling behaviors compromised, disrupted, or damaged personal, family or vocational pursuits:
☐ Yes ☐ No

Have you continued gambling despite an inability to pay debts, or if you have legal problems:
☐ Yes ☐ No

Have you ever had, or currently have facial tics, jerks of other parts of your body such as the head, neck or other sudden movements: ☐ Yes ☐ No

Have you ever found (or currently yourself involuntarily making noises (other than talking) like grunts, throat clearing, or saying words): ☐ Yes ☐ No

Have you ever used any drugs or medications other *than as prescribed*? (this includes medications, marijuana, PCP, LSD, amphetamines, barbiturates, cocaine, oxycontin/oxycodone, hydrocodone, ecstasy...) ☐ Yes ☐ No
If yes, please list: _____
_____

Are you currently using: ☐ Yes ☐ No
Describe: _____
_____
_____

Do you drink alcohol: ☐ Yes ☐ No

How much alcohol do you drink: _____ of drinks per ☐ day ☐ week ☐ month

Relationship Questions

Do you find it easy to make and keep friends? ☐ Yes ☐ No

Do you have stable, fulfilling friendships? ☐ Yes ☐ No

Have you had serious romantic relationships? ☐ Yes ☐ No

Has your relationship with your parents been good and healthy? ☐ Yes ☐ No

Do you have people in your life that you trust and confide in? ☐ Yes ☐ No

Do you find it easy to trust people? ☐ Yes ☐ No

Have you ever cut yourself/injured yourself in any way? ☐ Yes ☐ No

Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way: ☐ Yes ☐ No

In the past month, were you fearful or embarrassed being watched, being the focus of attention or fearful of being humiliated *(this includes things like speaking in public, eating in public or with others, writing while someone watches or being in social situations)*: ☐ Yes ☐ No

Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else: ☐ Yes ☐ No

Have you worried excessively or been anxious about two or more things *(for example, finances, children's well-being or misfortune, etc.)* over the past six months: ☐ Yes ☐ No

In the past month have you been bothered by recurrent thoughts, impulses or images that were unwanted, distasteful, inappropriate, intrusive or distressing *(for example, the idea that you were dirty, contaminated or had germs, or fear of harming someone even though you didn't want to, or obsessions with sexual thoughts, or images or impulses, or hoarding, collecting or religious obsessions)*:
☐ Yes ☐ No

Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks: ☐ Yes ☐ No

Signature: _____ Date: _____

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BDI®-II

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

Subtotal Page 1

Continued on Back

THE PSYCHOLOGICAL CORPORATION®
Harcourt Brace & Company
SAN ANTONIO
Orlando • Boston • New York • Chicago • San Francisco • Atlanta • Dallas
San Diego • Philadelphia • Austin • Fort Worth • Toronto • London • Sydney

0154018392

11. Agitation

0 I am no more restless or wound up than usual.

1 I feel more restless or wound up than usual.

2 I am so restless or agitated that it's hard to stay still.

3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.

1 I am less interested in other people or things than before.

2 I have lost most of my interest in other people or things.

3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.

1 I find it more difficult to make decisions than usual.

2 I have much greater difficulty in making decisions than I used to.

3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.

1 I don't consider myself as worthwhile and useful as I used to.

2 I feel more worthless as compared to other people.

3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.

1 I have less energy than I used to have.

2 I don't have enough energy to do very much.

3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.

1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.

2b I sleep a lot less than usual.

3a I sleep most of the day.

3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.

1 I am more irritable than usual.

2 I am much more irritable than usual.

3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.

1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.

2b My appetite is much greater than usual.

3a I have no appetite at all.

3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.

1 I can't concentrate as well as usual.

2 It's hard to keep my mind on anything for very long.

3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.

1 I get more tired or fatigued more easily than usual.

2 I am too tired or fatigued to do a lot of the things I used to do.

3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

16 17 18 19 20 A B C D E

_____ Subtotal Page 2

_____ Subtotal Page 1

_____ Total Score

308 Seaview Avenue
Staten Island, NY 10305
Phone: 718.351.1717
Fax: 718.980.5022
www.freedomfromfear.org
help@freedomfromfear.org

Follow Freedom From Fear on FaceBook, Youtube and Twitter.

FREEDOM FROM FEAR

Freedom From Fear is a National Non-Profit Mental Illness Advocacy Organization

Welcome to Freedom From Fear (FFF). We are glad you came.

The mission of Freedom From Fear is to impact, in a positive way, the lives, of all those affected by anxiety, depressive and related disorders through advocacy, education, research, and community support.

Freedom From Fear works with the private mental health clinicians of **Clinical Management Consultants.** These clinicians include licensed psychiatrists, psychologists, social workers and mental health counselors. **These clinicians are highly trained in mood and anxiety disorders. They are responsible to provide the treatment services at Freedom From Fear.**

Please carefully read the following information and sign. This is important since there are various protocols regarding treatment of individuals at Freedom From Fear.

- Unfortunately, there are several disorders that are not treated by our staff. We do not treat substance abuse, eating disorders, gambling problems, schizophrenia, and most chronic mental illnesses.

* Initial Here _____

- Co-payments/payments must be paid on the day of service is provided. In addition, cancellation of appointments must be given 72 hours in advance for therapy appointments, and 24 hours in advance for psychiatric appointments. We now provide a voice message service that will notify you two days before your scheduled appointment. There is a $50 fee if proper notice of cancellation is not given.

- Your intake today will be discussed with your treating psychiatrist prior to your appointment. During psychiatric evaluation, the doctor will confirm if you are appropriate for treatment at our facility. If appropriate, the doctor will then discuss your illnesss and treatment plan.

- I have read and I understand the terms and conditions of treatment.

Signature: _____ Date: _____

FFF's mission is to improve the lives of people with anxiety, depression and related disorders through advocacy, education, research and community support.

From Fear meets New York Philanthropic Advisory Service Standards for Charitable Solicitations.

PATIENT INFORMATION RE: CREDIT CARD ON FILE POLICY

To Our Patients:

As you are aware, healthcare has undergone dramatic changes in the past few years. High-deductible health plans are now a mainstay in the healthcare landscape. This means that more responsibility of payment is being placed on patients. We need to be sure that patient balances are paid in a timely manner. If you have ever stayed in a hotel or rented a car, you are familiar with the concept of having a credit card on file. Your credit card information is stored in a secure, encrypted manner and only accessed and charged if there is an outstanding balance due. As of January 1, 2024, Clinical Management Consultants has adopted a Credit Card on File Policy. An administrative fee of $3.00 will be included for each credit card transaction.

At the time of registration, we will request your credit card information. Your credit card numbers will be encrypted and stored on a secure server.

Payment and co-pays will be processed at the time of visit. If you have any questions about this payment method, please do not hesitate to call our **Billing Office** at **718-351-1717.**

How does credit card on file benefit me?
Using credit card on file, you will be able to:

- Pay balances and co-pays conveniently
- Make payments automatically using your credit card of choice
- Avoid writing checks to pay bills by mail

Your credit card on file can be used for the following reasons:

-Visit payments not collected from you at the beginning of the visit
-No show or late cancellation charges
-Insurance discrepancies
-Outstanding balance greater than 31 days past due

Credit Card Type (circle) **Visa** **MasterCard** **Discover** **Amex**

Credit Card Number _____ Security Code _____ Exp Date _____ Printed Name as it appears on card _____

Billing Address _____ City _____ State _____ Zip _____

Phone Number _____ Email _____

Patient Name _____ DOB _____ Patient Name _____ DOB _____

Patient Name _____ DOB _____ Patient Name _____ DOB _____

I authorize Clinical Management Consultants to charge the credit card above per the terms of this policy. This authorization shall remain in effect until CMC has received written notification from me of its termination.

Signature _____ Date _____

Physician-Patient Services Agreement

This document (the Agreement) contains information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires you be provided with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. It is very important that you read them carefully. When you sign this document, it will represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I/we have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

The first part of your treatment will be an evaluation. We will then offer a treatment plan to follow, if you decide to continue. Treatment recommendations may involve medicine and also talk therapy with/without medicine.

PROFESSIONAL FEES/BILLING

At the present time we accept GHI and Medicare. You are responsible for meeting your deductible and the co-payment at the time of your visit. For those who have other insurance we will provide you with a receipt. **You are responsible for contacting your health plan administrator should you have questions concerning your coverage.** If your account has not been paid for more than 60 days, and arrangements for payment have not been agreed upon, legal action may be taken to secure payment.

INSURANCE REIMBURSEMENT

Your contract with your health insurance company requires that we provide them with information relevant to the services provided to you. We are required to provide a clinical diagnosis. On occasion, we are required to provide additional clinical information (i.e. treatment plans/summaries, or copies of your Clinical Records. This information will become part of the insurance company's files. We will provide you with a copy of any report submitted, if requested.

LIMITS ON CONFIDENTALITY

The law protects the privacy of all communications between a patient and physician. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certainly legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities as follows:

- **Consult other health professionals about a case.** From time to time, I may find it helpful to consult other health professionals. During a consultation, every effort is made to avoid revealing the patient's identify. All health professionals are legally bound to keep the information confidential. Unless there is an objection, I will not tell you about these consultations unless it is important to our work together. All consultations will be noted in your Clinical Record.
- **Patients should be aware that we practice with other mental health professionals and that we employ administrative staff.** In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All health professionals are bound by the same rules of confidentiality.
- **If a patient threatens to harm himself/herself.** I may be obligated to seek hospitalization for her/him, or to contact family members or others who can provide protection.

Following are situations where information may be disclosed without patient's request or Authorization:

- **A government agency requests information** for health oversight activities
- **A patient files a complaint or lawsuit against the physician.** I may disclose relevant information regarding that patient in order to defend myself.
- **Providing treatment for conditions related to a worker's compensation claim.** I may have to submit such records to the Chairman of the Worker's Compensation Board.

Following are situations where the physician is legally obligated to take action:

- Information is received from a child or the parents or guardian or other custodian of a child that gives cause to suspect child abuse, or neglect, the law requires that this be reported to the appropriate governmental agency.
- A patient communicates an immediate threat of serious physical harm to an identifiable victim. We may be required to notify the potential victim, the police, or seek hospitalization for the patient.

PROFESSIONAL RECORDS

The laws and standards require that Protected Health Information be retained in the patient's Clinical Record. You may examine and/or receive a copy of your Clinical Record, if requested in writing except in unusual circumstances that involve danger to yourself and/or others or where others have supplied information confidentially. Because these are professional records that may be misinterpreted, it is recommended that you initially review them with your mental health professional, or have them forwarded to another mental health professional for discussion.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures.

MINORS & PARENTS

New York State law gives children of any age the right to independently consent to and receive mental health treatment without parental consent if they request it and I determine that such services are necessary and requiring parental consent would have a detrimental effect on the course of the child's treatment. In that situation, information about that treatment cannot be disclosed to anyone without the child's agreement. Even where parental consent is given, children over the age of 12 have the right to control access to their treatment records.

Signature of Patient	Signature of Clinician
Date	Date