PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____ Age: ____

Address: _____

Sex: ☐ Male ☐ Female Social Security #_____

Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Significant Other

Cell Phone # ( ) _____ Home #_____ Work #_____

Employer: _____ Occupation: _____

School: _____ Status: ☐Full-Time ☐Part-Time

Person(s) to be contacted in case of emergency:

Name_____ Relationship_____ Phone #_____
Address: _____

Name_____ Relationship_____ Phone #_____
Address: _____

Primary Care Physician: _____ Phone # _____
Address: _____

Referred by: _____ Phone # _____
Address: _____

COURT RELATED ONLY:

Do you have an attorney? _____ Yes. _____ No.
If yes: _____
Name Phone # Fax #

Court date: _____ Judge:_____
Reason: _____

PRESENTING PROBLEM(S):

If you are seeking counseling, please describe why (include date/month the problem started, any ideas about hurting self/others, etc.): _____

_____

Was there an event which made these issues or problems surface? _____Yes _____No

If yes, please describe: _____

_____

_____

MEDICAL HISTORY:

Please list any prescription medications you currently use (name, dosage, frequency):

_____

Please list any over-the-counter medications you currently use (name, dosage, frequency):

_____

Please list any past or present conditions for which you have been treated:

_____

When did you last have a physical examination? _____

Who did you see? Name: _____ Phone #_____

FAMILY HISTORY:

Describe any medical or psychiatric conditions of your parents and siblings:

PSYCHIATRIC HISTORY:

Have you ever received psychiatric or psychological treatment of any kind before? Yes__ No__

If yes: What type of care did you receive? ☐Inpatient/hospital ☐Outpatient ☐Both

When were you in treatment? _____
Where were you in treatment?_____
How long were you in treatment? _____
Who was your therapist/doctor?_____
Did your doctor prescribe medication at that time? _____Yes _____No
If yes, name of medication prescribed: _____

SUBSTANCE USE HISTORY:

Have you ever abused drugs or alcohol? _____ If yes, please describe:

Substance	Amount	Frequency	When? (first use; last use)

If yes, have you ever received substance abuse treatment of any kind? ____ Yes _____ No

Do you have a history of blackouts, seizures or withdrawal symptoms? ____ Yes _____ No

Please describe anything else you would like your clinician to know: _____

_____

Your Habits	**Amount Currently Using**	**Most Ever Used**
Coffee (cups/daily)		
Cigarettes (packs/daily)		
Other: _____		

If you have any allergies, please describe:_____

CONFIDENTIALITY:

All information between counselor and patient is held strictly confidential, unless:

1. The patient authorizes release of information with his/her signature.
2. The patient presents a physical danger to self.
3. The patient presents a danger to others.
4. Child/elder abuses/neglect care suspected.

In the latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

FINANCIAL TERMS:

Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed and your provider will be paid directly by the carrier. The patient will be responsible for any applicable deductibles and copayments. If you were not eligible for benefits at the time services were rendered, you are responsible for payment.

CANCELED/MISSED APPOINTMENTS:

A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled with less than 24 hours' notice, the provider may bill the patient according to the scheduled fee or according to the rules of the patient's health plan.

APPEALS AND GRIEVANCE:

I acknowledge my right to request reconsideration in the case that outpatient care (number of visits) are not authorized (appeal). I understand that I would request an appeal through my provider and that I risk nothing in exercising this right. I also acknowledge that I may submit a grievance to the Provider or Clinical Group administrator at any time to register a complaint about any aspect of my care. If I am not satisfied with the response I receive, I may submit a grievance directly.

CONSENT FOR TREATMENT:

I further authorize and request that JACQUELINE BASHKOFF, PH.D., and/or JAMES HISLOP, LCSW, BCH, carry out psychological examinations, treatments, and/or diagnosis procedures which now, or during the course of my care as a patient, are advisable. I understand that the purpose of these procedures will be explained to me upon request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

RELEASE OF INFORMATION:

I authorize the release of information for claims, certification/case management/quality improvement, and other purposes related to the benefits of my Health Plan. Releases of information to providers, family, etc., require a separate form.

_____ _____

Print name of Patient (or Parent/Guardian) Print Name of Witness

_____ _____

Signature of Patient (or Parent/Guardian) Signature of Witness Date

Date: _____

James M. Hislop, LCSW
939 Route 146, Suite 210
Clifton Park, NY 12065
Tel. (518) 577-8367
Fax (518) 306-5011

INFORMED CONSENT CHECKLIST FOR TELETHERAPY SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

There are potential benefits and risks of video-conferencing (e.g., limits to patient confidentiality) that differ from in-person sessions.

1. Confidentiality still applies to teletherapy services, and no one will record the session without the permission from the others person(s).
2. We agree to use the video-conferencing platform selected for our virtual sessions, and the provider will explain how to use it.
3. You need to use a webcam or smartphone during the session.
4. It is important to be in a quiet, private space that is free of distractions during the session (including cell phone or other devices).
5. It is important to use a secure internet connection rather than public/free Wi-Fi.
6. It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the provider in advance by phone or email.
7. We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
8. We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.

If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in teletherapy sessions.

As your Provider, I may determine that, due to certain circumstances, teletherapy is no longer appropriate and that we should resume our sessions in-person.

Provider Name: James Hislop, LCSW Signature: _____

Print Patient Name: _____

Signature of Patient/Patient's Legal Representative:

_____

Date: _____

AUTHORIZATION FORM (HIPAA)

Authorization for Disclosure of Protected Health Information

1. I authorize my healthcare practitioner (name) _____, located at: _____, and/or administrative and clinical staff, to disclose my protected health information, as specified below, to ***James M. Hislop, LCSW, 939 Route 146, Suite 210, Clifton Park, NY 12065.***

2. I hereby authorize the disclosure of the following protected health information (specifically describe the protected health information to be disclosed, such as date of service, type of service, and level of detail to be released:

   _____

3. This protected health information is being used or disclosed for the following purposes ("*At the request of* ***James M. Hislop, LCSW, BCH,***" is an acceptable purpose if the request is made by the patient and the patient does not want to state a specific purpose):

   _____

4. 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 named above. 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.

5. 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.

6. My healthcare practitioner will not condition my treatment on whether I provide an authorization for disclosure, except If healthcare services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____
Print patient's name (or of parent of minor patient)
(or of Personal Representative of Patient)

_____ Date: _____
Patient's signature (or of parent of minor patient)
(or of Personal Representative of Patient)

If a Personal Representative, state relationship to patient: _____