Mather Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777

Patient Label

Name: _____ **DOB:** _____

Gender: MALE FEMALE **Social Security #:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone Numbers:

Home: ( ) _____ Can we call you at Home? Yes No

Cell: ( ) _____

Work: ( ) _____ Can we call you at Work? Yes No

Email: _____

Marital Status (circle one): Single Married Divorced Separated

Race (circle one):

American Indian or Alaska Native	Black/African American	Chinese
Filipino	Guamanian or Chamorro	Korean
Hispanic White	Japanese	Other Asian
Native Hawaiian	Other Pacific Islander	Samoan
White/Caucasian	Other Race	

Ethnicity (circle one):

Cuban	Mexican/Mexican American	Not Hispanic or Latino
Other Hispanic or Latino	Puerto Rican	

Preferred Language (circle one):

English Spanish Chinese Italian Polish Russian French Turkish Other

Known Allergies: _____

Employer: _____ **Occupation:** _____

Are you a Student? Yes No **If yes, Name of School:** _____

THIS FORM IS NOT A PART OF THE PERMANENT RECORD

OUTPATIENT BEHAVIORAL HEALTH SERVICES
NEW PATIENT FORM

Primary Care Physician: _____ **Phone #:** _____

Address: _____

Therapist Name: _____ **Phone #:** _____

Discipline: _____

Preferred Pharmacy Name: _____ **Phone #:** _____

Pharmacy Address: _____

EMERGENCY CONTACT:

Name: _____**Relationship:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone Number: (H)_____**(C)**_____

Name: _____**Relationship:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone Number: (H)_____**(C)**_____

PRIMARY INSURANCE:

Insurance Plan: _____ **Policy #:** _____

Policy Holder: _____ **Relation to Patient:** _____

Policy Holder DOB: _____ **Policy Holder SS#:** _____

SECONDARY INSURANCE:

Insurance Plan: _____ **Policy #:** _____

Policy Holder: _____ **Relation to Patient:** _____

Policy Holder DOB: _____ **Policy Holder SS#:** _____

For Partial Hospitalization Clients Only

Will you be driving to the program? _____

Make/Model/Plate #: _____

THIS FORM IS NOT A PART OF THE PERMANENT RECORD

OUTPATIENT BEHAVIORAL HEALTH SERVICES
NEW PATIENT FORM

PH5626

ALLERGIES:_____ **SPECIAL DIET:**_____

1. CURRENT PROVIDER OF MEDICAL CARE: (Include name and address of regular health care providers).

Physician/Program Name Address Phone Number

2. GENERAL HEALTH HABITS

Have the following changed in the last year?	**NO**	**Yes, in what way has it changed?**
Appetite		
Weight		
Sleeping Habits		
Energy Level		
Amount of water you drink daily		
Urination frequency		
Bowel movement frequency		
Do you...	**NO**	**Yes, how often?**
Exercise		
Smoke		
Drink alcoholic beverages		
Recreational drug use (Legal, controlled, illegal)		
Drink coffee or tea		
Have you ever had...	**NO**	**If you answer "Yes" explain in the spaces below**
Blurred vision or glaucoma		
Ringing in your ears; loss of hearing		
Head injuries		
Weakness, light headedness, dizziness		
Rapid heart beat		
Pains, discomfort or tightening in chest		
Discomfort or shortness of breath		
Breathing problems when asleep		
Cuts, bruises or scars from previous injuries or self-harm		
Pain or discomfort in arm, joint, leg		
Swollen legs, ankles, or feet		
Frequent nausea or vomiting, blood in vomit		

2. GENERAL HEALTH HABITS (CON'T)	NO	If you answer "Yes" explain in the spaces below
Discomfort after eating		
Burning sensation after eating food		
Discomfort when swallowing		
Frequent Diarrhea or constipation		
Painful or bloody bowel movements		
Painful urination or blood/dark urine		
Loss of urine when laugh, sneeze, cough		
Tendency to bleed or bruise easily		
Other (Specify)		
If female... Amenorrhea or Irregular Menses		
Pregnant		
Menopause		
Vaginal itching, burning, discharge		
Tender breasts, discharge from nipples, lumps		
Date of last period		
Date of last PAP smear		
Date of last mammography		
If male...		
Testicular masses, enlargement		
Difficulty staring urine stream		
Sore on penis, discharge		

3. ILLNESS AND SYMPTOMS (Indicate if you or a blood relative has ever had any of the following).

	No, I have not	Yes	Specify Relative or Significant Other	If you answer "Yes" give dates and type of treatment in space below
Kidney				
Diabetes				
Cancer or Tumor				
Heart Trouble				
Epilepsy, seizure, convulsion				
Thyroid problems or goiter				
Stroke				
Ulcers - stomach or duodenal				
Allergies, asthma, hay fever				
High blood pressure				
High cholesterol				

3. ILLNESS AND SYMPTOMS (CON'T)	No, I have not	Yes	Specify Relative or Significant Other	If you answer "Yes" give dates and type of treatment in space below
Sickle cell anemia				
Tuberculosis Date of last PPD _____				
HIV/AIDS				
Hepatitis				
Sexually Transmitted Disease				
Anemia				
Eating Disorder				
Lupus				
Malaria				
Chicken Pox				
Measles - Rubeola				
German Measles - Rubella				
Rheumatic Fever				
Mumps				
Scarlet Fever				
Other (Specify)				

4. Dental History	Comments or additional information on Dental Treatment			
Date of Last Exam				
Tooth Enamel Erosion				
Cavities				
Dentist Name & Phone #				

Above Information Complete By

5. EVALUATION (To be completed by a Nurse Practitioner, Physician, Physician's Assistant or Registered Nurse).

T_____ P_____ R_____ B/P_____ Ht._____ Wt._____

Do you have current pain? ❑ Yes ❑ No

Do you have chronic or re-occurring pain? ❑ Yes ❑ No

*****If YES for either question, completed a Pain Assessment Form*****

Date of last physical within 1 year? ❑ Yes ❑ No

If No, Parent/Patient agrees to obtain history and physical by primary care physician? ❑ Yes

Does Patient require nutritional referral? ❑ Yes ❑ No

Patient is able to self administer medication while at Partial Hospital as per prescription? ❑ Yes ❑ No

_____

_____

Staff Signature _____ **Title** _____ **Date**_____ **Time**_____

PH5617

PH5617

Patient Name: _____ Date of Birth: _____

Please list below the current medications that you are taking for your psychiatric illness (please include any herbal remedies or dietary supplements).

Name	Dose	Route	Frequency	Reason

Are you prescribed any medications for your medical illness? ❑ Yes ❑ No

Do you take any medication including over the counter medications or herbal remedies or any dietary supplements for any other reason? ❑ Yes ❑ No

If you answered "Yes" please enter those medications on the additional medical medication form.

Form completed by: _____ Date: _____

I have reviewed the patient's Home Medication List and compared it to the medications being prescribed.

_____ _____ _____

Physician / NP Signature ID# Date

PATIENT/FAMILY SELF REPORTED HOME MEDICATION LIST
PSYCHIATRIC MEDICATIONS LIST

Patient Name: _____ Date of Birth: _____

Please list any of the medications that you are currently taking for your medical illnesses, or any other reason, and the name of the practitioner who prescribes them. Please include any over the counter medications or herbal remedies or dietary supplements. Please update this list when medications are discontinued, doses are changed, or new medications (including over the counter products) are added.

Name	Dose	Route	Frequency	Reason	Prescriber Name

Form completed by: _____ Date: _____

Mather Hospital
Northwell Health®

Patient Label

CS4414

CONSENT FOR AMBULATORY-BASED TELEHEALTH SERVICES

Telehealth involves the use of electronic information and communication technologies to enable healthcare providers to remotely provide healthcare services to patients.

Services Provided:
Telehealth services offered by Northwell Health, Inc. (Northwell) through its providers may include consultation, diagnosis, assessment, treatment, education, care management and/or self-management (Services).

The information you provide may be used for:

- A review of health records, images, and/or test results
- Live two-way interactive audio and video; and/or
- Reviewing output data from medical devices

The electronic communication systems we use will incorporate security protocols to protect your privacy and will include measures to protect your data against intentional or unintentional corruption.

Expected Benefits:

- Improved access to care by allowing you to remain in your home or at a doctor's office while another provider consults on your care.
- More efficient evaluation and care management.
- Obtaining expertise of a specialist, as appropriate.

Possible Risks:

- Delays in evaluation and treatment could occur due to failures of the equipment and technologies.
- A telehealth provider may decide that the transmitted information is of poor quality. If this is the case, you may need to reschedule the telehealth consult or meet with your local primary care doctor.
- Although unlikely, security protocols could fail, causing a breach of privacy of personal medical information.

Service Limitations:

- Our providers do not address medical emergencies. If you believe you are experiencing a medical emergency, you should dial 9-1-1 and/or go to the nearest urgent care center or emergency room.

By checking the box below, you acknowledge that you understand and agree with the following:

1. I hereby consent to receiving the Services via telehealth. I understand that it is up to the Northwell telehealth provider to determine whether my specific clinical needs are appropriate for a telehealth encounter.
2. I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that Northwell will take steps to make sure that my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal medical information to other health practitioners who may be located in other areas, including out of state.

Patient Label

CS4414

CONSENT FOR AMBULATORY-BASED TELEHEALTH SERVICES

3. I understand there is a risk of technical failures during the telehealth encounter beyond the control of Northwell. I agree to hold Northwell harmless for delays in evaluation or for information lost due to such technical failures.
4. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may suspend or terminate use of the telehealth Services at any time for any reason or for no reason.
5. I understand that I will be directed to contact emergency medical services or dial 9-1-1 immediately in the event of a medical emergency.
6. I understand that alternatives to the telehealth Services, such as in-person Services are available to me, and in choosing to participate in the telehealth Services, I understand that some parts of the telehealth Services involving tests may be conducted by individuals at my location, or at a testing facility, at the direction of the Northwell provider (e.g., labs or blood work).
7. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
8. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Persons, other than the Northwell telehealth provider, may be present during the telehealth Services in order to operate the telehealth technologies.
9. I understand that I will not be prescribed any narcotics for pain, nor is there any guarantee that I will be given a prescription at all.
10. I understand that I will be responsible for all copays and deductibles associated with the telehealth Services that I receive. To the extent that I do not have insurance or to the extent that I have insurance that does not cover the telehealth Services, I acknowledge and agree that I will be responsible for the costs of the telehealth encounter. I have been able to ask questions regarding any costs that I may incur and my questions have been answered to my reasonable satisfaction.
11. I understand that if I participate in a consultation, that I have the right to request a copy of my medical records which will be provided to me at reasonable cost of preparation, shipping and delivery.
12. To the extent that I receive group therapy Services via telehealth, I understand and agree that (a) I must participate in a private location, (b) I am not to record the telehealth encounter, (c) I am not to invite or allow others who are not participants in the group to view or listen to the encounter, and (d) I must keep the ID, password and link to the virtual group encounter confidential. Upon the conclusion of a group therapy session or if I need to leave a group therapy session before it concludes, I agree to promptly logoff of the electronic communications technology platform used to conduct the Services. To the extent that I violate the terms of this Section 11, I understand and acknowledge that my participation in the session may be terminated, and I may no longer be able to participate in the group therapy Services via telehealth.

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CS4414

CONSENT FOR AMBULATORY-BASED TELEHEALTH SERVICES

Patient Consent:

I have read this document carefully, I understand the risks and benefits of the telehealth Services, I have had my questions regarding the procedure explained, and give my consent to participate in the telehealth Services under the terms described herein.

❑ **ACCEPT.** By checking the Box for this **"CONSENT FOR AMBULATORY-BASED TELEHEALTH SERVICES"** I hereby state that I have read, understood, and agree to the terms of this document.

Patient/Agent/Relative/Guardian* (Signature)	Date	Time	Print Name (Relationship if other than patient)
Telephonic Interpreter's ID#	Date	Time	

OR

Interpreter (Signature)	Date	Time	Interpreter's Name and Relationship to Patient (Print)
Witness to Signature (Signature)	Date	Time	Witness Name (Print)

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.