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

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

Patient Label

OP Psychiatric MD Service

170 N. Country Road, Suite 3, Port Jefferson, NY 11777

Phone: (631) 928-3122 Fax: (631) 928-3192

Patient Name:____DOB: ____________

Presenting Problem(s): Please describe your reason for seeking help from a psychiatrist at this time (include date/month/year the problem started, any ideas about hurting yourself or others)?

____

____

____

____

____

Was there an event which made these problems or issues surface: Yes No

If yes, please explain:

____

____

____

Please indicate how your problems are affecting the following areas:

Category	**Level of Impact**				
	No Effect	**Mild Effect**	**Moderate**	**Marked**	**Extreme**
Marriage/Relationship/Family	1	2	3	4	5
Job/ School/Performance	1	2	3	4	5
Friendships/Peer Relationships	1	2	3	4	5
Financial Situation	1	2	3	4	5
Hobbies/Interest/Play	1	2	3	4	5
Physical Health	1	2	3	4	5
Activities of Daily Living	1	2	3	4	5
Sexual Functioning	1	2	3	4	5
Ability to Concentrate	1	2	3	4	5
Ability to Control Temper	1	2	3	4	5

Eating Habits:
Weight Loss ___________lbs; Weight Gain __________lbs Current Weight ____________lbs
Height _________

Sleeping Habits: (Please check if applicable)
_____ Difficulty Sleeping ______ Difficulty Staying Asleep ______Early Morning Awakening

For Children and Adolescents Only:
Are the child immunizations up to date? _____Yes ______ No
Is the child attending school? ____ Yes ______No Developmental Age: ______________
If Yes: Grade: __________________

Describe any difficulty in school if any: ____
____

All Patients please describe the following:
Environment and Home:
How many people live in your household? _________ Is your home safe: ____________
Your home is a _____ Single Family House _____ Apartment _____ Duplex
_____ Community Resident _____ Boarding House

Family Members:
List members of your family that live with you: ____
____
List close family members who you rely on for support: __________________________________
____

Leisure and Recreation:
What do you do for leisure and recreation? ____

Childhood History:
Are there any significant events from your childhood (i.e. Physical abuse, verbal abuse,
sexual abuse, deaths of significant people, illness, surgeries, injuries? _______________________
____

Military Service:
Have you served in the military? _____________________ Branch: ________________________

Financial Status:
Do you have any serious financial problems? (I.e. Bankruptcy, lawsuits?)
____

Current Abuse:
Are you currently the victim of sexual or physical abuse? _________________________________

Cultural Heritage:

What is your ethic background? ____

What is your religion? ____

Medical History:

Allergies: ____

Do you have pain now? _______ No _______Yes;

Have you had pain in the recent past? ______Yes ________No

Please list any past or present medical or surgical conditions that you have been treated for:

____

____

____

____

When did you last have a physical examination? ________________________________

Habits:	Amount Currently Using	Most Ever Used
Coffee (cups/day)	________________	________________
Cigarettes (packs/day)	________________	________________
Alcohol	________________	________________

Family History:

Describe a medical or psychiatric conditions of your parents or siblings:

____

____

____

Psychiatric History:

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

_____Yes ______No

If you checked yes to the above question, please answer the following:

What type of care did you receive?

_____Inpatient (hospital) _______Outpatient _______Both _____Partial

When were you in treatment? ____

Where were you in treatment? ____

How long were you in treatment? ____

Who was your provider? ____

Did your doctor prescribe medication at that time? ______Yes ______No

If Yes, what medication (please provide dosages:

____

____

If you were on medication what worked best for you? ________________________________

Substance Abuse History:

Have you ever abused drugs or alcohol? _______Yes _________No

If yes, please describe Substance Amount When (First use; Last Use)

____

____

____

____

If yes, have you ever received substance abuse treatment of any kind? _______ Yes _______No

If yes, what is the treatment setting? ____

Do you have any black outs, seizures, or withdrawal symptoms? ______Yes _______No

Legal Issues:

Do you have any legal charges against you? ______Yes ________No

Are you on probation? ______Yes ________No

Do you have any court dates in the near future? ______Yes ________No

Please describe anything else you would like your clinician to know?

____

____

____

____

____

_______________________________________ _______________ _______________

Signature Date Time

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

Patient Label

Patient Name: ____ Date of Birth: ________________

Please list below any medications that you are currently taking for medical and psychiatric illnesses, and the name of the practitioner who prescribes them. Please include any over the counter medications, herbal remedies or dietary supplements.

Medication	Dose	Route	Directions	Prescriber

Form Completed By: ____ Date: __________________

PATIENT/FAMILY SELF-REPORTED HOME MEDICATION LIST

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

Patient Label

Name of Patient: ____

I hereby give my consent to receive professional psychiatric services at this office.

I understand my rights to:

1. Competent and timely treatment delivered in a respectful manner from a trained mental health professional.
2. Participate in the development of my plan of care.
3. Expect that my communications are to be treated in a confidential manner. I will determine to whom any information will be released and this will occur only with my signed consent. I am aware that under certain circumstance information can be released without consent. This could occur if my record is requested by a court of law in the form of a subpoena, in response to a medical emergency, to a third party payer, insurance company or in response to a state or federal mandatory statuary or regulatory agency. I consent to the guarantor on my account to receive information regarding billing and payment for the services that I receive.
4. Have the opportunity to inspect my medical record in the presence of a staff member to assist in the interpretation of its contents.
5. I acknowledge receipt of the Privacy Notice outlining my rights regarding confidential protected health information.

I understand and agree with the responsibilities to:

1. Actively and earnestly cooperate with treatment by providing the necessary information and cooperating with the therapeutic interventions recommended by my treatment provider.
2. Keep scheduled appointments, or if it is necessary to cancel an appointment to notify the Office 24 hours in advance so that the time may be allotted to another client. Failure to keep 3 appointments in a 12-month period will result in my treatment provider withdrawing from further professional attendance to me.
3. Pay for treatment services at the time they are delivered. If covered by an insurance plan that my provider is "in network" with, I will be responsible for the applicable copay and deductible that is determined by my insurance company.
4. Smoking is not permitted inside or outside of the building.
5. Conduct myself in a respectful manner towards all staff members.
6. Honor this commitment, as failure to comply will result in my treatment provider withdrawing from further professional attendance to me.

If you have any questions about these statements, our office personnel will discuss them with you. Your signature indicates your agreement with these statements and that you have received a copy of this form.

If you have any complaints about your care, please direct them to the Assistant Vice President of Behavioral Health Services, John T. Mather Memorial Hospital, 75 North Country Rd., Port Jefferson, New York 11777 or call (631) 473-1320 x 5307.

Patient Signature (18 years or older)	Date	Time
Parent or Guardian Signature	Date	Time
Witness Signature	Date	Time

OP PSYCHIATRIC MD SERVICE CONSENT FOR TREATMENT AND STATEMENT OF RIGHTS AND RESPONSIBILITIES

Patient Label

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

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.

CONSENT FOR AMBULATORY-BASED TELEHEALTH SERVICES

Mather Hospital
Northwell Health®

Patient Label

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.

Outpatient Psychiatric MD Services

170 N. Country Rd, Suite 3, Port Jefferson, NY 11776
Telephone Number: (631) 928-3122 Fax Number: (631) 928-3192

FINANCIAL RELEASE AND ASSIGNMENT

I, the undersigned have insurance coverage with ___________________ an assign directly to my physician/provider, ______________________ medical benefits, if any payable to me for services rendered.

I understand I am financially responsible for all charges incurred, as well as co-pats, deductibles and non-covered services as determined by my insurance carrier, I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

____
Signature of Insured/Guardian

____
Date