MATHER
JOHN T. MATHER MEMORIAL HOSPITAL

Dr. Fritz, Dr. Delgado, Dr. Donoghue, Dr. Hussani,
Dr. Nichols, Dr. Sherwin, and Pasqual Spinelli, NPP
125 Oakland Ave, Port Jefferson, NY 11776
Telephone Number: (631) 928-3122 Fax Number: (631) 928-3192

Name:_____**DOB**:_____

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

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

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

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

Marital Status (circle one): Single Married Divorce Separated Widowed Living Together

Race (circle one): American Indian or Alaska Native Black/African American Chinese Filipino Guamanian or Chamorro Hispanic White Japanese Korean Native Hawaiian Other Asian Other Pacific Islander Other Race Samoan Vietnamese White/Caucasian Undisclosed

Ethnicity (circle one): Cuban Mexican/Mexican American Not Hispanic or Latino Other Hispanic or Latino Puerto Rican Undisclosed

Employer / School: _____ **Occupation:** _____

Emergency Contact Information

Name: _____ Relationship: _____
Primary Phone: _____ Secondary Phone: _____

Patient's Primary Care Physician

Name: _____
Address: _____
City, State, Zip: _____
Telephone #: _____

Therapist

Name: _____
Discipline: _____
Telephone #: _____

Insurance Information:

Primary Insurance Co: _____	Secondary Insurance Co: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip:_____
Telephone #: _____	Telephone #: _____
Insurance Policy ID #:_____	Insurance Policy ID #: _____
Policy Holder Name: _____	Policy Holder Name: _____
Policy Holder SS #: _____	Policy Holder SS #: _____
Address: _____+_____	Address: _____
City, State Zip: _____	City, State, Zip: _____
Phone #: _____	Phone #: _____
Policy Holder's Employer: _____	Policy Holder's Employer: _____
Policy Holder's DOB: _____	Policy Holder's DOB: _____

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CONSENT FOR TREATMENT AND STATEMENT OF RIGHTS AND RESPONSIBILITES

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. Not smoke while in the office.
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 Denise Driscoll, RNC,CARN CS NPP, AVP 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

_____

Parent or Guardian Signature Date

_____

Witness Signature Date

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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

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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
	No Effect	Mild Effect	Moderate	Marked Effect	Extreme
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

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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? _____

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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 examinations? _____

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

Family History:

Describe an 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? _____

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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

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Patient Name: _____ Date of Birth: _____

Patient/Family Self-Reported Home Medication List
Medical and Psychiatric Medications

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: _____