ESTEEMED

PSYCHOLOGY SERVICES, PLLC

2679 ROUTE 17M * SUITE 2 * GOSHEN, NY 10924
(P) 845.837.2373

Please Print Clearly and Complete All Applicable Sections

Today's Date: ____/____/_____
mm dd yyyy

Name: _____ _____ Parent/Guardian: _____
Last *First* *if under 18 y.o.*

Date of Birth: ____/____/_____ Age: ____ Social Security #: _____
mm dd yyyy

Sex: ☐M ☐F Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Address: _____ _____
Street *Apt*

_____ _____ _____
City *State* *Zip Code*

Home Phone: ( )_____ Cell Phone: ( )_____ Work Phone: ( )_____

Email: _____

I authorize Esteemed Psychology to leave a message regarding pending appointments:
(check all that apply)

☐home answering machine ☐with family member ☐on my cell ☐at work ☐email

Employer: _____ Occupation: _____

Emergency Contact: _____ _____ Relationship: _____
Last *First*

Telephone: ( ) _____

PRIMARY INSURANCE: Please provide copies of all insurance cards (front and back)

Name of Insurance: _____ Insurance Phone: ( ) _____

Policy ID #: _____ Group #: _____

Insurance Address: _____
Street

_____
City, State, Zip Code

Authorization Number: _____
if applicable

Employer Name: _____Employer Address: _____
Street

_____
City, State, Zip Code

ASSIGNMENT OF BENEFITS

I hereby authorize Esteemed Psychology Services, PLLC to provide medical/behavioral health information necessary for payment to my insurance carrier. In conjunction, I authorize my insurance carrier to direct payments of medical/behavioral health benefits to:

Jeremy M. Johnson, Psy.D.
Esteemed Psychology Services, PLLC
2679 Route 17M
Suite 2
Goshen, NY 10924
NPI: 1275890519

I understand that a verification of benefits is not a guarantee of payment. Plan coverage is determined by insurance companies only when a claim is received. I understand that it is my responsibility to contact my insurance carrier to confirm benefits. I understand that I am responsible for any co-pay and balance not covered by insurance. I agree to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this agreement shall be considered as effective and valid as the original.

Name: _____

Signature: _____

Date: ____ / _____/ _____

CONSENT TO OBTAIN AND RELEASE INFORMATION

PLEASE INDICATE THE NAMES BELOW *(IF YOU DO NOT WISH FOR INFORMATION TO BE OBTAINED OR RELEASED PLACE A SLASH OR N/A IN THE APPROPRIATE SECTION AND SIGN)*

THIS FORM MUST BE SIGNED AS PER HIPAA REGULATIONS

I, _____(print name), authorize Esteemed Psychology Services' therapist/doctor, _____, located at 2679 Route 17, Suite 2, Goshen, NY 10924 to release to and/or obtain from (circle one or both)

List person(s) and/or agency, address, and telephone number below:

(1)_____
(2)_____
(3)_____
(4)_____

Confidential information regarding my care and treatment including, but not limited to the following (list information):

_____
_____
_____
_____

I understand that the release of this information and exchange of communication between Esteemed Psychology Services, PLLC and the authorized person(s) and/or agency will be in the best interest of my treatment, health and well-being.

This authorization will remain in effect (not to exceed one year unless otherwise noted) from

____/____/_____ to ____/____/_____
(start date) (end date)

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information without the specific written consent of the individual to whom it pertains, or as otherwise permitted by such regulations.

_____ ____/____/_____
Client and/or Legal Guardian Signature mm dd yyyy

_____ ____/____/_____
Witness Signature (EPS Employee) mm dd yyyy

Privacy Practices/Statement of Understanding

To Our Clients:

We recognize the sensitive nature of your personal information. We take every precaution to protect your confidentiality.

Esteemed Psychology Services, PLLC and all affiliated employees conduct business in accordance with the guidelines established by the Health Insurance Portability and Accountability Act (HIPAA). This notice describes how private health information (medical information) about you may be used, disclosed and accessed. Please review this information carefully and feel free to ask questions at this time.

1. Your therapist maintains documentation of your contact information with him/her. This documentation includes a "minimum necessary" standard relevant of your protected health information. You may request, in writing, to inspect, copy, and amend your protected health information.
2. Your therapist provides a safe and secure place to address your personal problem(s). He/she will help assess your needs and develop the most appropriate plan of action with you. By acknowledging receipt of this document you are consenting to authorize and request that Esteemed Psychology Services, PLLC and your therapist carry out all necessary assessment, evaluation, diagnostic and treatment procedures that now, or during the course of your care, are advisable. You understand that the purpose of these procedures will be explained to you upon request and subject to your agreement. You also understand that while the course of treatment is designed to be helpful, it may at times be difficult and uncomfortable.
3. Your therapist will not release your private health information to other entities without your written authorization. Your authorization is subject to revocation upon written request at any time. Your therapist will provide an account of disclosures relevant to this authorization upon request.
4. You have to right to initiate restrictions on certain uses and disclosures of your protected health information. Your therapist will make every effort to reach a reasonable consensus with you in regard to your requested restrictions. However, Esteemed Psychology Services, PLLC may deny services should your therapist deem such restrictions would significantly preclude his/her ability to provide professional services.
5. Information used in and discussed between professional staff and the client are held strictly confidential. However, limitations of confidentiality (which are beyond the control of your therapist) include:
    a. Suspected abuse or neglect of a child, elderly person or disabled individual. Your therapist is required by law, as a mental health professional, to report this information to the State Child Abuse Registry or the State Adult Protective Services.
    b. Client presents as dangerous to themselves or others. In this circumstance, your therapist may need to break confidentiality in order assure your safety or the safety of others.
    c. If this practice is required to present records and/or a therapist to comply with court orders.

d. Treatment involving children and their parents. Access to information is an important and sometimes contentious topic. Parents are generally expected and encouraged to remain actively involved in the treatment of young children. For some youth, especially older children, trust and privacy are crucial to treatment success. However, parents also need to know certain information about the treatment. For this reason, your therapist will discuss terms of disclosure and privacy. It is the general philosophy of Esteemed Psychology Services, PLLC that parents should remain informed of treatment goals, progress and child attendance. It is also the standard practice of Esteemed Psychology Services, PLLC to inform parents of any suspected risk of self-harm and/or danger from others. Typically, a shared definition of dangerous behavior and expectations of confidentiality will be agreed upon so all involved parties are clear.

6. Your therapist serves as a privacy officer who makes every effort to assure your privacy is protected and attains the maximum standards of confidentiality. This practice relies on your input/feedback so we may continually ensure we are operating effectively, protecting your privacy, and communicating your privacy rights concisely. Should you wish to provide feedback and/or initiate requests, you may speak directly to your therapist or contact the office directly at (845) 837-2373. If you believe your privacy has been violated you may contact the Office of Civil Rights Privacy Unit at (866) 627-7748.
7. When entering into a therapeutic relationship, both the client and the therapist(s) have the right to terminate treatment at any time throughout the process. As best practice, upon termination, your therapist will provide you with culturally appropriate referrals, to which you can freely accept or decline. In accordance with APA Code of Ethics, appropriate reasons for termination of services include:
    a. It becomes reasonably apparent that the client is no longer in need of assistance
    b. The client is not likely to benefit from further treatment
    c. The client is being harmed by continued services
    d. The therapist is in jeopardy of harm by the client and/or person(s) with whom the client has a relationship
    e. The client does not pay fees as agreed upon
8. Your therapist and Esteemed Psychology Services, PLLC agree to abide by the terms of this notice. We reserve the right to make changes to our privacy practices at any time. Should changes occur, a revised notice relevant to your protected health information will be provided to you during your time as an active client.
9. A paper copy of the notice will be provided upon your request.

I, _____, (Client or Legal Guardian of Client) am in receipt of the Privacy Practices /Statement of Understanding Policy given to me on this _____ day of _____, 20____ by Esteemed Psychology Services, PLLC in compliance with and required by New York State HIPAA (Health Insurance Portability and Accountability Act). I have had the opportunity to review this document and ask any necessary questions. By signing below I agree to the terms stated above.

Name: _____ Signature: _____

Name: _____ Signature: _____

Therapist: _____ Signature: _____

Fiscal Responsibility and Cancellation Policy

Payment is due at the start of every session. If payment is not received, Esteemed Psychology Services, PLLC reserves the right to immediately suspend services provided by our agency. We will provide, to the best of our ability, referrals for alternative organizations/providers for you to continue treatment. ____ (initials)

There will be a $30 charge for any returned checks. ____ (initials)

Upon verification of Health Plan/Insurance coverage and policy limits, your insurance company will be billed for in-network services provided by Esteemed Psychology Services, PLLC. The client and/or legal guardian will be held responsible for payment of all applicable deductibles and copayments specified by your insurance company. If you are not eligible at the time services are rendered, or if for any reason your insurance carrier refuses to pay claims for services provided to the Insured and/or client, you are directly responsible for payment. Esteemed Psychology Services, PLLC can provide all clients using out-of-network benefits with a receipt that they can submit to their insurance company for attempted reimbursement. ____ (initials)

A scheduled appointment means that time is reserved exclusively for you. Should you cancel or miss a scheduled appointment, that unit of time cannot be recovered. We understand that unforeseen events occur which prevent you from attending your scheduled session. The first missed session within a six month time frame is not charged for, provided at least 2 hour notice is given. Thereafter, should an appointment be missed or cancelled with less than 24 hours notice, the responsible party will be billed according to the scheduled fee of $110 for individual and family sessions and $55 for group sessions. Esteemed Psychology Services, PLLC reserves the right to terminate treatment for frequent absences, defined as more than three cancellations within a six month period. Should this occur, you will be provided with notice and appropriate referrals to other treating sources. ____ (initials)

_____ _____

Name (Print) *Signature of Client/Legal Guardian*

Date: _____ / _____ / _____

INFORMED CONSENT FOR PSYCHOLOGICAL TREATMENT

I, _____ (*name of client*), hereby agree and consent to participate in psychological services provided by Esteemed Psychology Services, PLLC. I understand that I am agreeing only to those services that are either within the scope of the provider's license and training or within the scope of license, certification and training of behavioral health care providers directly supervising the services rendered to me.

If the client is under the age of eighteen or unable to consent to services provided, I attest that I have legal custody of the individual and/or am legally authorized to initiate and consent to psychological services on behalf of the individual.

_____ _____

Signature *Date*

_____

Relationship to Client (if applicable)

SOCIO-ECONOMIC INFORMATION

(Please check ALL that apply)

Marital Status

☐Single ☐Married (_____ yrs) ☐Divorced
☐Separated (_____ yrs) ☐Widowed (_____ yrs)

Education

☐High School Graduate ☐GED ☐Associate's Degree
☐Undergraduate Degree ☐Graduate Degree

Employment

☐Employed and Satisfied ☐Employed and Dissatisfied ☐Unemployed
☐Other: _____

Military History

☐Never in military ☐Served in military
Branch: _____
Years served: _____

Legal History

☐No legal problems ☐Involved in divorce or custody proceedings
☐Parole/Probation ☐Arrest(s) – substance related
☐Arrest(s) ☐Jail/Prison
Time Served: _____
Reason: _____

Support System

☐Large/Adequate support system ☐Limited support system
☐No friends ☐No family involvement

Financial Circumstances

☐Financially stable (no problems) ☐Dependent on others
☐Large Debts ☐Problems related to finances

Please describe the reason for you seeking psychological services:

_____

_____

_____

SYMPTOM CHECKLIST (please check all that apply)

☐Academic Concerns	☐ADHD/Learning Problems	☐Adjustment Problems
☐Aggressive behavior	☐Agitation/Anger	☐Anorexia
☐Anxiety	☐Appetite disturbance	☐Binge Eating
☐Body Image Concerns	☐Compulsive Behavior	☐Career Problems
☐Concentration Difficulties	☐Conduct problems	☐Crying/Tearfulness
☐Cutting or Self-Injury	☐Delusions	☐Depression/Sadness
☐Difficulty sleeping	☐Elevated mood	☐Family Problems
☐Fatigue	☐Fear	☐Guilt/Shame
☐Grief	☐Hallucinations (auditory)	☐Hallucinations (visual)
☐Hyperactivity	☐hopelessness	☐Impulsivity
☐Lack of motivation	☐Legal Problems	☐Loss/Grief
☐Medical Problems	☐Mood Swings	☐Nightmares
☐Need to repeat actions	☐Oppositional	☐Obsessions
☐Panic attacks	☐Paranoia/Suspicions	☐Phobias
☐Poor concentration	☐Racing thoughts	☐Social isolation
☐Self-harming behavior	☐Sexual problems	☐Substance Abuse
☐Suicidal thoughts	☐Suicide attempts	☐Trauma (Emotional)
☐Trauma (Sexual)	☐Worthlessness	☐Work/School Problems

☐Other: _____

Are your current symptoms affecting any of the following?

☐Relationships	☐Work	☐School
☐Finances	☐Legal	☐Hygiene
☐Home Environment	☐Health	☐Self Esteem
☐Sexual Activity	☐Family	☐Other

Previous history of psychological services (Check all the apply):

☐None	☐Outpatient Counseling	☐Group Treatment
☐Psychiatric Hospitalization	☐Drug/Alcohol Treatment	

Have you been prescribed psychiatric medication(s) in the PAST? ☐Yes ☐No

If yes, please list: _____

Are you CURRENTLY taking psychiatric medication(s)? ☐Yes ☐No

If yes, please list: _____

If yes, do you find the medication(s) effective? ☐Yes ☐No

Has anyone in your family experienced difficulties with the following?

☐Anxiety	☐Alcohol Abuse/Dependence	☐Bipolar Disorder
☐Depression	☐Eating Disorders	☐Learning Disabilities
☐Schizophrenia	☐Substance Abuse/Dependence	☐Suicide Attempts

SUBSTANCE USE HISTORY

Have you or are you currently using substances? ☐Yes ☐No
If *yes*, please identify below:

	Past Use		**Current Use (previous 6 months)**	
Substance	*Frequency*	*Amount*	*Frequency*	*Amount*
Alcohol				
Caffeine				
Cocaine/Crack				
Ecstasy				
Heroine				
Inhalants				
Hallucinogens (e.g. LSD)				
Marijuana				
Methamphetamines				
Opiates/Pain Killers				
PCP				
Steroids				
Barbiturates				

Please describe how these substances are affecting your life:

_____

_____

_____

Please identify family history of substance abuse:

☐Father ☐Mother ☐Grandparent(s) ☐Stepparent(s)
☐Aunt(s)/Uncle(s) ☐Spouse ☐Children ☐Sibling(s)

MEDICAL INFORMATION

Please describe your current physical health:
☐Good ☐Fair ☐Poor

Have you experienced any of the following medical conditions?

☐Alcoholism	☐Cancer	☐Chronic pain
☐Dementia	☐Diabetes	☐Dizziness/Fainting
☐Headaches	☐Head Injury	☐Hearing Difficulties
☐Heart Disease	☐Seizures	☐Sleep Disorder
☐Stomach Problems	☐Stroke	☐Thyroid Problems
☐Vision Problems	☐Other	

Please list current medications:

_____

_____

_____