Dr. Michele Winchester-Vega & Associates

Billing Policies Client Copy

● If you would like us to bill your insurance company, we will do so as a courtesy to you. We require a credit card on file for all clients. If you prefer at the time of the session to pay cash or write a check, we will not charge your card for that visit.
If your session is using telemedicine you must send a check or cash in advance of the session or your card will be billed.

● Please notify us of any changes to your primary and secondary insurances. Any changes to your insurance coverage, including termination, must be brought to our attention. A change in insurance carriers will affect your benefits and payment schedules. Your therapist may be required to obtain pre-authorization for treatment services. If you fail to report any changes and insurance claims are subsequently declined for payment, you will be billed the regular session fee.

● In the event your insurance should send a payment directly to you instead of Michele Winchester-Vega & Associates practice, you will endorse the check and immediately forward to the front office along with an explanation of benefits (which reflects the dates of services rendered) If you are unable to provide an endorsed check, (if check is for multiple providers), you will send payment for the same amount as issued by your insurance company.

● You understand that you must keep all your scheduled appointments so your therapist can monitor your progress and treatment. Sessions are 55 minutes, unless otherwise agreed upon. Your time has been reserved for you. Due to the overwhelming need for patient appointments, please cancel at least 24 hours prior to your scheduled appointment, so that we may offer that time slot to other patients. Missed appointments and late cancellations (less than 24-hour notice) will be billed at $75.00 out-of-pocket fee, as we are unable to bill your insurance for no shows.

● It is your responsibility to contact your insurance company to verify coverage and benefit eligibility for outpatient mental health treatment. You need to verify your percentage of payment per visit, any copayments, or deductibles and limits of visits per calendar or benefit year. If you are accessing out-of-network benefits, it is important to confirm that this benefit is available. The practice will make every effort to collect payment from your insurance company. However, you are ultimately responsible for the amount due.

● Fees are based on professional services provided and the amount for time involved. When multiple services are provided, fees for each service will be itemized (i.e., telephone sessions, preparation of special forms, reports, court time, etc.) The fee for these services should be discussed with you at the time of request, as some will not be covered by insurance.

● All co-payments, co-insurance and deductibles are due for services at the time of the visit. Insurance contracts restrict us from waiving these amounts. We offer debit and credit card processing but there will be a 3.5% credit card fee that will also be charged, payment by personal check is also accepted. If a check is returned for insufficient funds, you will be charged the bank fee in addition to the amount of the check. If insurance benefits pay you directly, you must forward these checks to our office. If you are being billed by Headway, you must provide a credit card to remain on file.

● After the insurance company has paid their portion of your claim, should your financial responsibility be unpaid after 90 days (unless other financial arrangements have been made) the account will be turned over to a collection agency. Collection agencies charge 33% of the unpaid bill. Should these additional costs be incurred, you will be responsible for them in addition to any unpaid balance.

● You have authorized the release of any medical information necessary to your insurance carrier to process claims. You permit a copy of this authorization to be used in place of the original. You have authorized Dr. Michele Winchester-Vega, DSW, LCSW-R and Associates to bill with IOU Billing and Headway and correspond with your insurance for services rendered. You have requested that payment from your insurance company be made directly to Dr. Michele Winchester-Vega & Associates. You have certified that the information you have reported, regarding your insurance coverage is correct. You understand that if you fail to report any changes to your insurance coverage, including termination, you will be responsible for any unpaid balances on your account.

Questions regarding billing, call IOU Billing at 800-819-7570.

Dr. Michele Winchester-Vega & Associates

3250 Rte 9W, New Windsor, NY 12553

Office Phone: (845) 562-9816 | Billing Phone: (800) 819-7570 option 4

Patient Demographic Update Form

We are currently updating all patient files with our new billing staff. Please provide the most current information regarding yourself, and your insurance company.

Client		Date of Birth	
Email		Address	
Phone		City State Zip	
Parent / Guardian		Email	
Relationship to Client		Phone	
Insurance Company		Policy Number	

Patient Information Regarding Credit Card on File Policy

We have implemented a policy requiring a credit card held on file. As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured. Some insurance plans require deductibles and copayments in amounts not known to you or us at the time of your visit. Similar to hotels and car rental agencies, you are asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share, then you will receive a statement.This card can be charged for the following reasons:

-Copays, Coinsurances, and Deductibles
-No show or late cancellation charges ($75)
-Insurance discrepancies that are not resolved within 90 days of the date of service
-Outstanding balance greater than 90 days past due

Client's Name		Cardholder's Name	
Email		Phone Number	
BIlling Address		City, State, Zip Code	
Credit Card #		Expiration Date	
CVV		Type of Card	

By signing this form, I am authorizing IOUBilling to charge my credit card for copays the morning after the session, and any balances that are left after insurance payments.

Signature:_____

Relationship to Patient: _____ Date:_____/____/_____

Office Use Only

Client ID_____

Dr. Michele Winchester-Vega and Associates
3250 US Route 9W, New Windsor, NY 12553
Tel: (845) 562-9816 Fax: (845) 863-0351
www.winchester-vega.com

Teletherapy Informed Consent Form

I _____ (client) hereby consent to engage in teletherapy with Dr. Michele Winchester-Vega & Associates, PLLC. I understand that "teletherapy" includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental information, both orally and visually. I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. Unless explicitly agreed otherwise, the teletherapy exchange is confidential. Any personal information I choose to share will be held in the strictest confidence. The laws that protect the confidentiality of my medical information also apply to teletherapy. Just as with face-to-face clients, the clinician will not release your information to anyone without your prior approval, or required to do so by law. In New York mental health providers are required to notify authorities if they become convinced a client is about to physically harm someone; or if they are abusing, or about to abuse, children, the elderly, or the disabled.

3. You understand that this teletherapy occurs in the state of New York, (USA), and is governed by the laws of that state. In a manner of speaking, you use modality to visit the clinician in his/her New York office.

4. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the clinician, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

5. In addition, I understand that teletherapy based services and care may not be as complete as face- to-face services. I also understand that if the clinician believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a I will be referred to a professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychologist, my condition may not be improve, and in some cases may even get worse.

Cont.

6. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.

7. I accept that teletherapy does not provide emergency services. During our first session, the clinician and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.

8. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session, (4) if I decide to keep copies of emails or communication on my computer, it is up to me to keep that information secure.

9. I understand that while email may be used to communicate with the clinician, confidentiality of emails cannot be guaranteed.

10. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law. I have read, understand and agree to the information provided above.

Client Name: _____ Client Signature:_____

Parent/Guardian Name: _____ Parent/Guardian Signature: _____

Date: _____

Dr. Michele Winchester-Vega & Associates
(845) 562-9816 Fax (845) 863-0351

3250 Route 9W
New Windsor, NY 12553

WELCOME TO OUR OFFICE

The mission of our caring and compassionate professional staff is to provide welcoming, collaborative, evidenced based effective and cost effective treatment approaches to improve outcomes for those we serve. We respect the complexity and diversity of each individual/family served towards promoting improved mental health, wellness, self-determination, self empowerment, and resiliency.

Please ask the Billing Coordinator if you have any questions about our fees, financial policy, or your requests in dealing with your insurance company. In order to have a satisfactory experience the following guidelines explain how we operate the business aspect of our practice. We are committed to providing you with the best possible care, and are available to discuss our professional services with you at any time. We want to know your experiences, so please feel free to provide feedback to our staff.

CONFIDENTIALITY

We recognize the privilege of confidential communication. By law, information about you will not be discussed with others, without your written consent and knowledge. If you request records to be released, your signature will be required.

I authorize Dr. Michele Winchester-Vega & Associates to contact me at:

Child:

_____ Cell Phone#_____ Can we leave a message? ☐ Yes ☐ No

_____ Home Phone#_____ Can we leave a message? ☐ Yes ☐ No

_____ Fax #_____ Text Messaging ☐ Yes ☐ No

_____ Email address:_____
(Your email address should be set to privacy settings with encryption for HIPPA compliance)

Caregiver / Name:

_____ Cell Phone#_____ Can we leave a message? ☐ Yes ☐ No

_____ Home Phone#_____ Can we leave a message? ☐ Yes ☐ No

_____ Fax #_____ Text Messaging ☐ Yes ☐ No

_____ Email address:_____
(Your email address should be set to privacy settings with encryption for HIPPA compliance)

Caregiver / Name:

_____ Cell Phone#_____ Can we leave a message? ___Yes ___No

_____ Home Phone#_____ Can we leave a message? ___ Yes ___No

_____ Fax #_____ Text Messaging ___Yes ___No

_____ Email address:_____
(Your email address should be set to privacy settings with encryption for HIPPA compliance)

Referred By: _____

How do you know them? _____

I would like you to speak with them about my treatment. ___Yes ___No Phone: _____

Chief Concerns:

Child: _____

_____

_____

_____

Mother:_____

_____

_____

_____

Father: _____

_____

_____

_____

MEDICAL - *CHILD ONLY*

Primary Care Physician: Name_____ Tel:_____

Conditions/any condition for which you are currently being treated:

_____

_____

Last Physical Exam Date: _____

Medications currently taking (Including over the counter):

_____

_____

_____

Allergies to any medications:

_____

Prior Hospitalizations (Year/Reasons):

_____

_____

_____

Psychiatrist: Name:_____ Tel:_____

HEALTH INSURANCE COVERAGE

If you would like us to bill your insurance company, we will do so as a courtesy to you**. Please notify us of both your primary and secondary insurance.** Any changes to your insurance coverage, including termination, must be brought to our attention. A change in insurance carriers will affect your benefits and payment schedules. Your therapist may be required to obtain pre-authorization for treatment services. If you fail to report any changes and insurance claims are subsequently declined for payment, you will be billed the regular session fee.

_____ _____

Initials - Caregiver Initials - Caregiver

In the event my insurance should send a payment directly to me instead of Michele Winchester-Vega & Associates practice, I will endorse the check and immediately forward to the therapist along with an explanation of benefits (which reflects the dates of services rendered) If I am unable to provide an endorsed check, (if check is for multiple providers), I will send payment for the same amount as issued by my insurance company.

I would like IOU Billing to bill my insurance company and will provide all billing information by my first session.

Caregiver:
I have primary insurance with _____

I have secondary insurance with _____

Caregiver:
I have primary insurance with _____

I have secondary insurance with _____

CANCELLATION AND MISSED APPOINTMENTS

Please keep all your scheduled appointments so your counselor can monitor your progress and treatment. Sessions are 45 minutes, unless otherwise agreed upon. Your time has been reserved for you. **Due to the overwhelming need for patient appointments, please cancel at least 24 hours prior to your scheduled appointment, so that we may offer that time slot to other patients**. **Missed appointments and late cancellations (less than 24-hours notice) will be billed at $75.00 out-of-pocket fee, as we are unable to bill your insurance for no shows**.

_____ _____

Initials - Caregiver Initials - Caregiver

PLAN BENEFIT AND ELIGIBILITY

It is your responsibility to contact your insurance company to verify coverage and benefit eligibility for outpatient mental health treatment. You need to verify your percentage of payment per visit, any copayments, or deductibles and limits of visits per calendar or benefit year. If you are accessing out-of-network benefits, it is important to confirm that this benefit is available to you. **The practice will make every effort to collect payment from your insurance company. However, you are ultimately responsible for the amount due.**

Fees are based on professional services provided and the amount for time involved. Please feel free to discuss finances openly with therapists and/or my Billing Coordinator. When multiple services are provided, fees for each service will be itemized (i.e., telephone sessions, preparation of special forms, reports, court time, etc.) The fee for these services should be discussed with us at the time of request, as some will not be covered by insurance.

All co-payments, co-insurance and deductibles are due for services at the time of the visit. Insurance contracts restrict us from waiving these amounts. We offer debit and credit card processing but there will be a 3.5% credit card fee that will be charged, payment by personal check is also accepted. If a check is returned for insufficient funds, you will be charged the bank fee in addition to the amount of the check. If insurance benefits pay you directly, you must forward these checks to our office.

After the insurance company has paid their portion of your claim, should your financial responsibility be unpaid after 90 days (unless other financial arrangements have been made) the account will be turned over to a collection agency. Collection agencies charge 33% of the unpaid bill. Should these additional costs be incurred, you will be responsible for them in addition to any unpaid balance.

I authorize the release of any medical information necessary to my insurance carrier to process claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize Michele Winchester-Vega, LCSW, PLLC to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to Dr. Michele Winchester-Vega & Associates. I certify that the information I have reported with regard to my insurance coverage is correct. I understand **that if I fail to** report any changes to my insurance coverage, including termination, I will be responsible for any unpaid balances on my account.

Please sign below indicating that you have reviewed and understand these guidelines. A copy of these procedures will be provided to you upon request.

_____
Child Date

_____
Caregiver Date

_____
Caregiver Date

_____
Therapist's Signature Date

NYS Penal Law § 265.01-e makes it illegal to possess a firearm (pistol, rifle, shotgun, etc.) in a sensitive location, which includes locations providing behavioral health or chemical dependency services. No firearms or weapons (including but not limited to knives or instruments of blunt force) are allowed in the office of the Practice. Should any patient be found carrying firearms or weapons while in the office, the patient will be discharged from the Practice.

AUTHORIZATION TO TREAT MINORS

I_____, hereby give permission to

Dr. Michele Winchester-Vega & Associates to provide counseling and/or psychotherapy services

to my minor child, _____.
(Name of child)

I attest that I am the legal guardian of the above named child.

Relation to child:_____

Signature:_____

Date:_____

Witness:_____

Title:_____

Dr. Michele Winchester-Vega & Associates
3250 US Route 9W
New Windsor, NY 12553

Tel: 845-562-9816 Fax: 845-863-0351

To be completed by child

Name	Date	ID

	Please mark under the heading that best fits you or circle Yes or No	Never 0	Sometimes 1	Often 2
–	1. Complain of aches or pains			
–	2. Spend more time alone			
–	3. Tire easily, little energy			
●	4. Fidgety, unable to sit still			
–	5. Have trouble with teacher			
–	6. Less interested in school			
●	7. Act as if driven by motor			
●	8. Daydream too much			
●	9. Distract easily			
–	10. Are afraid of new situations			
▲	11. Feel sad, unhappy			
–	12. Are irritable, angry			
▲	13. Feel hopeless			
●	14. Have trouble concentrating			
–	15. Less interested in friends			
■	16. Fight with other children			
–	17. Absent from school			
–	18. School grades dropping			
▲	19. Down on yourself			
–	20. Visit doctor with doctor finding nothing wrong			
–	21. Have trouble sleeping			
▲	22. Worry a lot			
–	23. Want to be with parent more than before			
–	24. Feel that you are bad			
–	25. Take unnecessary risks			
–	26. Get hurt frequently			
▲	27. Seem to be having less fun			
–	28. Act younger than children your age			
■	29. Do not listen to rules			
–	30. Do not show feelings			
■	31. Do not understand other people's feelings			
■	32. Tease others			
■	33. Blame others for your troubles			
■	34. Take things that do not belong to you			
■	35. Refuse to share			
◆	36. During the past three months, have you thought of killing yourself?		☐ Yes	☐ No
◆	37. Have you ever tried to kill yourself?		☐ Yes	☐ No

● = A ≥ 7 ▲ = I ≥ 5 ■ = E ≥ 7 | Note — the sub scores do not impact the overall score; they are for interpretation purposes only.

TS _____

FOR OFFICE USE ONLY

Plan for Follow-up ☐ Annual screening ☐ Return visit w/ PCP ☐ Referred to counselor
☐ Parent declined ☐ Already in treatment ☐ Referred to other professional

Q 36 or Q 37=Y ◆ TS ≥ 30

Source: Pediatric Symptom Checklist – Youth Report (PSC-Y)

Child's Name _____ Record Number _____
Today's Date _____ Filled out by _____
Date of Birth _____

Pediatric Symptom Checklist **(To be completed by parent/guardian)**

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark an "X" under the heading that best fits your child.

			Never (0)	Sometimes (1)	Often (2)
1.	Complains of aches/pains	1	_____	_____	_____
2.	Spends more time alone	2	_____	_____	_____
3.	Tires easily, has little energy	3	_____	_____	_____
4.	Fidgety, unable to sit still	4	_____	_____	_____
5.	Has trouble with a teacher	5	_____	_____	_____
6.	Less interested in school	6	_____	_____	_____
7.	Acts as if driven by a motor	7	_____	_____	_____
8.	Daydreams too much	8	_____	_____	_____
9.	Distracted easily	9	_____	_____	_____
10.	Is afraid of new situations	10	_____	_____	_____
11.	Feels sad, unhappy	11	_____	_____	_____
12.	Is irritable, angry	12	_____	_____	_____
13.	Feels hopeless	13	_____	_____	_____
14.	Has trouble concentrating	14	_____	_____	_____
15.	Less interest in friends	15	_____	_____	_____
16.	Fights with others	16	_____	_____	_____
17.	Absent from school	17	_____	_____	_____
18.	School grades dropping	18	_____	_____	_____
19.	Is down on him or herself	19	_____	_____	_____
20.	Visits doctor with doctor finding nothing wrong	20	_____	_____	_____
21.	Has trouble sleeping	21	_____	_____	_____
22.	Worries a lot	22	_____	_____	_____
23.	Wants to be with you more than before	23	_____	_____	_____
24.	Feels he or she is bad	24	_____	_____	_____
25.	Takes unnecessary risks	25	_____	_____	_____
26.	Gets hurt frequently	26	_____	_____	_____
27.	Seems to be having less fun	27	_____	_____	_____
28.	Acts younger than children his or her age	28	_____	_____	_____
29.	Does not listen to rules	29	_____	_____	_____
30.	Does not show feelings	30	_____	_____	_____
31.	Does not understand other people's feelings	31	_____	_____	_____
32.	Teases others	32	_____	_____	_____
33.	Blames others for his or her troubles	33	_____	_____	_____
34.	Takes things that do not belong to him or her	34	_____	_____	_____
35.	Refuses to share	35	_____	_____	_____

Total score _____

Does your child have any emotional or behavioral problems for which she/he needs help? ☐ N ☐ Y
Are there any services that you would like your child to receive for these problems? ☐ N ☐ Y

If yes, what services?_____

©1988, M.S. Jellinek and J.M. Murphy, Massachusetts General Hospital

Patient Name:_____ DOB:_____ Date:_____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Scoring

Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Name:_____ Date:_____

Brief Trauma Questionnaire

The following questions ask about events that may be extraordinarily stressful or disturbing for almost everyone. Please circle "Yes" or "No" to report what has happened to you.

If you answer "Yes" for an event, please answer any additional questions that are listed on the right side of the page to report: (1) whether you thought your life was in danger or you might be seriously injured; and (2) whether you were seriously injured.

If you answer "No" for an event, go on to the next event.

Event	Has this ever happened to you?	If the event happened, did you think your life was in danger or you might be seriously injured?	If the event happened, were you seriously injured?
1. Have you ever served in a war zone, or have you ever served in a noncombat job that exposed you to war-related casualties (for example, as a medic or on graves registration duty?)	No	No Yes	No Yes
2. Have you ever been in a serious car accident, or a serious accident at work or somewhere else?	No	No Yes	No Yes
3. Have you ever been in a major natural or technological disaster, such as a fire, tornado, hurricane, flood, earthquake, orchemical spill?	No	No Yes	No Yes
4. Have you ever had a life-threatening illness such as cancer, a heart attack, leukemia, AIDS, multiple sclerosis, etc.?	No Yes	No Yes	N/A
5. Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that: you were very frightened; or you thought you would be injured; or you received bruises, cuts, welts, lumps or other injuries?	No Yes	No Yes	No Yes
6. Not including any punishments or beatings you already reported in Question 5, have you ever been attacked, beaten, or mugged by anyone, including friends, family members or strangers?	No	No	No Yes
7. Has anyone ever made or pressured you into having some type of unwanted sexual contact? Note: By sexual contact we mean any contact between someone else and your private parts or between you and some else's private parts	No	No Yes	No Yes
8. Have you ever been in any other situation in which you were seriously injured, or have you ever been in any other situation in which you feared you might be seriously injured or killed?	No	N/A	No Yes
9. Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attack?	No	N/A	No Yes
10. Have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed? Note: Do not answer "yes" for any event you already reported in Questions 1-9	No	N/A	N/A

Dr. Michele Winchester-Vega & Associates

Emergency Contact Form

For the purposes of this form, an *emergency* is any situation in which your clinician believes there is a medical crisis that requires urgent intervention, a significant decline in your mental health that warrants concern or a situation in which a clinician is concerned about your overall wellbeing. Examples include, but are not limited to:

- Missed appointments and no follow up from client after multiple attempts from clinician leading to concern regarding overall wellbeing of the client.
- Severe changes in mental status (e.g., inability to care for basic needs, extreme confusion, disorientation).
- Medical emergencies such as loss of consciousness, seizure, or other life-threatening conditions occurring during a session.
- Imminent risk of harm to self or others.

In such cases, your clinician may contact your emergency contact.

Primary Emergency Contact

- Name: _____
- Relationship with Client: _____
- Phone Number (Best contact): _____
- Client Signature: _____
- Printed Name: _____
- Date: _____

This consent will be revoked upon termination of services from the practice

or on the specified date _____.

Dr. Michele Winchester-Vega & Associates, 3250 Route 9W, New Windsor, NY 12553
Tel: 845-562-9816, Fax: 845-863-0351

Medical/Mental Health Collaboration Date: _____

Attn: Dr._____ Fax:_____

Medical Practice:_____ Address:_____

City/State/Zip: _____Tel: :_____

I, _____, DOB_____ hereby authorize_____
(Patient Name) *(Social Worker/Therapist)*

with Dr. Michele Winchester-Vega & Associates to converse with and to disclose information regarding my treatment

to_____ for the specific purposes of providing coordination and continuity of care.
(MD/NP/PA)

My medical provider shall not be entitled to any information beyond such treatment information without my written consent. I understand that this consent form shall remain in effect throughout the course of treatment. I understand that I may revoke this authorization at any time by this notifying my behavioral health provider in writing.

_____ _____
Signature (or parent or guardian) Date

_____ _____
Social Worker/Therapist Date

Patient was seen today (date)_____ Impressions include: _____

****

Medical Provider Please complete.

Dr. Michele Winchester-Vega & Associates know that our collaboration with you will improve our treatment outcomes. Please complete questions below:

MedicalHistory:_____

_____

_____

Height: _____ Weight: _____ BMI: _____

Medication(s) Prescribed: _____

_____

Comments:_____

_____

_____

Form completed by Dr/Staff Member Name:_____ Date:_____

Fax back Medical UPDATE (if needed) to Dr. Michele Winchester-Vega & Associates 845-863-0351

Dr. Michele Winchester-Vega & Associates, 3250 Route 9W, New Windsor, NY 12553
Tel: 845-562-9816, Fax: 845-863-0351

School Collaboration

Attn: Guidance/Social Worker_____ Fax:_____

School:_____Address:_____

City/State/Zip:_____Tele:_____

I, _____, DOB_____ hereby authorize_____
(Student Name) *(Social Worker/Therapist)*

with Dr. Michele Winchester-Vega & Associates to converse with and to disclose information regarding my treatment

to_____ for the specific purposes of providing coordination and continuity of care.
(MD/NP/PA)

School staff shall not be entitled to any information beyond such treatment information without my written consent. I understand that this consent form shall remain in effect throughout the course of treatment. I understand that I may revoke this authorization at any time by this notifying my behavioral health provider in writing.

_____ _____
Signature (or parent or guardian) Date

_____ _____
Social Worker/Therapist Date

Dr. Michele Winchester-Vega & Associates know that our collaboration with you will improve our treatment outcomes. Please complete questions below:

General Impressions:

Academic (ever delayed?):_____

_____

Received Academic Support Services? IEP or 504 accommodations? Tested? (Please attach copies of reports)

_____

_____

Behavior in class?_____

_____

Relationship with Peers? Staff?_____

_____

Parental involvement?_____

_____

Extracurricular activities?_____

_____

Anything else you think I should know?_____

_____

Form completed by Guidance Counselor/Social Worker:_____ Date:_____

Direct Telephone #_____

Please fax back to Dr. Michele Winchester-Vega & Associates - FAX 845-863-0351