**Eileen Siciliano, L.C.S.W.-R.** **Patient Registration**

Name: _____ SS#: _____

Street Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Marital Status: S M W Sep D

Telephone Home: _____ Cell #: _____ Referred by: _____

Email Address: _____

Emergency Contact: _____ Telephone #: _____ Relationship_____

***PATIENT EMPLOYER INFORMATION***

Employer Name: _____ Telephone #: _____
Employer street address: _____ City/State: _____
Patient's Occupation: _____

***INSURED PERSON (IF NOT PATIENT)***

Name: _____ Telephone #: _____
Street Address: _____ City/State: _____ Zip: _____
Relationship to Patient _____
Employer Address _____ City: _____ State: _____

***INSURANCE***

Medicaid # (if applicable): _____ Medicare # (if applicable) _____
Primary Insurance Company Name: _____ ID #: _____
Group #: _____ Telephone #: _____
Secondary Insurance Company Name: _____ ID#: _____
Group #: _____ Telephone #: _____

***INFORMATION AND ASSIGNMENT OF BENEFITS***

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date: _____ Signature: _____

I hereby authorize Eileen Siciliano, L.C.S.W.-R (or to the party who accepts assignment). I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date: _____ Signature: _____
(Patient, parent or guardian)

# INITIAL INTAKE

## CONTACT INFORMATION

| **CLIENT NAME:** | **DOB:** | **Gender:** |
|---|---|---|
| Client Address: | | |
| Email: | | |
| H Phone: | C Phone: | |
| OK to leave message: ❑ Yes ❑ No | OK to leave message: ❑ Yes ❑ No | |

## REFERRAL

| Referred by: | OK to contact: ❑ Yes ❑ No |
|---|---|
| Phone: | Email: |

## REASON FOR SEEKING SERVICES

## INSURANCE (Complete if using insurance.)

| Insurance: | Insurance #: |
|---|---|
| Insured if not client: | DOB of Insured if not client: |
| Insurance Phone: | |

## FEE FOR SERVICE (Complete if not using insurance)

| Standard therapist fee: | Fee Adjustment if necessary: |
|---|---|
| Rational for adjustment: | |

## APPOINTMENT CONFIRMED

❑ Yes ❑ No Date of 1st Appointment: _____

# Insurance

## Information and Authorization to Bill Insurance Company

| **Client Name:** | **DOB:** | **Gender:** |
|---|---|---|
| Client Address: _____, _____, _____ _____ Street address City State Zip code | | |
| Cell Phone: | Home Phone: | Relationship to ensured: |
| **Policy Holder Name** (if different than client)**:** | | **DOB:** |
| Policy Holder Address: _____ _____, _____ _____ Street Address City State Zip Code | | |
| Cell Phone: | Home Phone: | Work Phone: |
| **Primary Insurance Company:** | | |
| Policy #: | | Behavioral Health Phone #: |
| Deductible: $ | Deductible met: $ | Co-pay: $ / Authorization needed after session #: |
| Address for primary insurance company for filing claims by mail: _____ _____, _____ _____ Street Address City State Zip Code | | |
| **Secondary Insurance Company:** | | |
| Policy #: | | Co-pay: $ |
| Address of secondary insurance company for filing claims by mail: _____, _____, _____ _____ Street Address City State Zip | | Behavioral Health Phone #: |
| **Name of person responsible for payment if not client:** | | |
| Address: _____ _____, _____ _____ Street Address City State Zip Code | | |
| Phone: | Email: | |
| **Is treatment related to an auto accident?** ❑ Yes ❑ No | **Is treatment related to a work accident?** ❑ Yes ❑ No | |

**Please read and initial:**

____ I hereby acknowledge that I give Eileen Siciliano, LCSW, permission to bill my insurance company. I understand that I am responsible for payment should my insurance company declare that my treatment is not medically necessary, refuses to authorize treatment and/or is not covered under your policy.

____ If my insurance is a company which Eileen Siciliano does not accept, I agree to pay Eileen Siciliano, directly for each session. Upon request, Eileen Siciliano, LCSW, will write a receipt for you, the client, to submit to your insurance company for reimbursement.

____ If I do not use my current insurance now but choose to use it in the future, I will not ask Eileen Siciliano, LCSW, to submit for sessions already received.

____ I understand that if I have any questions regarding the use of my insurance, I can contact Eileen Siciliano LCSW, at 516-746-2972 or at

| **Person responsible for payment if not client:** | |
|---|---|
| Phone: | Email: |
| Relationship to client: | |

_____ _____

**Signature of Client** **Date**

_____ _____ _____

**If a minor, Signature of Parent, Guardian or Personal Representative** **Relationship to minor** **Date**

**Eileen Siciliano, LCSW**
NY License # 053336
42 Ogden Avenue, East Williston NY 11596
516-746-2972; eslcsw@yahoo.com

# Client Rights and Responsibilities

I am strongly committed to respecting the basic human rights, worth and dignity of each person receiving services. In addition, you have the legal rights which are guaranteed by the constitution and state and federal laws and regulations. You also have responsibilities regarding your treatment. These rights and responsibilities are:

## The Right of Confidentiality

The right of confidentiality of all records and communications, as provided by Federal law with a few exceptions:

- If I suspect child or elder abuse is suspected.
- If I suspect you may harm yourself or someone else.
- If I receive a court order.
- If you enter into litigation against me.
- If you have an outstanding bill, I can use a collection agency.
- If the client is a minor, I may discuss aspects of the client's care with the client's parents or legal guardians.
- If I seek consultation with another professional about your case.

## The Right to Treatment

- The right to have all reasonable requests responded to promptly and adequately.
- The right to ask for and obtain a copy of all rules and policies which apply to clients.
- The right and responsibility to choose a therapist and mode of treatment that meets your needs. The modalities I use include but are not limited to: Internal Family Systems, CBT, Mindfulness, EMDR, Behavior Modification.
- The right to ask questions about my training, therapeutic approach, and progress of treatment.
- The right to be informed, when treatment begins, of expected results and/or side effects of treatment.
- The right to refuse treatment, unless court ordered.
- The right to life-saving treatment.
- The right to refuse to be a research subject.
- The right to adequate care or to be referred to another provider.
- The right to request the name and specialty of any person responsible for care or coordination of care.
- The right to revoke your authorization, in writing, to release or discuss your medical record except when action has already been taken.

## The Right of Informed Consent

- The right of confidentiality of all records and communications, as provided by Federal law with a few exceptions: If child or elder abuse is suspected; if I suspect you may harm yourself or someone else, if I receive a court order; if you enter into litigation against me; if you have an outstanding bill, I can employ a collection agency.
- The right and responsibility to participate in developing a treatment plan with your therapist.
- The right to receive and read a copy of your medical record, as long as doing so causes no harm.
- The right to maintain HIV status as confidential unless you provide written consent.
- The right to receive an itemized bill, including third party reimbursement paid toward the bill.

## The Right of Protection from Mistreatment

- The right to be treated in a manner which is ethical and free from abuse, discrimination and/or exploitation, meaning no romantic or sexual relationship, and your story will not be turned into a movie, book or TV show.
- The right to know that the therapeutic relationship will not be leveraged in an inappropriate manner or develop into a dual relationship.
- The right to be treated with respect no matter your culture, gender, sexual orientation, sexual preference, ability, and religion.

**The Right to File a Complaint**

If you are concerned about your clinical care and client rights, please speak with me in session or contact me in writing. You may also file a complaint with your State department of health and my licensing board.

New York State Department of Professions: 518- 474-3817

**Client Responsibilities**

- To keep your schedule appointments and let me know if you cannot keep it by giving 24 hours of notice.
- To be as honest and as open as possible.
- To think through any insights or concerns you are addressing between sessions.
- To follow through on treatment recommendations and complete any homework agreed upon during session.
- To have a termination session rather than not keeping your last appointment.
- To call 911 or go to your nearest emergency department if you feel you are in danger of harming yourself and then to inform me.

If you have any questions or concerns about your rights and responsibilities, I invite you to please bring them up in session.

Signing this document acknowledges that I have read and understand my rights as a client and have received a copy of them. I have also had the opportunity to ask questions.

_____ _____

Client printed name Date

_____

Client signature

_____ _____

Psychotherapist printed name Date

_____

Psychotherapist signature

  

**Eileen Siciliano, LCSW**
NY License# 053336
42 Ogden Avenue, East Williston, NY 11596
516-746-2972; eslcw@yahoo.com

# Notice of Privacy Practices
# HIPIAA

## Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
**Please review it carefully.**

### Your Rights
You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

### Our Uses and Disclosures
We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Comply with the law
- Respond to organ and tissue donation requests
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

### Your Rights
**When it comes to your health information, you have certain rights.**
This section explains your rights and some of our responsibilities to help you.
**Get an electronic or paper copy of your medical record**
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record**
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

**Ask us to limit what we use or share**

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

### Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

## Our Uses and Disclosures

### How do we typically use or share your health information?

We typically use or share your health information in the following ways.

**Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

**Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

**Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

## How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

## Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

## Other Instructions for Notice

- Insert Effective Date of this Notice: _____
- Name of Privacy Official: Eileen Siciliano, 42 Ogden Avenue, East Williston, NY 11596; eslcsw@yahoo.com.
- We never market or sell personal information.
- We will never share any substance abuse treatment records without your written permission.
- This information also applies to Billing Solutions.

# Notice of Privacy Practices (HIPAA) Acknowledgment

**Name:** _____ **Date of Birth**: _____

I, _____ have received a copy of Notice of Privacy Practices.
**Name of client or personal representative**

_____ _____
**Client signature** **Date**

Or

_____ _____
**Signature of client's personal representative** **Date**

**If signed by a personal representative, state your relationship to patient and/or reason and legal authority for signing below.**
Client is: ❑ minor ❑ incompetent ❑ disabled ❑ deceased
Legal authority is: ❑ parent ❑ legal guardian ❑ next of kin of deceased

**This Notice of Privacy Practices was given by:**
❑ face to face meeting ❑ mail ❑ email ❑ other

**Reason Individual or Personal Representative did not sign this form:**
❑ Individual or Personal Representative chose not to sign
❑ Individual or Personal Representative did not respond after more than one attempt
❑ Email receipt verification
❑ Other _____

**Good Faith Efforts:** The following good faith efforts were made to obtain the individual or Personal Representative's, if applicable, signature. Please document with detail dates/s, time/s, individual/s spoken to and outcome of attempts, the efforts that were made to obtain the signature. More than one attempt must have been made.
❑ Face to face presentation/s _____
❑ Telephone contact/s _____
❑ Mailing/s _____
❑ Email _____
❑ Other _____

**Staff or Clinician Signature:** _____ **Title:** _____

**Print Name:** _____ **Date:** _____

# Tele-mental Health Informed Consent

I, _____ (name of client) hereby consent to participate in tele-mental health with Eileen Siciliano, LCSW (name of provider) as part of my psychotherapy. I understand that tele-mental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to tele-health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

3) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to tele-mental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

4) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that tele-mental health services are not appropriate and a higher level of care is required.

5) I understand that I am responsible for: a) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, b) ensuring security on my computer, and c) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

6) I understand that during a tele-mental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at 5167462972 to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

## Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

My emergency contact person's name is: _

My emergency contact person's contact information is: _____

Phone: _____ Email: ____

Address: _____

_____ _____ _____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____

Signature of client/parent/legal guardian Date

_____

Signature of therapist Date

*The information is provided as a service to members and the social work community for educational and information purposes only and does not constitute legal advice. We provide timely information, but we make no claims, promises or guarantees about the accuracy, completeness, or adequacy of the information contained in or linked to this Web site and its associated sites. Transmission of the information is not intended to create, and receipt does not constitute, a lawyer-client relationship between NASW, LDF, or the author(s) and you. NASW members and online readers should not act based on the information provided in the LDF Web site. Laws and court interpretations change frequently. Legal advice must be tailored to the specific facts and circumstances of a particular case.* ***Nothing reported herein should be used as a substitute for the advice of competent counsel.***

**Eileen Siciliano, LCSW**
**053336-01**
42 Ogden Avenue East Williston, New York 11596
516-746-2972

# OFFICE POLICIES, INFORMATION & AGREEMENTS

Welcome. Before we begin out work together, it is important that you have information about my professional services and business policies. This document is our working AGREEMENT that we both understand the parameters of our work together.

**CONFIDENTIALITY:** Your work here is confidential and protected by HIPAA & state statutes. Please see the separate HIPAA document for full details.

**LENGTH OF SESSION:** Standard sessions are 45 – 50 minutes. Some sessions can be 55 minutes. The length depends on what you need and if you use insurance, if your carrier covers the longer session.

**PROFESSIONAL FEES/PAYMENT:**

**Session Fee:** My standard fee for the Initial Session without insurance is: 150.00. My fee for subsequent sessions is: 100.00.

Payment of agreed upon fee is due at time of appointment. If a check is returned there will be a charge equivalent to what the bank charges Eileen Siciliano. Eileen Siciliano has the right to raise the fee at any time, though usually once per year.

**Insurance & copays:** I currently accept [INSURANCE PLANS]. Your co-payment is expected at the time of service at the beginning of the session. I will bill your insurance company for the balance. For those insurances I do not accept, I am glad to give you an insurance acceptable receipt for fees paid, also referred to as a Superbill. In accordance with HIPAA we will discuss any diagnosis that is required for you to get reimbursed by your insurance carrier.

You are responsible for using your insurance in any way that serves you. It typically provides some coverage for mental health treatment. *It is very important that you find out exactly what mental health services your insurance policy covers; your copay, your deductible, if you have met it, and if not, how much is left.* I fill out the forms and assist you in receiving these benefits to which you are entitled and make every reasonable effort to collect payment from your insurance company. ***You agree that you are 100% responsible for any payment not made by your insurance company*.**

**Additional insurance information:** Your contract with your health insurance company requires that I provide it with information relevant to the services I provide, which includes a clinical diagnosis. Sometimes I am required to furnish additional clinical information such as treatment plans or summaries, progress notes, or copies of your clinical record. I make every effort to release only the minimum information that is necessary for the purpose requested. This information will become part of the insurance company files and will be stored [IN MY PASSWORD PROTECTED COMPUTER AND ENCRYPTED PROGRAM, IN AN ONLINE PROGRAM, OR OTHER]. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. It is my policy to review any report to an insurer with you prior to submitting it. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

**Insurance Audits:** Insurance companies can perform what is called an "audit" on my notes to determine whether your diagnosis, symptoms, and treatment meet the conditions of "medical necessity" or accepted standards of medical practice. (For a full definition of medical necessity, please see this link: https://definitions.uslegal.com/m/medical-necessity/.) If your symptoms do not meet criteria, the insurance company can deny or limit your coverage. I make every effort to document our work together to meet the standards of medical necessity. However, some people simply do not have the symptoms necessary for a clinical diagnosis. This does not mean that therapy is unwarranted. It simply means that a diagnosis cannot be ethically applied to your problem and thus, not covered by insurance. If coverage is denied, you will be responsible for the cost and need to decide whether you want to proceed with treatment.

**Additional Fees:** If additional reports or meetings not covered by the insurance company are needed, you agree to pay Eileen Siciliano, for the time it takes to write these reports and/or attend these meetings. Reports that would incur a fee

would be for but not limited to: a disability claim, Workman's Compensation, a review of treatment for an attorney. Meetings that would incur a fee are, but not limited to: attending an IEP meeting, speaking with an attorney and testifying at court. If I am needed for court, fees may include time lost for cancelled sessions, time for preparation, travel, or waiting, even if the need for testimony is cancelled.

**CANCELLATIONS:** Your time is set aside just for you. If you need to change your appointment, please give me as much notice as possible. **There will be a charge of $100.00 for any missed appointment with less than 24 hours of notice.** If possible, I will reschedule your appointment for the same week should my time allow. In that case, you will not be charged a cancellation fee.

**Emergency Cancellations**

*Emergency cancellation are events beyond your control such as snowstorms, car accidents, funerals, hospitalization, or an illness that would keep you out of work.* This policy applies to clients who use their insurance and those who do not. I cannot charge insurance companies for missed appointments, so you will be responsible for the contracted amount your insurance company pays me as well as your copay. This policy applies to an appointment you did not cancel because you decided not to continue counseling, an appointment you "forgot", an appointment which conflicts with another one you made, or if you choose to do something that is important to you rather than come to counseling.

**Repeat cancellations**

If you cancel *two* consecutive appointments before rescheduling, or have a history of cancelling multiple times, we will need to discuss your treatment goals and whether you are able to commit yourself to counseling at this time.

**No-Show:** If you do not show up for your appointment and do not contact me within 1 week to confirm your next appointment, I will assume that therapy no longer fits into your life and will terminate services. You will be informed by letter.

**REACHING ME / EMERGENCIES**: Voice mail is available 24 hours a day. I return calls as soon as possible. You can also reach me by email and text. *It is helpful if you give me several alternate times to call you back.* I do not have 24-hour coverage and if you need such coverage, we will need to decide how to handle it. In case of an emergency please leave a message stating the emergency on my voice mail, call your other supports, hotlines, community mental health center. Go to your local emergency hospital or call 911 if you cannot wait for a call back from me. During vacations, I will provide you with the name of an alternate therapist should you need to speak with someone.

**INCLEMENT WEATHER**

If the roads are dangerous and the city has issued a traffic advisory, we will not meet, and you will not be billed for the session. For those who do not use insurance and for those whose insurance covers video conferencing, we can do a video session instead of meet in person, if you would like. We will discuss this when the situation arises.

**CONTACTING ME**

**Phone Calls:** I am glad to answer occasional short calls (5-10 minutes) in between sessions. If we need to spend more time to handle a difficulty that has arisen, I am glad to do so. The time is billed at my full fee, in 15-minute increments starting from the time the call began, even if the full 15 minutes are not used. Phone call sessions are not covered by most insurance companies. It is your responsibility to find out if they are covered.

**Email and Text:** Because I do not use encrypted email and texting, I prefer that you use them primarily to arrange or modify appointments, or to let me know you are running late. I check emails and texts regularly during the day and much less frequently on the weekend.

I am in my office Monday through Thursday, but I will not answer the phone when I am with a client. When I am unavailable, my telephone goes to voice mail. I will make every effort to return your call within 24 hours, excepting weekends and holidays. In an emergency, if you are unable to reach me and feel that you can't wait for a return call, contact your family physician or the nearest emergency room and ask for the psychotherapist or psychiatrist on call.

**CONFIDENTIALITY**

The law protects the privacy of all communications between a patient and psychotherapist. In most situations I can release information about your treatment to others only if you sign a written authorization form that meets the HIPAA requirements.

There are some situations in which I am legally bound to take actions without a signed release. These situations are unusual

in my practice and if they should arise, I will discuss the situation with you either before taking action if possible and definitely after. I will limit my disclosure to only what is necessary. These limits are:

- If I have reason to suspect child or elder abuse or neglect or abuse of a disabled person. A child is anyone under 18 years of age. An elder is a person 60 years and older. In case of such circumstances, I must report this to the appropriate agency.
- Once such a report is filed, I may be required to provide additional information.
- If, in my professional opinion, you are in immediate danger of harming yourself, I may be obliged to seek hospitalization for you or to contact family members or others who can help provide protection.
- If I suspect that you pose an immediate threat to harm another person, I am required to take action which includes, but is not limited, to, notifying the potential victim and the police.

There are some situations where I am permitted or required to disclose information without either your consent or authorization.

- If you are involved in a court proceeding, your PHI (Protected Health Information) is protected by the therapist-client privilege law. I cannot provide any information without your written authorization or a court order.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it.
- If you file a complaint or lawsuit against me, I may disclose relevant information regarding your treatment in order to respond to the complaint.
- If you file a Workers' Compensation claim, your records relevant to that claim will not be confidential to entities such as your employer, the insurer and the Division of Worker's Compensation.

**Additional Disclosures**

I may find it helpful to consult other health and mental health professionals about your case. During a consultation, I make every effort to protect your identity. The other professionals are also legally bound to keep the information confidential. Consultations are noted in your Clinical Record (PHI) to protect the privacy of your information.

Please be aware that I practice with other mental health professionals and employ administrative staff. At times I need to share protected health information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. These other professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and will not release any information without the approval of a professional staff member.

**PROFESSIONAL RECORDS**

My professional standards and ethics require that I keep a record of our work together. These records are organized into two separate sections as follows.

**The Clinical or Medical Record:** This Protected Health Information (PHI) includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Upon written request you may examine and/or receive a copy of your Clinical Record, unless I believe that access would be harmful to you. In those situations, you have a right to a summary and to have your record sent to another mental health provider or your attorney. In most situations I am allowed to charge a copying fee of $0.25 per page up to 100 pages, and I may charge for certain other expenses. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon your request. Your records are stored for 7 years from the date of the record.

**Psychotherapy Notes**

Another section of your PHI consists of my Psychotherapy Notes. These are designed to assist me in providing you with the best possible treatment. Psychotherapy Notes vary from patient to patient, and can include the contents of our conversations, my analysis of those conversations, and how they impact your therapy. While insurance companies, attorneys, etc. can request and receive a copy of your Clinical or Medical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written authorization. The one exception is if a judge demands them. Insurance companies cannot

require your authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes unless I determine that it would adversely affect your well-being, in which case you have a right to a summary and to have your record sent to another mental health provider or your attorney. Again, I am allowed to charge a copying fee of $0.25 per page up to 100 pages.

Should I be required to provide the insurance company with your PHI, I make every effort to release only the minimum information that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. It is my policy to review any report to an insurer with you prior to submitting it. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

**MINORS & PARENTS**
Patients under 18 years of age and their parents should be aware that the law allows parents to examine their child's treatment records, unless I believe this review would be harmful to the patient and his/her/their treatment. I typically provide parents with general information about the progress of the child's treatment. If I feel that the child is in danger or is a danger to someone else, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any concerns he/she/they may have. A minor's records are stored until the minor is 21 years of age.

**THERAPIST VACATION, SICK TIME, JURY DUTY**
If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

**TERMINATION OF SERVICES**
Ending therapy can be a very empowering process whether terminating because you have reached your goals, are moving, or are unhappy with our work. Planning for the end of therapy and having a final session is ideal. We discuss what worked, what didn't work, what you accomplished and what work may be left. *Email, texts and voice mail are not an appropriate way to terminate services.* Signing this agreement means you agree to a termination session.

**MINDBODY PSYCHOLOGY:** [EMDR, TAPPING], psychotherapy techniques I use in my practice, are useful in creating a relaxed state of being. Utilizing such mind/body techniques may also alter (reduce the trauma attached to the event) or change memory of a traumatic event. If you are involved in a legal issue, this alteration may affect legal proceedings. It is possible that other memories of traumatic events may surface when these mind/body techniques. I will make every effort to support you through this time should it arise. If you do not wish for me to utilize these methods, it is your right and responsibility to let me know.

**Signing this document indicates that you have read, had the opportunity to ask questions, and understand and agree to these policies.**

**Client Name:** _____ **Client Date of Birth:** _____

**Client Signature:** _____ **Date:** _____

**Psychotherapist Name:** _____

**Psychotherapist Signature:** _____

**Eileen Siciliano, LCSW**
NY 053336
42 Ogden Avenue, East Williston, NY 11596 516-746-2972

# Social Media Policy

In the age of social media, having a policy about its use has become important for the confidentiality of both the client and the therapist. Given how quickly technology develops and changes, it may be necessary to update this policy. In this case, you will get a revised version of any changes in writing. This is an addendum to the other Information and policy form.

**SOCIAL MEDIA SITES**
I do not accept friend or contact requests from current or former clients on Facebook, LinkedIn, Twitter, Instagram or any other social media platform. Having clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

Though you may have found me on a social media site, like psychologytoday.com or viewed my website, I will do not do Google searches on you, preferring we get to know each other by what you tell me – or unless you want me to review something important to you and give me written permission to do so. An extremely rare exception would be in a time of crisis. For example, if I suspect you are in danger, if you have been missing appointments without notice or if you have not been in touch with me using your usual mode of communication (email, text, phone), then doing a Google search to find someone close to you may be necessary so I can check on your welfare. This unusual situation will be fully documented and discussed when we next meet. Finally, if I suspect that I am in danger for any reason, by any statements or behaviors you have made, I may rely on search engines for further information about you.

**TEXTS, VOICE MAIL and EMAILS**
Texts and Voice Mail: While convenient for letting me know you are running late or need to reschedule, texts and voice mail are not secure and should not be used for communicating therapeutic information.
Emails: Email is also not secure unless you use an encrypted email program. (I do not.) This means that emails are vulnerable to unauthorized people and can compromise your confidentiality. Any emails you may choose to send with personal content related to your therapy sessions will become part of your legal record. I will respond to your email in session.

**Telehealth**
We may use Zoom or a different HIPPA compliant site to do video conferencing. Some insurance companies cover video conferencing. Others do not. If your insurance cannot be billed or you don't use insurance for psychotherapy and you still choose to meet via video conferencing, full payment will be your responsibility. If you normally use insurance, the cost of the session will be your copay plus what is reimbursed by your insurance company. It is your responsibility to find out if your insurance company covers telehealth. If you do not use insurance, the cost will be the regular session fee.

**ONLINE REVIEW SITES**
I do not solicit psychotherapy testimonials nor am I part of any online review site. If you decide to post anything about our work together on one of these sites, it is doubtful I will see it. Even if I do, maintaining your confidentiality is a top priority for me. I take your privacy seriously and encourage you to do the same. Should you decide to share anything on one of these public business review sites, either positive or negative, please consider using an alias to protect your privacy. Finally, I would encourage you to bring any feelings you have about your therapy and/or me, to your sessions as this can be an important part of therapy.

**CONCLUSION**
Thank you for taking the time to read my social media policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, please bring them to my attention so that we can discuss them.

**Signing this document indicates that you have read and understand this social media policy.**

**Name**_____ **Date**_____
Print

**Signature:** _____

**Eileen Siciliano, LCSW-R**
NY# 053336
42 Ogden Avenue, East Williston, NY 11596
516-746-2972; eslcsw@yahoo.com

# RELEASE OF MEDICAL INFORMATION

I, _____, _____ give permission to
name of client date of birth
Eileen Siciliano, LCSW to speak with the following person or persons in order to share information regarding my psychotherapy treatment.

This permission is good for:

- ❑ Intake and discharge information
- ❑ Medication review
- ❑ Any information pertaining to psychotherapy
- ❑ Any information pertaining to alcohol and drug use
- ❑ Any information pertaining to HIV status

I have the right to rescind this release at any time by writing Eileen Siciliano, LCSW that I choose to rescind this permission. This release is good until then or one year from date of this document.

NAME of PROVIDER: _____
ADDRESS: _____
_____
ZIP _____
PHONE: _____
FAX: _____

Client Signature: _____

Date: _____

Or

Signature of parent or guardian: _____

Date: _____

## BIOGRAPHICAL DATA

Date: _____ Name: _____

1. Date of Birth: Month _____ Day _____ Year _____

2. Marital Status (Check one):

   - ☐ Single
   - ☐ Married
   - ☐ Divorced
   - ☐ Widowed

3. Occupation _____

4. Education: (Higher year completed) _____ Degree(s) _____

5. Next of Kin in case of emergency _____ Phone # _____

6. Members of household:

| Name | Relationship to Patient | Occupation | Date of Birth |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**7. Members of family not living in household:**

| Name | Relationship to Patient | Occupation | Date of Birth |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**List the names of family members who are currently in treatment:**

_____ _____

_____ _____

## SCREENING MEDICAL HISTORY AND PRESENT PHYSICAL CONDITION

Name (Please print full name): _____

Do you have any history of:

A. Hospitalization ☐ Yes ☐ No
If yes, Describe: _____

B. Serious Accident ☐ Yes ☐ No
If yes, Describe: _____

C. Surgery

D. Allergies

E. Please check (X) if yes:

- ☐ Eye Disease
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Prostate
- ☐ Loss of Consciousness or fainting
- ☐ Seizure Disorder (Epilepsy)
- ☐ Diabetes
- ☐ Lung Disease
  Asthma, Emphysema, Tuberculosis
- ☐ Gastrointestinal Disease, ulcers
- ☐ High blood pressure
- ☐ Have you ever been diagnosed with cancer?
  If so, what type and at what age?
- ☐ Do you smoke?
- ☐ Drug problem
- ☐ Other

F. Date of most recent physical examination: _____

G. Abnormal Laboratory Tests: _____
Name of Family Physician _____
Address: _____
Phone #: _____

H. What medication, if any, is currently prescribed for you: (if none, write "**None**")

_____ _____ _____

_____ _____ _____

Patient's signature: _____ Date: _____

[redacted]: _____

*Member's Name:* _____

*Date*: _____ _____

**Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully and check off your response.**

| | Not at All (0) | Several Days (1) | More Than Half The Days (2) | Nearly Every Day (3) |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | | | | |
| 2. Feeling down, depressed or hopeless | | | | |
| 3. Trouble falling asleep, staying asleep, or sleeping too much | | | | |
| 4. Feeling tired or having little energy | | | | |
| 5. Poor appetite or overeating | | | | |
| 6. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down | | | | |
| 7. Trouble concentrating on such things as reading the newspaper or watching TV | | | | |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have moving around a lot more than usual | | | | |
| 9. Thinking that you would be better off dead or that you want to hurt yourself in some way | | | | |

*This Section for Mental Health Use Only*

- **Total Score:** _____
- **Check *One*:** o Initial PHQ o Follow Up PHQ

# THE MOOD DISORDER QUESTIONNAIRE

**Instructions:** Please answer each question as best you can. Upon completing this form, you will be able to print your completed form and take it to your health care practitioner.

**1. Has there ever been a period of time when you were not your usual self and...**

| | | |
|---|---|---|
| ...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? | ○ Yes | ○ No |
| ...you were so irritable that you shouted at people or started fights or arguments? | ○ Yes | ○ No |
| ...you felt much more self-confident than usual? | ○ Yes | ○ No |
| ...you got much less sleep than usual and found you didn't really miss it? | ○ Yes | ○ No |
| ...you were much more talkative or spoke much faster than usual? | ○ Yes | ○ No |
| ...thoughts raced through your head or you couldn't slow your mind down? | ○ Yes | ○ No |
| ...you were so easily distracted by things around you that you had trouble concentrating or staying on track? | ○ Yes | ○ No |
| ...you had much more energy than usual? | ○ Yes | ○ No |
| ...you were much more active or did many more things than usual? | ○ Yes | ○ No |
| ...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night? | ○ Yes | ○ No |
| ...you were much more interested in sex than usual? | ○ Yes | ○ No |
| ...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? | ○ Yes | ○ No |
| ...spending money got you or your family into trouble? | ○ Yes | ○ No |

**2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?** ○ Yes ○ No

**3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please select one response only.**

○ No Problem ○ Minor Problem ○ Moderate Problem ○ Serious Problem

Process Reset

# General Anxiety Disorder (GAD-7)

**Feeling nervous, anxious, or on edge**

- [ ] Not at all
- [ ] Several days
- [ ] More than half the days
- [ ] Nearly everyday

**Not being able to stop or control worrying**

- [ ] Not at all
- [ ] Several days
- [ ] More than half the days
- [ ] Nearly everyday

**Worrying too much about different things**

- [ ] Not at all
- [ ] Several days
- [ ] More than half the days
- [ ] Nearly everyday

**Trouble relaxing**

- [ ] Not at all
- [ ] Several days
- [ ] More than half the days
- [ ] Nearly everyday

**Being so restless that it's hard to sit still**

- [ ] Not at all
- [ ] Several days
- [ ] More than half the days
- [ ] Nearly everyday

**Becoming easily annoyed or Irritable**

- [ ] Not at all
- [ ] Several days
- [ ] More than half the days
- [ ] Nearly everyday

**Feeling afraid as if something awful might happen**

- [ ] Not at all
- [ ] Several days
- [ ] More than half the days
- [ ] Nearly everyday