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)

Eileen Siciliano, L.C.S.W.-R.
50 Ackerly Pond Lane
Southold, New York 11971
(516)7462972

Patient's Name _____ Date _____

PRIVACY NOTICE

Your Privacy is Important:
Eileen Siciliano, L.C.S.W.-R. understands your privacy is important. You have received this notice in accordance with applicable state and federal laws and because you are a current or potential patient. This notice will help you understand what types of nonpublic personal information – information about you that is not publicly available – we may collect, how we use it, and how we protect your privacy.

This is a summary of our Privacy Practices – if you would like more information, please inquire with the therapist

Eileen Siciliano, L.C.S.W.-R's Privacy Policy Highlights:

- We collect nonpublic personal information to process and administer our patients' business.
- We have policies and procedures in place to protect nonpublic personal information about our patients or their families.
- We do not sell nonpublic personal information about our patients or their families to third parties, i.e., companies or individuals that are not affiliated with us.
- We do not disclose any nonpublic personal information about our patients or their families to anyone, except as permitted by law.
- We disclose your private health information routinely to insurance companies, other providers, and others for purposes of treatment, payment, and healthcare operations.
- For all other purposes, we will either obtain your authorization or remove all information that could identity you as an individual.
- Our Privacy Policy applies to both current and former patients.

Questions and Answers that detail Eileen Siciliano, L.C.S.W.-R.'s Privacy Policy:
What types of nonpublic personal information does Eileen Siciliano, L.C.S.W.-R. collect:
Eileen Siciliano, LCSW-R's employees, representative, agents and selected third parties may collect nonpublic personal information about our patients or their families, including:

- Information provided to us, such as on applications or other forms.
- Information about transactions with affiliates, our third parties, or us.
- Information from others, such as credit reporting agencies, employers, and federal or state agencies.

THIS PRIVACY NOTICE IS PROVIDED TO YOU FOR INFORMATIONAL PURPOSES ONLY.
YOU DO NOT NEED TO CALL OR TAKE ANY ACTION IN RESPONSE TO THIS NOTICE.
WE RECOMMEND THAT YOU READ AND RETAIN THIS NOTICE FOR YOUR PERSONAL FILES.

Eileen Siciliano, LCSW
50 Ackerly Pond Lane
Southold, New York 11971
516-746-2972

AUTHORIZATION TO PROVIDE INFORMATION TO PRIMARY CARE PHYSICAN

Patient Consent to Exchange Information Health Plan_____

I _____, authorize/do not authorize Eileen Siciliano,
Please Print **Circle one**

my behavior health provider, and _____
Primary Care Physician Name

_____
Primary Care Address and Phone Number

To exchange information regarding my mental health and medical healthcare for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care or substance abuse care and/or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for one year from the date of my signature below, or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral healthcare provider. I also understand that it is my responsibility to notify my behavioral healthcare provider if I choose to change my Primary Care Physician.

_____ _____
I Authorize Communication between my PCP and Eileen Siciliano, LCSW Date

_____ _____
I Do Not Authorize Communication between my PCP And Eileen Siciliano, LCSW Date

_____ _____
Signature of parent or guardian if pt. is a minor Date

_____ _____
Witness Date

Eileen Siciliano, LCSW-R

PATIENT RESPONSIBILITY FOR PAYMENT

I understand that I am financially responsible for all services rendered, for the following reasons:

- Expenses not covered by my insurance company
- I do not have the required referral form or required authorization
- I have not met my deductible
- The services rendered are deemed unnecessary by the insurance company
- All copays (I must notify therapist of any changes in the amount of the copayment)
- I am responsible for a **$75 fee** for appointments which are missed or not cancelled within 24 hours

This applies to present and future visits

_____ _____

Signature of Patient or Authorized Representative Date

_____

Print Name

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: _____

Physician/Nurse Review Signature: _____

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