Eileen Siciliano, L.C.S.W.-R.
NY License #–053336 || FL License #–SW21379

Client Registration

Name:						**Date of Birth:**	
Pronouns:	☐	**She/Her**	☐	**He/Him**	☐ **They/Them**	☐	**Other: _____**
Street Address:							
City:			**State:**			**Zip Code:**	
Home Phone:				**Cell Phone:**			
OK to leave message:	**Yes** ☐ **No** ☐			**OK to leave message:**		**Yes** ☐ **No** ☐	
Email Address:							

Referral Information

Referred by:		**OK to contact:**	**Yes** ☐ **No** ☐
Telephone:		**Email Address:**	

Biographical Data

Marital Status:	☐	**Single**	☐	**Married**	☐ **Widow**	☐	**Separated**	☐	**Divorced**
Occupation:			**Education (Highest Degree Completed):**						
Employer Name:						**Telephone:**			
Employer Street Address:						**City/State:**			

Members of Household:

Name	Relationship to Client	Occupation	Date of Birth

Members of Family Not Living in Household:

Name	Relationship to Client	Occupation	Date of Birth

List of Names of Family Members Who are Currently in Treatment:

_____ _____

_____ _____

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Medical History and Present Physical Condition

Name: | **Date of Birth:**

Do you have any history of:

A. Hospitalization Yes ☐ No ☐
If yes, please describe: _____

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

C. Surgery Yes ☐ No ☐
If yes, please describe: _____

D. Allergies Yes ☐ No ☐
If yes, please describe: _____

Please check (X) if you experience any of the following:

Eye Disease	☐	Gastrointestinal Disease	☐	Diabetes	☐
Heart Disease	☐	Lung Disease	☐	Loss of Consciousness	☐
Kidney Disease	☐	High Blood Pressure	☐	Cancer	☐
Liver Disease	☐	Seizure Disorder	☐	If so, what type? _____	

What other health issues do you face? (if none, write "none" or "n/a"): _____

Do you have any history of:

A. Smoking or Vaping Yes (Smoking) ☐ Yes (Vaping) ☐ No ☐
If yes, please describe the frequency and amount: _____

B. Drinking Alcohol Yes ☐ No ☐
If yes, please describe the frequency and average number of drinks: _____

C. Drug Use Yes (Cannabis) ☐ Yes (Other) ☐ No ☐
If yes, please describe the frequency of use: _____

Name of Family Physician: | **Date of Last Physical Examination:**

Physician Address: | **Telephone:**

What medication, if any, is currently prescribed for you? (if none, write "none" or "n/a"):

_____ _____
_____ _____
_____ _____

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Intake Information

Name:	**Date of Birth:**
Please describe the reason for seeking services: _____ _____ _____ _____ _____ _____	
Will you be using insurance?	**Yes** ☐ **No** ☐
Is your appointment confirmed?	**Yes** ☐ **No** ☐ **If so, what date/time?** _____

Emergency Contact Information

Name:	**Telephone:**
Street Address:	**Email:**
City:	**State:** **Zip Code:**

_____ _____
Client Printed Name **Date**

_____ _____
Client Signature **Date**

Or

_____ _____ _____
Personal Representative Signature **Role** **Date**

For Office Use Only:

FEE FOR SERVICE (if not using insurance): standard therapist fee $250/initial consultation; $200/session	
Fee adjustment if necessary:	Rationale for adjustment:

Insurance Information

Name:	**Date of Birth:**	
Policy Holder Name (if different than client):	**Date of Birth:**	
Policy Holder Street Address:	**Telephone:**	
City:	**State:**	**Zip Code:**
Is treatment related to an auto accident?	**Yes** ☐	**No** ☐
Is treatment related to a work accident?	**Yes** ☐	**No** ☐

Primary Insurance Company

Name of Company:	**Behavioral Health Telephone:**	
Policy #:	**Group #:**	**Co-pay: $**
Deductible: $	**Deductible met: $**	**Allowable sessions per calendar year:**
Address for filing claims by mail:		
City:	**State:**	**Zip Code:**

Secondary Insurance Company

Name of Company:	**Behavioral Health Telephone:**	
Policy #:	**Group #:**	**Co-pay: $**
Address for filing claims by mail:		
City:	**State:**	**Zip Code:**

Person Responsible for Payment if Not Client

Name:	**Relationship to Client:**	
Telephone:	**Email Address:**	
Street Address:		
City:	**State:**	**Zip Code:**

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Insurance Authorization

Name:	**Date of Birth:**

Please read and initial (for example, if your name is John Anthony Smith, write "JAS" on the line):

_____ I hereby acknowledge that I give Eileen Siciliano, LCSW permission to bill my insurance company. I certify that the information I have reported with regard to my insurance coverage is correct.

_____ 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. This authorization may be revoked by either me or my insurance company at any time in writing.

_____ I understand that I am responsible for payment should my insurance company declare that my treatment is not medically necessary, refuse to authorize treatment, and/or does not cover me under my policy.

_____ If my insurer is a company that Eileen Siciliano, LCSW does not accept, I agree to pay Eileen Siciliano, LCSW directly for each session. Upon request, Eileen Siciliano, LCSW will write a receipt for me to submit to my 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.

_____ _____
Client Printed Name **Date**

_____ _____
Client Signature **Date**

Or

_____ _____ _____
Personal Representative Signature **Role** **Date**

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Release of Medical Information

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

I,_____ (name of client) give permission to Eileen Siciliano, LCSW to speak with the following person in order to share information regarding my psychotherapy treatment:

Name of Provider: _____ Telephone: _____
Street Address: _____ Fax: _____
City: _____ State: _____ Zip Code: _____

This permission is valid for:

- ☐ Intake and discharge information
- ☐ Medication review
- ☐ Any information pertaining to psychotherapy
- ☐ Any information pertaining to alcohol and drug use

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 until one year from the date of this document.

_____ _____
Client Printed Name **Date**

_____ _____
Client Signature **Date**

Or

_____ _____ _____
Personal Representative Signature **Role** **Date**

Client Rights and Responsibilities

I, Eileen Siciliano, LCSW, am strongly committed to respecting the basic human rights, worth, and dignity of each person receiving services. In addition, you have the legal rights the United States Constitution and state and federal laws and regulations guarantee. You also have responsibilities regarding your treatment. These rights and responsibilities are:

The Right of Confidentiality

You have the right to confidentiality of all records and communications, as federal law provides, with a few exceptions:

- If I suspect child, elder, or vulnerable adult abuse is occurring.
- 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 that apply to clients.
- The right and responsibility to choose a therapist and mode of treatment that meet your needs. The modalities I use include but are not limited to: Internal Family Systems, Cognitive Behavioral Therapy (CBT), Mindfulness, Eye Movement Desensitization and Reprocessing (EMDR), Dialectical Behavior Therapy (DBT), and 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 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 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 I believe doing so causes no harm to you.
- 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 that is ethical and free from abuse, discrimination, and/or exploitation.
- 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 the state department of health and my licensing board.

- New York State Department of Professions: 1-800-442-8106
- Florida State Department of Health Enforcement: https://complaint-portal.mqa.flhealthsource.gov/home

Client Responsibilities

- To keep your scheduled appointments and let me know if you cannot keep an appointment by giving me 24 hours of notice.
- To be as honest and 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 or others.

I have read the information provided above and, if necessary, discussed it with my therapist. I understand my rights and responsibilities as a client and all of my questions have been answered to my satisfaction.

_____ _____
Client Printed Name **Date**

_____ _____
Client or Personal Representative Signature **Date**

_____ _____
Psychotherapist Printed Name **Date**

_____ _____
Psychotherapist Signature **Date**

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Tele-mental Health Informed Consent

I, _____ (name of client), hereby consent to participate in tele-mental health with Eileen Siciliano, LCSW 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-mental 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 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 tele-mental health therapy 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 tele-mental health therapy session.

(6) I understand that during a tele-mental health therapy 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 (516) 746-2972 to discuss since we may have to reschedule.

(7) I understand that my therapist may need to contact my emergency contact listed on my registration form and/or appropriate authorities in case of an emergency. This person will be contacted to go to my location or take me to the hospital in the event of an emergency. I agree to inform Eileen Siciliano, LCSW of the address where I am at the beginning of each tele-mental health therapy session. In case of emergency, my location is: _____.

I have read the information provided above and, if necessary, 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 or personal representative **Date**

Eileen Siciliano, L.C.S.W.-R.
NY License #–053336 || FL License #–SW21379

Notice of Privacy Practices (HIPAA)

Effective Date: August 25, 2025

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. This information also applies for Sessions Health, which is the software I use. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of my responsibilities to help you. You have the right to:

- **Get a copy of your paper or electronic medical record**
  - You can ask to see or get an electronic or paper copy of your medical record and other health information I have about you. Ask me how to do this.
  - I will provide a copy or a summary of your health information, usually within 30 days of your request. I may charge a reasonable, cost-based fee of $0.75 per page for paper copies and the lesser of either $0.75 per page or a total of $100 for electronic copies.
- **Correct your paper or electronic medical record**
  - You can ask me to correct health information about you that you think is incorrect or incomplete. Ask me how to do this.
  - I may say “no” to your request, but I’ll tell you why in writing within 60 days.
- **Request confidential communication**
  - You can ask me to contact you in a specific way (for example, home or cell phone) or to send mail to a different address.
  - I will say “yes” to all reasonable requests.
- **Ask me to limit the information I share**
  - You can ask me not to use or share certain health information for treatment, payment, or my operations. I am not required to agree to your request, and I 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 me not to share that information for the purpose of payment or my operations with your health insurer. I will say “yes” unless a law requires me to share that information.
- **Get a list of those with whom I’ve shared your information**
  - You can ask for a list (accounting) of the times I’ve shared your health information for seven years prior to the date you ask, who I shared it with, and why.
  - I will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked me to make). I’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 received the notice electronically. I 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 or personal representative, that person can exercise your rights and make choices about your health information.
  - I will make sure the person has this authority and can act for you before I take any action.
- **File a complaint if you believe your privacy rights have been violated**
  - You can complain if you feel I have violated your privacy rights by contacting me at (516) 746-2972 or eileen@eileensiciliano.com.
  - 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/.
  - I will not retaliate against you for filing a complaint.

My Uses and Disclosures

How do I typically use or share your health information?

- **Treat you**
  - I 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 my organization**
  - I can use and share your health information to run my practice, improve your care, and contact you when necessary.
  - *Example: I use health information about you to manage your treatment and services.*
- **Bill for your services**
  - I can use and share your health information to bill and get payment from health plans or other entities.
  - *Example: I give information about you to your health insurance plan so it will pay for your services.*

How else do I use or share your health information?

I am 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. I must meet many conditions in the law before I can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html. I never market or sell personal information.

- **Help with public health and safety issues**
  I can share health information about you for certain situations such as:
  - Preventing disease
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety
- **Comply with the law**
  - I 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 I'm complying with federal privacy law. For more information see: https://omh.ny.gov/omhweb/hipaa/phi_protection.html and Fla. Stat. 491.0147(3) and Fla. Stat. 456.059.
- **Address workers' compensation, law enforcement, and other government requests**
  I 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
- **Respond to lawsuits and legal actions**
  - I can share health information about you in response to a court or administrative order, or in response to a subpoena. I will discuss this situation with you prior to taking action.

Your Choices

For certain health information, you can tell me your choices about what I share.

You have both the right and choice to tell me to share information with your family, close friends, or others involved in your care.

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

Our Responsibilities

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

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

Eileen Siciliano, L.C.S.W.-R.
NY License #–053336 || FL License #–SW21379

Notice of Privacy Practices (HIPAA) Acknowledgment

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

I, _____ (name of client), have received a copy of the Notice of Privacy Practices (HIPAA).

Client Signature: _____ **Date:** _____

or

Personal Representative Signature: _____ **Date:** _____

If signed by a Representative:

Print Name: _____ **Role:** _____

For Office Use Only:

If the individual has a representative with legal authority to make health care decisions on the individual's behalf, the notice must be given to and acknowledgment obtained from the representative. ***If the individual or representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.***

Notice of Privacy Practices given to the individual on _____
date

___ Face-to-face meeting
___ Mailing
___ Email
___ Other _____

Reason Individual or Representative did not sign this form:
_____ Individual or Representative chose not to sign
_____ Individual or 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's or Representative signature. Please document with detail (e.g., date(s), time(s), individuals 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 _____

Psychotherapist Signature: _____

Print Name: _____

Date: _____

Office Policies, Information, and Agreements

Welcome. Before we begin our 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 "Notice of Privacy Practices (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: $250.00. My fee for subsequent sessions is: $200.00.

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, LCSW. I have the right to raise the fee at any time, though usually once per year.

Insurance & Co-payments (Co-pays): I accept numerous insurance plans, including but not limited to: Aetna, Anthem/Blue Cross Blue Shield, Carelon, CHAMPVA, Cigna, Medicare, Meritain, Northwell Direct, NYSHIP Empire Plan, Oxford, and United Healthcare. 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; if I am in network for your specific plan; your co-pay; your deductible, if you have met it, and if not, how much is left. We use Zoom to do video conferencing. Some insurance companies cover video conferencing. Others do not. It is your responsibility to find out if your insurance company covers tele-mental health services (telehealth).

Your co-pay 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.

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. 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. Some people, however, 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, therapy is 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, LCSW for the time it takes to write these reports and/or attend these meetings. Reports that would incur a fee include but are not limited to a disability claim, Workers' Compensation, or a review of treatment for an attorney. Meetings that would incur a fee include but are 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 regardless of whether you use insurance or not.** This policy applies to an appointment you did not cancel because you decided not to continue therapy, an appointment you "forgot", an appointment that conflicts with another one you made, or if you choose to do something that is important to you rather than come to therapy.

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 therapy at this time.

No-Show: If you do not show up for your appointment and do not contact me within one week to confirm your next appointment, I will assume that therapy no longer fits into your life and will terminate services. You will receive a termination of treatment letter by mail.

EMERGENCIES: In case of an emergency please leave a message stating the emergency on my voicemail, call your other supports, hotlines, or community mental health center. Go to your local emergency hospital or call 911 if you cannot wait for a call back from me.

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 meeting in person, if you would like. We will discuss this when the situation arises.

CONTACTING ME:

Phone Calls: Voicemail is available 24 hours a day. I return calls as soon as possible, but it is helpful if you give me several alternate times to call you back. I am glad to answer occasional short calls (5-10 minutes) in between your 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 weekday and much less frequently on the weekend.

CONFIDENTIALITY: The law protects the privacy of all communications between a client 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 action without a signed release discussed in "Notice of Privacy Practices (HIPAA)" and "Client Rights and Responsibilities". These situations are unusual in my practice. 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.

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 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 (PHI) 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 my approval.

Client Initials: _____
Date: _____

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 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 $0.75 per page for paper copies, and the lesser of either $0.75 per page or a total of $100 for electronic copies. I may charge for certain other expenses such as postage. 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 seven 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 client to client, 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 subpoenas them. Insurance companies cannot neither 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 $0.75 per page for paper copies, and the lesser of either $0.75 per page or a total of $100 for electronic copies.

MINORS & PARENTS: Clients 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 client and the client's 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 the child may have. A minor's records are stored until the minor is 22 years of age, or for seven years, whichever is later.

MINDBODY PSYCHOLOGY: EMDR, tapping, and other 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 are used. 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.

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 did not work, what you accomplished, and what work may be left. Email, texts, and voicemail are not an appropriate way to terminate services. Signing this agreement means you agree to a termination session if possible.

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.

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.

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

_____	_____
Client Printed Name	**Date**
_____	_____
Client Signature	**Date**

Or

_____	_____	_____
Personal Representative Signature	**Role**	**Date**

General Anxiety Disorder Assessment (GAD-7)

Name:	Date of Birth:

Over the last <u>two weeks</u>, how often have you experienced these symptoms?		**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1	Feeling nervous, anxious, or on edge?				
2	Not being able to stop or control worrying?				
3	Worrying too much about different things?				
4	Trouble relaxing?				
5	Being so restless that it is hard to sit still?				
6	Becoming easily annoyed or irritable?				
7	Feeling afraid as if something awful might happen?				

Patient Health Questionnaire (PHQ-9)

Name:	Date of Birth:

Over the last <u>two weeks</u>, how often have you been bothered by the following problems?		**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1	Little interest or pleasure in doing things				
2	Feeling down, depressed, or hopeless				
3	Trouble falling asleep or staying asleep, or sleeping too much				
4	Feeling tired or having little energy				
5	Poor appetite or overeating				
6	Feeling bad about yourself—or that you are a failure or have let yourself or family down				
7	Trouble concentrating on things, such as reading the newspaper or watching television				
8	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual				
9	Thoughts that you would be better off dead or of hurting yourself in some way				

Eileen Siciliano, L.C.S.W.-R.
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Mood Disorder Questionnaire

Name:	Date of Birth:

Has there ever been a period of time when you were not your usual self and…	**Yes**	**No**
…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?		
…you were so irritable that you shouted at people or started fights or arguments?		
…you felt much more self-confident than usual?		
…you got much less sleep than usual and found you didn't really miss it?		
…you were much more talkative or spoke much faster than usual?		
…thoughts raced through your head or you couldn't slow your mind down?		
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
…you had much more energy than usual?		
…you were much more active or did many more things than usual?		
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
…you were much more interested in sex than usual?		
…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
…spending money got you or your family in trouble?		
If you checked YES to more than one of the above, have several of these ever happened during the same period of time?		

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

Client Initials: _____
Date: _____