JOANNE DELLAVALLE, LCSW-R

499 Glen Street, Glens Falls, NY 12801

Tel(518)798-9187/Fax(518)223-0567

CLIENT INFORMATION (ADULT)

Today’s Date:

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE INFORMATION

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Insurance (If different)\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Insurance ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Authorization Code\_\_\_\_\_\_\_\_

Copay Amount \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is deductible paid (if applicable) Y N

FAMILY COMPOSITION

Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse/Partner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children Gender Age School Grade

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PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient and the particular problems you are experiencing. There are many different methods that may be used to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant parts of your life, you may temporarily experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems and significant reductions in feelings of distress. There are no guarantees of what you will experience

Therapy sessions sometimes involve a large commitment of time, money, and energy, so you should be very thoughtful about the therapist you select. Our first few sessions will involve an evaluation of your needs and requests so that I can offer impressions and formulate a treatment plan if you decide to continue therapy. You should evaluate this information along with your own opinions o whether you feel comfortable working with me. You should participate in your treatment plan and have the right to review and revise it at any time.

OFFICE POLICIES AND PROCEDURES

1. Therapy sessions are approximately 45 minutes. Payment is due in full at the time of the appointment for non-insured patients.
2. Proof of Insurance is required at time of initial appointment. It is the patient’s responsibility to inform office staff of any changes in insurance coverage and billing information in order that we may file as a courtesy to you.
3. All deductibles, co-pays and non-covered services are due at the time of service unless payment arrangements have been made in advance. I accept cash and personal checks.
4. In the case that your insurance company denies payment of any claim we file on your behalf we will bill you the denied amount. Payment will be due at the time of your next appointment.
5. Scheduled appointments are commitments. Please make every effort to be on time. If you are late, time will be lost from your session. If you miss an appointment and fail to notify the office at least 24 hours in advance, you will be charged a missed appointment fee of $50.00 which will be billed to you with payment expected within 15 days of the billing date.
6. All records and communications about the patient will be treated confidentially with applicable state and federal laws. These laws may oblige me to report suspected abuse or neglect, domestic violence, and those who pose a danger to themselves or others. Managed care requires that you waive your rights to keep your psychotherapy confidential. They require treatment reports which request information about why you are using your outpatient mental health benefit. They will not authorize and therefore will not pay for sessions without this information.

INFORMED CONSENT FOR TREATMENT

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read and understand the above contract and policies and agree to its terms and give informed consent for treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Guardian Date

REASON(S) FOR SEEKING AN APPOINTMENT

Brief statement about the reason for which you are seeking help.

Why do you think this problem exists?

What was going on in your life when the problem first started?

Have you sought help before with this problem? When, where, how, results?

Are you currently working with another behavioral health practitioner?

Y (Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ N

Have you worked with another therapist in the past?

Y(Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates \_\_\_\_\_\_\_\_\_\_) N

MEDICAL INFORMATION

Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone # \_\_\_\_\_\_\_\_\_\_\_

Current Medical Conditions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications Dosage Prescribing Physician

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Do you use:

Alcohol Y N Amount \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recreational Drugs Y N Amount \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco Y N Amount \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine Y N Amount \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you Exercise? Y N Amount \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you participate in spiritual practices? Please describe.

Do you have a history of physical or sexual abuse as a child or adult? Y N

Family history of psychological problem (e.g. depression, anxiety, bi-polar disorder), please describe.

Do you engage in integrative health practices (e.g. acupuncture, yoga, tai chi, qigong, reiki, Chinese herbal medicine, etc.)?

PATIENT CONTACT AUTHORIZATION

Occasionally, it is necessary for our office to call to discuss insurance information, coordinate/discuss referral to another physician or practitioner, or schedule/change appointments. As a courtesy, our office calls to remind you of appointments. Please note that sometimes we are unable to make reminder calls and **it is your responsibility to keep track of your appointments.**

Telephone number where you want to receive calls \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission to leave a message Y N (If No, please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can confidential messages (i.e. messages to call the office regarding appointments) be left on your answering machine or voicemail? Y N

May we call you at your place of employment if you cannot be reached at home? Y N

Would custodial parent need to be notified if non-custodial parent requests information? Y N

Patient Name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle one Self /Guardian/Custodial Parent

PAYMENT AUTHORIZATION

\_\_\_\_\_\_\_\_ Bill Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_Self-Pay

I give permission to file with my insurance company. Y N

My co-pay for outpatient psychotherapy is $\_\_\_\_\_\_\_. My required deductible is $\_\_\_\_\_\_\_.

I authorize payment of insurance benefits to be made directly to the provider of services. I further authorize the provider to release, to my insurance company/companies, information from my records that is necessary for the insurance company/companies to process claims for services provided.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge the receipt of the HIPAA Privacy Information found at the end of this packet.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

I wish to take the Notice or Privacy Practices (HIPAA) form for my records. Y N

PRIVACY OFFICER INFORMATION

The HIPAA Privacy Officer for this Office is Daniah Cornell (518-798-9187). The Privacy Officer:

* Can answer your questions about privacy practices.
* Can accept any complaints you have about our privacy practices.
* Can give you information on how to file a complaint.

CONSENT FOR TREATMENT

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, will be receiving psychotherapy services from Joanne DellaValle, LCSW-R. These services will be confidential in nature with a few exceptions:

* If there is an allegation of child or elder abuse or neglect it will be necessary for me to share pertinent information with the proper authorities.
* If there is an expressed intention to harm yourself or someone else, pertinent information would be shared with proper authorities to prevent such harm.
* Whenever permission has been granted in writing by you or your parent, as applicable, information may be shared with the identified entity.
* Information may be released to third party payers, such as your insurance company’s carve-out payment vendor, for the purposes of receiving payment for services. This information will be limited to the information relevant to receive payment.

In addition, Joanne DellaValle may consult with another mental health professionals in order to provide the best treatment options.

Joanne DellaValle can be reached at her office during normal business hours at 499 Glen Street, Glens Falls, NY, (518-798-9187. Please leave a message with the secretary or on her confidential voicemail system. She will do her best to return phone calls in a timely manner. However, in the event of an emergency, call 911 or go to your nearest emergency room.

If you are in need of support, and it is not an emergency but you feel it is urgent, you may call my urgent number at (518-320-6357). Be advised that I may not be available for several hours and therefore, may not be able to return your call immediately.

You may also consider calling one of the following resources:

Child Protective Hotline 800-635-1522

Hopeline: 800-784-2433

NY Domestic Violence Hotline: 800-942-6906

Rape/Sexual Violence Hotline: 800-656-4673

Suicide and Crisis Hotline (Albany) 689-4673

The information contained in this document, limitations to confidentially and contct information has been reviewed. I understand that if I have additional questions or concerns regarding these matters, I will ask that they be addressed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient (12 years of age or older Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Legal Guardian Date

JOANNE DELLAVALLE, LSCW-R

499 Glenn Street, Glens Falls, NY 12801

Tel(518)798-9187/Fax(518)223-0567

RELEASE OF INFORMATION/AUTHORIZATION

I authorize Joanne DellaValle, LCSW-R, to exchange my protected health information or the protected health information of my child (whichever is applicable) to the person(s) designated below (i.e., physician, pediatrician, school official, relative, etc.):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) I do not wish my primary care physician or my child’s pediatrician (whichever is applicable)be contacted.

By signing below, I am authorizing the exchange of information related to my diagnosis, treatment, and progress for the purpose of coordinating treatment.

This authorization will remain in effect for one year from the date below or until treatment is terminated. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Joanne DellaValle, LCSW-R. However, I understand that my revocation will not be effective to the extent that Joanne DellaValle has taken action in reliance on the authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of this information and no longer protected by HIPAA or any other federal or state law.

I understand that Joanne DellaValle, LCSW-R will not condition my treatment on whether I provide an authorization for disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient Relationship to Patient