eopa
East Orange Psychiatric Associates, LLP
400 Stony Brook Court, Suite 1
Newburgh, NY 12550
Phone: 845-565-0600
Fax: 866-733-1910

Enclosed in this packet, you'll find the forms you should bring to your initial appointment at EOPA. The "X's" mark where the appropriate information should be filled in. Sign and date at the marked lines on the first 5 pages. Please, fill out the History Form completely. There are 4 pages, front and back, with every question needing an answer. If you don't have a specific answer to a question, you may write "no", "none", "I don't know", "N/A", etc. Please, bring the completed forms with you to your initial visit as well as your insurance card and driver's license.

If you have a copay or deductible to meet, be aware, payment is due at the time of service.

Thank you and we look forward to meeting you!

PATIENT ACKNOWLEDGMENT

Patient Name:_____

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices of

East Orange Psychiatric Associates, LLP

400 Stony Brook Court Suite 1

Newburgh, New York 12550

X_____

Signature of Patient (or authorized representative)

_____

Name of Patient (please print)

_____

Date

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Financial Agreement

Financial Policy

It is the policy of this office to collect co-payments, co-insurance, deductibles and any other expenses incurred at the time of service unless other specific arrangements are made in writing.

By signing this agreement, you are accepting responsibility for a payment of any and all expenses related to the provision of care, regardless of insurance coverage expectations.

Insurance Information and Financial Responsibility

Although we may accept your insurance plan, all services may not be covered. It is your responsibility to know and understand your benefit coverage and limitations.

Services provided at this office fall under the category of mental health and substance abuse. As such, your primary insurance company (i.e. GHI, MVP, BCBS, The Empire Plan, CDPHP...) may contract with another entity (i.e. Value Options, UBH, Magellan...) for these specialty services.

Your insurance Company may require authorization for these services. You are expected to obtain authorization if your plan requires this.

By accepting services at this office, you personally guarantee payment for all services provided which may include non covered services. Examples of non-covered services include, but are not limited to: case management, coordination of care with other providers, review and interpretation of medical records, preparation of reports, preparation of disability papers, telephone consultation and clinical case reviews.

Medication Policy

If medication is or will be a part of your treatment, you are responsible for obtaining a list of your insurance company's authorized medications, their Formulary. This will prevent you from having to schedule an additional visit due to insurance coverage limitations. Prescriptions are dispensed at your appointment time with the prescriber. Medication needs are discussed at this visit. It is imperative that you be aware of all your medication needs at this time.

Missed Appointments and Cancelations

Fees will be applied for missed appointments. Our policy requires 24 hour notice when cancelling an appointment without a charge. Failure to cancel an appointment with the 24 hour notice will result in a $50.00 fee payable at the next scheduled appointment. Exceptions may be made in the event of a true emergency.

If more than 3 appointments have been missed you will be referred to your provider to discuss financial obligations and treatment compliance and collection activity may be initiated.

Agreement of Financial Responsibility

I agree to be responsible for all non insurance covered services rendered by providers in this office.

I have been offered a copy of the HIPPA compliant privacy policy for this office as it pertains to services rendered by providers at this location. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

This agreement is in effect until it is revoked by me in writing

_____ _____

Signature of Patient or Parent/Guardian — Date

_____ _____

Printed Name — Relationship to Patient

_____ _____

Witness Signature — Date

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AUTHORIZATION FOR RELEASE OF INFORMATION

Part I:

I,_____,hereby authorize_____ to
(Name of Patient) (Psychiatrist/ Clinician)

Release/receive the health care information described below to:
Name, address and phone of person/organization releasing/receiving information:
Emergency Contact:_____

_____

_____

This request and authorization applies to the following protected healthcare information:

☐ Psychosocial Assessment ☐ History ☐ Other : Emergency

☐ Progress Notes ☐ Relevant Case Data

The purpose for the use or release/receipt of this information is:

☐ Coordination of treatment services ☐ Discharge Planning

☐ Referral ☐ Specific Purpose: Emergency

This request and authorization will expire:

☐ One year from this date ☐ On this specific date:_____

☐ When acted upon/once specific disclosure has been made

I understand that, except for action already taken, I may revoke this authorization in writing at any time by delivering or sending written notification to my therapist or physician at 400 Stony Brook Court, Suite 1, Newburgh, NY 12550
I also understand that I have the right to receive a copy of this authorization and that a copy will be maintained in my patient record. I understand that I have the right to refuse to sign this authorization .
The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law.
Please sign below to authorize the use or release of your personal health information for the reasons and with the conditions established above:

×_____ _____
Signature of Patient/Parent/Guardian Date

_____ _____
Witness Date

Part II: Cancellation/Refusal to Release Information

☐ I hereby cancel my permission to release/receipt information indicated in Part I, to the person/organization whose name is indicated above.

☐ I hereby refuse to authorize the release/receipt of information indicated in Part I, to the person/organization indicated above.

_____ _____
Signature of Patient/Parent/Guardian Date

_____ _____
Witness Date

Part III: Consent Review and Update: I have reviewed the above information and agree it remains accurate.

_____ **Patient Initials** _____ **Date** _____ **Patient Initials** _____**Date** _____ **Patient Initials** _____ **Date**

_____ **Patient Initials** _____ **Date** _____ **Patient Initials** _____**Date** _____ **Patient Initials** _____**Date**

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AUTHORIZATION FOR RELEASE OF INFORMATION

Part I:

I,_____,hereby authorize_____ to
(Name of Patient) (Psychiatrist/ Clinician)

Release/receive the health care information described below to:
Name, address and phone of person/organization releasing/receiving information:
Insurance Company:_____

_____

_____

This request and authorization applies to the following protected healthcare information:

☐ Psychosocial Assessment ☐ History ☐ Other :Benefits and Claims

☐ Progress Notes ☐ Relevant Case Data

The purpose for the use or release/receipt of this information is:

☐ Coordination of treatment services ☐ Discharge Planning

☐ Referral ☐ Specific Purpose: Benefits and Claims

This request and authorization will expire:

☐ One year from this date ☐ On this specific date:_____

☐ When acted upon/once specific disclosure has been made

I understand that, except for action already taken, I may revoke this authorization in writing at any time by delivering or sending written notification to my therapist or physician at 400 Stony Brook Court, Suite 1, Newburgh, NY 12550
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Please sign below to authorize the use or release of your personal health information for the reasons and with the conditions established above:

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_____ _____
Signature of Patient/Parent/Guardian Date

_____ _____
Witness Date

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_____ **Patient Initials** _____ **Date** _____ **Patient Initials** _____**Date** _____ **Patient Initials** _____ **Date**

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AUTHORIZATION FOR RELEASE OF INFORMATION

Part I:

I,_____,hereby authorize_____ to
(Name of Patient) (Psychiatrist/ Clinician)

Release/receive the health care information described below to:
Name, address and phone of person/organization releasing/receiving information:
Primary Care Physician:_____
Address:_____
Tele:_____

This request and authorization applies to the following protected healthcare information:

☐ Psychosocial Assessment ☒ History ☒ Other :Bloodwork,Labs within last 1yr
☐ Progress Notes ☒ Relevant Case Data

The purpose for the use or release/receipt of this information is:

☒ Coordination of treatment services ☐ Discharge Planning
☐ Referral ☐ Specific Purpose:

This request and authorization will expire:

☒ One year from this date ☐ On this specific date:_____
☐ When acted upon/once specific disclosure has been made

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×_____ _____
Signature of Patient/Parent/Guardian Date

_____ _____
Witness Date

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☐ I hereby refuse to authorize the release/receipt of information indicated in Part I, to the person/organization indicated above.

_____ _____
Signature of Patient/Parent/Guardian Date

_____ _____
Witness Date

Part III: Consent Review and Update: I have reviewed the above information and agree it remains accurate.

_____ **Patient Initials** _____ **Date** _____ **Patient Initials** _____**Date** _____ **Patient Initials** _____ **Date**

_____ **Patient Initials** _____ **Date** _____ **Patient Initials** _____**Date** _____ **Patient Initials** _____**Date**

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HISTORY FORM

Name: _____ **Age:** _____ **DOB:** _____

- **PRESENTING PROBLEM:** Describe the problems you are having and when they began:

_____

_____

_____

_____

_____

_____

- **SYMPTOM CHECKLIST:** Please check any symptoms you are experiencing.

___ Aggression/Anger Outbursts	___ Eating Disorders	___ Hopelessness	___ Sexual Difficulties
___ Dizziness	___ Elevated Mood	___ Irritability	___ Sleeping Problems
___ Anxiety	___ Fatigue	___ Loneliness	___ Suicidal Thoughts
___ Avoidance of People	___ Indecisiveness	___ Memory Problems	___ Impulsivity
___ Chest Pains	___ Muscle Tension	___ Mood Swings	___ Weight Gain/Loss
___ Depression	___ Gambling	___ Worrying	___ Withdrawal
___ Difficulty Concentrating	___ Hallucinations	___ Panic Attacks	___ Worthlessness
___ Difficulty Thinking	___ Headaches	___ Racing Thoughts	___ Other Symptoms
___ Distractibility	___ Helplessness	___ Restlessness/On Edge	_____

- **CURRENT STRESSORS:** Please check all that apply.

___ Marital Conflict	___ Poor Peer Relations	___ Legal Problems
___ Financial Problems	___ Health Problems	___ Recent Death
___ Conflict with Children	___ Job Loss or Change	___ Substance Abuse Problems
___ Conflict with Parents	___ Problems at School	___ Housing Problems
___ Conflict with Siblings	___ Recent Move	___ Other (List): _____

- **PAST HISTORY OF MENTAL HEALTH PROBLEMS/TREATMENT:**

Prior Outpatient Treatment: Yes or No

Date:_____to_____ Clinician : _____City/State:_____

Date:_____to_____ Clinician : _____City/State:_____

Date:_____to_____ Clinician : _____City/State:_____

Prior Psychiatric Hospitalizations: Yes or No Date:_____to_____ Hosp. Name/State:_____

Date:_____to_____ Hosp. Name/State:_____

Psychiatric Medication History:

Medication	Dosage	Length of Usage	Outcome

- **FAMILY HISTORY OF MENTAL HEALTH PROBLEMS:** Include diagnoses, treatment, and relationship to you

Family member/Relationship	Diagnosis	Treatment

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- **SUBSTANCE USE:** Please indicate both current and past use & fill in appropriate substance names as needed

Substance	Current Use Yes	Current Use No	Past Use Yes	Past Use No	Amount Used	Frequency	Date Last Used
Tobacco	___	___	___	___	_____	_____	_____
Caffeine	___	___	___	___	_____	_____	_____
Alcohol	___	___	___	___	_____	_____	_____
Marijuana	___	___	___	___	_____	_____	_____
Cocaine/Crack	___	___	___	___	_____	_____	_____
Heroin	___	___	___	___	_____	_____	_____
Opiates:_____	___	___	___	___	_____	_____	_____
LSD	___	___	___	___	_____	_____	_____
Ecstasy	___	___	___	___	_____	_____	_____
Inhalants	___	___	___	___	_____	_____	_____
IV Drug Use	___	___	___	___	_____	_____	_____
Prescription Drugs	___	___	___	___	_____	_____	_____
Over The Counter	___	___	___	___	_____	_____	_____
Other:_____	___	___	___	___	_____	_____	_____

(Include Names of Prescription Drugs and Over The Counter below and indicate if they were prescribed for you)

_____

- **PAST HISTORY OF SUBSTANCE ABUSE TREATMENT:** Include AA/NA, counseling, hospitalization, and residential care.

Hospitalization: Yes or No _____
Rehab Treatment: Yes or No _____
Residential Care: Yes or No _____
AA/NA Program: Past Attendance ? Yes or No Current Attendance ? Yes or No Frequency _____

- **HISTORY OF LEGAL PROBLEMS:** Include any current charges, pending court dates, history of arrests, probation, child custody and divorce issues, or guardianship issues. _____

_____

- **MEDICAL HISTORY:**

Do you have a Primary Care Physician (PCP)? ___Yes ___No Name of PCP: _____
Telephone #_____ Address:_____
Date of last visit: _____ Date of last physical: _____
Do you now have or have you ever had any of the following medical problems: (check off what applies) or circle---- **None**

___ Head Injury	___ Seizures	___Thyroid Problems	___ Hypertension
___ Heart Disease	___ Lung Disease	___ Liver Disease	___ Kidney Disease
___ Hepatitis	___ TB	___ HIV	___ Sexually Transmitted Diseases
___ Hypoglycemia	___ Diabetes	___ Cancer	___ Memory Problems
___ Asthma	___ Arthritis	___Chronic Pain	___ Headaches
___ High Fevers	___ Meningitis	___ Loss of Consciousness	___ Other _____
___ Other _____			

Describe any checked items above, including age of onset._____
List any hospitalizations/surgeries: _____

_____

- **Current Medications: (Physical Illness related)**

Medication	Dosage	Date Started	Prescribed By	Condition it is for

Patient Name: _____

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Allergies: Yes or No (If Yes please list) _____
Family History of Medical Problems: _____

- **SOCIAL HISTORY:**

Place of Birth: _____
Where did you grow up? _____
Did your family move around? If yes, please describe: _____
_____
How many siblings do you have? _____
Which family members are you close to? _____
_____
Describe your childhood: _____
_____
Abuse History: Sexual: Yes or No Mental: Yes or No Physical: Yes or No Neglect: Yes or No Ritualistic: Yes or No
Victim or Perpetrator or Both : If yes please explain: _____
_____
Who do you rely on for emotional support? _____
Have there been significant losses, changes or crises in your life? If yes, please describe. _____
_____
Do you have any type of belief system (moral, spiritual, cultural, religious) that influences your life? Yes or No _____
_____

- **EDUCATIONAL HISTORY:**

Highest grade you completed? _____Some College_____College Degree_____ Graduate Degree_____ Professional_____
History of Learning Disability or Behavioral Problem in School? Yes or No (Explain) _____
_____

- **MILITARY HISTORY:**

Military Service? Yes or No Branch: _____Dates of service: _____ to _____
Were you stationed in a combat or other high-risk zone? _____
Currently Serving ? Yes or No Medical Type of discharge: Honorable Dishonorable

- **OCCUPATIONAL HISTORY:**

Are you currently employed? Yes or No Where ? _____ Length of employment: _____
Current position? _____ Do you like your job? ___ Yes ___ No
Are there any current job stressors you are experiencing? Yes or No (Explain) _____
_____

- **RELATIONSHIP HISTORY:** Marital status? ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated __ Other

Describe your current relationship, including any problems: _____
_____
Describe any prior marriages or long-term relationships and the reason for the divorce/break up: _____
_____
List the names and ages of any children you have had, including any who are deceased:
_____ _____ _____
_____ _____ _____
Describe any problems you are currently experiencing with your children? _____
_____
List all people currently residing in your home:
_____ _____ _____
_____ _____ _____

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- **RISK ASSESSMENT:**

	Past	Now	Never
Have you ever had thoughts of hurting yourself?	___	___	___
Have you ever had thoughts of committing suicide?	___	___	___
Have you ever had a plan to commit suicide?	___	___	___
Have you made threats to kill yourself?	___	___	___
Have you ever made a suicide attempt?	___	___	___
Have you ever mutilated yourself?	___	___	___
Have you ever had thoughts of harming someone?	___	___	___
Have you ever had plans to harm someone?	___	___	___
Have you ever attempted to harm someone?	___	___	___
Have you made threats to harm someone?	___	___	___

Is there any other information that would be helpful for your clinician to know?_____

What are your expectations for treatment?_____

Are there any family members or significant others you would like to involve in your treatment?_____

Clinical Staff Use Only In This Area

- **Diagnosis:**

Axis I: _____ _____ _____

Axis II: _____ _____ _____

Axis III: _____ _____ _____

Axis IV: _____ _____ _____

Axis V: **Current GAF =** _____

Additional Clinician Notes:_____

_____

_____

_____
Patient Signature Date

_____
Todd Rochman, M.D. Date

_____
Clinician Signature Date

Patient Name: _____