SMITHTOWN CONSULTATION CENTER

Background Information Questionnaire

Your cooperation in providing full and complete, information is requested.

Today's Date: _____

Please Complete BOTH PAGES of this form.

Patient Information

Patient Name:					
Street Address:					
Town:			New York	Zip Code:	
Home Telephone #:			Work Telephone #:		
Email:			Cell Phone #		
Social Security Number:			Date of Birth:		
Sex: Male Female	Marital Status: Single Married Divorced Separated Widowed				

Mailing Address

(If different from one provided above)

Name:				
Street Address:				
Town:		New York	Zip Code:	

Other Household Members

Name:	Date of Birth	Age	Relationship to Patient

How Did You Learn of Our Services?

(Please check all that apply)

Source	Specifics
☐ Family Doctor Please Note Who ☛	
☐ Attorney Please Note Who ☛	
☐ Yellow Pages (Large NYNEX Book) ☛☛	☐ Under "Counselors" ☐ Under "Psychologists"
☐ Yellow Book (Small, Local Book) ☛☛	☐ Under "Counselors" ☐ Under "Psychologists"
☐ Other Please Note Who / What☛	

What are the reasons you are seeking services?

(Please be specific)

Patient's Employment / School Information

Employer's / School Name:			
Street Address:			
Town & State:		Zip Code:	
Job Title:			

Insurance Information

Insured's Name:			
Street Address:			
Town & State:		Zip Code:	
Company Name:			
Street Address:			
Town & State:		Zip Code:	
Job Title:			
Policy Number:		Group Number:	
Social Security Number:		Date of Birth:	
Sex: Male Female	Marital Status: Single Married Divorced Separated Widowed		
Relationship to Patient:	Self Spouse Child Parent Other		

Please Note: Our office policy is to accept assignment from only one carrier.
We will gladly assist in the coordination of benefits if more than one carrier is involved.

Additional Insurance Information

Insured's Name:			
Street Address:			
Town & State:		Zip Code:	
Company Name:			
Street Address:			
Town & State:		Zip Code:	
Job Title:			
Policy Number:		Group Number:	
Social Security Number:		Date of Birth:	
Sex: Male Female	Marital Status: Single Married Divorced Separated Widowed		
Relationship to Patient:	Self Spouse Child Parent Other		

Thank You for taking the time to complete this form.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA HEALTH INSURANCE CLAIM FORM PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER | 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | 3. PATIENT'S BIRTH DATE MM DD YY SEX M F | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) | 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other | 7. INSURED'S ADDRESS (No., Street)

CITY STATE | 8. PATIENT STATUS Single Married Other | CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( ) | Employed Full-Time Student Part-Time Student | ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | 10. IS PATIENT'S CONDITION RELATED TO: | 11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO | a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F | b. AUTO ACCIDENT? PLACE (State) YES NO | b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME | c. OTHER ACCIDENT? YES NO | c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME | 10d. RESERVED FOR LOCAL USE | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | 17a. I.D. NUMBER OF REFERRING PHYSICIAN | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE | 20. OUTSIDE LAB? $ CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

1. | 3.

23. PRIOR AUTHORIZATION NUMBER

2. | 4.

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO | 28. TOTAL CHARGE $ | 29. AMOUNT PAID $ | 30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) | 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

SIGNED DATE | PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Brief Health Information Form

A. Identification

Client's name: _____ Date: _____

B. History

1. Starting with your childhood and proceeding up to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E.)

Age	Illness/diagnosis	Treatment received	Treated by	Result

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take

3. List *all* medications or drugs you take or have taken in the last year—prescribed, over-the-counter, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by

(cont.)

Client's name: _____ Date: _____

4. Have you done any kinds of work where you were exposed to toxic chemicals?

Date	Kinds of chemicals	Kind of work	Effects

C. Medical caregivers

1. Your current family or personal physician or medical agency:

Name	Specialty	Address	Phone #	Date of last visit

2. Other physicians treating you at present or in last 5 years:

Name	Specialty	Address	Phone #	Date of last visit

D. Health habits

1. What kinds of physical exercise do you get? _____

2. How much coffee, cola, tea, or other sources of caffeine do you consume each day? _____

3. Do you try to restrict your eating in any way? How? Why? _____

(cont)

Client's name: _____ Date: _____

4. Do you have any problems getting enough sleep? _____

_____

_____

E. For women only

1. At what age did you start to menstruate (get your period):_____
2. Menstrual period experiences:
   a. How regular are they? _____
   b. How long do they last? _____
   c. How much pain do you have? _____
   d. How heavy are your periods? _____
   e. Other experiences during period? _____

3. Please list all of your pregnancies, and what happened with each pregnancy?

	Your age	Miscarriage	Abortion	Child born	Problems?
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____

4. Menopause:
   a. If your menopause has started, at what age did it start? _____
   b. What signs or symptoms have you had? _____

   _____

F. Other

Are there any other medical or physical problems you are concerned about? _____

_____

_____

_____

_____

Child Checklist of Characteristics

Name: _____ Date: _____

Age: _____ Person completing this form: _____

Many concerns can apply to both children and adults. If you have brought a child for evaluation or treatment, first, please mark all of the items that apply to your child on the "Adult Checklist of Concerns." Then review this checklist, which contains concerns (as well as positive traits) that apply mostly to children, and mark any items that describe your child. Feel free to add any others at the end under "Any other characteristics."

- O Affectionate
- O Argues, "talks back," smart-alecky, defiant
- O Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
- O Cheats
- O Cruel to animals
- O Concern for others
- O Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
- O Complains
- O Cries easily, feelings are easily hurt
- O Dawdles, procrastinates, wastes time
- O Difficulties with parent's paramour/new marriage/new family
- O Dependent, immature
- O Developmental delays
- O Disrupts family activities
- O Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
- O Distractible, inattentive, poor concentration, daydreams, slow to respond
- O Dropping out of school
- O Drug or alcohol use
- O Eating—poor manners, refuses, appetite increase or decrease, odd combinations, overeats
- O Exercise problems
- O Extracurricular activities interfere with academics
- O Failure in school
- O Fearful
- O Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- O Fire setting
- O Friendly, outgoing, social
- O Hypochondriac, always complains of feeling sick
- O Immature, "clowns around," has only younger playmates
- O Imaginary playmates, fantasy
- O Independent
- O Interrupts, talks out, yells
- O Lacks organization, unprepared

(cont.)

Name: _____ Date: _____

- O Lacks respect for authority, insults, dares, provokes, manipulates
- O Learning disability
- O Legal difficulties—truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
- O Likes to be alone, withdraws, isolates
- O Lying
- O Low frustration tolerance, irritability
- O Mental retardation
- O Moody
- O Mute, refuses to speak
- O Nail biting
- O Nervous
- O Nightmares
- O Need for high degree of supervision at home over play/chores/schedule
- O Obedient
- O Obesity
- O Overactive, restless, hyperactive, overactive, out-of-seat behaviors, restlessness, fidgety, noisiness
- O Oppositional, resists, refuses, does not comply, negativism
- O Prejudiced, bigoted, insulting, name calling, intolerant
- O Pouts
- O Recent move, new school, loss of friends
- O Relationships with brothers/sisters or friends/peers are poor—competition, fights, teasing/provoking, assaults
- O Responsible
- O Rocking or other repetitive movements
- O Runs away
- O Sad, unhappy
- O Self-harming behaviors—biting or hitting self, head banging, scratching self
- O Speech difficulties
- O Sexual—sexual preoccupation, public masturbation, inappropriate sexual behaviors
- O Shy, timid
- O Stubborn
- O Suicide talk or attempt
- O Swearing, blasphemes, bathroom language, foul language
- O Temper tantrums, rages
- O Thumb sucking, finger sucking, hair chewing
- O Tics—involuntary rapid movements, noises, or word productions
- O Teased, picked on, victimized, bullied
- O Truant, school avoiding
- O Underactive, slow-moving or slow-responding, lethargic
- O Uncoordinated, accident-prone
- O Wetting or soiling the bed or clothes
- O Work problems, employment, workaholism/overworking, can't keep a job
- O Any other characteristics: _____

Please look back over the concerns you have checked off and choose the one that you most want your child to be helped with. Which is it? _____

Chemical Use Survey

Name: _____ Date: _____

In order to treat you effectively, I need information about the ways you and your family have used alcohol, drugs, and other chemicals that can affect you psychologically. So please answer these questions fully.

A. What have you used?

1. Think about any and all chemicals you have used, and indicate how much you used (amount) and how often (frequency). Then indicate all the effects it had on you (mental, physical, family, legal, etc.).

Chemical	First use Age	First use Amount	Last use Date	Last use Amount	Over the last 30 days Amount and how often	Over the last 30 days Effects/ consequences	See question 3, below
Caffeine							
Tobacco							
Smoked							
Chewed							
Alcohol							
Marijuana							
Cocaine/ Crack							
Injected							
Smoked							
Inhalants							
Others: Specify							

2. Write "P" above next to your primary drug of choice. **3.** For each chemical you currently use, what causes you to stop? Enter one or more of these letters in the last column above: A = The money runs out. B = I use up my supply. C = Personal choice. D = Unconsciousness. E = Achieved my purpose. F = Other reasons: _____

4. What are or were your sources of money for buying the chemicals you have used? _____

_____

B. Which of these have you had? ( ) Blackouts ( ) Bad reactions ( ) Withdrawal symptoms

( ) Overdoses ( ) Detoxification in a hospital ( ) Other problems:

C. Treatment for chemical use

Dates From	Dates To	Agency/provider	Type of program*	Voluntary? (Yes or no)	Length of treatment	Methods used	Participation in aftercare programs (No/Which?)	Effects of treatment†

*In the fourth column, use these codes: AA/NA = Alcoholics Anonymous/Narcotics Anonymous; O = Outpatient counseling; ID = Inpatient detoxification; IT = Inpatient treatment (e.g., 28-day); O = Other.

†In the last column, use these codes: W = made situation Worse; N = No change; U = better Understanding of addiction; Rÿ20= Reduction of use; BA = Brief abstinence; LA = Long-term abstinence; O = Other: _____

Chemical Use Survey (page 2 of 2)

Name: _____ Date: _____

D. Family patterns of chemical use

Please describe the chemical(s) used by family members.

			First use		Last use		Over the last 30 days		
Name	Chemical	Age	Amount	Date	Amount	Amount	How often	Effects
Father									
Mother									
Brothers/ sisters									
Spouse									
Other relatives									

Please add any other information you think is important: _____

_____

_____

F. Self-description of use

1. Would you say you are a social drinker are a heavy drinker are an alcoholic or have a drinking problem? Or how would you describe your use? _____

_____

2. Would you say you are a recreational drug user are an addict or have a drug problem? Or how would you describe your use? _____

_____

G. Other

Has your drinking/drug use caused you any spiritual problems? _____

_____

_____

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between behavioral health providers and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share protected health information (PHI) with your Primary Care Physician (PCP). This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication if necessary.

I, _____ (Patient Name – Please Print), _____ (Patient Identification Number), _____ (Patient Date of Birth - MM/DD/YYYY)

authorize _____ (Provider Name – Please Print), to release protected health information related to my evaluation and treatment to:

PCP FAX: _____

PCP Name: _____ **PCP Phone:** _____

PCP Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Information to be completed by Behavioral Health Provider

I saw _____ (Patient Name – Please Print) on _____ (Date) for _____ (Reason / Diagnosis)

Summary: _____

The following medication was or will be started (indicate medication & dosage): _____

If no medication is indicated, check as appropriate:

_____ Medication not prescribed _____ Patient refused medication _____ Psychotherapy suggested before trying medication

Treatment recommendations:

Lab tests for the following: _____ CBC _____ Thyroid Studies _____ Chem Panel _____ EKG

Other treatment recommendations: _____

If you have any questions or would like to discuss this case in greater detail, please call me at: _____ (Phone Number)

_____ (Provider Signature) _____ (Provider Printed Name) _____ (Licensure)

Patient Rights

- You can end this authorization (permission to use or disclose information) any time by contacting:

_____

- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law.
- You do not have to agree to this request to use or disclose your information.

Patient Authorization

I, the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified. I have read and understand the above information and give my authorization: PATIENT PLEASE CHECK ONE

_____ To release any applicable mental health / substance abuse information to my primary care physician.

_____ To release only medication information to my primary care physician.

_____ I DO NOT give my authorization to release any information to my primary care physician.

_____ (Patient Signature) _____ (Date) _____ (Signature of Patient's Authorized Representative) _____ (Date)

If signed by Authorized Representative, describe relationship to patient: _____

PROVIDER: PLEASE SEND A COPY OF THIS SIGNED FORM TO THE PRIMARY CARE PHYSICIAN AND KEEP THE ORIGINAL IN THE TREAMENT RECORD

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this ...