Jacob Palathinkal NP Psychiatric Services PLLC
Adult Psychopharmacologist/Psychodynamic Psychotherapist

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Today's Date:_____

Patient Name: _____ DOB:_____

Forms completed by (if not self): _____

Patient Address: Sex: Male Female

_____

(Street/Apartment) *(City)* *(State)* *(Zip)*

Contact Number: (_____)_____ Name/Relation _____

*Please indicate where we may leave you a voicemail with an asterisk**

E-mail Address: _____

Religion: _____ Ethnicity: _____

Presenting Problem (reasons why you are seeking psychiatric service today)

_____

_____

Referral Source:

Doctor_____

(Name) (Address) (Phone)

Friend or relative_____

Other (please specify)_____

In Case of Emergency Contact:

Name: _____ Relationship to you: _____

Phone Number(s): _____

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Home Phone: (_____) _____ Work Phone: (_____)_____

Cell Phone: (_____)_____ Other Phone: (_____)_____
*Please indicate where we may leave you a voicemail with an asterisk**

E-mail Address: _____
*Please consider the sharing of confidential information (appointment times, names, etc.) with this email address**

Occupation/Place of Business: _____

Highest Level of Education Achieved & Date of Completion: _____

Religion:_____ Ethnicity:_____

Marital Status: _____ Spouse Name: _____

Please describe any known health problems, medical problems, medical issues, past hospitalizations, surgeries, developmental problems, etc. for the patient:

_____

_____

_____

Current medications:

_____

_____

_____

Allergies:

_____

Please describe any significant mental or physical health issues of patient's family members (parents, siblings, grandparents, aunts, uncles, children, spouse, etc.)

_____

_____

_____

_____

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Current/Previous Psychological Evaluations and Treatments:

Name of Doctor, Agency, Hospital, etc.	City, State	Date(s)	Briefly explain services provided and outcome

Additional information not previously mentioned:

_____

_____

_____

_____

_____

_____

_____

_____

220 South Service Rd, Suite 23, Roslyn Heights , NY 11577

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PRACTICE POLICY STATEMENT

Fees and Payment

Initial evaluations are approximately 1 hour in length. The standard fee for the initial evaluation session is $475.

Regular Medication management: The standard fee for a medication management visit is $250.

Fees are set at the beginning of treatment and based on: (1) the standard charge of the doctor, and (2) the patient's ability to pay. Insurance plan coverage is considered part of the patient's ability to pay. Once determined, this fee forms the basis for all regular psychotherapy billings. "Cost of living" increases may be levied, but this will not be done within the first year of treatment and will not be done without first informing the patient that an increase is planned.

Payment is due at each session for medication management; payment for the therapy session is expected at the end of the month or after four-five sessions . You may pay by cash,zelle, or check (made payable to Jacob Palathinkal NP). If you wish to pay by check, please do so at the beginning of the session so that we may utilize the full session time to address your clinical concerns. Failure to pay for two consecutive sessions may result in suspension of therapy until payment is made. Credit card information provided at the initiation of treatment will be used to secure payment if none is made within the requested time period or for cancelation policy.

Returned checks will result in an additional $35 fee charged to the patient.

I have read and understood the aforementioned practice policies regarding payment and fees. I accept the fees set by the office as stated in the policy above. I am aware that I will be charged the full session fee in the event that I cancel my session within forty-eight (48) hours of my session day and time.

Patient: _____

Signature & Date: _____

Insurance

"Reimbursable diagnoses": Please be aware that not all psychological disorders are considered "reimbursable" by all insurance companies. It is illegal to alter a diagnosis simply to fit insurance company guidelines.

Insurance forms: Receipts of payments will be emailed following each session. It is fraudulent to submit forms for reimbursement prior to receipt of payment.

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Protected Health Information: Communication with insurance companies for the purpose of reimbursement requires that the doctor/clinician release Protected Health Information. In order that the doctor may communicate with insurance companies, the patient or guardian must sign a release form explicitly permitting this communication, as specified in federal HIPAA regulations designed to protect patient confidentiality. No Protected Health Information will be released to insurance companies without a signed release of information explicitly permitting such an action. Please see accompanying form outlining further details of Protected Health Information and HIPAA guidelines.

Cancellation Policy
Once treatment has begun, consistency and regularity of sessions will contribute to your reaching your therapeutic goals. Your doctor/NP reserves specific time for you.

Discontinuing treatment- If patient is not seen once within a 3-month period, provider will assume that he/she is no longer interested in receiving treatment and their chart will be closed

Credit card information will be collected at the time of the initial appointment. If less than forty-eight-hour notice is given for a cancelled appointment, your credit card will automatically be charged at the fee mentioned above.

Emergencies
In the event of an emergency, the patient should go to the nearest emergency room.

Advance Practice Nurse Availability
Your doctor/NP will not answer calls while in session and there may be an unavoidable wait before a telephone call is returned. Please refer to the office emergency policy or any specific policy put into place by your doctor in the event that you need immediate care.

I have read and understood the policies surrounding insurance, cancellations, emergencies and availability.

Patient (Print name): _____

Signature & Date: _____

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CONSUMER ISSUES

As a consumer of psychological services, you retain the following rights:

1. The right to know the training and qualifications of your doctor/prescribers such as: degrees, licenses, specialized trainings.

2. The right to know and to participate in setting the goals of therapy.

3. The right to know the progress made toward these goals during the course of therapy.

4. The right to know and to participate in the establishment of the treatment plan.

5. The right, as a competent adult, to refuse treatment for yourself or your child.

6. The right to terminate therapy or refuse to participate in research, at any time, without prejudice.

7. The right to obtain a second opinion from a qualified professional.

8. The right to give feedback, at any time, to your doctor.

9. The right to know the rationale for treatment decisions.

10. The right to complete confidentiality [except in circumstances when express written permission is given by the patient or parent, or if: (1) the patient threatens to harm him/herself, (2) the patient threatens to harm another and identifies that individual, (3) there is suspicion of child abuse at any time.]

This list is meant to inform but is by no means exhaustive. You also have the right to investigate with qualified sources any further rights you may have. In New York, licensed professionals are monitored by the State Board of advance practice nursing and must adhere to the ethical guidelines established by the Board. Professional societies, such as the ANA also provide guidelines of conduct for Nurse Practitioners.

You are encouraged to resolve any issues directly with your doctor/Clinician. However, the above organizations are available to you if a resolution is not reached to your satisfaction.

I have read and understood the stated consumer issues and acknowledge my right to resolve any issues directly with my doctor.

Patient (Print name) :_____

Signature & Date:_____

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HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization

I authorize_____ *(healthcare provider)*
to use and disclose the protected health information described below to:

_____ *(individual seeking the information)*

2. Effective Period

This authorization for release of information covers the period of healthcare from:

☐ a. _____ to _____

OR

☐ b. all past, present, and future periods

3. Extent of Authorization

☐ a. I authorize the release of my complete health record (including records relating to mental healthcare, and treatment of alcohol or drug abuse).

OR

☐ b. I authorize the release of my complete health record with the exception of the following information

☐ Mental Health Records
☐ Alcohol/Drug Abuse Treatment
☐ Other (please specify):_____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my 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.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

X_____ _____
***Signature** of Patient or Personal Representative* *Date signed*

X_____ _____

220 South Service Rd, Suite 23, Roslyn Heights , NY 11577

Printed *Name of Patient or Personal Representative* *Relationship to Patient*

MAJOR CREDIT CARD INFORMATION

Name on card:_____

Billing Address:_____

_____

Type of Credit Card (Circle one): Visa Master Card Amex

Credit Card Number:_____

Expiration Date (Month/Year):_____

Security Code (3-digit code on back near signature):

- **I understand that my credit card information is being obtained by Jacob Palathinkal NP, Psychiatric Services PLLC and will be utilized for the purpose of securing payment if I:**

  (1) Fail to pay for scheduled sessions

  (2) Cancel a session with less than 48-hour notice

  (3) Choose this method of payment for sessions

- **I will notify NP Palathinkal should the payment/credit card information change.**

Patient (Print name): _____

Signature & Date:_____