HARRIS PSYCHIATRIC SERVICES, PLLC

Harris Psychiatric Services PLCC

222 Middle Country Road
Suite 310
Smithtown, NY 11787

(p) 631-265-1622
(f) 631-265-3042

Last Name_____ First_____ Date: _____

Address_____

Home Phone_____ Work Phone_____ Cell Phone_____

e-mail address_____

Employer/School_____ Occupation_____ Student/Grade_____

Social Security No _____-_____-_____ Date of Birth_____ Age_____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed Gender: [ ] Male [ ] Female

Emergency Contact Name _____ Relationship to patient _____

Home Phone_____ Mobile Phone _____

Referred By _____ Address/Phone _____

Primary Care Physician_____ Address/Phone _____

OTHER TREATING PROVIDERS

Name_____ Address/Phone _____

Name_____ Address/Phone _____

INSURANCE INFORMATION

**** *skip to next page if worker's compensation or no-fault* ***

Primary Insurance: Carrier Name _____

Insured Name _____ Insured D/O/B_____ Relationship to patient _____

Address _____

Ins. ID#_____ Group# _____

Employer: _____ Insured Social Security # _____

Secondary Carrier: Carrier Name _____

Insured Name _____ Insured D/O/B_____ Relationship to patient _____

Address _____

Ins. ID#_____ Group# _____

Employer: _____ Insured Social Security # _____

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Insurance Carrier Information :
(Worker's Compensation and No-Fault Patients only)

Please Select: [ ] Worker's Comp [ ] No-Fault

Patient's Name: _____ Date of Accident/Injury: _____

Insurance Carrier Name: _____

Address: _____

City/State/Zip _____

Phone: _____

Claims Adjuster: _____

Adjuster Phone #: _____ Adjuster Fax #: _____

Claim #: _____

W.C. B. Case #_____W.C. Carrier Case #: _____

Are you currently working? [ ] YES [ ] NO

If no, provide first date of disability (when you stopped working): _____

Worker's Compensation / No Fault Attorney Info:

Name:_____

Address/City/State/Zip:_____

Phone #:_____ Fax #: _____

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STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please provide us with the names of persons/organization to whom protected health information may be disclosed (*examples: spouse children, attorney, therapist, primary care provider*). Mark the category of information you wish to release.

Name of person/organization
( ) All medical information
( ) All billing information
( ) Appointments
( ) Other

Name of person/organization
( ) All medical information
( ) All billing information
( ) Appointments
( ) Other

Name of person/organization
( ) All medical information
( ) All billing information
( ) Appointments
( ) Other

Name of person/organization
( ) All medical information
( ) All billing information
( ) Appointments
( ) Other

Expiration of Authorization
This authorization is in effect until it is revoked or terminated in writing by the patient or patient's personal representative.

Name of patient (print or type) Date

X _____
Signature of Patient or Signature of Patient Representative / Relationship of Patient Representative to Patient

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information within the past 6 years
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide mental health care

We may use and share your information as we:

- Treat you
- Bill for your services
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

When it comes to your health information, you have certain rights.

- You can request alternative means or location for receiving confidential communication
- You can ask to see or get copy of your medical record and other health information we have about you.
- You can ask us to correct health information about you that you think is incorrect or incomplete. You can ask for a paper copy of this notice at any time. We will provide you with a paper copy promptly.
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we 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 us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting our office manager at 631-265-1622
- 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/*

For certain health information, you can tell us your choices about what we share. Share information with your family, close friends, or others involved in your care

We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We typically use or share your health information in the following ways:

We 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.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Reporting suspected child abuse / neglect
- Preventing or reducing a serious threat to anyone's health or safety

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it upon request.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Effective 2/6/2018

.....

[ ] By checking this box I acknowledge that I have reviewed the notice of privacy practices and am aware that I can receive a copy upon request.

X _____ _____

Signature of patient / patient's legal representative **Date**

FOR OFFICE USE ONLY

[ ] patient refused to sign acknowledgement of receipt of privacy practices

Reason: _____ *Date:* _____ *Initials:* _____

Informed Consent to Psychiatric Care and Statement of Office Policies

Informed Consent: Thank you for choosing Harris Psychiatric Services. We want you to know what to expect as you participate in treatment at our office. We offer both psychiatric medical treatment as well as individual/group psychotherapy for the treatment of psychiatric illness.

Confidentiality: Your confidentiality is one of our highest priorities. We are in compliance with the legislation called HIPAA, which stands for Health Insurance Portability and Accountability Act. At your first visit, you will be asked to review and sign a release indicating any individuals/companies that you wish us to disclose our health information.

Scheduling and Keeping Appointments: Keeping appointments are an important part of treatment as well as for the management of our practice. Please keep this in mind as you schedule your appointments. If you are unable to keep an appointment for any reason, please call us as soon as possible. No -Show/Rescheduled or Cancelled appointments will impact your ability to receive future prescriptions. Prescriptions and refills can only be given at a follow-up appointment. **Certain medications that you may be prescribed cannot be stopped abruptly. Should you run out of medications, you may need to seek emergency treatment if withdrawal symptoms occur.** After two missed appointments or late cancellations, appropriate action will be taken. If you come late or early for an appointment, patients that arrive at their scheduled time will be seen before you.

Prescriptions: When medications are prescribed, they must be taken as directed. As with any medications, there are always possible side effects that you and your provider will discuss. It is your responsibility to keep track of the quantity of your medications. We require 72 hours advanced notice for all prescriptions needed including controlled substances. If you have refills, please contact your pharmacy. Prescription requests will only be handled during our normal business hours.

Forms and Paperwork: Most forms will not be completed on the same day as they are received. Requests to handle forms and paperwork may require an additional session with the provider to complete.

Emergency/After Hours: If you have an **emergency** after hours, please go to the nearest emergency room, or call 911.

If you have an **urgent** need for a practitioner after hours, please listen to our entire voicemail message. It will have options for you to contact your practitioner.

I have read, understand, and agree with the above informed consent and office policy statements. I have discussed any issues that may have been raised by this document with staff.

Signature (client, parent or guardian as needed) Date

WORKERS COMPENSATION ONLY

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER			

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature _____ Date _____

Provider's Name and Address Harris Psychiatric Services, PLLC

222 Middle Country Road #310, Smithtown, NY 11787

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.

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CONTROLLED SUBSTANCE POLICY

In coordination with standards of care as well as current medical guidelines and regulations, Harris Psychiatric Services will be implementing a strict policy regarding prescription of controlled substances.

1. Patients must come, in person, to their appointments in order to continue treatment with controlled medication without interruption

2. If, for any reason, you must cancel your appointment, you will only be given enough medication to get you through to your next appointment AND if you cancel or do not show up to that appointment you will not be prescribed any controlled substance until you can be seen in the office for an appointment.

3. Please review the attached list of withdrawal symptoms and names of commonly prescribed psychotropic controlled substances. If, at any point, you suspect that you are withdrawing from medication, please present to your local emergency room. No Show/Reschedules or Cancelled Appointments may affect your ability to receive future prescriptions.

4. Our providers may decide to discontinue treatment with controlled medications if there is any suggestion of abuse or misuse of medication. Providers may also discontinue treatment with controlled medication if there is a trend of cancelling, rescheduling or not showing up for appointments

I have reviewed the Harris Psychiatric Services' policy for controlled substances and understand that I will need to be compliant with attending appointments in order to continue my treatment with controlled medication. I have also been provided with a list of commonly prescribed controlled psychiatric medications and have been educated as to symptoms of withdrawal.

Printed Name: _____

Signature: **X** _____ Date: _____

Updated 2/7/2018 -AKC

COMMONLY PRESCRIBED CONTROLLED SUBTANCES IN PSYCHIATRY

please take this list home

Benzodiazepines

- Xanax (alprazolam)
- Ativan (lorazepam)
- Klonopin (clonazepam)
- Restoril (temazepam)
- Halcion (triazolam)
- Valium (diazepam)
- Serax (oxazepam)

Amphetamines / Stimulants

- Adderall / Adderall XR (dextroamphentamine/ amphetamine/ mixed amphetamine salts)
- Ritalin/Ritalin LA (methylphenidate)
- Concerta (methylphenidate)
- Vyvanse (lisdexamfetamine)
- Provigil (modafinil)
- Nuvigil (armodafinil)

Sedative Hypnotics

- Ambien /Ambien CR (zolpidem)
- Luesta (eszoplicone)
- Sonata (zaleplon)
- Belsomra (survorexant)
- Rozerem (ramelteon)

MEDICATION WITHDRAWAL

Withdrawal from benzodiazepine medication can be dangerous and should be taken seriously. If you have run out of medication and are experiencing symptoms of withdrawal, please go to your nearest emergency room. Some of the most common symptoms include:

- Agitation / Restlessness
- Diarrhea
- Dizziness
- Double vision
- Elevated blood pressure
- Fatigue/Weakness
- Flu-like symptoms
- Gastrointestinal upset
- Nausea and vomiting
- Headache
- Hot and cold spells
- Insomnia
- Sweating
- Rapid heartbeat and heart palpitations
- Tremor
- Hallucinations
- Seizure
- Irritability

Amphetamine withdrawal can be uncomfortable however is unlikely to cause serious medical complications. Some of the most common symptoms include:

- Fatigue/Weakness
- Insomnia / Hypersomnia (too much/ too little sleep)
- Increased appetite
- Vivid, unpleasant dreams
- Mood decline

The sedative hypnotics listed above are unlikely to cause symptoms of withdrawal

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WORKERS COMPENSATION / NO-FAULT ONLY

PATIENT DEMOGRAPHICS FOR TITAN PHARMACY

NAME:_____ DOB:_____

TODAYS DATE: _____

ADDRESS (please include apartment number):

_____

_____

PHONE: _____

ALLERGIES: _____

DATE OF INJURY: _____

INSURANCE CARRIER: _____

CASE CARRIER #: _____

WCB #: _____

TITAN PHARMACY:
(F) 718-267-8562
(T) 718-267-8063