Client Name: _____ DOB: _____

PANICCIA
PSYCHOTHERAPY

Patient Demographic Form

Name (As it appears on insurance card):_____

Preferred Name: _____ Administrative Sex: _____ Gender Identity:____

Preferred Pronouns: _____ Date of Birth:_____

Address: _____

Mobile Phone:_____ Home Phone: _____ Email: _____

Are text message reminders for appointment okay? _____

Sexual Orientation: _____ Race: _____ Languages Spoken: _____

Employment: _____ Marital Status: _____

Emergency Contact (Name/Relationship/Phone Number):_____

Insurance Information

Primary Insurance: _____ ID #:_____ Group #:_____

Policy Holder Name/DOB: _____ Phone #: _____

Secondary Insurance: _____ ID #:_____ Group #:_____

Policy Holder Name/DOB: _____ Phone #: _____

Client Name: _____ DOB: _____

Past Psychiatric Treatment Information

In the past year have you been hospitalized/gone to the ER or DASH for a psychiatric emergency? _____ If yes, please elaborate:

_____

_____

_____

Are you on any psychiatric medications? _____ If yes, who is your prescriber? _____

Have you engaged in any psychiatric treatment (therapy/medication management/partial programs/drug and alcohol programs/inpatient programs etc.) in the past 5 years? _____ If yes, please elaborate:

_____

_____

_____

Client Name: _____ DOB: _____

Paniccia Psychotherapy
1777 Veterans Memorial Hwy, Ste. 14
Islandia, NY 11749
631.212.2405

Informed Consent

What to Expect During Counseling:

The purpose of our sessions is to get help with problems in your life that are bothering you or that are keeping you from being successful at work, in relationships or any other important areas of your life. You may be here because you wanted someone to talk with who could help you sort out some of your feelings and/or problems. You may also be here because someone else suggested you seek help such as a significant other, doctor, employer or legal entity because of their concerns for you. Either way, when we meet, we will discuss these problems and your feelings surrounding these problems. I will ask you important questions listen to your answers and make suggestions to help you begin to deal with these problems. It is important that you feel comfortable talking and sharing information with me regarding the issues that are bothering you. Sometimes the topics we will explore will be difficult for you to discuss for many reasons (embarrassment, fear, sadness etc.). For most people, knowing that what they say will be kept private helps them to feel more comfortable sharing information. This leads to having more trust in the therapeutic process. Privacy, also called confidentiality, is an important and necessary part of good counseling.

Confidentiality is the golden rule of good counseling and I will keep the information you share with me in our sessions confidential unless I have written consent to disclose information. Nevertheless, there are some exceptions to the rule that are important for you to understand before you share the information with me. There are some situations where I am required by law or the guidelines of my profession to disclose information whether or not I have your permission. The following is a list of some of these situations.

Confidentiality Cannot Be Maintained When:

You tell me that you have a plan to cause serious harm or death to yourself and I believe you have the intent and the ability to carry out this threat in the near future. I must take steps to protect you from harming yourself which may include alerting an emergency contact, physician and/or calling emergency services.

You tell me that you plan to cause serious harm or death to someone else who can be identified and I believe that you have the intent and ability to carry out this threat in the near future. I must take steps to protect the person who is being threatened which may include alerting an emergency contact, physician, calling emergency services and contacting the person who you intend to harm.

A formal request is made by the courts regarding information discussed in our therapy session due to your involvement in a court case. If this happens, I will not disclose information without your written agreement ***unless*** the court requires me to do so. I will do everything I can within the law to protect your confidentiality and inform you of the disclosure to the courts if I am unable to refrain from the disclosure.

Sometimes your doctor and I may need to work together; for example if you need to take medication in addition to seeing a therapist. I will get your written permission before sharing any information with the doctor. The only time I will share information with the doctor without permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

I have read the Informed Consent Form and I understand my rights and agree to the above stated policies about confidentiality.

Client/Parent Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Client Name: _____ DOB: _____

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631-212-2405

Patient Contract

I, _____ have read, understand and agree to the following contract with the office of Megan Paniccia, LCSW.

_____ Fees and Copays are due at the time of the visit in form or cash, check or credit card. In the event that your insurance company does not reimburse this office for services rendered, the balance is your responsibility to pay in full.

_____ There is a fee of $50.00 for missed therapy appointments **without 24 hours' notice of cancellation.**

_____ Should you fail to cancel an appointment, and I arrive when you are not home, you will be responsible for the **full fee associated with the session**.

Client/Parent Signature:_____Date:_____

Witness Signature: _____Date:_____

Client Name: _____ DOB: _____

Paniccia Psychotherapy
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631.212.2405

Informed Consent & Confidentiality Agreement

I, _____ agree and consent to participate in behavioral health treatment provided by Megan Paniccia, LCSW. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within the scope of the provider's license, certification and training or the scope of the license, certification and training of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of 18 or unable to consent for treatment, I attest that I have legal custody of this individual and I am authorized to initiate and consent for treatment and/ or legally authorized to initiate and consent to treatment behalf of this individual.

I understand that information and treatment sessions are kept strictly confidential except in certain events. Please initial each statement to indicate your understanding/acceptance.

_____ My therapist is required by law to report suspected child abuse or neglect to the proper authorities (Police, CPS).

_____ If I indicate that I intend to harm myself or I pose an immediate danger to myself, my therapist is required to take steps to try to protect me, including notifying others such as police, other health care providers and/or my family who may assist in protecting me.

_____ In the event I inform my therapist that I intend to harm another individual, she is required to take steps to warn or protect that person by informing the individual, the police and/or other health care providers.

Client/Parent Signature:_____Date:_____

Witness Signature:_____Date:_____

Client Name: _____ DOB: _____

Paniccia Psychotherapy
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Islandia, NY 11749
631.212.2405

Insurance Release Form

I, _____ consent that the following information acquired by Megan Paniccia, LCSW be disclosed to:

Person or Agency: _____
_____
_____

_____ The specific information to be disclosed: Demographics, Treatment Dates, Diagnosis, Treatment Goal, Treatment Issues, Treatment Authorization, Policy Coverage and any other Insurance Related Information.

_____ The specific purpose and need for such information is: **INSURANCE REIMBURSEMENT**

_____ I understand my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without written consent unless otherwise provided for in the regulations. I also understand I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically when payment for all provided services has been paid in full by me and/or my insurance company named above.

Client/Parent Signature:_____Date:_____

Witness Signature:_____Date:_____

Client Name: _____ DOB: _____

Paniccia Psychotherapy
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Islandia, NY 11749
631.212.2405

Emergency Contact Release Form

I, _____ consent that the following information acquired by Megan Paniccia, LCSW be disclosed to:

Person or Agency: _____
_____
_____

_____ The specific information to be disclosed:
_____
_____
_____
_____.

_____ The specific purpose and need for such information is to coordinate care regarding the above information.

_____ I understand my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without written consent unless otherwise provided for in the regulations. I also understand I may revoke this consent at any time.

Client/Parent Signature:_____Date:_____

Witness Signature: _____Date:_____

Client Name: _____ DOB: _____

Paniccia Psychotherapy
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Islandia, NY 11749
621.212.2405

Release Form

I, _____ consent that the following information acquired by Megan Paniccia, LCSW be disclosed to:

Person or Agency: _____
_____
_____

_____ The specific information to be disclosed:
_____
_____
_____

_____ The specific purpose and need for such information is to coordinate care regarding the above information.

_____ I understand my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without written consent unless otherwise provided for in the regulations. I also understand I may revoke this consent at any time.

Client/Parent Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Client Name: _____ DOB: _____

Paniccia Psychotherapy
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Islandia, NY 11749
631.212.2405

NPI# 1194319210

Telemedicine Informed Consent Form

I, _____ , hereby consent to engaging in telemedicine with Megan Paniccia, LCSW as part of my psychotherapy. I understand that "telemedicine" includes the practice of healthcare delivery, diagnosis, consultation, treatment using interactive audio-video communications. I also understand that, with my signed consent, telemedicine may involve the electronic communication of my medical/mental healthcare information to other healthcare practitioners. The rights stated supplement those rights I have generally as a patient of the above-named provider.

I understand that I have the following rights with respect to telemedicine:

I have the right to withhold/withdraw consent to telemedicine treatment at any time.

The laws that protect the confidentiality of my medical/healthcare information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there may be mandatory exceptions to confidentiality, including reporting child abuse and the imminent risk of danger to self or others. If I put my mental state at issue in certain legal proceedings, then the psychotherapist may be compelled to release otherwise confidential information about my evaluation and treatment.

I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that the transmission of my medical information could be interrupted or distorted by technical failures or unauthorized persons, and that the electronic communication of my medical information could be accessed by unauthorized persons.

I understand that telemedicine-based services and care may not be as complete or effective as face-to-face services. I also understand that if my therapist believes I would be better served by in-person psychotherapeutic services, I will be referred to a psychotherapist who can provide such services in my area. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may even get worse. I understand that I may benefit from telemedicine, but that the results cannot be guaranteed or assured.

As with all medical records, I understand that I have a right to access my medical information and copies of my medical records of telemedicine treatment in accordance with New York State law.

I have read and understand the information provided above. I have discussed it with the above-mentioned therapist and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment.

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Signature Date

Client Name: _____ DOB: _____

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631.212.2405

NPI #1194319210

Credit Card Agreement

Name on Card: _____ Card Type: _____

Card Number: _____ Exp. Date: _____ Sec. Code: _____

I understand that there is a **$50 no show fee** applied to all missed appointments that are not cancelled within 24 hours. In the event that I miss an appointment and do not call within this designated time I understand that this fee will be automatically applied to the above listed credit card.

_____ _____

Client/Parent Signature Date