Sheehan Psychotherapy Associates, Inc.
33 College Hill Rd., Suite 30E, Warwick, RI, 02886
Phone: (401) 821.6070 Fax: (401) 821.6047

Date of 1st Appointment: ____________________

Name _____________________ **Date of Birth** __/__/____ **Age** __ **Social Sec. #** __________
Gender M__ F__ Other ______________ **Email Address** ______________________
Address _______________________________ **City** _______________ **State** __ **Zip** _______
Telephone: *Cell* _____________ *Home* ____________ *Work* __________ Ext. _____
May we contact you at the numbers/address listed regarding appointments? __________
If not, what is your preferred method of contact? _____________________________
Marital Status: Single Married Divorced Separated Widowed Domestic Partnership
If employed, employer name ________________________ Occupation ___________________
How did you find out about our agency? ____

Insurance Information
Primary Insurance ____________________ **Secondary Insurance** __________________
Policy # ____________________________ **Policy #** ____________________________
Name of Policy Holder _________________ **Name of Policy Holder** _________________
Policy Holder Date of Birth ______________ **Policy Holder Date of Birth** ______________
Subscriber's Address (if different from above) Primary _______________________________
Subscriber's Address (if different from above) Secondary _____________________________
Relationship: Self__ Spouse __ Child __ Other __ /// Self __ Spouse __ Child __ Other __
Is the condition you are seeking help for related to your employment? Yes __ No __
➔ An accident? Yes __ No __ If you answered yes to either of the questions above,
please explain and let us know who is responsible for claims related to your care
____

Health Information
Please describe any mental health/psychiatric care you are currently receiving or have received in the past
____
____
____

Name of Primary Care Physician _______________________ **Phone** __________________
Please list **all** current medications and prescribers (feel free to attach a list if necessary)
____
____
____

Name of **emergency contact person** and their **relationship** to you _______________ - ________
Emergency Contact Phone: Cell ________________ Home _______________ Work ___________

X ____ __________
Client Signature (or Parent/Guardian Signature if Client is under 18 years of age) **Date**

Please sign above before proceeding

Sheehan Psychotherapy Associates, Inc.

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Rights and informed consent

Welcome to our practice! All of our therapists are licensed to practice in the state of Rhode Island. All persons are eligible for our services, regardless of race, ethnicity, gender, sexual orientation, disability, religion, or creed. We use a number of different approaches in our work and will discuss with you the strategies we believe may best meet your needs.

Psychotherapy works best when it is a cooperative and collaborative effort. It calls for a very active effort on your part, and you will have to work on what we talk about both during our sessions and at home. You have the right to be informed about your therapy, any risks it may involve, and your therapist's qualifications to treat you. You have the right to request or refuse any particular technique or to withdraw from therapy at any time. If you could benefit from treatment we cannot provide, it is our ethical obligation to offer to refer you to someone who may be able to help you. If you wish to examine your records, your therapist will go over them with you and answer questions you may have. To do this, we require one week notice in order to review your record. Your feedback about therapy is always welcome, and you should communicate with your therapist about any concerns you might have. If you would like further assistance, you may speak with the Director of the practice, Ashley Marzullo, or your therapist will help you find another professional.

Psychotherapy has helped many people, but success is never guaranteed. There are some risks in treatment; as problems are faced, they do sometimes worsen. As people work to improve the quality of their lives, their decisions can lead to painful outcomes or conflict with others. Psychotherapy has been shown to have many benefits; therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. You are the final judge of the benefits and risks of therapy.

Assignment of Benefits and Authorization to Release Information

I hereby authorize direct payment of mental health benefits to Sheehan Psychotherapy Associates, Inc., for services rendered. I understand that I am financially responsible for any balance not covered by insurance. I also authorize Sheehan Psychotherapy Associates, Inc., to release any medical/mental health information that may be necessary for either medical care or in processing applications for financial benefit. I request that payment of authorized benefits be made on my behalf. I am aware and do consent and authorize Sheehan Psychotherapy Associates, Inc., to disclose information pertaining to my Review/Managed Care Company or subcontractor employed by my insurance company.

This information needs to be disclosed for the purpose of obtaining health insurance payments for charges incurred by the patient as a result of treatment at Sheehan Psychotherapy Associates, Inc. I am aware that my records are protected under the Health Insurance Portability and Accountability Act of 1996 (45CFR, parts 160 and 164), Federal regulation 42 CFR Part 2 (Confidentiality of Alcohol and Drug Abuse treatment), otherwise specifically provided for by law.

Emergencies

For after-hours emergencies, please call 911 or go to the nearest emergency room.

Urgent Calls

You may leave a message on the emergency line 401-821-6070 ext. 3 for urgent needs. These include new suicidal thoughts and worsening mental illness. Appointment changes and questions are not considered urgent and will be returned by the office during the next business day.

X ____

Signature of Patient/Guardian/Parent **Date**

HIPAA Notice of Policies and practices:

I am required by Federal Law (Health Insurance Portability and Accountability Act, known as HIPAA) and by State law to protect the privacy of your personal information and to give you a notice that describes (a) how clinical information about you may be used and disclosed and (b) how you can get access to this information. Please ask for a copy of the HIPAA Notice of Policies and Practices should you wish to have a complete copy for your records. (this can also be found on our website)

Fees and Payment

We charge fees for various services as listed below. Feel free to contact the business office for information.

$25 returned check fee **$80** late cancellation/missed appointment fee (less than 24 hour notice)
$135 diagnostic interview **$110** family psychotherapy
$100 individual psychotherapy **$40** group psychotherapy

A fee is charged for other professional services you may need, such as report-writing, telephone conversations lasting longer than 5 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request. If you become involved in legal proceedings that require the participation of your psychotherapist, you will be expected to pay for all of the therapist's professional time, including preparation and transportation costs, even if your therapist is called to testify by another party. We charge $120 per hour for preparation and attendance at any legal proceeding.

Cancellation Policy

The length of psychotherapy sessions is 45 minutes. That time has been specifically set aside for you. Should you be unable to come to your appointment, we ask that you provide at least 24-hour notice of cancellation so that we may offer other clients the appointment time. **Since we are unlikely to fill your appointment slot with less than 24-hour notice, we ask for your cooperation and understanding in paying the late cancellation or missed appointment fee of $80 if you provide less than 24-hour notice, even if you are sick. The one exception to this requirement is in the case of dangerous weather.** We do not require 24-hour notice when there is dangerous weather, but you will be charged if you have not notified us that you will need to cancel due to the weather. Our answering machine is working 24 hours per day and records the time and date of your calls.

It is expected that psychotherapy appointments will be kept by you, as part of your commitment to treatment. If you cancel or miss 3 appointments, or if there is a pattern of canceling/missing appointments, then we will talk with you about taking a break from therapy until you are able to commit to appointments.

You are financially responsible for all costs for the care you receive, except those services for which you are eligible through your health insurance coverage. Clients are expected to pay any co-payments, deductibles, co-insurances, and non-covered amounts when services are received. All requests for payments are based on estimated amounts and are not considered final billing totals, as we will adjust your bill after final payments have been received from insurance carriers. Insurance claims are submitted as a courtesy service and do not relieve you of financial responsibility. Our office is happy to answer any questions you may have about insurance.

Sheehan Psychotherapy Associates Inc. notice of privacy practices and additional information can be found on our website www.sheehanpsychotherapyassociates.com

Your signature indicates that you have read this document and agree to all of its terms

X ____
Signature of Patient/Guardian/Parent **Date**

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Coordination of Care Communication Form

MAY WE CONTACT YOUR PRIMARY CARE PHYSICIAN? YES ____ NO ____
If no, please skip to the next page

Patient Authorization for Release of Information

I, ______________________________, do hereby authorize Sheehan Psychotherapy Associates to release and exchange medical/psychiatric and psychological information pertaining to me/my child with my primary care physician. This authorization is for the exchange of information between the primary care physician and behavioral health clinician, and vice versa. This information will include information concerning diagnosis, treatment plan, tests, and medications. This authorization will expire no later than one year from the date of signature.

Signed (client/guardian) ________________________________ **Date** ______________
Notice to Recipient: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, Part 2) and/or state law. In accordance with the Federal and State law requirements, the information received pursuant to this document is confidential and recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally Investigate or prosecute any alcohol or drug patients.

Date: ____/____/____

Primary Doctor Name: ____________________________
Address: ____________________________
____
____
Doctor's Phone: ____________________________

Patient name: __________________________
DOB: _____________________________

This information is provided to facilitate coordination of treatment/continuity of care.

DSM V Diagnoses ____
____
The recommended treatment regimen is:
____
____

Please call me if you need to discuss this case further or if you require additional information.

_____________________________ _________________________ __________________
Signature of Psychotherapist Name (printed) Degree/License

Symptoms

Please rate your problems/symptoms for the last few weeks. 0 = not at all; 10 = severe

Anxious, nervous, shaky	____	Not able to deal with problems	____
Sad or blue	____	Not able to accomplish things	____
Hopeless about future	____	Financial problems	____
Everything is an effort	____	Angry feelings	____
No interest in things	____	Guilty feelings	____
Heart racing or pounding	____	Panic attacks	____
Trouble sleeping	____	Racing thoughts	____
Fearful or afraid	____	Worthless feelings	____
Problems at home/socially	____	Helplessness	____
Problems at school/work	____	Suicidal thoughts	____
Feeling bad about myself	____	Homicidal thoughts	____

Please circle any of the symptoms that you have experienced over the past 2 months:

low energy/fatigue   impulsiveness   inertia/moving slowly   restlessness   aggression

deceit/stealing   destructive behavior   disorganized   recklessness   self-harm

violating rules/rights of others   sensitive to rejection   phobias   anger

excessive worry   not caring/numb   inappropriate guilt   hopeless   tearfulness

irritability   loss of interest/pleasure   low self-esteem   mood swings   difficulty speaking

diminished thinking   distracted   indecisiveness   impaired memory   talking more than usual

talking faster than usual   jumping from topic to topic   poor concentration/attention   self-critical

hallucinations   obsessive thoughts   paranoia   dissatisfaction with looks   binge eating

self-induced vomiting   excessive laxative use   excessive exercising   gain/loss of weight of ≥ 5 lbs

trouble sleeping   waking up during the night   waking up too early   sleeping more than usual

Please describe any relevant medical problems:

____
____
____
____

Goals

What issues do you wish to change by coming to therapy? ______________________________________

____
____
____
____

Risk Assessment
Have you ever/are you currently engaged in self-harming behaviors such as cutting? _______________
Have you ever thought about/attempted suicide? If so, when and by what means? _________________
____
Are you currently thinking about suicide? ____
____
If yes, are there things in your life that would hold you back (family, friends, religious beliefs)? ________
____
Are you thinking about seriously hurting or killing someone else? If so, about whom are you having these thoughts? ____

Substance Use
Please indicate past and present use of the following substances

Substance	**Ever used? Y/N**	**Currently using? Y/N**	**If currently using, how much per day/week?**
Caffeine			
Alcohol			
Tobacco			
Marijuana			
Any other illegal substances (specify):			

Have you ever believed that substance use/abuse has caused problems in your life? _________________
Has anyone else expressed concern over your use/abuse of certain substances? ___________________
Have you ever experienced withdrawal symptoms when attempting to stop using substances? __________
Have you ever experienced blackouts related to substance use? ______________________________
Have you ever had problems with relationships, work, or the law related to your use/abuse of substances?
____
Have you ever participated in drug or alcohol treatment? _______________ If so, please describe:
____

Family of Origin
Please indicate members of the family of which you were raised and any relevant family history

Relation	Name	Age (or age of death)	Cause of death (if deceased)	History of alcohol/substance use/anxiety/ depression/eating disorder/bi-polar/psychosis/ trauma, etc.
Father				
Mother				
Stepparent				
Stepparent				
Sibling				
Sibling				
Others:				

Family Information
Please list the people living in your household, their relationship to you, and their ages (including children even if out of the house):
____
____
____
____
____

Trauma/Abuse
Have you ever been a victim of or witnessed any of the following types of abuse? If so, please briefly describe who was involved and when this took place.
Physical abuse (hitting, kicking, etc.) by a spouse/partner/parent/sibling? _______________________
____
Sexual abuse (such as unwanted touching or rape)? ___________________________________
Emotional abuse (such as threats, name-calling, intimidation)? ____________________________
Financial abuse (such as withholding child support, gambling)? ____________________________
If you have experienced any of the above, is the abuse still going on? ________________________

Spiritual Considerations
Do you feel that your religious or spiritual beliefs help you in life? Are you currently affiliated with a faith community? (church, temple, mosque) or spirituality-based group?
____
____

Your wishes:
Would you list the most important things you want to improve or change for you (such as: less depressed, able to make decisions, improved finances, less anxious, able to sleep)
____
____
____
____

Is there anything else you would like us to know, to help us help you?
____
____
____

Thank you for taking the time to fill out this form to help us understand your situation better.