14 Harwood Court, Suite 512
Scarsdale, NY 10583
tel. 914-723-MBHA
fax. 914-723-2156

142 East 27th Street, Suite 1A
New York, NY 10016
www.mbhany.com
Twitter: @MBHACTR

PATIENT INFORMATION FORM

Patient Name _____
Patient Email: _____DOB ____/____/____ Age: _____
Social Security Number: __ __ __ - __ __ - __ __ __ __ Gender: ___ Male ___ Female
Address_____
_____
Home Tel. ( ) _____ Cell Phone ( ) _____
Business or Other Number: ( ) _____

If under age 18, parents' cell numbers if applicable:
Mom: ( ) _____ Dad ( ) _____
If under age 18, parents' work numbers if applicable:
Mom: ( ) _____ Dad ( ) _____

School You Attend (if applicable): _____ Grade/Year: _____
Occupation (if applicable):
_____
Employer (if applicable):
_____

Responsible Party/Financial Guarantor: _____ myself _____ other (see below)
Name _____
Relationship to Patient: _____
Address (if different than patient):
_____
Tel: ( )_____ Alternate #: ( ) _____

If there is a medical or mental health emergency while under the care of Metro Behavioral Health Associates, please call:
Name: (print)_____
Relationship:_____ Cell: _____

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PAYMENT AND CANCELLATION POLICIES

1. You are responsible for all fees, which are due and payable at each session unless some other arrangement has been made in advance.

2. If you are unable to give 48 hours notice of an appointment cancellation, you will be responsible for the full fee for the missed session. (Cancellations for Monday appointments must be communicated by Friday as Sundays do not count as part of the 48 hour notice).

3. We do not participate directly in managed care. However, if you have out of network benefits, we will supply you with all you need to submit claims for reimbursement ***OR*** sometimes we can get what's called a single case agreement, wherein your insurance makes an arrangement to pay us out of network as if we were in network only if a) we are willing to accept their fees; b) there is a good reason not to use one of their in-network providers such as because they don't have a facility or program with this specialty or because geographically we are less burdensome than an existing in-network facility or because you have already seen or attended the provider or program that they might recommend in-network and prefer not to return.

My signature below that indicates that I have read & understood the Payment/Cancellation Policies.

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian if under age 18 Date

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TELL US YOUR STORY

Adapted in part from the Aronson Frommer Eating Patterns Questionnaire

Name (print) _____ **Date:** _____

Age:_____**Birthdate:** ___/___/____ **Gender:** ___M ___F____Other: _____

Living Situation (with whom, if applicable and the setting):

_____

1. Are you presently taking any prescribed medications? ____ Yes ___ No

Medication	Dosage and how often	Since when are you taking these…….

2. Overall, currently, how comfortable are you with your present patterns of eating?
_____ Very uncomfortable
_____ Somewhat uncomfortable
_____ Slightly uncomfortable
_____ Somewhat uncomfortable
_____ Somewhat comfortable
_____ Very Comfortable

3. Currently, how comfortable do you feel in or with your body:
_____ Very uncomfortable
_____ Somewhat uncomfortable
_____ Slightly uncomfortable
_____ Somewhat uncomfortable
_____ Somewhat comfortable
_____ Very Comfortable

p.2 **Name (print)** _____ **Date:** _____

4. Can you imagine loving your body at any size and returning to or starting to feed that body in an intuitive way? Please share your reactions and/or thoughts about this:

_____
_____
_____

5. **Only if applicable**, do you find yourself bingeing and/or emotional eating? If yes, check all that apply:
   _____ During meals, I sometimes can't stop eating
   _____ After meals are over
   _____ Between meals
   _____ I don't eat meals, but just binge

6. **Only if applicable**: what are the triggers that might make you restrict or not eat at all:
   _____
   _____
   _____

7. Does anyone know about your eating behaviors? ____ Yes ____ No
   Please explain in more detail who knows and who you don't want to know if applicable:
   _____
   _____
   _____

8. **Only if applicable**: What methods do you now use in an attempt to change your weight?

_____ Over-Exercise	_____Enemas
_____ Short-term fasting	_____Diet pills
_____ Self-induced vomiting	_____Restrictive eating
_____ Laxatives	_____Diuretics

   Other _____

9. **Only if applicable**: If you purge by self-induced vomiting, how often (by this we mean how many sessions and how many attempts per session)
   #of times per day ____ **or** #of times per week ___ **or** #times per month ____

10. **Only if applicable**: If you use laxatives, how often:
    #of times per day ____ **or** #of times per week ___ **or** #times per month ____

    How many do you take at a time _____

11. **Only if applicable**: If you use diuretics, how often:
    #of times per day ____ **or** #of times per week ___ **or** #times per month ____

12. Do you smoke cigarettes? ___Yes ___ No If so, how many per day? ___ per week? ___

 Name (print) _____ **Date:** _____

13. If you drink alcoholic beverages, what do you typically drink, how many, and how often? (**reminder: this questionnaire is absolutely confidential**)

_____
_____
_____

14. **Only if applicable**: check the substances you use or have used in the past 6 months and specify on average, how often you use or have used them:

Drug	Frequency (# times per day, week or month)
_____Marijuana	_____
_____ Heroin	_____
_____ Cocaine	_____
_____ Ecstasy	_____
_____ Quaaludes	_____
_____ Acid	_____
_____ Others (**please specify**)	_____

_____
_____

15. Overall, how often do you engage in social/interpersonal activities and in what settings? Please describe your comfort or discomfort level with these activities:

_____
_____
_____

16. What do you love to do for fun? In other words, what are the times that you feel completely engaged or able to have fun or creative or satisfied, etc? Please tell us:

_____
_____
_____
_____
_____
_____
_____

17. Is there anything else you would like us to know about you, why you have sought our assistance or about your situation?

_____
_____
_____
_____
_____
_____
_____

Thank you for taking the time to answer these questions honestly and thoughtfully. Doing so is a step toward resolution of the reasons why you have sought treatment.

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HIPAA NOTICE OF PRIVACY PRACTICES

Please sign only the 3rd page which follows to acknowledge your receipt of this document and keep the first 2 pages for your records.

"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."

(i) Uses and disclosures.

(A) Metro Behavioral Health Associates ("MBHA") may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual;

(B) MBHA may contact a group health plan, or a health insurance issuer or HMO with respect to a group health plan and may disclose protected health information to the sponsor of the plan if requested.

(C) Other uses and disclosures will be made only with your written authorization. You may revoke such authorization as provided by § 164.508(b)(5).

(ii) Individual rights.

(A) You have the right to request restrictions on certain uses and disclosures of protected health information as provided by § 164.522(a), including a statement that MBHA is not required to agree to a requested restriction;

(B) You have the right to receive confidential communications of protected health information as provided by § 164.522(b), as applicable;

(C) You have the right to inspect and copy protected health information as provided by § 164.524;

(D) You have the right to receive an accounting of disclosures of protected health information as provided by § 164.528; and

(E) You have the to receive the notice electronically in accordance with paragraph (c)(3) of this section or to obtain a paper copy of the notice from MBHA upon request.

(iii) Our Duties:

(A) MBHA is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information;

(B) MBHA is required to abide by the terms of the notice currently in effect; and

(C) For MBHA to apply a change in a privacy practice that is described in the notice to protected health information that the covered entity created or received prior to issuing a revised notice, in accordance with § 164.530(i)(2)(ii), a statement that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains. The statement must also describe how it will provide individuals with a revised notice.

(iv) Complaints.
You may make a complaint to MBHA if you believe your privacy rights have been violated, either by requesting a meeting with the Director, Jennie Kramer, LCSW or by writing a letter or email to same, and will not be retaliated against in any way for filing a complaint. She can be reached by calling 914-907-2600 or sending an email to jjkramer@optonline.net or writing to the address on the cover page of this document.

(v) Effective date. This notice is in effect as of April1, 2008.

(PROCEED TO SIGNATURE PAGE – SEPARATE ATTACHMENT)

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Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Patient Name:_____ D.O.B. _____

___ (check) I hereby acknowledge that I have received and have been given an opportunity to read a copy of the HIPAA Notice of Privacy Practices.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Guardian if under age 18 Date

If applicable, other than as the parent of a minor, pescribe legal authority and reasons to act as personal representative for this individual:

_____

_____

_____ _____
Clinician (Print & Sign) Date

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Communication Guidelines

1. **CALLS:** When calling your primary therapist or case manager or nutritionist here at MBHA, by leaving a voicemail at their specific extensions, they will get an immediate notification of your call via email. If, however, it is after 9pm M-F or over the weekend, you may not get a return call until the next business day.

   PLEASE NOTE: If you have an emergency after hours, please call 911 or visit your nearest emergency room and leave us a message to let us know you have done so. We will follow up promptly.

2. **EMAIL**:
   a. Please **NEVER** use email for emergencies, urgent matters, etc. We will not give advice over email. It doesn't serve you or the process responsibly.

   b. If you choose to communicate via email and send one with lengthy thoughts that you are simply sharing or wish to talk about at the next session, we certainly encourage that. However, we will not necessarily respond but will likely print the email to discuss at your next session. We encourage you to do the same. If, however, you wish a response, this form of communication between sessions must first be agreed upon between you and your therapist, case manager or nutritionist here at MBHA.

   c. Please do not include us in mass emails you may send to others on general subjects.

3. **SOCIAL MEDIA**: Please do not be offended if we do not accept invitations to be friended on social media. This is a boundary issue. You are of course welcome to join our MBHA pages on all social media to be part of the conversation.

I have read and understood these guidelines and have been given a copy for my records.

_____
Name (Print)

_____ _____
Patient Signature Date

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CREDIT CARD AUTHORIZATION

Patient Name _____

Name as it appears on credit card _____

If cardholder is not patient, what is relationship to patient: _____

Visa _____ Mastercard _____ Discover _____ American Express _____

Credit Card # _____

Expiration Date ____/_____ (mo/yr only)
Address where credit card bills are received including zip code & security code:

_____

I authorize charges for service to this card as incurred unless I specify that another form of payment will be used.

Cardholder's Name (please print): _____Date _____

Cardholder's Signature: _____ Date _____