



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

*19 West 34th Street, Suite 1207
New York, NY 10001
www.mbhanyc.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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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 April 1, 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, prescribe legal authority and reasons to act as personal representative for this individual:

Clinician (Print & Sign)

Date



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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
 If so, please list:

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 comfortable
 _____ Somewhat comfortable
 _____ Very Comfortable

3. How hopeful do you feel about being able to address, lessen or eliminate symptoms?
 _____ Very pessimistic
 _____ Slightly pessimistic
 _____ Slightly optimistic
 _____ Very optimistic

Please tell us more about this:

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

4. What is your present weight? _____ (If you don't normally weigh yourself, approximate as best you can.) **What is your height:** _____
5. How long have you been at this weight? _____
6. During the last year, what has been your lowest weight? _____ highest? _____
7. Over the course of your life, what has been your lowest weight? _____ highest? _____
8. Currently, how satisfied do you feel with your body (shape, size, proportions, etc.)?
____ very dissatisfied ____ slightly satisfied ____ somewhat dissatisfied
____ somewhat satisfied ____ slightly dissatisfied _____ very satisfied ____ neutral

9. What would you change if anything:

10. Do you want to lose weight now? ____ **Yes** ____ **Not Applicable**
11. Have you felt you have ever become too thin? ____ **Yes** ____ **Not Applicable**
12. Have other people felt you became too thin? ____ **Yes** ____ **Not Applicable**
13. **Only if applicable**, which statement(s) best describes the foods you eat during a binge:
____ I don't crave particular foods, but I eat foods that I wouldn't otherwise eat.
____ I eat any type of food that is around.
____ I crave specific foods or types of foods (please be as specific as possible)

14. **Only if applicable**, when do you find yourself bingeing?
____ During meals, I sometimes can't stop eating
____ After meals are over
____ Between meals
____ I don't eat meals, but just binge

15. **Only if applicable**: what are the emotional and/or food triggers that might make you restrict or not eat at all:

16. 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:

17. **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 _____ | |

p.3 **Name (print)** _____ **Date:** _____

18. **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 week _____ or #of times per day _____ or #times per month _____

19. **Only if applicable:** If you use laxatives, how often:

#of times per week _____ or #of times per day _____ or #times per month _____

How many do you take at a time _____

20. **Only if applicable:** If you use diuretics, how often:

#of times per week _____ or #of times per day _____ or #times per month _____

Over the counter or prescribed : _____

21. Approximately how many hours a day do you spend either engaged in various eating disorder behaviors or thinking about food and body? _____

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

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

24. **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	_____
------------	-------

_____ Other (please specify)	_____
---------------------------------------	-------

25. Overall, how often do you engage in social/interpersonal activities (dating, getting together with friends, parties, etc.)?

Per week _____ or Per month _____ or Per year _____

26. How comfortable do you generally feel in social situations?

_____ Very uncomfortable

_____ Fairly uncomfortable

_____ Fairly relaxed and comfortable

_____ Very relaxed and comfortable

Comments: _____

p.4 **Name (print)** _____ **Date:** _____

27. Is there anything else you would like us to know:

*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.*

This, as all other paperwork, will be held in the strictest of confidence.



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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



METRO BEHAVIORAL HEALTH ASSOCIATES

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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 _____