INTAKE FORM for Barbara Forloney, APRN, CNS, CNP Date_____

PERSONAL INFORMATION:

Name:_____ Date of Birth:_____

Preferred Name:_____ Pronouns:_____

Address:_____

City/State/Zip: _____

Phone: Home ( )_____ Cell ( ) _____ Office ( )_____

Email: _____

Primary Care Provider: _____ Pharmacy:_____

Who may we thank for referral to our office?:_____

RESPONSIBLE PARTY: (fill in if under 18 or if someone other than patient is responsible for payment)
Name: _____

Address: _____
City/State/Zip: _____
Primary Phone ( )_____ Business Phone ( )_____

INSURANCE INFORMATION:
Primary Insurance Company: _____

Provider Phone (located on back of card): ( )_____

Subscriber Name (if other than patient): _____DOB: _____
Insurance ID#:_____

FINANCIAL POLICY
Appointments cancelled with less than 24-hour notice will be charged $75.00.
I am responsible for the entire balance of services performed regardless of whether there is insurance coverage.
Secondary insurance will be billed as a courtesy.
I understand and agree to the above stated financial policy.

Signed:_____ Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS FOR INSURANCE
I authorize the use or disclosure of my individually identifiable health insurance information necessary to process insurance claims. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Signed:_____ Date: _____

I authorize payment of medical benefits to my provider for services performed.

Signed:_____ Date: _____

Initial Evaluation

Patient Report:

Name: _____

Date: _____

Please write your answers under each question.

What is the main reason for your visit?

Have you been bothered by these problems? Please circle the ones that apply to you:

Syndrome A

Down, sad, irritable, unable to enjoy, unmotivated, poor concentration, forgetful, indecisive, worthless, failure, helpless, hopeless, suicidal, tired, change in appetite, change in sleep, decreased sexual drive

Syndrome B

Worry, anxiety, muscle tension, palpitations, sweating, dry mouth, nausea, agitation, irritability, fatigue, concentration difficulty, sleep disturbance

Syndrome C

Feeling "High", mood liability, racing thoughts, distractibility, increased self-confidence, decreased need to sleep, increased energy and sexual drive, restless, talkative, start multiple projects, increased socializing, risk taking

Syndrome D

Hearing voices, being spied on, others could read your mind, things seem especially arranged for you, having great abilities, seeing visions

Specialist Report:

Have your problems that you circled on the previous page affected your functioning? Please circle what applies to you:

Marriage/Relationship/Family
Job/School Performance
Friendship/Peer Relationships
Financial Situation
Hobbies/Interests/Play Activities
Physical Health
Activities of daily living (personal hygiene, bathing, etc.)
Anything else?
_____
_____

Have you experienced any of these life events? Please circle what applies to you.

Death in the family
Serious injury or illness
Serious troubles at work
Serious financial problems
Serious relationship problems
Significant traumatic events
Physical abuse
Sexual abuse
Emotional abuse
Anything else?
_____
_____

Please list all medications you are currently taking (including over the counter medications, vitamins, etc.)

Please list any allergies to medications:

Specialist Report:

List any physical health problems and pertinent family health history:

Did you ever receive treatment from mental health professionals? Have you ever been hospitalized for mental health issues? Please describe:

Have you ever attempted suicide or self-injury? Please describe:

Did or are you abusing alcohol or other drugs including prescription medication? Please describe.

Do you have family members who are diagnosed with mental health disorders? Please list

Do you gamble?

Are there guns in your home?

List your current support system:

List the 3 most important events that affected Your life:

1.)

2.)

3.)

Specialist Report:

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Barbara Forloney, APRN, CNS, CNP

1130 Ten Rod RdE101
North Kingstown, RI 02852
Phone: 401-294-6900 ext. 111
Fax: 401-294-6690
Website: cduarteandassociates.com

Authorization to Release Protected Health Information

I authorize Barbara Forloney, and her administrative staff to □ request from and □ release to information from □ my clinical record and/or □ the clinical record of _____ (DOB: _____). If requested, specify information to be disclosed:

This information is to be released to OR received by: (name, address, and telephone number to whom the information is to be released and/or received):

I am requesting my therapist to release this information for the following reasons ("at the request of the individual" is all that is required if you are my client and you do not desire to state a specific purpose):

This authorization shall remain in effect until (date) _____ or until (a reason):

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my therapist may not condition clinical services upon my signing an authorization unless the clinical services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Signature of Patient (or Parent/ Legal Guardian) Date

_____

Relationship to Patient

Barbara Forloney, APRN, CNS, CNP

1130 Ten Rod Rd., Building E Suite 101

North Kingstown, RI 02852

Phone: (401) 294-6900

Fax: (401) 294-6690

Coordination of care notice

Date: _____

Dear _____ has recently been evaluated and treated at Psychotherapy Practices of North Kingstown, LLC. I am writing to provide information on the patient's diagnosis and medication, in order to assist in the coordination of care with you as the primary care provider.

In accordance with HIPPA guidelines, the patient has signed the consent for release of information at the bottom of this letter.

Your Patient _____ was seen on _____.
The diagnosis at this time is:

_____.

The following medications are currently being used to treat this condition:

- _____
-
- _____
-
- _____

I hope this information is helpful. Please contact me if there are any questions.

Sincerely,

Barbara Forloney, APRN, CNS, CNP

Release of Information

I, _____ give consent to Psychotherapy Practices of North Kingstown, LLC, to provide the above information about me to my primary care provider for the benefit of coordination of care. This will remain in effect until revoked by the patient. I have read and understand the information above:

Signature: _____

Date: _____

Barbara Forloney, APRN
Advanced Practice Registered Nurse

1130 Ten Rod Rd. E101
North Kingstown, RI 02852
Phone: 401-294-6900 ext. 11
Fax: 401-294-6690
Website: cduarteandassociates.com

HIPAA Privacy Notice

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND 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 for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *Protected Health Information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.

- *"Treatment, Payment and Health Care Operations"*
    - *Treatment* is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychotherapist.
    - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
    - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "*Use*" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

- "*Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*Authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause to know or suspect that any child has been abused or neglected, as defined below, or is a victim of sexual abuse by another child, I must, within 24 hours, transfer that information to the Rhode Island Department of Child, Youth and Families, or its agent.

  Child abuse and/or neglect is defined as a child whose physical or mental health or welfare is harmed, or threatened with harm when his or her parent or other person responsible for his or her welfare:

  - Inflicts, or allows to be inflicted physical or mental injury;
  - Creates or allows to be created a substantial risk of physical or mental injury;
  - Commits or allows to be committed an act of sexual abuse, sexual assault against, or exploitation of the child;
  - Fails to supply the child with adequate food, clothing, shelter, or medical care;
  - Fails to provide the child with a minimum degree of care or proper supervision or guardianship because of his/her unwillingness or inability to do so; and abandons or deserts the child.

- **Health Oversight:** If a complaint is filed against me with the Rhode Island Board of Psychology, the Administrator of Professional Regulation (of the Division of Health) has the authority to subpoena confidential mental health information from me relevant to that complaint.

- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I provided to you and the records thereof, such information is privileged under state law, and I will not release this information without: 1) written authorization by you or your legal representative; or 2) a subpoena of which you have received official notification and you have failed to inform me that you are opposing the subpoena; or 3) a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** I may release your confidential health care information to appropriate law enforcement personnel, or to a person, if I believe that person or their family to be in danger from you.

- **Workers' Compensation**: If you file a worker's compensation claim, I must release your relevant mental health care information for the proceedings.

There may be additional disclosures of PHI that I am required or permitted by law to make without your consent or authorization; however, the disclosures listed above are the most common.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of Protected Health Information about you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will inform you either in person or by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, believe that your privacy rights have been violated and wish to file a complaint, or have other concerns about your privacy rights, you may discuss these with me at 1130 Ten Rod Road, E101, North Kingstown RI 02852, 401-294-6900.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on September 5, 2006.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. At such time I will notify you of this change either in person or by mail. The current version of this document will always be available to you at my office.