Nike F. Carli, LCSW-R
Phone: 716-633-6900 ◆ Fax: 716-633-6902
5500 Main Street, Suite 207, Williamsville, New York 14221
Individual, Couple, and Family Therapy

New Patient Office Visit Checklist

This checklist can help you prepare for your upcoming appointment. Please mail the following or bring it to your first appointment.

Nike F. Carli, LCSW-R
5500 Main Street, Suite 207
Williamsville, New York 14221

☐ **Completed Forms.** Please complete all of the enclosed forms in their entirety and bring the completed forms with you to your appointment. This information can be submitted electronically through my website at: www.nikecarli.com

- Patient Information & History (four pages)
- Patient Bill of Rights, Confidentiality and Treatment Information (one page)
- Acknowledgement of Receipt of Notice of Privacy Practices and Confidentiality and Treatment Information (one page)
- Authorization For Release Of Confidential Information Primary Care Physician (one page)
- Use of E-mail Authorization (one page)

☐ **A copy of a valid Photo ID for each patient or patient's guardian.**

☐ **A copy of your Insurance Card.** Please contact your insurance company to verify if a referral from your Primary Care Physician is needed. If a referral is needed, please contact your primary care physician for the referral, prior to your appointment. *Please note if your insurance information and/or referral are not in place by the time of your appointment, your appointment will be rescheduled.

☐ **Co-pay/Payment.** To be in compliance with federal regulations, we are required to collect your co-payment and or deductible, should you have one, at each appointment. Co-pays/deductibles and fees (if you are not utilizing insurance) may be paid by mailed check or by credit card online through my website at - www.nikecarli.com

Thank you!

Nike F. Carli, LCSW-R
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5500 Main Street, Suite 207, Williamsville, New York 14221
Individual, Couple, and Family Therapy

Patient Information & History

Please provide the following information as best you can. I appreciate your willingness to cooperate in helping me obtain your history. *Thank you for printing.*

Full Name: _____ **Date:** _____ **Sex: (M) (F)**

Address: _____
Street City State Zip

Telephone: _____

Date of Birth: _____ **Age:** _____ **Marital Status: Check One (S) (M) (D) (W)**

Number of years married or cohabitating: _____ **Spouse/Companion's Name** _____

Employer's Name: _____**Telephone:** _____

Employers Address: _____
Street City State Zip

Emergency Contact Name: _____ **Relationship:** _____

Address: _____**Telephone:** _____
Street City State Zip

How did you hear about me? (Who referred you?) _____

INSURANCE INFORMATION: Please List All Insurances

Primary Insurance: _____**Is pre-authorization required? (Yes) (No)**

_____/_____/_____/_____
Certificate ID # Group # Subscriber Name Effective Date

Secondary Insurance: _____**Is pre-authorization required? (Yes) (No)**

_____/_____/_____/_____
Certificate ID # Group # Subscriber Name Effective Date

Have you used your benefits this year with any other counseling service? (Yes) (No) Number of visits: _____

Insured's or Authorized person's Signature:

I authorize the release of any medical or other information necessary to process any insurance claim(s). I also authorize payment of medical benefits for services described on above mentioned claim(s). I understand that I am ultimately responsible for payment of all services rendered and that I will be charged for appointments if canceled with less than 24 hours notice. In order to utilize insurance, I understand that all copays must be paid at time of service.

Signed: _____ **Date:** _____

Patient History ~ Page 2 Name:

1) Prior Mental Health History:

Have you ever seen a psychiatrist, therapist, or counselor? (Yes) (No)
If so, give names and dates:

_____

_____

_____

Was it helpful, not helpful, or harmful?

_____

_____

_____

Have you been or are you on medication? (tranquilizers, antidepressants, others) (Yes) (No)
If so, give names of medications and dates that you have been on them and how you responded to them.

_____

_____

_____

2) Family History: (circle one)

Do any members of your family (grandparents, uncles, etc.) see a mental health professional? (Yes) (No)
Is there alcoholism in your family? …… (Yes) (No)
Have any members of your family ever committed suicide?..... (Yes) (No)
(Yes) (No)

If yes to any of the above please describe the relationship. _____
_____

Do you have any children?..... (Yes) (No)

Name of child: _____ Age _____
Name of child: _____ Age _____
Name of child: _____ Age _____
Name of child: _____ Age _____

Do you have any brothers or sisters?

Name of sibling: _____ Age _____
Name of sibling: _____ Age _____
Name of sibling: _____ Age _____
Name of sibling: _____ Age _____

3) Social History

Education:
(Circle highest grade completed) K 1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4+

Are you currently employed (Yes) (No)
Are you having problems related to your present job, with others workers or supervisors? (Yes) (No)
If yes, please describe the problem.

_____

_____

4) Military History:

Have you been in the Military? (Yes) (No)
If yes, give branch of service, dates, rank on discharge, disciplinary action, and any disability.

_____

_____

Patient History ~ Page 3 Name:

5) Legal History:

Have you ever been arrested? (Yes) (No)
Do you have any legal problems? (Yes) (No) If yes please describe:

_____
_____
_____

6) Medical History:

Are you on medication for a medical condition (ex: insulin, heart pills, seizure medication)? (Yes) (No)
Names and dosages of all current medications:

_____
_____
_____

Have you had any surgery? (Yes) (No)
If yes, give approximate year and name of procedure (ex: appendix, tonsils, open heart, etc.):

_____
_____
_____

List all medical conditions (ex: allergies, diabetes, heart disease, high blood pressure, etc.)

_____
_____
_____

Primary Care Doctor's Name: _____

Address: _____ Phone Number: _____

Have you ever had any of the following symptoms or difficulties (circle one)

1. **Repeated headaches……..…… (Yes) (No)**
2. **Dizziness or loss of balance …….. (Yes) (No)**
3. **Blurring of vision …….. (Yes) (No)**
4. **Epilepsy or seizures …….. (Yes) (No)**
5. **Head Injury ……... (Yes) (No)**
6. **Back Injury …… (Yes) (No)**
7. **Loss of strength or loss of sensation in part of your body ……. (Yes) (No)**
8. **Excessive use of alcohol …… (Yes) (No)**
9. **Drug use (heroin, cocaine, marijuana, barbiturates, diet pills, etc) ……. (Yes) (No)**
10. **Excessive use of prescription medication (Valium, sleeping pills, etc.) …… (Yes) (No)**
11. **Glaucoma ……... (Yes) (No)**
12. **Menstrual or prostate difficulties …… (Yes) (No)**
13. **Sexual difficulties …….. (Yes) (No)**
14. **Physical abuse ……..……... (Yes) (No)**
15. **Sexual abuse/rape …….. (Yes) (No)**
16. **Other (please list) …….. (Yes) (No)**

Patient History ~ Page 4 Name:

7) Summary:

What do you expect from your treatment? What are your goals?

Is there any other information which might help to better understand your problems?

What brings you joy or helps you deal with current stressors?

Nike F. Carli, LCSW-R

1. **PATIENT BILL OF RIGHTS, CONFIDENTIALITY AND TREATMENT INFORMATION**

I understand that my treatment provider will work with me to develop a treatment plan that is best suited to me. This plan will help us deal with my problems as quickly and effectively as possible. I also understand that my insurance plan will help to define what services are covered and which are not. If I have questions that are not answered by my provider to my satisfaction, I may contact my health care plan for further
2. clarification.

I have been assured that my provider will make every effort to be ready to meet with me at the scheduled time. Similarly, I will make every effort to be on time for my appointment(s). If I am late for a session, we
3. will make other arrangements by mutual agreement. Appointments are for 50 minutes.

When I give you an appointment, I have reserved that time for you. If you cannot keep your appointment, I expect AT LEAST 24 HOURS NOTICE OF CANCELLATION. Unless you are involved in a SERIOUS EMERGENCY, failure to provide the required notice will result in your being charged for your missed appointment. If you are using insurance they will not pay any portion of this charge. Lengthy or frequent calls
4. to my provider may result in the calls being counted as sessions with a co-payment/coinsurance being applied

I am aware that most visits require a co-payment (a dollar amount) or co-insurance (a percentage of the provider's fee) at the time the service is rendered. Subsequent visits will be scheduled only when co-payment/ coinsurance is made in full. I understand that I am responsible for my co-pay or coinsurance payment. I am
5. also aware that my insurance plan may have a deductible.

I should contact my provider for any serious situation that arises during or after normal working hours. If my provider fails to get back to me in a reasonable time, I will call my health care plan's emergency service, or one of the following community psychiatric services: (**Crises Services: 834-3131) (Buffalo General Hospital Psychiatric Emergency Room: 859-2902) (Comprehensive Psychiatric Emergency Program at**
6. **ECMC: 898-3465)** .

Since I want to be provided with the best treatment for me, I agree to allow my treatment provider and my health care plan to consult with other healthcare professionals about my care. This should aid me in receiving appropriate care. I understand my provider will communicate and coordinate my care with my primary care physician (unless otherwise specified by me on the report to the PCP). All records and communications about
7. me will be treated as confidential in compliance with applicable state and federal laws.

I have a right to be treated with respect at all times. I will report any misconduct by my provider including social invitations, suggestive remarks, or unwanted touching to my health care plan and/or the appropriate state agency. Naturally, if I have any questions, complaints or concerns about this or any other aspect of my
8. treatment, I can contact my health care plan.

One of the cornerstones of psychological services is confidentiality. All information shared by you is kept in strict confidence. Notes and other pertinent records are stored in a locked file cabinet. No oral or written contact will be made with family, friends, or other professionals without your consent. Confidentiality, however, is not absolute. There are several situations in which confidentiality cannot be guaranteed including, but not limited to, the following: You or someone else appears to be in imminent danger, there is a reason to suspect that child abuse or neglect has occurred, a court orders the release of information, or an insurance company requires information to substantiate a claim.

Nike F. Carli, LCSW-R

NOTICE OF PRIVACY PRACTICES

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.

Effective Date: April 14, 2003 / Last Revised: July 30, 2013

WHO WILL FOLLOW THIS NOTICE
This notice describes the information privacy practices followed by me and my staff.. The practices described in this notice will also be followed by any other therapist who provides "call coverage" for me if I am not available.

YOUR HEALTH INFORMATION
This notice applies to the information and records I have about your health, health status, and the health care and services you receive at this office. I am required by law to give you this notice. It will tell you about the ways in which I may use and disclose health information about you and describes your rights and my obligations regarding the use and disclosure of that information.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU
I use and disclose health information about you for treatment, payment and healthcare operations. For example:

For Treatment I may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

For Payment I may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party.

For Health Care Operations I may use and disclose health information about you in order to run the office and make sure that you and my other patients receive quality care. For example, I may use your health information to evaluate the performance of my staff in caring for you.

Appointment Reminders I may contact you as a reminder that you have an appointment at the office. Please notify me if you do not wish to be contacted for appointment reminders.

Required By Law I will disclose health information about you when required to do so by federal, state or local law.

Family and Friends I may disclose health information about you to your family members, friends or another person, only if I obtain written authorization to do so. If you bring another person into a therapy session I may assume you agree to my disclosure of your personal health information during the session.

National Security and Intelligence I may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. I may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

To Avert a Serious Threat to Health or Safety I may disclose you health information to appropriate authorities If I reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. I may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION I will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* I must obtain your *Authorization* separate from any *Consent I* may have obtained from you. If you give me *Authorization* to use or disclose health information about you, you may revoke that *Authorization,* in writing, at any time. If you revoke your *Authorization,* I will no longer use or disclose information about you for the reasons covered by your written *Authorization,* but I cannot take back any uses or disclosures already made with your permission.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION Without your authorization, I am expressly prohibited to use or disclose your protected health information for marketing purposes. I may not sell your protected health information without your authorization. Authorization is required to disclose your psychotherapy notes if they exist.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU You have the following rights regarding health information I maintain about you: (continued on next page)

Right to Inspect and Copy You have the right to inspect and copy your health information, such as therapy and billing records, that I use to make decisions about your care. Psychotherapy notes (if they exist) are specifically excluded and you do not have a right to inspect or copy them. You must submit a written request in order to inspect and/or copy your health information. If you request a copy of the information, I may charge a fee for the costs of copying, mailing or other associated supplies. I may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, I will select a licensed health care professional to review your request and my denial. The person conducting the review will not be the person who denied your request, and I will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Health Records You have the right to request to be given to you or have transmitted to another individual or entity, an electronic copy of your health records, if they are maintained in an electronic format. I will make every effort to provide the electronic copy in the format you request however if it is not readily producible by me I will provide it in either my standard format or in hard copy form (fees may apply).

Right to Amend If you believe health information I have about you is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment as long as the information is kept by this office. To request an amendment, complete and submit a Medical Record Amendment/Correction Form. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask me to amend information that: a) I did not create, unless the person or entity that created the information is no longer available to make the amendment. b) Is not part of the health information that I keep. c) You would not be permitted to inspect and copy. d) Is accurate and complete.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures." This is a list of the disclosures I made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. If you request this accounting more than once in a 12-month period I may charge you for the costs of providing the list.

Right to Request Restrictions You have the right (unless restricted by law) to request additional restrictions on my use or disclosure of your health information. You may restrict disclosure of your health information to a health plan if you choose to pay out-of-pocket in full for the services at the time they are provided.. To request restrictions, you must complete and submit *the Request For Restriction On Use/Disclosure Of Medical* Information form.

Right to Request Confidential Communications You have the right to request that I communicate with you about your health information in a certain way or at a certain location. For example, you can ask that I only contact you at work or by mail. To request confidential communications, you must complete and submit the *Request For Restriction On Use/Disclosure Of Medical Information And/Or Confidential Communication* form.. I will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to be Notified of a Breach I will notify you if your unsecured health information is breached.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy.

CHANGES TO THIS NOTICE

I reserve the right to change this notice provided such changes are permitted by applicable law, and to make the revised or changed notice effective for health information I already have about you as well as any information I receive in the future. I will post a copy of the current notice in my office. You are entitled to a copy of the notice currently in effect.

QUESTIONS AND COMPLAINTS

If you want more information about my privacy practices or have questions or concerns, please contact me. If you believe your privacy rights have been violated, or you disagree with a decision I made about your health information in response to a request, you may file a complaint with me or with the Secretary of the Department of Health and Human Services. To file a complaint with me use the, contact information below. I will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. You will not be penalized for filing a complaint.

Contact Officer: Nike F. Carli, LCSW-R **Telephone:** 716-633-6900 **Fax:** 716-633-6902 **Email:** nike@nikecarli.com
Address: 5500 Main Street, Suite 207, Williamsville, New York 14221

Nike F. Carli, LCSW-R

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

And

PATIENT BILL OF RIGHTS, AND TREATMENT INFORMATION

* You May Refuse to sign This Acknowledgement*

I, _____, have received a copy of this office's "Notice of Privacy Practices", and have been given an opportunity to review it. I have also received a copy of the "Patient Bill of Rights and Treatment Information", and have been given an opportunity to review it.

_____
Please Print Name

_____
Signature

_____
Signature of Parent or Guardian

_____
Date

For Office Use Only

I attempted to obtain written acknowledgement of receipt of my "Notice of Privacy Practices" and "Patient Bill of Rights and Treatment Information", but acknowledgement could not be obtained because:

Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented me from obtaining acknowledgement

☐ Other (Please Specify)

☐

_____

_____

_____

Authorization For Release Of Confidential Information
Primary Care Physician

❑ **To:**
❑ **From: Nike Carli, CSWR**
5500 Main St. Suite 207
Williamsville, NY 14221
Phone: 716-633-6900 Fax: 716-633-6902

❑ **From:**
❑ **To:** _____
_____
_____
_____

Information to be disclosed (include printed name of client): _____
_____

Purpose: Coordination of treatment.

I hereby authorize the release of the above information from my record. I understand that the information to be released from my record is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time before it is released. I also understand that my consent to release information will expire:

❑ **Upon discharge from treatment**
❑ **To: 90 days from this date**

Signature of responsible parent, relative or guardian. If client is over 14 years of age and under 18 years of age, client must sign also.

_____
Witness

Nike Carli, CSWR
Printed Name of Witness

_____
Date

_____
Signature of Client

_____
Printed Name of Client

_____
Date

_____
Signature of Parent or Guardian

_____
Printed Name of Parent or Guardian

_____
Date

For Cancellation or Refusal Only

❑ **I hereby cancel my permission to release information from my record to the person or organization whose name & address is:**

_____
_____
_____

_____
Signature of Client

_____
Printed Name of Client

_____
Date

_____
Witness

_____
Printed Name of Witness

❑ **I hereby refuse to give my permission to release information from my record to the person or organization whose name & address is:**

_____
_____
_____

Signature of responsible parent, relative or guardian. If client is over 14 years of age and under 18 years of age, client must sign also.

_____
Signature of Parent or Guardian

_____
Printed Name of Parent or Guardian

_____
Date

Nike F. Carli, LCSW-R

www.nikecarli.com ~ nike@nikecarli.com

USE OF E-MAIL AUTHORIZATION

Many patients find it convenient and helpful to communicate with me by e-mail. While I welcome such communications, due to the inherent risks involved in e-mail use, it is important to understand the following:

No one can guarantee the security and privacy of e-mail messages.

- Employers generally have the right to access any e-mail received or sent by a person at work.
- While unlikely, It is possible for email to be intercepted while in rout.
- I have no control over or responsibility for messages that I send once they are sent.

If you do choose to communicate with be by e-mail you should know that:

- E-mail is confidential, I will be the only one reading your messages.
- E-mail communication is a convenience and not appropriate for emergencies or time-sensitive issues.
- I check my e-mail often and will respond in a timely manner.
- I will only e-mail you if you request an e-mail reply.
- Clinically relevant messages and responses will be documented in your health record.
- I take all relevant security precautions including the use of passwords, firewalls and virus protection.
- I Use an auto-reply to notify my patients when my e-mail account will not be monitored during a vacation or office closure.

I, _____, have read this notice and:

I authorize Nike F. Carli, LCSW-R to communicate with me by email

E-mail address: _____ or _____

I do **not** authorize Nike F. Carli, LCSW-R to communicate with me by email

_____
Please Print Name

_____
Signature

_____
Signature of Parent or Guardian

_____
Date

.