Amy Silverman, MD, PC
450 Mamaroneck Avenue, Suite 415
Harrison, New York 10528
T. 914 630-2030 | F. 914 315-6505
Amy@AmySilvermanMD.com

PRACTICE POLICIES

Welcome to my practice! Please note the following policies and procedures and sign at the bottom indicating that you have read and accept the policies of the office. PLEASE KEEP A COPY OF THESE PRACTICE POLICIES SO YOU MAY REFER TO THEM AS NECESSARY.

How to Contact Me

My office number is (914) 630-2030. I check voicemail frequently during business hours. You may also message our office through KLARA, which is a HIPAA protected, secure messaging platform for medical practices. To access KLARA, press the Blue "Message Us" button on the website.

For after-hours emergencies, you may call my cell phone at (914) 621-7884. If you are unable to reach me or cannot wait for my return call, please call 911 or go to your nearest emergency room. If I am away, the name and contact information for the covering doctor can be found by calling my office. My email address is Amy@AmySilvermanMD.com. Email is not a secure form of communication—most communications should go through KLARA.

Fees

Full payment is due at the time of each session. I do not participate in any insurance plans. I will provide a statement you can submit to your insurance company for out of network reimbursement. I accept cash, check, Zelle or credit cards. The current fee for 45 minute follow up sessions is $575. Initial evaluations are typically divided into 2 sessions and billed at $750 for each session. Small fee increases occur annually. Other services including calls, letters or forms that require more than 15 minutes of my time outside of a session will be billed on a prorated basis.

Cancellations

Appointments cancelled less than 24 hours prior to the scheduled time will be charged at full fee. I do not charge for cancellations due to medical emergencies or weather related issues making it realistically unsafe to travel.

Prescription Refills

I will not prescribe any medication to a patient who has not been seen in more than 3 months without an appointment. It is your responsibility to ensure that you have appointments scheduled in a timely fashion. There will be no exceptions to this rule.

Please provide advance notice for all prescription refills. All requests must be made by phone or through KLARA; requests cannot be made over email. When requesting a refill please leave all pertinent information including date of birth and pharmacy phone number. If you are requesting a refill and have not had an appointment in the past 3 months, you will need to schedule an appointment at that time as well.

_____

Signature Date

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Adult Initial Intake Questionnaire

Please fill out and bring to first appointment

Patient Name _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Date of Birth _____

Occupation _____ Employer _____

Highest Education _____ Religion _____

Referred by _____

Primary Care Physician _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Work Fax _____

Therapist (if applicable) _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Work Fax _____

Email _____

Insurance Company_____ ID number_____

Contact Number_____ BIN/PCN/Rx group if listed on card_____

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What is your primary reason for seeking psychiatric consultation?

History of Presenting Problem

When did these symptoms begin? _____

Did something occur to precipitate them? _____

What has the course of symptoms been? _____

Past Psychiatric History

When did the patient first receive treatment? _____

Describe the prior treatment. (What type of treatment(s)? Who was the therapist? When did treatment take place?) _____

Has the patient ever been psychiatrically hospitalized? If yes, when, where, and for what reason?

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Does the patient have a history of suicidality or self injurious behaviors? Please describe:

Describe the patient's activities, interests, hobbies, skills, strengths:

Describe any problems with the patient's eating or sleeping habits:

Any other concerns?

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Current Medications **Allergies?** _____

Name of Medication	Dose Taken	Why Taken	Who Prescribes	Comments Helpfulness/Side Effects

Past Medications

Name of Medication	Dose Taken	Why Taken	Who Prescribed/When	Comments Helpfulness/Side Effects

Current or Past Alcohol /Substance Use

What?	When started?	How much used?	Last use?

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Medical History

Current Medical Problems: _____

Prior Illness: _____

Medical Hospitalizations: _____

Surgeries: _____

Date of most recent physical exam: _____

Does the patient see any other medical specialists? _____

_____

Family History

1. Who else lives in the home? (name, age, relationship)

_____

_____

_____

_____

_____

2. Any other immediate family members NOT living in the home? _____

_____

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Family Psychiatric History

Has any family member had any of the following? Please check and indicate which family member.

_____ Depression
_____ Mania/Bipolar Disorder
_____ Suicidal thoughts/urges/behaviors
_____ Anxiety
_____ Panic
_____ Obsessions/Compulsions
_____ Rituals
_____ Movement Disorders
_____ Tics
_____ Psychiatric Hospitalizations
_____ Unusual noises/vocalizations
_____ Eating Disorder
_____ ADHD/ADD
_____ Learning Disability
_____ Coordination Problems
_____ Mental Retardation
_____ Autism/Asperger's Disorder/PDD
_____ Sleep Disorder
_____ Legal Problems

Please elaborate on above as needed: _____

_____

_____

_____

_____

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Developmental, Educational and Occupational History

Please describe any developmental problems or delays. _____

_____

Schools attended: _____

_____

_____

Any special services or accommodations? (e.g. 504/ IEP) _____

_____

Any prior psychological, educational or neuropsychological evaluations? _____

_____

_____

_____

Please list occupational history: _____

_____

_____

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DSM-5 Self Rated Symptom Measure - Adult Psychiatry Screen

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 WEEKS**.

	None	Rare	Occasional	Often	Severe
During the past two weeks, how much or how often have you been bothered by the following problems?	not at all	< 1-2 days	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?					
2. Feeling down, depressed or hopeless?					
3. Feeling more irritated, grouchy or angry than usual?					
4. Sleeping less than usual but still have a lot of energy?					
5. Starting lots more projects than usual or doing more risky things?					
6. Feeling nervous, anxious, frightened, worried, or on edge?					
7. Feeling panic?					
8. Avoiding situations that make you anxious?					
9. Unexplained aches and pains?					
10. Feeling that your illnesses are not being taken seriously enough?					
11. Thoughts of actually hurting yourself?					
12. Hearing things other people couldn't hear (voices when no one there)?					
13. Feeling that someone could hear your thoughts or was trying to hurt you?					
14. Problems with sleep?					
15. Problems with memory, learning or attention?					
16. Unpleasant thoughts, urges or images that repeatedly enter your mind?					
17. Feeling driven to perform certain behaviors or mental acts over and over?					
18. Feeling detached or distant from yourself, your body, or surroundings?					
19. Not knowing who you really are or what you want out of life?					
20. Not feeling close to others or enjoying your relationships with them?					
21. Using alcohol, marijuana or any illicit drug? (circle all that apply)					
22. Smoking cigarettes or vaping?					

23. Using any painkillers, stimulants or sedative meds ON YOUR OWN (without a Rx) or in greater amounts or longer than prescribed?

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Credit Card Authorization

Cardholder Name: _____

Billing Address: _____

_____

CC type: _____ MC _____Visa _____ AmEx

Credit Card Number: _____

Expiration date: _____

Card Identification Number: _____

I hereby authorize Amy Silverman, MD, PC to charge my credit card for cancellations made with less than 24 hours notice, balances that are over 30 days past due, and to charge office visits at the time of service with my permission.

Signature: _____

Print Name: _____

Date: _____

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Authorization to Use or Release Personal Health Information

Patient Name _____

1. I hereby authorize _____to release the health care information described below to:

   Name _____

   Entity _____

   Address _____

2. This request and authorization applies to only the following health information:

3. List each purpose or reason for the use or release of the protected health information:

4. This authorization shall remain in full force and effect until _____
5. I understand that, except with respect to action already taken in reliance on this authorization, I may revoke this authorization in writing at any time by delivering or sending written notification to Amy J. Silverman, M.D.
6. I understand that Dr. Silverman may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is related to the research project.
7. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.
8. I understand that I have the right to receive a copy of this authorization after I have signed it. I understand that a copy of this authorization will be maintained in my patient record.
9. I understand that I have the right to refuse to sign this authorization.

_____
Signature of Patient or Patient's Personal Representative

_____ _____
Name of Patient or Patient's Personal Representative Date

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Patient Acknowledgement

Patient Name _____

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices and practice procedures of **Amy J. Silverman, MD, PC.**

_____
Signature of Patient or Authorized Representative

_____ _____
Name of Patient or Authorized Representative Date