Amy Silverman, MD, PC
600 Mamaroneck Avenue, Suite 400
Harrison, New York 10528
T. 914 301-9465 | F. 914 301-9466
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) 301-9465. I check voicemail frequently during business hours. You can reach Eileen (Practice Assistant) for scheduling, billing or administrative questions at (914) 334-1138 or by email at silvermanpractice@gmail.com. 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.

I can also be reached by email at Amy@AmySilvermanMD.com. Email is not a secure form of communication—if you are concerned about this, please leave a phone message instead. Email should only be used to share non-urgent information.

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, checks or credit cards. The current fee for follow up sessions is $475 and initial evaluations are charged at $500/hour and typically take between 1 ½ - 3 hours which are often divided. All fees are subject to change.

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 3 days' advance notice for all prescription refills. All requests must be made by phone or through my website; requests cannot be done over email. When requesting a refill please leave all pertinent information including date of birth and pharmacy phone number.

_____

Signature Date

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REGISTRATION FORM

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Fax _____

Email _____

Complete below If the patient is a minor

Mother's Name _____

Home Phone _____ Work Phone _____

Cell Phone _____ Fax _____

Email _____

Father's Name _____

Home Phone _____ Work Phone _____

Cell Phone _____ Fax _____

Email _____

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School _____ Phone _____

Emergency Contact _____ Relationship _____

Home Phone _____ Cell Phone _____

Primary Physician _____

Address _____

Phone _____

Additional therapist _____

Address _____

Phone _____

Insurance Company _____ ID Number _____

Contact Number _____

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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 _____ Religion _____

Highest Education _____ Marital Status _____

Referred by _____

Primary Care Physician _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Work Fax _____

Email _____

Therapist (if applicable) _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Work Fax _____

Email _____

History of Presenting Problem

When did these symptoms begin? _____

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Did something occur to precipitate them? _____

What has the course of symptoms been? _____

_____

_____

Past Psychiatric History

When did you first receive treatment? _____

What kind of treatment have you had? _____

Have you ever been psychiatrically hospitalized? If yes, when, where, and for what reason?

_____

_____

_____

Any history of suicidality or self injurious behaviors? Please describe.

_____

_____

_____

_____

_____

_____

Current Medications **Allergies?** _____

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

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Past Medications

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

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Have you used any alcohol or drugs? If yes, please specify below.

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

Any household daily drug or alcohol use? Yes _____ No _____

Any household substance abuse? Explain. _____

_____

_____

_____

_____

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Medical History

Current Medical Problems: _____

Prior Illness: _____

Medical Hospitalizations: _____

Surgeries: _____

Date of most recent physical exam: _____

Please list any current or past history of medical problems in the family. _____

_____

_____

_____

_____

Family History

Who lives in your home? (Name / Age / Relationship) _____

_____

_____

_____

Who are 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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Describe your activities, interests, hobbies, skills, strengths: _____

Any change in your eating habits?: _____

Any change in your sleeping habits?: _____

Describe any other concerns: _____

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Does the patient have any of the following problems?

	Never	In Past	Occasionally	Often	Very Often
Short Attention Span					
Impulsivity (acts before thinking)					
Irritable, poor frustration tolerance					
Easily angered/ bad temper					
Gets out of control					
Cries easily					
Gets giddy and silly					
Gets tired easily					
Lack of interest in activities					
Isolates self from others					
Sadness					
Poor appetite					
Problems getting to sleep					
Early morning awakening					
Self injurious behaviors					
Excessive sleepiness					
Weight gain/ loss					
Worries a lot					
Specific fears (animals, heights, etc.)					

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	Never	In Past	Occasionally	Often	Very Often
Catastrophic fears					
Repeated unwanted thoughts					
Compulsive behaviors & rituals (counting, checking, etc.)					
Hair pulling					
Excessive concerns about body defects					
Involuntary movements					
Involuntary sounds					

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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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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