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

Child/Adolescent/Young Adult Initial Intake Questionnaire

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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 ____________ School ______________ Grade ______

Parent/Guardian Name ______________________ DOB ____________

Address ______________ City ____________ State ________ Zip ______

Home Phone ______________ Work Phone ______________

Cell Phone ______________ Email ______________

Occupation ______________ Employer ______________

Highest Education ______________ Religion ______________

Parent/Guardian Name ______________________ DOB ____________

Address ______________ City ____________ State ________ Zip ______

Home Phone ______________ Work Phone ______________

Cell Phone ______________ Email ______________

Occupation ______________ Employer ______________

Highest Education ______________ Religion ______________

Referred by ______________________________________

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Primary Care Physician ____________________

Address ____________ City ____________ State ________ Zip ______

Work Phone ____________ Work Fax ____________

Email ____________________

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____________

What is your primary reason for seeking psychiatric consultation?

____

____

____

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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

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Current or Past Alcohol /Substance Use

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

Medical History

Current Medical Problems: ______________________________

Prior Illness: ______________________________

Medical Hospitalizations: ______________________________

Surgeries: ______________________________

Date of most recent physical exam: ______________________________

Does the patient see any other medical specialists? ______________________________

____

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Family History

1. Give the names, ages and relationships of people living in your home(s)

Home #1

Parent/Guardian Name: ____________________ Age: _____ Relationship: __________

Parent/Guardian Name: ____________________ Age: _____ Relationship: __________

Siblings (Names/Age/Grade or Occupation): ____

____

____

____

Home #2 (if applicable)

Parent/Guardian Name: ____________________ Age: _____ Relationship: __________

Parent/Guardian Name: ____________________ Age: _____ Relationship: __________

Siblings (Names/Age/Grade or Occupation): ____

____

____

____

Are there any other immediate family members NOT living in the home? ______________

____

Does anyone else live 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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____

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Prenatal History

Was the pregnancy full-term? Yes ________ No _________ C-Section? Yes _____ No _________

Any complications during the pregnancy or delivery? Yes ____________ No _________

Please describe: ____

____

Did the mother smoke during pregnancy? Yes _________ No _________

If yes, how much? ________________ Was labor spontaneous or induced? _________________

Was anesthesia used? Yes ________ No _________ If yes, what type? ______________________

Developmental History

1. Describe anything notable about the patient's early temperament or personality:

____

____

2. Did the patient have any delay in meeting any developmental milestones? ____________

____

____

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School History

Schools attended: ____

____

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

____

____

Repeat Grade? Yes __________ No _________ If yes, which? ____________________

Any prior psychoeducational or neuropsychological evaluations? (who performed?

when?) ____

____

Results? ____

____

____

____

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Child/Adolescent/Young Adult Psychiatry Screen

Patient's Name:_________________________________ Date of Birth:________________________

Form Completed By:____________________________ Relationship to Patient:________________

For each item below, check the one category that best describes the patient **during the past 6 months. Indicate 'past' if there was a history of this behavior but it has not occurred in the past 6 months.**

None—never or very rarely exhibits this behavior
Mild—exhibits this behavior approximately 1x/ week, and few others notice or complain about this behavior
Moderate—exhibits this behavior at least 3x/ week, and others notice or comment on this behavior
Severe—exhibits this behavior almost daily, and multiple others complain about this behavior
Past—used to have significant problems with this behavior, **but not during the past 6 months**

	None	Mild	Mod	Severe	Past
1. Has difficulty separating from parents (or guardian)					
2. Resists going to school or elsewhere because of fears of separation					
3. Has difficulty going to sleep without parent/ guardian nearby					
4. Fears/avoids being observed by others (speaking in front of class or performing)					
5. Has discrete periods of intense fear that peak within 10 minutes					
6. Has excessive/unreasonable fear of a specific object or situation					
7. Worries about getting sick/ complains often about multiple physical symptoms					
8. Has physical symptoms but medical work-ups don't identify cause					
9. Has recurrent intrusive thoughts that cause marked distress (e.g. germs/fears)					
10. Driven to perform repetitive behaviors (e.g. handwashing/counting)					
11. Has recurrent, distressing recollections of past difficult or painful events					
12. Is excessively cautious or avoids places that remind them of past events					
13. Worries too much about multiple things (e.g. school, family, health, etc.)					
14. Perceives is, or desires to be, the other gender					
15. Wets the bed or has bowel movements at inappropriate times /places					
16. Makes noises, and is often unaware of them					
17. Makes repetitive, sudden, nonrhythmic movements					
18. Fails to pay close attention to details or makes careless mistakes					
19. Has difficulty sustaining attention during play or school activities					
20. Has difficulty organizing tasks and activities					
21. Loses things necessary for tasks/activities (e.g. books, pencils, cleats, cellphone)					
22. Is easily distracted by irrelevant stimuli					
23. Is fidgety or squirms in seat					
24. Has difficulty remaining seated					

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	None	Mild	Mod	Severe	Past
25. Talks excessively					
26. Acts impulsively (blurts out answers, interrupts others, acts before thinking					
27. Has difficulty waiting turn					
28. Severe temper outbursts at least 3 times per week for over 1 year					
29. Temper outbursts are out of proportion to events /triggers					
30. Temper outbursts are unlike those of same-age children					
31. Discrete episodes of unusually elevated or irritable mood					
32. During elevated mood episode, grandiosity or inflated self esteem (superhero)					
33. During elevated mood episode, more talkative than usual/ can't stop talking					
34. During episode, dangerous involvement in pleasurable activity (spending, sex)					
35. Sad, Depressed or irritable mood most of the day, most days for at least 1 week					
36. Loss of interest in previously enjoyable activities					
37. Notable change in appetite (while not trying to gain or lose weight)					
38. Difficulty falling or staying asleep, or excessive sleeping					
39. Loss of energy /fatigue					
40. Feelings of worthlessness or inappropriate guilt most days					
41. Thinks /talks about dying or suicide, or wouldn't care if died					
42. Smokes cigarettes, Vapes, drinks alcohol, OR uses drugs (circle all that apply)					
43. Has bad things happen when under the influence of substances					
44. Has made unsuccessful efforts to stop using a substance					
45. Is excessively worried about gaining weight (even though not overweight)					
46. Thinks he/ she is fat, even though not overweight					
47. Engages in binging and/or purging (eats excessively, vomits, laxatives—circle)					
48. Eats unusual, nonnutritive substances (e.g. hair, dirt)					
49. Bullies, threatens or intimidates others					
50. Initiates physical fights					
51. Uses/ has access to weapons that could harm others					
52. Has been physically cruel to animals					
53. Has shoplifted or stolen items					
54. Has deliberately set fires					
55. Has deliberately destroyed others' property					
56. Lies to obtain things or to avoid obligations					
57. Has run away from home overnight					
58. Skips school /classes					
59. Won't follow rules/ directions					
60. Deliberately annoys others and/or is easily annoyed by others					
61. Blames others for his/ her mistakes or misbehavior					
62. Has unusual thoughts that others cannot understand or believe					
63. Hears voices speaking to him /her that others do not hear					
64. Believes things others do not (feels paranoid, someone listening/ doing harm)					
65. Has difficulty at school with reading					

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	None	Mild	Mod	Severe	Past
66. Has difficulty at school with writing					
67. Has difficulty at school with math					
68. Has difficulty at school with spelling					
69. Had delayed speech or has limited language now					
70. Avoids eye contact during conversations					
71. Does not follow when other point to objects					
72. Shows little interest in others					
73. Difficulty conversing; will "monologue" after others lose interest					
74. Uses unusual phrases or says the same things over and over					
75. Does not engage in make-believe play/ plays more alone than with others					
76. Unusual routines or unusual preoccupations with objects (lines things up etc)					
77. Difficulty with transitions; may be inflexible about rules /routines					
78. Unusual physical mannerisms (hand flapping, shrieking, odd movements)					

Please list any other symptoms that concern you:

____

____

____

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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