easterseals New York
Diagnostic and Treatment Center
103 White Spruce Blvd. Rochester, NY 14623
Phone: 585-292-5830 Fax: 585-292-5847

Intake Application

I. Patient Demographics and Contact Information

Name of Patient: _____
First Name Middle Name Last name

Date of Birth: _____ Social Security No: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: (____) _____ ❒ Patient's private # ❒ Parent/guardian # ❒ Agency #

Gender: ❒ Male ❒ Female Email address: _____

Patient's current residential setting: ❒ Alone in own home ❒ with family ❒ with friend/others

❒ Family care ❒ Residential agency housing, list type and name of agency _____

Marital Status: ❒ Single ❒ Married ❒ Widowed ❒ Divorced

In School Status: ❒ Full Time ❒ Part Time ❒ Not in School

Name of School _____ Grade: _____

Employment Status: ❒ Full Time ❒ Part Time ❒ Not Employed

Name of Employer: _____ Type of Work: _____

Parent's Information: If address is different from patient, please complete contact information

Mother's Name: _____ Father's Name: _____
First Name Last Name First Name Last Name

Address: _____ Address: _____

City _____ State _____ Zip code _____ City _____ State _____ Zip code _____

Phone #: _____ Phone #: _____

Emergency Contact: _____ Phone #: (____) _____
First Name Last name

Address: _____

Relationship to Patient: _____ Agency (if applicable) _____

Legal Guardian (if applicable)

Has guardianship been legally established? ❒ Yes ❒ No ❒ Pending ❒ Not applicable

Guardian's Name _____ Relationship to Patient: _____

Address: _____ Phone #_____

The DTC requires a copy of the guardianship papers for proper coordination of care.

Name of Person Preparing this Form: _____ Date: _____

Phone #: _____ Fax #: _____

Relationship to Patient_____ Length of time you have known the patient: _____

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Patient's Name: _____ DOB: _____

Preferred Method of Contact:

❒ Home Phone ❒ Cell Phone ❒ Other Phone ❒ Mail

Race: ❒ American Indian/Alaska Native ❒ Asian ❒ Black/African American
❒ White/Caucasian ❒ Hawaiian/Pacific Islander ❒ Other ❒ Decline

Ethnicity: ❒ Hispanic/Latino ❒ Not Hispanic/Latino ❒ Decline

Primary Language, if other than English: _____

Consent for Treatment: I hereby give my consent for Easter Seals Diagnostic and Treatment Center, to provide diagnostic and clinical services to me/my child/ward, the above named individual, so long as I choose to receive services from the DTC.
Print Name: _____

Signature: _____ Date: _____

(If the patient is over 18 years old and does not have a legal guardian the patient may be the signor)
Relationship to patient (Check appropriate choice): ❒ Self ❒ Parent ❒ Guardian

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Receipt of the HIPAA Privacy Regulations and Bill of Rights
I have received a copy of the Easter Seals NY Notice of Information Practices for Release of Health Information in compliance with the Privacy Regulations of HIPAA and am aware of its contents. I have also received a copy of the Patients' Bill of Rights in accordance with NY State Department of Health.

I understand that if I have questions, at any time, regarding the Easter Seals New York DTC compliance with HIPAA or regarding the Patients' Bill of Rights, I may phone the DTC to speak with an employee of Easter Seals or request an appointment to speak with an employee of Easter Seals to discuss my questions.

Signature: _____ Date: _____

Relationship to patient (Check appropriate choice): ❒ Self ❒ Parent ❒ Guardian

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Financial Guarantor: _____ ❒ Self ❒ Parent ❒ Other
Name & relationship of other: _____
Address: _____
Phone: _____
The financial guarantor is not responsible for paying for services him/herself (except a parent on behalf of a minor) out of personal funds. The financial guarantor is legally responsible for the management of the patient's personal funds and is responsible for payment of the patient's financial obligations including medical bills.

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Financial Policy

Easter Seals New York, Inc. ("ESNY") behavioral health clinic is committed to providing you with quality care. We want to be sure that you completely understand the fees for our services and what you may need to pay if your insurance plan does not cover the cost of services or if you have no insurance. We will always be available to answer any questions you may have about our services, our fees, your insurance payments or insurance statements, payments from other parties and insurance coverage. This Financial Policy Agreement is intended to help you understand the costs of our services and your obligations for payment. Please read and sign this agreement.

Cost of Service & Appointments

Every service provided by this program has a cost. If you have insurance, all or part of these costs may be covered by your insurance. Some insurance policies have a Co-Pay, Co-Insurance, or Patient Responsibility that you will need to pay at the time of your visit. The payments you owe are determined by your insurance plan. We will discuss your costs with you before you begin treatment. If you do not have insurance, you will be responsible for payment, based on our fee schedule at the time of your visit.

Please keep all scheduled appointments or let us know within twenty-four hours if you cannot keep your appointment. ESNY is committed to you and to providing the services you need, however if you do not keep your appointments, do not notify us before the appointment or cancel multiple times we may no longer be able to provide services to you.

Private Pay

Clients who fall into any one of these three categories are considered to be private pay:

1. ***No Insurance Coverage***
2. ***Insurance Coverage that ESNY does not Participate in***
3. ***Indemnity Coverage (You can choose any provider)***

If you cannot afford our private pay fees, please let us know and we will work with you to adjust our fees based on your income and family size.

Managed Care (when ESNY participates)

If you have managed care insurance you need to know what your insurance plan covers. Contact your plan to talk to them about your coverage and what your copayment or deductible may be. You may also want to ask if ESNY services need authorization before the services begin. We are here to help so speak to someone in our Billing Office if you have questions about your insurance plan.

Deductible: Some managed care plans have a deductible. If we receive notice from your plan that a part of your deductible has been applied to ESNY services you will need to pay the deductible amount at your next visit.

Copayments: Some managed care plans require that you pay a co-payment for each service provided. If your plan requires a co-payment, this payment will be collected at each visit upon check in. Co-payments are non-negotiable as they are a part of the contract between yourself and your insurance carrier.

Number of visits/maximum benefits: Some managed care plans have a limit to the number of visits you may have and type of services you may receive from us. If you want to continue to receive services after your plan stops paying ask to speak with the ESNY Billing Office so that we can discuss the costs with you.

Non-covered services: Some service types may not be covered by your insurance. If at all possible we will tell you before the appointment in order for you to decide if you want to proceed as private pay.

Medicaid (Non Managed Care)

If you have regular (Non-Managed Care) Medicaid, you must show your active Medicaid Card at <u>every</u> visit. We will determine at each visit if you are covered. If you are not covered at the time of service and have not been to the Medicaid office to fix this, you may have to pay for your visit. If you are new to Medicaid, you will be private pay until your Medicaid coverage is active. Once your coverage is active, ESNY will send claims for services that have already been provided. If we are paid for services already provided and you have paid the fee, the fee will be refunded to you.

Spend down: If you have a Medicaid spend down you will be need to give us a copy of the letter stating the amount of monthly spend down. If you have a Medicaid spend down, you can:

1. Pay at the Medicaid office each month before you have services or;
2. Pay at each visit until you have paid the monthly spend down amount

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Medicare Part B
Medicare has a yearly deductible and co-insurance. You are required by law to pay ESNY for any deductible or co-insurance that Medicare tells us is owed by you (if you do not have other insurance that will pay these costs).

VERY IMPORTANT: It *is very important* that you notify us if there is any change in your insurance coverage.

- If your insurance becomes inactive, you may be responsible for payment for services provided.
- If you receive a letter from Medicaid or Computer Science Corporation about your **service limits** please bring the letter to your next visit.
- If you receive a letter telling you that you need to recertify your Medicaid benefits (once a year) **please contact the Medicaid office immediately or you may lose your benefits** and be responsible for paying for all your medical/dental services including those you receive at ESNY.

Insurance Releases and Authorizations

I, the undersigned, authorize ESNY, its providers, or its agent to submit claim(s) to my insurance carrier for payment. In addition I authorize release/give any information and copies of my medical records (including information about mental illness and/or AIDS/ARC/HIV/substance abuse as outlined in the HIPAA Privacy Notice supplied at registration) needed by my insurance company to review medical claims for services provided at ESNY. I authorize payment of my insurance benefits to be made directly to ESNY from any insurance or other third-party payer.
I agree to pay ESNY for any services provided which are not covered by my insurance carrier or other third party payer.
I have read, understand and agree with all information in the Financial Policy Agreement.

Medicare Beneficiaries
I certify that the information given by me in applying for payment under the Medicare Program (Title XVIII of the Social Security Act) is correct. I agree that any holder of medical or other information about me may release to the Medicare Program (Social Security Administration, Health Care Financing Administration, or intermediaries or carriers) any protected health information (including information about mental illness and/or AIDS/ARC/HIV) needed to review claims for my medical services. I request that the Medicare Program send payment to ESNY, the Part B Provider directly instead of to me. I assign to the Part B Provider all benefits payable for professional services rendered by ESNY, the Part B Provider.

_____
Print Name of Patient, Guardian, Guarantor Signature Date

_____
Print Name of Witness Signature Date

IF an ESNY REPRESENTATIVE SIGNS AUTHORIZATIONS AND AGREEMENTS ON BEHALF OF PATIENT, COMPLETE THE FOLLOWING:
(As Required by IOM 100-4, chapter 1, section 50.1.6 c.)

Patient Name: _____ Provider/Facility Name: Easter Seals New York, Inc.

____ Patient is unable to sign Authorizations and Agreements because of a physical or mental condition.

____ The following individuals are unavailable to sign Authorizations and Agreements on behalf of Patient:
Legal Guardian - Relative - Friend - Governmental Agency Providing Assistance

Representative Payee (designee of SSA or other government agency to receive incompetent beneficiary's monthly cash benefits)

Representative of Facility

Signature: _____ Date: _____
Name: _____ Title: _____

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Patient's Name: _____ DOB: _____

Medical History: Please indicate if the individual has a history or is currently being treated for any of the listed conditions

Medical problems	Patient	Medical problems	Patient
Cardiac Related Illness		**Genital/Urinary Problems**	
Chest Pain		Abnormal Pap Smear	
Edema		Breast Masses	
Heart Attack		Menstrual Problems	
High Blood Pressure		Painful Urination	
Heart Murmur		Frequent Urination	
Other		Pregnancy	
Dental Disease Problems		Vaginal Bleeding-Abnormal	
type (_____)		Kidney Disease	
Dermatological Problems		Other Incontinence	
Eczema/Rashes		**Hematological /Blood Disease**	
Allergies or Hives		Anemia	
Skin or Hair Changes		Bleeding Problems	
Other		Leukemia	
Endocrine Related Problems		Blood Disease	
Diabetes Mellitus		Hemophilia	
Elevated Cholesterol		Sickle Cell Disease/Traits	
Obesity		Other	
Thyroid Disease		**Respiratory Related Illness**	
Other		Asthma	
Genetic Conditions		COPD/ Emphysema	
Downs Syndrome		Shortness of Breath	
Fragile X Syndrome		Other	
Other		**Neurological Problems**	
Gastro-Intestinal Related Illness		Cerebral Palsy	
Constipation		Dizziness or Fainting	
Diarrhea		Glaucoma	
Gallbladder Disease or Surgery		Hearing Loss or Changes	
GERD/ Gastro Esophageal Reflux		Memory Changes	
Celiac Disease		Migraines/ Headaches	
Hepatitis		Multiple Sclerosis	
Irritable Bowel, Crohn's Disease		Stroke	
Liver Disease		Tinnitus	
Nausea, Vomiting		Vertigo	
Ulcers		Visual Loss or Change	
Ulcerative Colitis		Weakness	
Lactose/Milk Intolerance		Tics	
Other		Dementia	
Muscular Skeletal Problems		Other	
Arthritis			
Osteoporosis			
Back Pain			
Other			

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Patient's Name: _____ DOB: _____

Medical History: Continued

Medical problems	**Patient**	**Medical problems**	**Patient**
Infectious Diseases		**Seizure Disorder**	
HIV or AIDS		History of Seizures	
Sexually Transmitted Disease		Type (_____)	
Tuberculosis or Positive PPD		**Occurrence of Seizures**	
Other		Daily, Monthly, Occasionally	
Other Disorders		**Head Injury**	
Cancer (Type _____)		Date of Injury (_____)	
Sleep Disorder (Type _____)		Type of Injury (_____)	
Lead Poisoning			
Eating Disorder (Type _____)			

Significant Family Medical History:

	Patient		**Patient**
Attention/Concentration problems-ADHD		Talk of Suicide or Suicide Attempts	
Hyperactivity-ADD		Schizophrenia	
Autism & Autism Type Syndromes		Psychosis, Hallucinations	
Brain Injury/Head Trauma			
Anxiety		Alcohol Abuse	
Obsessive Anxiety		Drug Abuse	
Obsessive Compulsive Behavior		Tobacco Abuse	
Panic Attacks		Legal Problems	
Manic Depressive (Bipolar)			
Depression			
Intellectual Disability-specific degree	❒ **Mild** ❒ **Moderate** ❒ **Severe** ❒ **Profound**		

Other Problems (list):

Hospitalization for Medical Treatment: List hospital admissions

Date of Hospital Admission	**Level of Care:** i.e. Ambulatory Surgery, Emergency Room Care, Inpatient, Other (List Type)	**Facility:** Strong Memorial (SMH), Rochester General (RGH), Unity Health System (UH), Other (List Agency)	**Reason for Hospitalization**	**Length of Time in the Hospital**

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Patient's Name: _____ DOB: _____

Substance Abuse History

Have you ever or are you currently using the following substance? (Check if using or used)

Substance

	None		Valium		Marijuana		PCP		Alcohol
	Ecstasy		Xanax		Crack/Cocaine		LSD		Opiates
	Sedatives		Klonopin		Amphetamines		Tobacco		Heroin
	Mushrooms	Inhalants (Huffing) (List substance _____)							
	Over the Counter Drugs, (i.e. Cough medicine, diet pills, herbal medicines, sleep aids, etc.) List Type _____								
	List Others _____								

List Substance Abuse Treatment History

Date of Substance Abuse Treatment	**Level of Care:** i.e. Outpatient/Clinic, Inpatient, Partial Hospitalization, Residential, Other (List Type)	**Facility:** Strong Memorial (SMH), Rochester General (RGH), Unity Health System (UH), Other (List Agency)	**Substance**	**Length of Time in Treatment**

Current Medications

List currently used medications, over the counter medications or attach a copy of the medication record

Name of Medication	**Dosage & When taken**	**Reason(s) Prescribed**	**Doctor Prescribing**

Drug allergies and Past Drug Trials

Name of Medication	**Response to medication including Adverse Reactions**

Allergies:

List non-medication allergies (i.e. food, environmental, other)

Name of Allergen	**Adverse Reactions**