Long Island
Select Healthcare

Phone: 631-650-2510

Please return packets to:

Long Island Select Healthcare, Inc.
883 East Main St
Riverhead NY 11901
or
Fax number: 631-727-8713

****Packets must include any previous psychiatric records. If there is no previous psychiatric treatment, please provide most recent physical. Packets received without records will experience delay in treatment****

If handing in at office, please keep this top document for your records as confirmation of receipt.

Initials of Staff who received packet:_____
Date Packet received: _____

******* MAKE COPY AND GIVE TO PATIENT*******

An Introductory Intake Appointment will be scheduled for the following services:

- **Behavioral Health Counseling**
- **Psychological Testing**
- **Neuropsychological Testing**
- **Psychiatric Services and/or Medication Management**

*Please note - If you are requesting an evaluation for legal purposes (e.g. court-appointed, to obtain guardianship papers, or requested by a school district) these services may not be considered medically necessary and may not be covered by your health insurance company. Evaluations for legal purposes will be considered self-pay.

**Long Island Select Healthcare is a full-service Federally Qualified Health Center (FQHC) with eight locations throughout Suffolk County. In addition to mental health services we offer Primary Care, GYN, Neurology, Podiatry, Allergy, Dermatology, Endocrinology, Dental, Audiology, and Optometry. We also provide Physical Therapy, Occupational Therapy, and Speech Therapy to patients with developmental disabilities. If you are interested in additional services, please let us know.

Behavioral Health Services Packet

What services are you seeking? Select all that apply.

___ **Psychiatric or Psychological Evaluation** – An introductory appointment used to gather information about the patient, determine needs, and refer for additional services. Script from a physician, nurse practitioner or physician assistant required if not internal.

___ **Psychosocial Evaluation –** An appointment used to gather information about a person's family history, work history, and other social factors often used by various state agencies. Script from physician, nurse practitioner or physician assistant required if not internal.

___ **Psychological Testing –** A series of tests which may include IQ Testing, Adaptive Assessments, Aptitude testing, or more designed to evaluate general cognitive and personality functioning. Used to diagnose psychiatric conditions. Script from a provider required.

___ **Neuropsychological Testing** – An extensive set of specific tests designed to evaluate cognitive strengths and weaknesses. These tests help healthcare providers gather a better understanding of the patient's brain functioning. Script from a provider required if not internal.

___**Behavioral Health Counseling short and long term –** Regular appointments designed to help individuals talk through issues, determine the underlying causes for certain behaviors, and manage those behaviors. Script from psychiatrist required.

___ **Medication Management –** Ongoing appointments used to monitor psychiatric medication and treatment plans to determine the best course of action to improve an individual's mental health. No script needed.

Long Island
Select Healthcare

Patient Name:_____Date of Birth:_____

Have you had any of the following evaluations within the Past 5 Years?

(Mark all that apply)

****If yes, please provide copies of reports.**

___ Psychosocial_____Psychological_____Neurological_____Neuropsychological

___ Neuropsychiatry ___ Psychiatric_____Developmental_____Educational_____Genetic

Dates of past evaluations: _____

Reason for seeking treatment: _____

Is this a court appointed evaluation? Select one (YES)___(NO) ____

If yes, what is the reason? _____

_____

Do you have any past or present legal issues? Select one (YES)____(NO) _____

If yes, please explain: _____

Do you have a referral from your PCP? Select one (YES)___(NO)___

If yes, please provide the name and phone number of your PCP:

PCP Name:_____ Phone Number: _____

Have you had a recent physical exam by your PCP? Select one (YES) (NO)

Date of your last physical exam: _____

Does the patient have a developmental disability? Select one (YES)___(NO) ____
If yes, what is the patient's diagnosis?

_____

_____

Long Island Select Healthcare

Patient Name:_____Date of Birth:_____

Please List All Current Medications.

Medication	Dosage	Frequency

Person Completing This Form

Name:_____Relationship:
_____

Phone number: _____

****Packets must include any previous psychiatric records. If there is no previous psychiatric treatment, please provide most recent physical. Packets received without records will experience delay in treatment****

269BH-Revised 6/2019

MEDICAL/ PSYCHIATRIC RECORDS CONSENT FOR RELEASE INDIVIDUAL AUTHORIZATION

Patient Name/Chart #: _____ Date: _____

We understand that information about you and your health is personal and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

Who will disclose the information?

_____

Who will use and/or receive the information?

_____

What information will be used or disclosed?

_____

What is the purpose of the use or disclosure?

When will this authorization expire?

In one year, unless you choose to rescind it at any time.

SPECIFIC UNDERSTANDING

By signing this authorization form, you authorize the use of disclosure of your protected health information as described above. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and in that event such information may no longer be protected by the federal HIPAA privacy regulations.

You have a right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.

You have a right to see and copy the information described on this authorization form in accordance with agency policies. You also have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that the agency has already taken action based upon your authorization. To revoke this authorization, please write to Long Island Select Healthcare, C/O Chief Privacy Officer at the agency.

SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

_____

Signature of Patient or Legal Representative Date

_____

If not Patient, state Relationship

INFORMATION TO BE SENT TO:

Name: _____

Street: _____

City/Zip: _____

Original to be retained by Long Island Select Healthcare. The patient/representative may be provided with a copy of this form after it has been signed.