CONFIDENTIAL PERSONAL DATA

Name:_____ Date:_____

Patient:_____

Last Name First Name Middle Initial

Responsible Party (if a Minor):_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Phone: Home:_____ Office:_____

Mobile:_____ Other:_____

E-mail: _____

Patient Information:

Date of Birth:_____ Age:_____ Sex: ___ M ___F

Marital Status: ___Single ___Married ___Divorced___ Separated__

Account Information:

Who is responsible for this account:_____

Relationship to Patient:_____

Referral and Background Information:

Who may we thank for referring you?_____

Phone:_____

Address:_____

Name of Primary Physician:_____

Phone:_____

Address:_____

Have you (or your spouse) ever been involved in therapy: ___ Yes ___ No

If yes, When?_____ Where?_____

Reasons for considering therapy at this time_____

_____

Have you ever, or are you now being treated for alcohol or drug dependency?

____ Yes ____ No

If yes, When?_____ Where?_____

By whom? _____ Length of treatment?_____

I understand that I am responsible for any unpaid balance on my account and for charges for any missed appointments not cancelled within 24 hours.

_____ _____

Signature of Responsible Party **Date**

Medical Checklist

Look over each condition and fill in those that apply.

Condition	Date	Treatment
Abdominal bleeding		
Abnormal bleeding		
Adverse reactions to food		
Allergies		
Blindness, double vision, spots, eye pain		
Body hair changes		
Bowel or bladder changes, gas, diarrhea, constipation		
Broken bones		
Chest pain		
Coughing, wheezing, sputum, shortness of breath		
Deafness, ringing sound, discharge, internal itching		
Decreased sexual drive, pain, bleeding		
Easy bruising		
Excessive itching		
Excessive thirst or hunger		
Finger or toenail changes		
Hemorrhoids, rectal bleeding		
Infected wounds		
Joint pain or swelling		
Lumps or masses under skin		
Masses in breast, nipple pain, discharge		
Muscle pain or stiffness		
Nausea, vomiting		
Nose bleeds, sinus problems, excessive discharge		
Painful or frequent urination, blood in urine		

Medical Checklist Continued

Condition	Date	Treatment
Skin disease/rashes		
Temperature tolerance change		
Transfusions		
Trouble swallowing		
Venereal disease		
Voice changes, hoarseness		
Weight changes of more than ten pounds in two weeks		
Other		

Drug Use Checklist

Look over each drug and fill in those that apply.

Drug	Amount (mg)	Frequency	Duration
Cocaine			
Crack			
Heroin			
PCP			
Marijuana			
LSD			
Stimulants (non-Rx)			
Barbiturates (non-Rx)			
Narcotics (non-Rx- painkillers, morphine)			
Tobacco			
Other drugs			

List of Operations Over Course of Lifetime

Date	Hospital	Operation	Reason	Other Treatment

The information above and on the previous pages are true to the best of the undersigned's memory.

_____

Patient's Signature

Wade H. Silverman, Ph.D.
American Board of Professional Psychology Diplomate

Notice of Privacy Practices – Brief Version

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This pamphlet is a shorter version of the full, legally required NPP and you may have a copy of this to read and refer to it for more information. However, we can't cover all possible situations so please talk to our Office Manager (see the end of this pamphlet) about any questions or problems.

We will use the information about your health, which we get from you or others mainly to provide you with treatment, to arrange payment for our services, and for some other business activities, which are called, in the law, health care operations. After you have read this NNP, we will ask you to sign a consent form to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If you or we want to use or disclose (send, share release) your information for any other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Of course we will keep your health information private, but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.

2. Some lawsuits and legal court proceedings.

3. If a law enforcement official requires us to do so.

4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

Your Rights Regarding Your Health Information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place, which is more private for you. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.

3. You have the right to look at the health information we have about you such as your medical billing records. You can even get a copy of these records, but we may charge you. Contact our Office Manager to arrange how to see your records. See below.

4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kind of changes (called amending) to your health information. You have to make this request in writing and send it to our Office Manager. You must tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this NNP, we will post the new version in our waiting area and you can always get a copy of the NPP from our Office Manager.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Office Manager and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact the Psychologist who is **Dr. Wade H. Silverman** and can be reached by phone at 786-536-7033.

The effective date of this notice is April 30, 2003.

Also, you may have other rights, which are granted to you by the laws of our state and these may be the same or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

Signature:_____ Date:_____

Wade H. Silverman, Ph.D.
Diplomate American Board of Professional Psychology
(786)536-7033 , (561)999-9890

Aventura
1031 Ives Dairy Road
Suite 228
Avenura, FL 33179

Boca Raton
4710 NW 2nd Avenue
Suite 104
Boca Raton, FL 33431

Patient Rights

- The right to refuse and/or terminate treatment at any time;
- The right to a complete description and explanation of any treatment;
- The right to refuse any electronic and/or visual recording of my treatment;
- The right to confidentiality whereby information revealed to me during treatment will be kept strictly confidential and will not be revealed to anyone without authorization. However, **knowledge of child abuse, intent to harm others or myself will be reported.**

I hereby certify and I understand the above and have been informed of policies and procedures regarding appointments and fees. Furthermore, I authorize treatment by Wade H. Silverman.

_____.
Signature of Patient Date

_____.
Signature of Guardian (if applicable) Date

Financial Policy

Thank you for choosing me as your mental health care provider. I am committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of the Financial Policy, which you are required to read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

- FULL PAYMENT IS DUE AT THE TIME OF SERVICE -
- WE ACCEPT CASH, CHECKS, OR CREDIT CARDS -

Appointments are scheduled for the same day and time each week unless altered by the doctor or yourself in advance.

Timely Payment
I understand that payment is expected upon receipt of service. I agree to pay 1.5% per month if I am delinquent in my account and have to be re-billed. I also understand that should any action need to be taken to collect for professional services rendered, the professional provider shall be entitled to recover any attorney fees.

Regarding Insurance
We do not accept insurance.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients
Adult patients are responsible for full payment at time of service.

Minor Patients
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-paid by credit card or cash.

Missed Appointments
We require, at least 24 hours in advance, to cancel an appointment. Any calls made after 5:00pm or on Saturdays and Sundays to cancel appointments will **not** be accepted .Thus, if your appointed is after five o'clock, *you must call before five o'clock on the previous day*. If your appointment is on a Monday, *you must call before 5:00pm on the previous Friday.* **Please help us serve you better by keeping scheduled appointments.**

Telephone Time
Unless it is an emergency, all therapeutic contacts take place in the office. Should you request therapeutic interventions on the telephone you will be charged $225 per hour prorated in .10 hours. Most insurance companies will not reimburse telephone time.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy:

X_____ Date _____
Signature of Patient or Responsible Party

Wade H. Silverman, Ph.D.

Adult Clinical Fees

OUTPATIENT PSYCHOTHERAPY

SERVICE:	**FEE:**
Diagnostic Interview	250.00/hr.
Individual Psychotherapy	200.00/45min. 250.00/ 1 hr.
Marital and Family Psychotherapy	200.00/45 min. 250.00/1 hr.
Preparation of Report	225.00/hr.

PSYCHOLOGICAL TESTING

SERVICE:	**FEE:**
Beck Depression Inventory (BDI)	100.00
Beck Anxiety Inventory (BAI)	100.00
Child Abuse Potential (CAP-VI)	325.00
Detailed Assessment Post-traumatic Stress (DAPS)	325.00
Drug Abuse Screening	100.00
Mini Mental Status Exam (MMSE)	100.00
Minnesota Multiphasic Personality Inventory (MMPI-2)	375.00
Millon Clinical Multiaxial Inventory (MCMI-IV)	275.00
NEO Personality Inventory (NEO-PI-Revised)	275.00
Personality Assessment Inventory (PAI)	375.00
SASSI 4 (Substance Use)	250.00
Wechsler Adult Intelligence Scale (WAIS-III)	650.00

Cancellations must be made 24 hours in advance. Patients will be charged for session if they do not call and cancel.