Dr. John Carosso, Psy.D. & Associates

ADULT: CONSENT TO TREATMENT

My signature below attests that I give consent to receive treatment/evaluation for myself, from Dr. John Carosso, Psy.D., Licensed Psychologist, and/or a Practice Associate(s). I am seeking treatment with the intent of receiving the following:

Assessment and/or Counseling

I have been informed that I will be provided treatment/assessment for said presenting problem in accordance with ethical principles and research-based best practices. In this regard, an "evaluation" will consist of a clinical interview and possibly projective, intellectual, visual-motor, developmental, objective, and/or academic/intellectual assessment (drawings, inkblots, WRAT-4, Wechsler Scales, Developmental Inventory). Psychotherapy will consist of talk and possibly art, couples, and/or family-therapy to address pertinent issues.

I am aware that treatment results are not guaranteed and that appropriate referrals will be provided, as needed. I have been informed that I can change clinicians, or end the therapy/evaluation, at any time.

I have been informed that Dr. Carosso, Psy.D. has a doctorate in the field of Psychology, is licensed as a Psychologist in the State of PA (www.psychologyinfo.com/directory/PA/board), and has a Certification in School Psychology. He also has a Graduate Certificate in Applied Behavioral Analysis in Special Education. He specializes in evaluating and providing treatment for children and teenagers but also has extensive experience in providing evaluations and treatment of adults and does so on a regular basis. Dr. Carosso works in private practice (Dr. John Carosso & Associates, PC) and is a partner of the mental health agency, Community Psychiatric Centers, Inc, and the Autism Center of Pittsburgh.

Confidentiality and Releases / Received HIPAA

I have been informed that psychological services will be provided in an atmosphere of trust and, as such, all information will be kept confidential. However, with my consent and at my request, evaluation reports containing clinical and, possibly, personal information, will be sent to relevant agencies (including Primary Care Physician). I have been informed of the need to make the Dr. Carosso, and/or a Practice Associate, aware of any specific pieces of information that I do not want included in the final report. I have been offered a copy of my HIPAA privacy rights.

I have also been informed that I present as a danger to self or others, or in the case of child abuse, that this information will need to be disclosed to the proper authorities. However, I have been informed that these issues may first be discussed with me before being disclosed to relevant others.

I give consent for Dr. Carosso to share written and verbal information regarding myself with a practice associate and/or Community Psychiatric Centers staff, if I decide to seek treatment at Community Psychiatric Centers.

Costs for Services

I have been informed of fee arrangements (insurance will be billed; out of pocket payment will be discussed and agreed upon prior to evaluation) and any relevant discounts. I give permission for Dr. John Carosso to bill my insurance company, and/or the funding source, and I understand that I am responsible to pay if the service is not covered by insurance, and/or the co-pay, that will be due at the end of the evaluation or at the end of each session.

Appointments and Emergencies

In regards to psychotherapy, I have been informed that the service will be provided at the time scheduled. I am aware of the importance of keeping the appointment in regards to maintaining the continuity and effectiveness of therapy and, if I cannot attend, to provide at least 24 hours notice. In the case of emergencies, I have been informed that I can contact the Practice of Dr. Carosso at 724-787-0497(cell) or 412-372-8000 or 724-850-7200.

If there is no answer, I have been informed to leave a message on voice-mail (picks-up after five or six rings) and the call will be returned as soon as possible. I have also been informed of other emergency contact options such as the authorities (911).

_____ _____

Signature Date

_____ _____

Signature Date

INTAKE: ADULT

Client Information

Name: _____
Date of Birth: _____
Age: _____ **Please circle: Male / Female**

Height: _____ **Weight:** _____
Hair color: _____ **Eye color:** _____

Address: _____
Phone Number: _____
Alternative: _____

Insurance: _____ #_____
Cardholder Name: _____
Cardholder DOB: _____

Please list all those who live in the home with you:

Name	Age	Relationship
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____

Please list number of siblings living outside the home, or living parents outside home:
# of brothers: _____ **Parents: Mother (alive; deceased)**
# of sisters: _____ **Father (alive; deceased)**

Marital Status: Married; Never Married; Separated; Divorced; Widowed.

Do you have any Children: No / Yes: how many:_____

School Information

Name of High School Attended: _____
Graduated from High School: ____ **Yes** ____ **No**
If not, in what grade did you leave school: **7, 8, 9, 10, 11, 12**

GED: Yes / No

History of Special Education: ____ No ___ Yes: Type: Learning Support
Emotional Support
Other:

Post High School Experience (please circle)? Vocational / College / Military

<u>Heath / Medication / Mental Health</u>

Any previous diagnoses?: ___ No ___ Yes. Please specify:_____
_____
_____

<u>Medications (for mental health reasons)</u>:

Name	Dose
_____	_____
_____	_____
_____	_____

Who prescribes the medication: _____

PCP: _____
Doctor's Phone # _____

<u>Medical Conditions</u>

Allergies	**___ No**	**___ Yes: Type-**
Asthma	**___ No**	**___ Yes**
Seizures	**___ No**	**___ Yes**
Hearing deficits (hearing aide?)	**___ No**	**___ Yes**
Vision deficits (glasses?)	**___ No**	**___ Yes**
Serious medical conditions?	**___ No**	**___ Yes**

<u>Services</u>

Any current mental health services? ____ No ____ Yes

If yes, please specify type (outpatient counseling, wraparound…):

_____

Please identify the agency providing the mental health services:_____

PRIMARY CONCERNS

Please check all that apply:

___ Depression (sadness, no motivation, no energy…)
___ Anxiety (nervous all the time, worry…)
___ Mood swings (one day you're feeling great, the next terrible)
___ Very uncomfortable in social situations
___ Panic attacks (intense anxiety, sweating, dizziness, heart palpitations…)
___ Compulsive behaviors (doing things over and over such as washing your hands or checking to make sure the stove is off…)
___ Obsessing on things (can't get thoughts out of your mind…)
___ Difficulty taking orders from bosses/supervisors
___ Argue with others
___ Temper outbursts
___ Poor sleep
___ Nightmares
___ Flashbacks
___ Medical/physical problems (chronic pain, no energy, easily fatigued)
___ Vision Problems
___ Hearing problems
___ Can't read or write
___ I have trouble learning
___ Alcohol Abuse
___ Substance Abuse (cocaine, heroine…)
___ Hearing voices others can't hear
___ Poor concentration
___ Poor memory
___ Easily distracted (can't pay attention)
___ Can't sit still (always fidgety and moving)
___ History of incarceration (being in prison)