IRENE DASHIELL, LCSW.
31 Oak Street, Suite 14
Patchogue, NY 11772
Phone number (631)289-8765, Fax number (631)447-9717

Consent to use and disclose your child's health information

This consent is an agreement between you as a parent / guardian ____________________
(Name)
regarding your child ______________________________ and Irene Dashiell, LCSW.
(Child's Name)

When I diagnose, treat, or refer your child, I will be collecting what the law calls Protected Health Information (PHI) about him or her. I need to use this information to decide on what treatment is best for your child and to provide treatment for him or her. I may also share this information with others who provide treatment for your child or to arrange for treatment reimbursement.

By signing this form, you are agreeing to let me use your child's information and send it to others. The Notice of Privacy Practices explains in more detail about your rights as a parent / guardian and how I can use and share your child's information. Please read my Privacy Practices carefully before you sign this Consent Form.

If you do not sign this Consent Form agreeing to what is in my Notice of Privacy Practices I cannot treat your child.

If you are concerned about sharing some of your child's information, you have the right to ask me not to use or share some of his or her information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although, I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wishes.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your child's information from that time on. I may already have used or shared some of your child's information and cannot change what has occurred in the past.

Please be aware by signing this Consent Form you are acknowledging you have received, read and understood my Notice of Privacy Practices.

____ ____________________
Signature of Parent / Guardian Date

____ ____________________
Print Name of Parent / Guardian Date

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Children & Adolescent Insurance Form

Child's Name ________________________________ Today's Date ____________

Date of Birth ___/___/____ Relationship to the Insured Person ____________

Home Address _______________________________ City ___________ State ________

Zip Code ___________ Home Phone ____________________

Insurance Name __________________________________

Insurance I.D. Number ______________________________

Insurance Group Number (if relevant) ______________________________________

Insured's Name __________________________________

Insured's Date of Birth ___/____/____

Insured's Home Address ____

City ____________ State __________ Zip Code ___________ Home Phone _________

Insured's Employer ______________________________

Is There Another Insurance Plan? Yes_______ NO _______

Second Insurance Name (if relevant) ____

Second Insurance I.D. Number (if relevant) ______________________________

Second Insurance Group Number (if relevant) ______________________________

Second Insured's Name (if relevant) _____________________ __________

Second Insured's Date of Birth (if relevant) ___/____/____

Second Insured's Home Address (if relevant) ______________________________

City ____________ State ____________ Zip code_________ Home Phone _________

Second Insured's Employer (if relevant) ______________________________

Child's Relationship to Second Insured Person (if relevant) _____________________

I Authorize Irene Dashiell, LCSW. to receive payment of medical benefits for the services she provides for my child.

_________________________________ ________________
Signature of Parent / Guardian Date

________________________________ __________________
Print Name of Parent / Guardian Date

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Children & Adolescent Intake Form

Child's Name ______________________________ Today's Date ____________

Date of Birth _____/_______/_______ Age _________

Home Address _____________________________ City ___________ State ________

Zip Code ___________ Home Phone ____________________

Parent Information:

What is the parent's current living situation? ____ Married ____Not Married

____ Separated ____ Divorced ______ Living Together

Who does the child live with? _______Both parents ______One parent ______

______ splits time between both the parents' weekly ______Other living situation

Mother's Name ____________________________

Step-Mother's Name (if relevant) _______________________

Mother's Home Address (if different) ____

City ____________ State __________ Zip Code ___________ Home Phone _________

Mother's Occupation ________________________ Employer ________________

Work Phone _____________ Cell Phone _____________

E-mail Address ___________________________

Father's Name _____________________________

Step-Father's Name (if relevant) ________________________

Father's Home Address (if different) ____

City _____________ State __________ Zip Code ____________ Home Phone ______

Father's Occupation _________________________ Employer _________________

Work Phone _____________ Cell Phone _____________

E-mail Address (if different) _________________________

Legal Guardian's Name (if relevant) _________________________________

Home Address ____________________________________City ___________

State________ Zip Code __________ Home Phone _________

Guardian's Occupation __________________ Employer ________________

Work Phone _________ Cell Phone ____________

E-mail Address _________________________________

Why is this Child living with the Legal Guardian? ________________________

How long has this Child lived with the Legal Guardian? _____________

Other Family Members Names & Ages in the Household:

1. _______________________________ 2. ___________________________

3. _______________________________ 4. ___________________________

Referral Information:

Name of referral agency or person _________________________________

Address ______________________________ City _____________ State _______

Zip code ___________ Phone _________________

Why is treatment needed now? _____________________________________

Prior Treatment Information:

Has your child received prior treatment? Yes _____ No _____

Name of agency or person _______________________________________

Address ______________________________ City ________ State __________

Zip code ______________ Phone __________________

Dates of treatment ______________________________

Why was treatment needed? __________________________________

Education Information:

Name of child's school _________________________________ Grade __________

School Address ____

City ___________________ State __________ Zip Code ___________

School Phone ___________________________

Teacher's Name (if elementary school) _____________________________________

Guidance Counselor's Name (if middle school or high school) __________________

Special Education:

Is your child in a Special Education class or receiving individual Special Education services?   Yes ______ No______

What is your child's disability? ___________________

What type of Special Education services does your child receive? Self - contained Class ___

Inclusion Class ___ Resource Room ___ Speech Therapy ___ Occupational Therapy ___

Physical Therapy ___ Counseling ___ Other ___________________________

When did your child first start receiving Special Education services? _________

Medical Information:

Does your child have any medical problems?   Yes ________ No _________

Does your child take any medication?   Yes________   No __________

Name of medication & dosage _________________________________

Name of Physician ___________________________

Address ______________________________ City ____________ State __________

Zip code _____________ Phone ___________________

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I hereby authorize Irene Dashiell, LCSW. to contact me concerning my child's appointment at one or more of the following places.

Under HIPAA, you have the right to request how I communicate with you and that our communication method is confidential. I will approve your request if in my opinion it is reasonable. Once I agree to your request, I am obligated to honor it, except if an emergency arises.

I wish to be contacted as follows: (check all that apply)

At my home phone number: ___________________________
___You can leave a message with detailed information
___Leave a message with a call - back number only
___ Call only at specified times of the day ______________________

At my work phone number: __________________________
___You can leave a message with detailed information
___Leave a message with a call - back number only
___Call only at specified times of the day ______________________

At my cell phone number: _____________________________
___You can leave a message with detailed information
___Leave a message with a call - back number only
___Call only at specified times of the day ______________________

___________________________________ _______________
Signature of Parent / Guardian Date

_________________________________ _______________
Print Name of Parent / Guardian Date

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Notice of Privacy Practices

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

My commitment to you or your child's privacy

My practice is dedicated to maintaining privacy for you or your child's personal health information. I am required by law to do this. These laws are complicated, but I must provide you with important information.

I will use the information about you or your child's health, which I get from you or from other people mainly to provide **treatment** and to arrange **payment** for my services or for some other business activities, which are called, in the law, **Healthcare Operations.** After you have read this NPP I will ask you to sign a **Consent Form** to let me use and share your or your child's information. If you do not consent and sign this form, I cannot treat you or your child.

If you or I want to use or disclose (send, share or release) information about you or your child for any other purpose I will discuss this with you and ask you to sign an Authorization to allow this.

Of course I will keep your or your child's health information private, but there are some times when the law requires me to use or share it such as:

A. When there is a serious threat to you or your child's health and the safety or the health and safety of another individual or the public. I will only share information with a person or organization that is able to help prevent or reduce the threat.

B. Some lawsuits and legal or court proceedings.

C. If a law enforcement official requires me to do so.

D. For Workers Compensation and similar benefit programs.

Your rights regarding your or your child's health information

A. You can ask me to communicate with you about you or your child's health and related issues in a particular way or at a certain place. For example, you can ask me to call you at home and not at work to schedule or cancel an appointment. I will try my best to do as you ask.

B. You have the right to ask me to limit what I tell certain individuals involved in your or your child's care or for the payment for you or your child's care such as family members and friends. While I do not have to agree to your request, if I do agree, I will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you or your child. Please be aware in the situation where parents are separated or divorced, I am required by the law to release health information to each parent who has custody.

C. You have the right to look at the health information I have about you or your child such as your medical and billing records. You can even get a copy of these records but, I may charge you. Speak with me to arrange how to see your or your child's records.

D. If you believe the information in your or your child's record is incorrect or incomplete, you can ask me to make some changes (called amending) to the health information. You have to make this request in writing and send it to me. You must tell me the reasons you want to make the changes.

E. You have the right to a copy of this notice. If I change this NPP, I will give you a new copy of my NPP.

F. You have the right to file a complaint if you believe your or your child's privacy rights have been violated. You can file a complaint with me 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 healthcare I provide to you or your child in any way.

If you have any questions regarding this notice or my health information privacy policies, please ask in person or reach my office at (631) 289-8765.

The effective date of this notice is May, 2019