Campus Map with Sheehan Building Location:

Map is for appointment on the main campus

If your appointment is at Frawley Main Clinic Follow the map above
255 Lafayette Ave Suffern Ny 10901 (Sheehan Building)

Other Offices Associated with Frawley Outpatient Clinics:

Rockland Pulmonary Med & Associates (RPMA) - 2 Crosfield Ave # 318, West Nyack, NY 10994

Hudson Valley Medical Associates (HVMA)- 26 Firemens Memorial Dr # 215, Pomona, NY 10970

Roberta Glinton Medical Office Building(BSC) - 32 Canal Street, Port Jervis, NY 12771

Please complete all paperwork for first appointment and send it to email addres: frawley-oc@wmchealth.org and bring a copy with you.

Dear Friend;

We want to welcome you and thank you for choosing the Frawley Mental Health Clinic. It is our mission to provide you with the best clinical practices to serve you and your family in the treatment of your mental health needs. Your physical health is also as important to us as your mental health. We can assist in providing in-house or community referrals for primary health care physicians. Providing a holistic approach has been correlated to reducing unnecessary hospitalizations. We believe in collaboration, confidentiality, your right to self–determination but most importantly we believe in you. We demonstrate this belief by creating individualized treatment plans that gets revisited and revised every three months. Our clinical staff at Frawley utilizes an array of evidenced based treatment tailored to our person-centered approach. This is evident by the culturally sensitive and gender inclusive services we provide.

Please complete the attached paperwork for your intake appointment. If you have any questions regarding the paperwork please ask staff for assistance. Please do your best to answer all the assessment tools in the packet before you meet with the clinician.

Thank you for choosing Frawley Clinic as your provider. We look forward to providing the utmost care for you and your family.

Warmly;

Frawley Outpatient Team

(845)368-5222

Located in the Sheehan Building

First Appointment/Visit Paperwork to Complete:

-Complete the attached paperwork for the 1st visit at the clinic.
-Screening Tools will be completed 2nd visit at the clinic.

Name:	Birthdate:	Date:
SS #:	SS # of Parent: *(if applicable)*	Referral Source:
Gender Identity:	Sex Assigned at Birth:	Marital Status:
Sexual Orientation:		
Address:		
City:	State:	
Religion:	Ethnic Group(s):	
Email:	Military Status:	
Phone (Home):	Emergency Contact Name:	
Phone (Work):	Emergency Contact Number:	
Phone (Cell):	Relationship to Client:	
Employed: ☐ Yes ☐ No ☐ Other:	Do you have any children? ☐ Yes ☐ No	
Employer:	What are their ages?	
Address:		

Do you have a Healthcare Proxy/Advanced Directive? ☐ Yes ☐ No
If not, would you like information on how to create one? ☐ Yes ☐ No
Have you been hospitalized for Psychiatric or Substance Abuse treatment: ☐ Yes ☐ No
If so, Please give the dates and locations:
Brief statement of problem for which you are seeking help:
Medicaid #: Medicare #:
Is Medicare due to: ☐ Age ☐ Disability ☐ End Stage Renal Disease

HEALTH SCREENING

PATIENT'S NAME: _____
D.O.B: _____ SEX: _____ DATE COMPLETED: _____

ACCESS TO FIREARMS: ☐ YES ☐ NO

CURRENT OR PAST HISTORY OF THE FOLLOWING: Mark with an "X"

Please Check All That Applies:	Self	Family	Please specify which family member
ABNORMAL MUSCULAR MOVEMENT			
ALLERGY			
APPETITE CHANGES			
ASTHMA			
BLOOD DISORDER (e.g., Anemia)			
BONE OR JOINT PROBLEM			
CAFFEINATED BEVERAGES (E.G., Coffee, Cola)			
CANCER			
CONCENTRATION/MEMORY DIFFICULTIES			
DIABETES			
EATING DISORDER			
EAR, NOSE, AND THROAT DISORDER			
ENDOCRINE DISORDER (e.g., Thyroid)			
EXERCISE (Currently)			
ENERGY CHANGES			
EYE DISEASE (e.g., Glaucoma)			
GYNECOLOGICAL PROBLEM			
HEARING DISORDER			
HEADACHES			
HEAD INJURY (e.g., Loss of Consciousness)			
HEART AND/OR CIRCULATORY PROBLEM			
HIGH OR LOW BLOOD PRESSURE			
IMMUNIZATIONS			
HIGH OR LOW BLOOD SUGAR			
LIVER DISEASE (e.g., Hepatitis)			
LUNG DISEASE			
LYME DISEASE			
NIGHTMARES			
PREGNANCY			
PHYSICAL LIMITATION			
SEIZURE DISORDER (e.g., Epilepsy)			
SEXUAL FUNCTIONING PROBLEMS			
SEXUALLY TRANSMITTED DISEASE (e.g., Syphilis)			
SLEEP DIFFICULTIES			
SMOKING OR TOBACCO USE			
STOMACH OR BOWEL PROBLEMS			
UNUSUAL THIRST			
TICS (Verbal or Motor)			
URINARY DISEASE (e.g., Kidney, Bladder)			
DRUG OR ALCOHOL USE			
DRUG/ALCOHOL TREATMENT, REHAB, DETOX			
PSYCHIATRIC PROBLEMS			
PSYCHIATRIC TREATMENT/HOSPITALIZATIONS			
SUICIDE ATTEMPTS			
HOSPITALIZATIONS (MEDICAL/SURGICAL)			

SIGNIFICANT MEDICAL PROBLEMS			
LEARNING DISABILITIES/SCHOOL PROBLEMS			
WEIGHT:	**HEIGHT:**		

HAVE YOU HAD A PHYSICAL EXAM IN THE LAST YEAR? ☐ Yes ☐ No DATE OF LAST VISIT: _____

REASON FOR EXAM: _____

NAME OF YOUR DOCTOR: _____ PHONE: _____

ADDRESS: _____

PHARMACY: _____

CURRENT MEDICATIONS: (Prescription and Over-the-Counter)

Name and Purpose	Dose/Frequency	Date Started

PAST MEDICATIONS: (Prescription and Over-the-Counter)

Name and Purpose	Dose/Frequency	Date of Use

COMPLETED BY _____ REVIEWED BY _____

Patient's Signature Intake Clinician Date

Please type to confirm agreement*

ASSESSMENT AND RECOMMENDATIONS BY MEDICAL PROFESSIONAL, BASED ON REVIEW OF HEALTH SCREEN

_____ No apparent medical problem. Physical assessment recommended on as needed basis.

_____ Currently receiving medical care and follow up at private MD/Clinic

Copies of medical reports needed YES ____ NO ____

_____ Needs medical care and follow up. Refer to _____

COMMENTS:

_____ _____

Medical Professional Signature **Date**

MONSIGNOR PATRICK J. FRAWLEY MENTAL HEALTH CLINIC

Insurance Information

NAME: _____ SS #: _____

PRIMARY INSURANCE COMPANY: _____

IDENTIFICATION #: _____ GROUP #:_____

PRIMARY POLICY HOLDER: _____

DATE OF BIRTH: _____ SS #: _____

RELATIONSHIP TO PATIENT: _____ AUTH #: _____

EMPLOYER NAME & ADDRESS: _____

_____

SECONDARY INSURANCE: _____

IDENTIFICATION #: _____ GROUP #:_____

PRIMARY POLICY HOLDER: _____

DATE OF BIRTH: _____ SS #: _____

RELATIONSHIP TO PATIENT: _____ AUTH #: _____

EMPLOYER NAME & ADDRESS: _____

_____

ASSIGNMENT: (PRINT NAME AND SIGN ON THE LAST LINE)

I, _____, AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO PROCESS CLAIMS SUBMITTED BY GOOD SAMARITAN HOSPITAL

I, _____, AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO GOOD SAMARITAN HOSPITAL FOR SERVICES PROVIDED BY THE OUTPATIENT MENTAL HEALTH CLINIC.

WHEN REQUIRED IT IS THE RESPONSIBILTY OF THE PATIENT/RESPONSIBLE PARTY TO GET ANY NEEDED REFERRALS AND PREAUTHORIZATIONS PRIOR TO THE FIRST VISIT. THE PATIENT/RESPONSIBLE PARTY IS ALSO HELD RESPONSIBLE FOR ANY COYPAYMENTS AND/OR DEDUCTIBLE AMOUNTS

I, _____, HAVE READ AND UNDERSTAND THE ABOVE.

SIGNATURE: _____ DATE: _____

MONSIGNOR PATRICK J. FRAWLEY MENTAL HEALTH CLINIC
Acknowledgement Disclaimers

ACKNOWLEDGEMENT OF FEES AND PRACTICES

I have read the statement regarding changes in fee payment procedure and understand that I will not be able to attend my session with either my MD or therapist if payment is not made prior to my appointment. I understand that to make alternate plans or exception to this procedure, I must discuss this with my therapist, office manager or clinical director for approval or further assistance.

Name: _____

Signature: _____

Date: _____ _____

……

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospital and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may receive separate authorizations for special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information and mental health information.

_____

Signature of Patient or Personal Representative

_____ Date: _____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

……

I have received, read and understand the Monsignor Patrick J. Frawley Welcome Letter.

Name: _____

Signature: _____

Date: _____

Welcome to the Monsignor Patrick J. Frawley Mental Health Clinic!

We are glad that you have chosen our service and look forward to our mutual participation and cooperation in the therapy process. There are certain obligations, which each of us have. We have outlined these expectations below for your reference.

General: Access to treatment is free of discrimination and treatment shall, at all times, recognize and respect the personal dignity of the client. Treatment will be planned in a collaborative process between you and your therapist to meet your individual needs. The individual sessions are generally 45 minutes in length and you and your therapist will determine the frequency of your visits during treatment planning. Of course, if you need a change, the treatment plan will reflect those changes.

Attendance: Your recovery will be greatly enhanced by consistent and strong engagement in the therapeutic process. You will demonstrate your commitment to your recovery through regular attendance and active participation in your treatment. Therefore, we expect you to place the highest importance on attending therapy sessions, as this time has been especially reserved for you. When you do not come in as scheduled, it deprives others of this time. Therefore, we ask for your cooperation in letting us know at least 24 hours in advance when possible of any appointment you will be unable to attend. If you cancel or fail to show frequently, your therapist may reevaluate your treatment plan with you and see you only on an as needed basis vs. regularly scheduled appointments. Because doctor time is limited, we may discontinue scheduling appointments if they are chronically missed. If you have any questions about this, please discuss with therapist or the Director of the clinic.

Problems/Grievances: Therapy is a relationship and sometimes problems may develop between you and your therapist. There is a process to deal with resolving any issues, which may occur. The first step is to let your therapist know how you are feeling. Often these issues are a normal part of the therapy process and bringing your feelings to your therapist is important to your progress. However, if you and your therapist cannot resolve the issue or complaint you can speak to the Director of Behavioral Health Services. If this issue is not resolved there is a Patient/Consumer Advocate that the Director can assist you in contacting. If this last step does not meet your needs, you can contact the N.Y.S. Office of Mental Health or the Mental Health Association for further assistance. These agencies are listed in the Patient's Bill of Rights' booklet given to you at intake, or the director can assist you as well. Complaints/ grievances will not cause termination of care nor will there be any reprisals; it is your right to initiate that process.

Fees and Payment: The clinic is a non-profit service supported by a combination of hospital, state, local and patient fees, along with third party reimbursement including Blue Cross, Medicare, Medicaid, and other commercial insurance carriers. We will be requiring you to pay your self-pay fee/co-payment and/or co-insurance prior to your session with either your therapist or physician. Patient fees are essential to the continuing delivery of our services. Clients with insurance will be responsible to pay the co-payment toward the clinic full charge. Your insurance company frequently sets this co-pay. If you have a managed care or HMO policy, you will be asked to pre-authorize your treatment here through your insurance company. Failure to do so will result in your HMO's refusal to reimburse the hospital for your services and you will be charged the full fee. Our fee negotiator can assist you with this if you run into difficulties. If you are uninsured, our Billing Department, 1 855-346-2090 option 2 will assist you to set a self-pay rate, which is a sliding scale and based upon your "family net income." Every patient is expected to pay either his or her co-payment or self-pay fee at the time services are rendered.

Prior to your Session: If you have not discussed your fee with the Billing Department, please do so as soon as possible. If your financial or insurance status should change, your fee may be adjusted accordingly. If you have any questions or concerns about your fee, please discuss with your therapist. The therapist is your principal contact and can answer any question you may have. If you are unable to pay and have been denied by Medicaid, please discuss the option of charity care with our fee negotiator. Again, thank you for choosing Frawley Outpatient as your modality of care.

AUTHORIZATION FOR MEDICAL TREATMENT: I hereby authorize the physicians, house staff, nursing, paramedic and allied health professional staff, assisted by the employees of Bon Secours Charity Health System (BSCHS), to provide medical treatment to me or the above named patient. I agree to diagnostic tests and procedures, including X-rays and the administration/injection of pharmaceutical products and medication, in addition to the drawing of blood. I understand and authorize the administration of pharmaceutical agents and medications by any one of several techniques including peripheral intravenous access (inserted into a vein in an arm or leg) and peripheral insertion of a venous catheter that then enters the central circulation (PICC line). I acknowledge that no guarantees or assurances have been made to me concerning the results or findings intended from treatment or examination at BSCHS.

RELEASE OF MEDICAL INFORMATION: I hereby authorize and direct BSCHS and my attending physician to release such medical information from my medical records as is necessary to complete forms for continued care, payment by insurance carriers, health care plans and third party payors.

ASSIGNMENT OF BENEFITS, GUARANTEE OF PAYMENT AND CHARITY CARE NOTICE: I hereby assign to BSCHS any and all rights, title, and interest that I have in any insurance proceeds or benefits payable to me or on my behalf for services rendered to me by BSCHS, whether such services are considered in-or out-of-network with respect to any third party payor. I therefore hereby authorize and direct my insurance carrier and/or health care plan to make payment of any and all such amounts directly to BSCHS, rather than to myself or any other insured. I acknowledge that as a member of a health care plan, I may be responsible to notify my primary care physician or obtain pre-certification for services. I understand that I am financially responsible to BSCHS for all charges, including those not paid by insurers or health care plans for services not authorized as specified in my benefit package, incurred by me or in my behalf. I understand I will receive a separate bill from my attending physician, emergency department physician, radiologist, anesthesiologist and other consultants. (However, if treatment has been given in accordance with New York State's No-Fault Law, it is understood that my liability is limited to charges authorized under such law and applicable New York State No-Fault Fee Schedules.) As part of BSCHS's commitment to serving the community it recognizes that it is sometimes necessary to provide care to the uninsured or underinsured patients who cannot afford to pay for care according to established hospital guidelines. BSCHS has a Charity Care Program for patients who financially qualify. Please ask for more details.

CONSENT TO RECEIVE TELEPHONE CALLS, TEXTS AND EMAILS: I hereby consent to BSCHS to contact me by voice call, text message and email at the Account contact telephone number (s) and Email address (es) reflected on my account. I understand that, by giving this consent BSCHS may contact me about my

PATIENT OR LEGAL AUTHORIZED REPRESENTATIVE TELEPHONE CONSENT IF GRANTED BY (if required):

Patient or Legal Authorized Representative **Telephone Consent if Granted by: "if required"**

Patient Print Name/Signature:_____ Name of Legal Guardian:_____

Legal Author/
Representative:_____ Signature of Caller:_____

Patient unable/refused to Sign: _____

MEDICARE PATIENTS ONLY -LIFETIME RESERVE DAYS:

In the event that I am hospitalized as an inpatient beyond Medicare's allotted 90 days, I authorize Westchester Medical Center to utilize my Lifetime Reserve Medicare days.

Patient Print Name/Signature: _____ Date:

medical care, or my account, such as appointment, the results of any tests or procedures, billing, the repayment or collection of amount due and that these calls may be using automatic dialers or pre-recorded voice messages. I further understand and agree that, if the Account contact telephone number (s) or email address (es) provided are for a cellular telephone or other services that charge me in any way for calls or messages received (for example, per minute, per message, per unit of data received or otherwise), I am solely responsible for any charges incurred under my agreement with my cellular telephone or other service provider.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE: By signing below, I acknowledge receipt of the Notice of Privacy Practices, which outlines how health information about me may be used or disclosed.

ACKNOWLEDGEMENT OF RECEIPT OF IMPORTANT INFORMATION ABOUT PAYING FOR YOUR CARE: By signing below, I acknowledge receipt of the important information about paying for your care.

TELEPSYCHIATRY: I have been given basic information regarding the use of Telepsychiatry and consent to participate in services utilizing this technology. If I am under the age of 18, such information was shared with and consent is obtained from my parent or guardian. I understand I have the right to refuse to participate in Telepsychiatry services, in which case evaluations will not be withheld, but will be conducted in-person by appropriate clinicians. I also understand that upon my refusal of such services I will be apprised of the alternatives to Telepsychiatry services, including any delays in service, need to travel, or risks associated with not having the services provided by Telepsychiatry. Furthermore, I am made aware that each Telepsychiatry session shall not be recorded without my consent.

I do not want to participate in Telepsychiatry:

_____ (Please print name of signature)

RELEASE OF LIABILITY FOR PERSONAL PROPERTY: I understand and agree that personal property (i.e. money, jewelry) should not be brought into the hospital and Initials understand and agree that BSCHS shall not be liable for loss or damage to any personal property.

IF ADMITTED AS AN INPATIENT: I have received the Patient's Bill of Rights, information on the Self Determination Act under New York State Law, a copy of the New York State Health Care Proxy, the "Important Message from Medicare", information on DNR (do not resuscitate) order, the letter from the New York State Department of Health explaining the SPARCS data collection system, maternity information (if a maternity patient) with information about how I can exercise the right explained in

these materials. If I have any questions or concerns regarding my care, including ethical issues, I can ask my physicians or nurses for more information.

CONSENT TO PRESENCE OF AN OBSERVER

☐ By checking here I CONSENT to the presence of an "Observer" during my care/treatment including during procedures and/or surgery. I understand that I am not required to sign this consent in order to receive treatment. I further understand that an Observer is someone who gains greater understanding of hospital operations and patient care by observing/shadowing clinicians in a hospital setting, is not a clinician, student, vendor, volunteer or contractor, and is prohibited from assisting with or participating in my care. I can revoke this consent at any time before or during the procedure/care.

☐ By checking here I DO NOT consent to the presence of an "Observer" during my care and treatment including during procedures and/or surgery.

PATIENT OR LEGAL AUTHORIZED REPRESENTATIVE TELEPHONE CONSENT IF GRANTED BY (if required):

Patient or Legal Authorized Representative Telephone Consent if Granted by: "if required"

Patient Print Name/Signature:_____ Name of Legal Guardian:_____

Legal Author/Representative:_____

Signature of Caller:_____

Patient unable/refused to Sign: _____

MEDICARE PATIENTS ONLY -LIFETIME RESERVE DAYS: