SIGNATURE SIGN IN SHEET

DATE_____PATIENT NAME

DATE_____PATIENT NAME

Dr. Brad Shamis & Associates, LLC

Updated policy on Letters, Forms, and Legal Documents effective January 1, 2016

The following policies are guidelines and all letters and forms are subject to the discretion of our therapists:

You must be an existing and active client or at least 90 days in order to request any form or letter (Exceptions apply at the discretion of the Provider and or Office Manager.) Any letter written for personal, employment or school use will be given within 14 business days and will carry a fee of $35.00.

Any form for employment, medical leave, school or disability will be given within 7 business days and will carry a fee of $55.00.

** Dr. Brad Shamis & Associates, LLC will not be involved in any legal matters. We will not write letters or fill out forms for lawyers, custody issues, court cases or any legal issues.

Dr. Brad Shamis & Associates, LLC will not fill out forms or write letters for homebound Services.

As always, your medical records can be requested at any time and will carry an administrative fee of $35.00 which must be paid at the time of request. Please allow 7-10 business days to receive your medical records.

I have read, understand and agree to the above mentioned policies:

_____

Patient Name (Please Print)

_____

Patient Signature/Date

_____

Office manager Signature/Date
And or Provider

4802 Neshaminy Blvd. – Ste. - 6
Bensalem, PA 19020

Phone: 215 / 752-2287
Web-Site: bradshamis.com

301 Oxford Valley Road - Ste. - 1001-A
Yardley, PA 19067

Fax 215 / 752-7094
E-Mail: shamisbrad@comcast.net

DR. BRAD SHAMIS & ASSOCIATES, LLC
NOTICE OF HIPPA PRIVACY PRACTICES

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.

We have a legal obligation to protect your health information. We are required by law to:

- Assure medical information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to medical information about you: and
- Follow the terms of notice that is currently in effect.

You may request a copy of his notice at any time by contacting our Complaints/Client Rights Officer.

Dr. Brad Shamis & Assoc., LLC collects health information from you and stores it in a paper chart and on a computer.

We use and disclose your information as explained below:

1. Use and disclosures that require your consent and authorization:
    a. Consent/Authorization: With your consent/authorization, we may use/disclose your protected health information (PHI) to anyone with your written permission. Unless you give us written authorization, we cannot use or disclose your PHI for any reason except those described in this notice. If you request, we will fax or email the information to the recipient identified on the authorization. However, the privacy of either of these alternate delivery methods cannot be assured by Dr. Brad Shamis & Assoc., LLC.
    b. To Your Family, Friend, Employers or Others: We may disclose your PHI to a family member, friend, employer, or other persons to the extent necessary to help with your health care or with payment of your health care if you give us written authorization to do so.
2. Use and disclosure that do not require your consent/authorization:
    a. For Treatment: We may use medical information about you to provide you with behavioral health and medical treatment or services. We may disclose information to other practice personnel such as doctors, nurses, counselors, etc., or people outside the practice who may be involved in your care.
    b. For Payment: We may use and disclose medical information about you to our Billing Services and your health plan so that the treatment and service you receive from us may be billed to and payment may be collected from you, your insurance company, or third party.
    c. For Health Care Operations: We may use and disclose information about you necessary to operate our business and to make sure that all our clients receive quality care. For example, we may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you. We may use and disclose information about you to health oversight agencies for audits, surveys, inspections, certification and investigations.
    d. When required by Federal, State, or Local law, judicial or administrative proceeding or law enforcement: We will disclose your information when a law requires that we report information to government agencies and law enforcement personal about victims of abuse, neglect or domestic violence, in response to a court order, when necessary to avert serious threat to your health and safety and health of another person or the public.
    e. Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or services. We will contact you by telephone at the number you provide us to confirm appointments; and if you are not available, we will leave a message regarding an appointment or ask that you call Dr. Brad Shamis & Assoc., LLC, unless you tell us not to call.
    f. Eligibility Determination Enrollment: We may disclose medical information for eligibility determination or enrollment into public benefit programs according to specific requirements.
    g. Health-Related Benefits & Services/Treatment Alternative: We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you or tell you about or recommend possible treatment options or alternatives that may be of interest to you.
    h. For Public Health Activities: To report information about births, deaths and various diseases to government officials in charge of collecting that information.
    i. Correctional Institutions/Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose medical information about you to the correctional institution or law enforcement official. This disclosure would be necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.
    j. Specific Government Functions: We may disclose your information to authorized federal officials or intelligence, counterintelligence, and other national security activities such as protective services for the President and others.
    k. Workers' Compensation: We may disclose medical information about you for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries and illness.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

1. You have the right to consent to the use and disclosure of your PHI for the limited purpose of diagnosing you and administering and paying for your treatment.
2. You have the right to authorize the sharing of your PHI for other purposes.
3. You have the right to inspect and obtain a copy of your PHI. Your request must be in writing. Dr. Brad Shamis & Assoc., LLC must respond to your request within 30 days from the date of your request. If your request to receive a copy of your PHI is approved, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with the request. In certain situations we may deny your request. If we so do, we will let you know in writing, our reason why and explain how you can have the denial reviewed.
4. You have the right to request that we amend you PHI, if you believe the information we have about you is incorrect or incomplete. You have the right to request an amendment as long as this information is kept by Dr. Brad Shamis & Assoc., LLC. Your request, including a reason for the amendment must be in writing. Dr. Brad Shamis & Assoc., LLC will respond to your request to amend your PHI within 60 days from the date of your request. We may deny your request to amend your PHI in certain situations. If we do, we will let you know, in writing our reason why and explain how you can have the denial reviewed.
5. You have the right to request confidential communication about medical matters in a certain way or at a certain location. We will accommodate all reasonable requests. Your request must be in writing and specify how or where you wish to be contacted.
6. You have the right to restrict how we use and disclose your PHI. We do not have to agree on your restrictions. If we do agree, we must follow your restrictions.
7. You have the right to request an accounting of disclosures. This is a list of disclosures we made of medical information about you. Your request must be in writing and must state a time period that may not be longer than six years and may not include dates for March 1, 2008.
8. You have a right to have a copy of this Privacy Notice.

Change to this notice

If our privacy policies should change at any time in the future, we will promptly change and post the new notice. We reserve the right to apply any changes to our privacy policies of this notice to all of the protected health information that we maintain including information collected before the date of the change.

REVOCATION: You may revoke your consent authorization for us to use and disclose PHI. You must do so in writing. We are permitted to use and disclose your PHI based on your consent/authorization until we receive your revocation. However, if you revoke your consent, we reserve the right to refuse to provide further treatment to you, on the basis of your refusal to allow us to share your information for the purposes of treatment, payment, and healthcare operations.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose medical information about you, you may revoke that authorization in writing at any time.

If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provide you.

FOR REQUESTS OR COMPLAINTS: If you have any questions about this notice or complaints about your privacy practices please contact:
Dr. Brad Shamis & Assoc., LLC.

INITIAL HERE: _____

Dr. Brad Shamis & Associates, L.L.C.

Tel: (215) 752-2287 / (215) 752- 7094

Neshaminy Medical/Professional Center
4802 Neshaminy Blvd. - Ste. 6
Bensalem, PA 19020

Makefield Executive Center
301 Oxford Valley Road - Ste. 1001-A
Yardley, PA 19067

WELCOME TO OUR PRACTICE

THE TREATMENT TEAM

The treatment team includes the Patient/Parent/Guardian, Psychologist and Office Manager as determined by the initial evaluation and treatment plan.

RESPONSIBILITIES OF THE MENTAL HEALTH REPRESENTATIVES

Our responsibilities include the expectation that services will be provided to the patient according to the highest standard of care within their profession and as expected by Dr. Brad Shamis and Associates, LLC.

RESPONSIBILITIES OF THE PATIENT & PARENT/GUARDIAN

Successful treatment also requires patient and parent/guardian participation as members of the team including:

Participate in sessions at least once per week or as determined by the treatment plan. Sessions last for 45 minutes.

Attend all scheduled appointments and participate in development of the treatment plans and goals.

Comply with treatment plans and goals as determined by the patient, family, and Mental Health Professionals.

Provide open and honest communication with all members of the treatment plan.

FINANCIAL RESPONSIBILITY

Although Dr. Brad Shamis & Assoc., LLC accepts payment from most insurance companies, the patient's parent/guardian must assure financial responsibility for the services. The parent/guardian must inform Dr. Brad Shamis & Assoc., LLC / therapist of any changes in insurance coverage, address or telephone number during treatment.

The parent/guardian may be required to pay in full (unless limited by contract)

A copay amount for each session/day of treatment as required by the insurance company.

We only Accept Checks or Cash for These Payments. There is a Charge of $30.00 if a check bounces.

Signatures:

_____	_____	_____
Print Name parent/guardian Date	Patient Name Date	Psychologist and or Office Manager Date

BRAD SHAMIS & ASSOCIATES, L.L.C.
BRAD SHAMIS, PhD

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Yardley, Pa 19067

Tel: (215) 752-2287 / (215) 752-7094

PATIENT DATA

Patient's Name: _____

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Patient's Phone #: Home ( ) _____ Cell: ( ) _____

Patient's DOB: _____ Sex: M (____) F (____)_____

Marital Status: Married (____) Single (____) Social Security #: _____

Employer Name: _____

Address: _____

Emergency Contact: Name: _____ Address: _____

City: _____ State: _____ Phone #: ( ) _____Cell #: ( ) _____

Health Insurance Data

Insurance Company Name: _____

Insurance Co. Address: _____

City: _____ State: ____ Zip Code: _____ Phone Number: ( )_____

Insurance Company I D #: _____ Group #: _____

Subscriber's Name: _____ DOB: _____

Subscribers Address: _____

City: _____ State: _____ Zip Code: _____

Subscriber's Telephone #: Home ( ) _____ Cell: ( ) _____

Subscriber's Social Security #: _____ Sex: M (___) F (___)

Relationship to Subscriber: Self: (____) Spouse: (____) Dependent: (____)

Secondary Ins. Co: _____ I.D. # _____ Group #: _____

City: _____ State: _____ Zip Code: _____ Phone Number: ( ) _____

I have no Secondary Insurance: (____)

Please sign: _____ Date: _____

DR. BRAD SHAMIS & ASSOCIATES, L.L.C.

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Yardley, PA 19067

Tel: (215) 752-2287 / Fax: (215) 752-7094

DR. BRAD SHAMIS, Ph.D.
GILBERT SCHWARTZ, L.C.S.W.
TAX ID: 23-3081378

Insurance Authorization Form

DATE: _____ EFF. DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

INS. CO. _____

TELEPHONE #: _____

OF VISITS: _____

AUTHORIZATION #: _____

DEDUCTIBLE $: _____ MET: ( ) Y _____ ( ) N_____

COPAYMENT$: _____

SUBMIT CLAIM TO: _____

_____

SPOKE TO: _____

TIME OF CALL: _____

CALL RECORDED: ( ) Y_____ ( ) N_____

PRE-CERTIFICATION REQUIRED: ( ) Y _____ ( ) N _____

Dr. Brad Shamis & Associated, LLC

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Yardley, PA 9067

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Consent to use or disclose your health information.

This form is an agreement between you, _____ and me Dr. Brad Shamis & Associates, LLC. When we use the word, you, below, it will mean your child, relative or other person if you have written his or her name here _____.

When we examine, diagnose, treat or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this consent form. If you do not sign this Consent Form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

If there is a breach of your confidentiality, then I must inform you as well as Health and Human Services. A breach means that information has been released without authorization or without legal authority unless I (the covered entity) can show that there was a low risk that the PHI has Been compromised because the unauthorized person did not view the PHI or it was de-identified. If you are self-pay, then you may restrict the information sent to insurance companies.

Most uses and disclosures of psychotherapy notes and of protected health information for marketing purposes and the sale of protected health information require an authorization. Other uses and disclosures not described in the notice will be made only with your written authorization. You must sign a (release of information form) for releases that are not mentioned in this Privacy Notice (such as mandated reporting of child abuse, reporting of elder abuse, reporting of impaired driver, etc.) You have a right to receive a copy of your Protected Health Information in an electronic format or (through a written authorization) designate a third party who may receive such information.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it you may get a copy by calling (215) 752-2287, or from our Privacy Officer. If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have the right to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wishes.

After you have signed this consent, you have the right to revoke it, (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may have already used or shared some of your information and cannot change that.

……
Signature of client or his or her personal representative

……..
Date

……..
Printed name of client or personal representative

…….
Relationship to client

……
Description of personal representative's authority

Date of NPP, April 14, 2003, revised September 23, 2013
Copy given to the client/parent/personal representative

Patient Name: _____

Date: _____

INFORMED CONSENT FOR TREATMENT

I _____ (name of patient) agree and consent to participate in behavioral health care services offered and provided at/by _____ (name of provider) a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the a provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient.

I also authorize the following:

(A.)The use of this form on all my insurance submissions.
(B.) The use of this form on all my insurance submissions.
(C.) The responsibility to pay for my bill if my insurance company does not pay for it.
(D.) The release of information to all my insurance carriers.
(E.) I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
(F.) Direct insurance payments to my doctor.
(G.) I permit a copy of this authorization to be used in place of the original.

If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Name: _____

Signature: _____ Date: _____

Relationship to Patient (If applicable): _____

NESHAMINY MEDICAL-PROFESSINAL CENTER
4802 NESHAMINY BLVD. – Ste. 6
BENSALEM, PA 19020

MAKEFIELD EXECUTIVE CENTER
301 OXFORD VALLEY ROAD – Ste. 1001-A
YARDLEY, PA 19067

TEL: (215) 752-2287 / FAX: (215) – 752-7094

DR. BRAD SHAMIS & ASSOCIATES, LLC
LICENSED PSYCHOLOGISTS

Name: _____

Statement of Member's Right

Members have the right to fair treatment, regardless of their race

Members have the right to fair treatment, regardless of their race, religion, gender, ethnicity, age disability or source of payment.

Members have the right to have their treatment and other member information kept private. Only where permitted by law, may records be released without member permission.

Members have the right to easily access timely care in a timely fashion.

Members have the right to know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.

Members have the right to share in developing their plan of care

Members have the right to information in a language they can understand.

Members have the right to have a clear explanation of their condition and treatment options.

Members have the right to information about your managed care, company, its practitioners, services and role in the treatment process.

Members have the right to information about your managed care. used in providing and managing their care.

Members have the right to ask their provider about their work history and training.

Members have the right to give input on the Member's Rights and Responsibilities policy.

Members have the right to know about advocacy and community groups and prevention services.

Members have a right to feely file a complaint or appeal and to learn how to do so.

Members have a right to know of their rights and responsibilities In the treatment process.

Members have the right to receive services that will not jeopardize their employment.

Members have the right to list certain preferences in a provider.

Statement of Member's Responsible

Members have the responsibility to treat those giving them care with dignity and respect.

Members have the responsibility to give providers information they need. This is so providers can provide their best possible care.

Members have the responsibility to ask questions about their care. This is to help them understand their care.

Members have the responsibility to follow the treatment plan. The plan of care is to be agreed upon by the member and provider.

Members have the responsibility to follow the agreed upon medication plan,

Members have the responsibility to tell their provider and primary care physician about medication changes including medications given to them by others.

Members have the responsibility to keep their appointments. Members should call their provider as soon as they know they need to cancel visits.

Members have the responsibility to let their provider know when the treatment plan isn't working for them.

Members have the responsibility to let their provider know about any problems with paying fees.

Members have the responsibility to report abuse and/or fraud.

Members have the responsibility to openly report their concerns about the quality of care they receive.

My signature shows that I have been informed of my rights and responsibilities, and that I understand this information.

_____

Member signature Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

_____

Provider Date

Approved August 2, 2002

Initial Mental Health Assessment

Patient Name: _____ SS#: _____

Identification:

Name: _____
Referral Source:_____
Previous Diagnosis: _____
Current Treatment: _____

Medication:

Medication	Dosage	Directions	Prescribed by

1. Indication for Outpatient Level of Care/Reason for referral:

2. History of Present Illness: (current sxs requiring treatment: ppting events; stressors contributing to sxs; treatment immediately prior to referral):

Initial Mental Health Assessment

Patient Name: _____ S.S. #: _____

3. Past History

First Psychiatric tx. _____
_____
Psychiatric Hospitalization (when, where, indication, tx.): _____
_____
_____
_____
Suicide Attempts:_____
_____
Medication hx:_____
_____
Additional hx:_____
_____
_____
_____
_____
_____

Psychiatric Review of Symptoms (past or present)

Psychotic symptoms:

Hallucinations: _____
Delusions: _____
Thought Disorder, Disorganization: _____
General (duration, other): _____
_____

Affective Symptoms:

General: _____
_____
Depressive: _____
Sleep: _____ Suicidal Thoughts: _____
Appetite: _____ Crying: _____
Energy: _____ Concentration: _____
Interest/Motivation: _____ Psychomotor Agitation/Retardation: _____
Hedenia: _____
Manic:
Racing Thoughts: _____ Irritability: _____
Grandiose thoughts: _____ Lability of mood: _____
Impulsivity (spending, recklessness): _____
Distractibility: _____
_____

Initial Mental Health Assessment

Patient Name: _____ SSN#: _____

4. Anxiety Disorders:

General: _____

Panic sxs: palpitations, sweating, trembling, SOB, chocking, CP nausea, dizzy, chills, fear of dying/going crazy, derealization, paresthesia. Onset, Duration, Agoraphobia/avoidance sxs: _____

Phobias (social, specific): _____

GAD (worry, restless, fatigue, irritability, tension, sleep): _____

_____

Traumatic/Dissociative Symptoms:

Traumatic Event(s): _____

Re-experiencing: intrusive thoughts, recurrent dreams, re-experiencing (flashbacks and related), triggering:

_____

Avoidance: avoid thoughts, places, activities: impaired memory, decreased interest, detachment, restricted affect:

_____

Increased Arousal: sleep difficulty, anger outburst, increased startle, hyper-vigilance: _____

Dissociation: amnesic periods, de-realization, depersonalization, alter personalities: _____

_____

Substance Abuse Symptoms (Response required for patients 12 years or older):

General: _____

_____

_____

_____

Cigarette Use: _____

Specific Substances: _____

Last usage and quantities used: _____

Use out of control: _____

Legal, vocational, interpersonal impacts: _____

Tolerance/withdraw: _____

Organic/Developmental Symptoms:

Seizures/head trauma: _____

Physical Disorders affecting psychological function: _____

Developmental delays/LD: _____

ADHD symptoms: _____

Language disturbance: _____

Impaired motor function: _____

Other: _____

_____

Impulse Control/Compulsive Disorders:

OCD (checking, rituals, obsession): _____

Compulsive gambling, sexual behavior, stealing, etc: _____

Rage attacks/tantrums: _____

Eating disorders (bulimia, purging, laxative abuse, anorexia: _____

Stealing, arson: _____

Truancy, running away: _____

Other**:** _____

_____

___

Initial Mental Health Assessment

Patient Name: _____ SS#: _____

5. Medical History

General (currently treated for, significant physical problems/hx?)

_____
_____
_____

Current MD/treaters: **Tel #:** **Address:**

_____
_____
_____
_____

Medication Allergies:

_____
_____
_____
_____

Current Diagnosis

Axis: III # 1. _____
2. _____
3. _____
4. _____

Seizures: _____
Surgery: _____
Infectious disease (TB, STD, etc.): _____

6. Social History

General: _____
_____
_____

School/Education: _____
_____
_____
_____

Current Home (Who lives there, cultural, language, spiritual issues): _____
_____
_____
_____

Employment/Financial hx: _____
_____
_____
_____

Interpersonal relationships/Support System: _____
_____
_____
_____

Legal: _____
_____
_____

Initial Mental Health Assessment

Patient Name: _____ SS#: _____

7. Family History:

General: _____

_____

_____

_____

_____

_____

Suicide Attempts: _____	Drug/Alcohol hx: _____
_____	_____
_____	_____
_____	_____

Hospitalizations/other treatment:

_____

_____

_____

_____

8. Mental Status Exam:

Appearance: _____

Behavior: _____

Affect/Mood: _____

Thought: _____

Suicidal Ideation: _____

Homicidal Ideation: _____

Hallucinations: _____

Delusions: _____

Sensorium:

Orientation: _____ Calculation: _____

Memory/Immediate: _____ Recent: _____ Remote: _____

Abstraction (similarities, proverbs): _____

Insight: _____

Judgment: _____

Initial Mental Health Assessment

Patient Name: _____ SS#: _____

10. Assessment: Diagnosis, formulation and recommendations

Axis I Diagnoses:

#1. _____

#2. _____

#3. _____

Axis II. _____

Axis III Diagnoses:

#1. _____ #4. _____

#2. _____ #5. _____

#3. _____ #6. _____

Axis IV (current stressors: _____	**Axis V. Current level of function:** _____ **Best in last year:** _____

11. Initial Treatment Plan – (Specify Measurable Goals)

Problem	**Therapeutic/Intervention**	**Expected Outcome**	**Est. Time Frame**

Any Group Therapy or Support Group recommendation:

_____

_____

_____

Treatment Plan discussed with Patient & Patient response to recommendations:

_____

_____

_____

Next Appointment Scheduled: _____

Signature: _____ Date: _____

Patient Name: _____
Patient: _____
Date: _____

ATTACHMENT H
DISCHARGE SUMMARY

Must be completed within 60 days from last visit

Reason for Discharge and Date (was patient in agreement with discharge at this time?):

_____
_____
_____

If patient did not return for scheduled appointment, was/were attempts(s) made to contact patient to reschedule? (Circle One) YES NO (If yes, dates of outreach and outcome):

_____
_____
_____
_____

Discharge Medications:

_____

Discharge DSM IV

Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

Referral Options Given (if applicable)

- _____ Relapse Prevention
- _____ Support Group
- _____ Other (list): _____
- _____ Stress Management
- _____ Other Provider
- _____ N/A

If patient became homicidal, suicidal, or unable to conduct activities of daily living during course of treatment, was patient referred to appropriate level of care? (Explain):

_____
_____
_____
_____

Signature: _____ Date: _____

Date: _____

DR. BRAD SHAMIS & ASSOCIATES, L.L.C.

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Yardley, PA 19067

TAX IDENTIFICATION NUMBER 23-3081378

DR. BRAD SHAMIS, Ph.D. LICENSE NUMBER
PA PS005689L / NJ 35S100275200
GILBERT SCHWARTZ, L.C.S.W. LICENSE NUMBER CW 12079
JACK PAYSON, M.A. LICENSE NUMBER PS002134L

STATEMENT

PATIENT NAME: _____ DATE: _____

Date of services	CPT Code	Diag.	Charged	Paid

Type of Service: Initial Psychological Evaluation _____
Individual Psychotherapy Session _____