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**Dr. John Carosso, Psy.D. & Associates, Inc.**  
Community Psychiatric Centers / Autism Center of Pittsburgh / Dyslexia Diagnostic & Treatment Center

**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 talking 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](http://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 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 myself 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

ADULT: INTAKE FORM

**Client Information:**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Please circle: Male / Female      Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Hair color: \_\_\_\_\_      Eye color: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_

Alt Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Insurance:**

Provider Name: \_\_\_\_\_ ID #: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_

Cardholder DOB: \_\_\_\_\_

**Family Information:**

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

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

Please list the number of siblings living outside the home and living parents who reside outside the home:

# of brothers: \_\_\_\_\_      Parents: Mother (alive / deceased)

# of sisters: \_\_\_\_\_      Father (alive / deceased)

Do you have contact with any of your siblings? If so, please describe how often:

\_\_\_\_\_  
\_\_\_\_\_

Marital Status (please circle): Married / Never Married / Separated / Divorced / Widowed

Do you have any Children: No / Yes: How many?: \_\_\_\_\_

Names and ages of your children:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Intake Form

**School Information**

Name of High School Attended: \_\_\_\_\_

Graduated from High School (please circle): Yes / No

If not, in what grade did you leave school (please circle): 7 8 9 10 11 12

GED: Yes / No

History of Special Education?: Yes / No Type: Learning Support / Emotional Support / Other

If other, please specify:

**Post-High School Experience** (please select all that apply):

Vocational: Yes / No

what did you study? \_\_\_\_\_

College: Yes / No

Where did you attend? \_\_\_\_\_

Degree Earned? \_\_\_\_\_

Military: Yes / No

Branch? \_\_\_\_\_

Current job/Occupation: \_\_\_\_\_

How long have you worked there? \_\_\_\_\_

**Heath / Medication / Mental Health**

Any previous diagnoses?: Yes / No

Please specify:

**Medications (for mental health reasons):**

Name	Dose
_____	_____
_____	_____
_____	_____

Who prescribes the medication?: \_\_\_\_\_

PCP: \_\_\_\_\_

Doctor's Phone #: \_\_\_\_\_

**Medical Conditions** (please check all that apply):

- Allergies      Type?:
- Asthma
- Hearing deficits (hearing aide?)
- Head injury / Concussion
- Other Serious medical conditions?
- Seizures
- Vision deficits (glasses?)
- Traumatic Head Injury (TBI)

Please Specify:

## Intake Form

Please describe any bodily aches, pains, or ailments:

### Services

Any past mental health services? Yes / No

If yes, please describe

Any current mental health services? Yes / No

If yes, please specify type (outpatient counseling, medication...):

Group/Agency providing current mental health services?: \_\_\_\_\_

Please describe any mental health history in your direct or extended family:

### **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 (repeatedly re-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, heroin...)
- 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)

## CONSENT TO ELECTRONIC TRANSMISSION FORM

In an effort to be environmentally sensitive, we're offering the option of emailing you a password-protected and encrypted evaluation report, as opposed to mailing a hard copy. Along with the report, in an accompanying email, you'll be emailed a password to download the file.

Another benefit of an emailed digital file is that you'll receive the report days earlier compared to standard mailing. *Please indicate your consent by checking the box below:*

I consent to have a password-protected report emailed to me for my review.

My email address is: \_\_\_\_\_

No, do not email me the report, I prefer a standard hard copy mailed to me.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_