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

Contents of this file:

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Dr. John Carosso, Psy.D. & Associates, Inc.

Community Psychiatric Centers / Autism Center of Pittsburgh / Dyslexia Diagnostic & Treatment Center, Inc.
Psychological and Educational Services for Children, Teens, and Adults

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:

Treatment Assessment and/or Counseling: Psychological Evaluation:
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. He is also Executive Director of 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. 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 to be included in the final report. I have been offered a copy of my HIPAA privacy rights.

I have also been informed that if 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 any time, at 724-787-0497 or the following number(s):1-877-899-6500 or 412-372-8000.

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

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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:

_____ _____

_____ _____

_____ _____

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:

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: _____