Warren L. Huberman, PhD., PLLC
Clinical Psychologist
20 East 49th Street, 2nd Floor
New York, New York 10017
212-983-6225

11 Medical Park Drive, Suite 202
Pomona, New York 10970
917-647-6971

CLIENT INFORMATION SHEET

NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

HOME PHONE: _____

CELL PHONE: _____

EMAIL ADDRESS: _____

EMPLOYER: _____

ADDRESS: _____

WORK PHONE: _____

INSURANCE COMPANY: _____

POLICY NUMBER: _____

PHONE: _____

PHYSICIAN'S NAME: Christine Ren-Fielding MD, George Fielding MD,
Bradley Schwack MD, Megan Jenkins, MD
NYU Langone Weight Management Program

ADDRESS: 530 1st Avenue, Suite 10S, New York, NY 10016

PHONE: 212-263-3166

FAX: 212-263-8084

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Notice of Psychologists' policies and practices to protect the privacy of your health information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If, in my professional capacity, a child comes before me which I have reasonable cause to suspect is an abused or maltreated child, or I have reasonable cause to suspect a child is abused or maltreated where the parent, guardian, custodian or other person legally responsible for such child comes before me in my professional or official capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child, I must report such abuse or maltreatment to the statewide central register of child abuse and maltreatment, or the local child protective services agency.
- **Health Oversight:** If there is an inquiry or complaint about my professional conduct to the New York State Board for Psychology, I must furnish to the New York Commissioner of Education, your confidential mental health records relevant to this inquiry.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without your written authorization, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I must inform you in advance if this is the case.
- **Serious Threat to Health or Safety:** I may disclose your confidential information to protect you or others from a serious threat of harm by you.
- **Worker's Compensation**: If you file a worker's compensation claim, and I am treating you for the issues involved with that complaint, then I must furnish to the chairman of the Worker's Compensation Board records, which contain information regarding your psychological condition and treatment.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will mail you a revised copy of the notice.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at 212-983-6225.

If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to me at Warren L. Huberman, PhD., PLLC
20 East 49th Street, 2nd Floor New York, NY 10017.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by giving it to you during our first meeting following the time that I make such changes.

I have received a copy of the privacy policy for the office of Warren L. Huberman, PhD., PLLC

_____ _____

Print Name Date

_____

Sign Name

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AUTHORIZATION FORM

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize my psychologist, Warren L. Huberman, PhD., PLLC and/or his administrative staff to release medical, psychological, psychiatric, and substance abuse evaluation, diagnoses, and treatment information as well as a copy of a psychological report based upon information from the evaluation occurring on the date specified below to:

1) Christine Ren-Fielding MD, George Fielding MD, Bradley Schwack MD, or Megan Jenkins, MD and their clinical and administrative staff at the NYU Langone Weight Management Program 530 1st Avenue, Suite 10S, New York, NY 10016

   AND (please write the name and address of your health insurance carrier below)

2) _____

I am requesting my psychologist to release this information for the following reasons: **to contribute information to a multidisciplinary evaluation for weight loss surgery.**

This authorization shall remain in effect until: revoked in writing

I understand that the information from the psychological evaluation is but part of the overall evaluation and that the decision to determine my candidacy for bariatric surgery is ultimately made by Drs. Ren-Fielding, Fielding, Schwack, or Jenkins.

- You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.
- I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Print Name Date

_____
Sign Name

If a personal representative of the patient signs the authorization, a description of such representative's authority to act for the patient must be provided.

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Consent to participate in a telepsychology evaluation/session

Telepsychology provides psychological services using interactive video conferencing tools, in which the psychologist and the client are not at the same location. Dr. Huberman uses a teleconference platform that is HIPAA-compliant and meets the highest levels of security currently available, however, I understand that there are potential risks to this technology including interruptions, unauthorized access and technical difficulties.

- I understand that all rules and regulations which apply to the practice of psychology in the State of New York also apply to telepsychology.
- I understand that the teleconference platform used by Dr. Huberman uses encryption and incorporates network and software security protocols to protect the confidentiality of information and audio/visual data.
- I have the right to withdraw my consent to the use of telepsychology at any time.
- I understand that Dr. Huberman has the right to withhold or withdraw consent for the use of telepsychology during the course of my care at any time.

Your Responsibilities:

- I will not record any telepsychiatry sessions without the prior written consent of Dr. Huberman and I understand that Dr. Huberman will not record telepsychiatry sessions without my consent.
- I will inform Dr. Huberman if any other person(s) will be present during the session.

Dr. Huberman has explained to me how the video conferencing technology will be used. I understand that this consultation will not be the same as a direct client/psychologist visit due to the fact that I will not be in the same room as my health care provider.

By signing below, I am confirming that I have read this document carefully and understand the risks and benefits of teleconferencing and hereby consent to participate in a telepsychology evaluation with Dr. Huberman under the terms described herein.

_____ _____

Print Name Date

_____

Sign Name

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PAYMENT INFORMATION

This document is to serve as a contract between _____ and Warren L. Huberman, PhD., PLLC. Your signature on this form constitutes your agreement with all statements below. Read this form carefully and ask all questions at this time.

- The current fee for an individual, 60-minute comprehensive psychological evaluation is $275.00. This fee includes a comprehensive typewritten report of the evaluation and consultation with consented parties regarding the findings.

- Payment is due on the day services are provided.

- If paying by personal check, a copy of the evaluation report will be forwarded to the consented parties *upon clearance of the check*. Checks returned for any reason (i.e. insufficient funds, closed account, etc.) will be viewed as failure to pay for services.

- You are responsible to pay the full fee as stated above unless Dr. Huberman has agreed upon an alternate arrangement. Reimbursement from your insurance carrier is <u>your</u> responsibility. Dr. Huberman is not responsible for your insurance carrier's decision to not reimburse you for the cost of this evaluation. A receipt will be provided for each session so that you may seek reimbursement from your insurance carrier.

- If it is urgent that you speak with Dr. Huberman after hours, please call 212-692-9288 and Dr. Huberman will be contacted by an answering service. In case of emergency, either call 911 or present yourself to the nearest hospital emergency room.

_____ _____
Client's Name (please print) Date

_____ _____
Client's Signature Warren L. Huberman, PhD., PLLC

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CONFIRMATION OF PAYMENT FOR SERVICES

Name: _____
Address: _____
_____
_____

Date of Evaluation: _____

CPT/Procedure code: 90791

ICD-10/DSM-V diagnosis: _____

Service provided: Sixty-Minute Psychological Diagnostic Evaluation to assist in a multidisciplinary evaluation for weight loss surgery. The fee paid for this service includes a typewritten report and correspondence with the consented parties.

Fee for service: $275.00 - PAID IN FULL

_____
Warren L. Huberman, PhD., PLLC
Clinical Psychologist
N.Y.S. License #012385
TAX ID#: 83-1609125

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WEIGHT LOSS SURGERY QUESTIONNAIRE

Name: _____ Age: _____

Today's Date: _____

Surgery Information:

1. Which surgery are you considering? (circle) Lap Band Gastric Bypass Gastric Sleeve
2. Have you attended the information session or taken the online session? Yes No
3. Have you previously had weight loss surgery? Yes No If yes, which one? _____

Work Information:

1. What is your occupation? _____
2. How long have you been at your current job? _____
3. Do you enjoy your work? Yes No

Family Information:

1. Circle One: single married divorced widowed partnered other

   If married (or in another relationship), how many years? _____
2. Do you have children? If so, please provide ages and gender_____

   _____
3. Who lives in your home? _____
4. Who in your household is overweight? _____
5. Are your parents living or deceased? _____
6. How many brothers and sisters do you have?_____
7. Do you (or did you) have good relationships with your parents and siblings? Yes No
8. Are (were) your parents and siblings overweight? _____

Personal Information:

1. What is your current weight? _____ Height? _____
2. What is the most you have ever weighed? _____ When? _____
3. Were you overweight as a child (before age 10)? Yes No
4. How long have you weighed within 10 pounds of your current weight? _____
5. What is the least you have weighed as an adult? _____ At what age? _____
6. Have you ever gained over 25 pounds in one year? Yes No
   If yes, when? _____

Dietary Information:

1. Please indicate which statement best describes your daily eating routine? (circle one)

   a. I only eat meals and typically do not have snacks
   b. I eat meals and have a snack or two during the day or night
   c. I eat meals and snack multiple times throughout the day or night
   d. Some other pattern: _____

2. Describe the size of your typical meal & snack portions: (circle one)

   a. "Normal" size (an amount of food that you believe most people consume)
   b. Smaller than normal
   c. Larger than normal
   d. Much larger than normal

3. Which of the following applies to you? (circle ALL that apply)

   a. I usually clean my plate both at home and in restaurants
   b. I usually eat until I feel full
   c. I usually eat until I feel physically uncomfortable
   d. I never feel full
   e. I often feel disgusted with myself when I have finished eating

4. Which meals do you usually eat? (circle all that apply) breakfast lunch dinner

5. Describe a typical breakfast: _____

   _____

   Describe a typical lunch:_____

   _____

   Describe a typical dinner: _____

   _____

6. Do you snack on most days? (circle one) Yes No (# days out of 7 _____)

   What are your preferred snacks?_____

   _____

7. Please circle the items that you eat **at least** 2-3 times per week on most weeks:

a. ice cream/frozen yogurt	b. chocolate (candy bars)	c. milkshakes/coffee drinks
d. cookies/snack crackers	e. cake/muffins	f. potato chips/pretzels
g. fruits/vegetables	h. sugary soda/juice/drinks	i. leftovers/meal foods
j. bread	k. other _____	

8. Are you an **emotional** eater? (circle one) Yes No

   Emotional eating is where a person **commonly** eats in response to specific emotional states (at least once or twice per week). It is essentially using food as a drug. Many people eat to "medicate" negative mood states such as depression or anxiety, while others eat to celebrate every accomplishment or occasion.

9. Are you a **binge** eater? (circle one) Yes No (if no, skip to question 11)

   Binge eating is defined as eating a large amount of food (as you define the term large) during a very brief period of time (less than 2 hours), accompanied with the feeling of being unable to control your eating behavior. Binge eating is usually done rapidly and is generally NOT done in the presence of others. The defining feature of a binge episode is the sense that one is not in control of his/her behavior.

10. How often do you binge eat? (circle one) Twice or more per week Less than twice per week

11. Do you believe that emotions such as stress, depression, anxiety, loneliness, anger, and others have played a significant role in the development of your obesity? Yes No

12. What do you believe are the primary causes of your obesity? (For example: big meals, a history of excessive snacking, too much fast food, a high-fat diet, family history, emotional eating, etc..)

    _____

13. Have you ever induced yourself to vomit or used laxatives or diuretics (water pills) specifically for the purpose of trying to lose weight? (circle one) Yes No

14. Have you ever participated in therapy with a psychologist or social worker? Yes No
    If yes, when, and what were you seeking treatment for? _____

    _____

15. Is there a history of physical, sexual, or emotional abuse? Yes No
    If yes, please specify: _____

16. Have you ever been prescribed psychiatric medication? Yes No
    If yes, what medications did you take and when?_____

Weight Loss History

Please check each diet you have attempted. Indicate the number of times you attempted each diet, when you were on the diet, and the maximum amount of weight lost. Try to recall as much information as possible.

Commercial Diet Programs:

	Method	# of attempts	dates	weight lost
___	Atkins/South Beach Diet	_____	_____	_____
___	Jenny Craig	_____	_____	_____
___	Grapefruit/Ice Cream/Cookie Diet	_____	_____	_____
___	The Diet Center	_____	_____	_____
___	Stillman Diet	_____	_____	_____
___	Scarsdale Diet	_____	_____	_____
___	NutraSystem	_____	_____	_____
___	Weight Watchers/StartFresh	_____	_____	_____
___	SlimFast	_____	_____	_____
___	Zone Delivery	_____	_____	_____
___	LA Weight Loss	_____	_____	_____
___	OptiFast/MediFast	_____	_____	_____
___	TOPS	_____	_____	_____
___	Structured Exercise Programs	_____	_____	_____
___	Overeaters Anonymous (OA)	_____	_____	_____
___	Herbalife	_____	_____	_____
___	Others: _____	_____	_____	_____
	_____	_____	_____	_____

Self-directed Programs:

	Method	# of attempts	dates	weight lost
___	Home exercise program	_____	_____	_____
___	Calorie counting/restriction	_____	_____	_____
___	Others: _____	_____	_____	_____
	_____	_____	_____	_____

Medications:

	Type	# of attempts	dates	weight lost
___	Phentermine	_____	_____	_____
___	Topomax	_____	_____	_____
___	Wellbutrin	_____	_____	_____
___	Belviq	_____	_____	_____
___	Qsymia:	_____	_____	_____
___	Contrave:	_____	_____	_____
___	Saxenda:	_____	_____	_____
___	Fen-Phen	_____	_____	_____
___	Redux	_____	_____	_____
___	Meridia	_____	_____	_____
___	HCG	_____	_____	_____
___	Dexetrim	_____	_____	_____
___	Amphetamines	_____	_____	_____
___	Stacker/Xenedrine	_____	_____	_____
___	Others: _____	_____	_____	_____

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(OPTIONAL)

AUTHORIZATION TO SUBSCRIBE TO AN EMAIL NEWSLETTER AND RECEIVE OTHER ELECTRONIC CORRESPONDENCES FROM WARREN L. HUBERMAN, PhD.

I, _____ am consenting to receive an email newsletter and other electronic correspondences from Warren L. Huberman, PhD., PLLC I understand that this information is purely for informational purposes and is not intended to diagnose or treat any psychological or medical condition(s). I also understand that by agreeing to receive this newsletter and other correspondences does not constitute a treatment relationship between Dr. Huberman and myself.

Dr. Huberman will not distribute my information to any additional parties, however, I agree not to hold Dr. Huberman responsible should my email information be captured or "stolen" by any third party such as "hackers" or others.

By checking the box below, I am giving my authorization and consent to receive a newsletter and other informational communications via email from Dr. Huberman to the email address(es) provided.

☐ Please send e-mails to the following address (es): _____

_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dr. Huberman.

_____ _____

Signature of Patient Date