Alssaro Counseling Services, PLLC

481 Main Street, Suite 401
New Rochelle, NY 10801
Phone: (914) 355-2440
Fax: (914) 235-0822
Email: info@alssaro.com

Confidentiality Notice: Confidential Health Information May Be Enclosed

Protected health information (PHI) is personal and sensitive information related to a person's health care. You, the recipient, are obligated to maintain it safe, secure and confidential manner. Inappropriate re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law.

If you are not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any disclosure, copying or distribution of this information is **Strictly Prohibited.** If you have received this message in error, please notify the sender immediately to arrange for return or destruction of these documents.

CONFIDENTIAL

Alssaro Counseling Services, PLLC
481 Main Street Suite 401
New Rochelle, NY 10801
Phone (914) 355-2440 Fax: (914) 235-0822

REGISTRATION FORM

(Please Print)

Today's Date 7/3/19

PATIENT INFORMATION

Patient's Last Name	First	Middle	Marital Status (Circle One)
Kassenoff	Charlotte	Y	(Single) / Married / Other

Is this your legal name?	If not, what is your legal name?	(Former Name)	Birth Date	Age	Sex
☒ Yes ☐ No			2/1/11	8½	☐ M ☒ F

Street Address	Apt #	City	State	ZIP Code	Social Security	Home Phone No.
161 Beach Ave		Larchmont	NY	10538	- -	( )

P.O. Box	City	State	ZIP Code	Cell Phone No.
				(917) 836-5200

Occupation	Employer	Email
		ckassenoff@yahoo.com

CK (Patient/LegalGuardian Initials) I consent to receive text messages from the practice at my cell phone and my number fowarded or transferred to that number or emails to receive communication.

Referred from (Please check one box & list)

☐ Internet/Google ☐ Dept. Of Social Services ☐ Other________
☐ Insurance ☐ Primary Care Doctor
☐ CPS/ACS ☐ School________

***PLEASE LIST ANY HEALTH PROBLEMS AND CURRENT MEDICATIONS YOU ARE TAKING:

PARENT/ GUARDIAN INFORMATION

Name: Catherine Kassenoff

Relationship to Patient:
Biological father - (Mother) Legal Guardian - Foster Parent - Other:

Marital Status of Parents/Legal Guardians:
Single - Married - Live-In Partner - Separated
Divorced - Widowed

If divorced: Joint Custody – Mother Sole Custody- Father Sole Custody
Please provide legal custody documentation

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE OFFICE MANAGER)

Insured's Name	Insured's S.S. #	Birth Date
UHC		/ /

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home or Cell Phone No.	Alternative Phone No.
Aurelie Zambau	Nanny	914-648-1445	

Alssaro Counseling Services, PLLC

REGISTRATION FORM

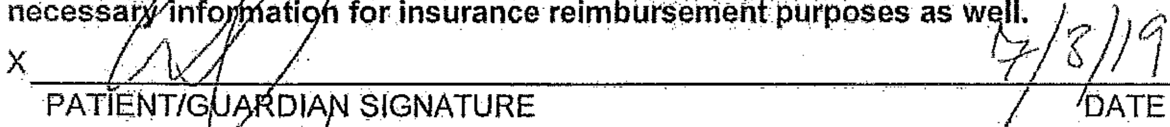
(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY

***What to Expect in Your Initial Session**

During the first meeting, your therapist will ask you to complete some paperwork about your history. In order to determine the best way to help you, he or she will also ask you questions about your history and why you're seeking treatment. The intake process is vital to the formation of any counseling relationship. Keep in mind that the initial appointment consists of both the written information and the verbal exchange.

I understand that I am fully responsible and liable for the entire amount of any/all charges for the services rendered which have not been paid by any other source. I also agree that the failure of third-party payer to make payments, for whatever reason, will in no way prevent Alssaro Counseling Services, PLLC from enforcing this agreement. I hereby authorize the release of necessary information for insurance reimbursement purposes as well.

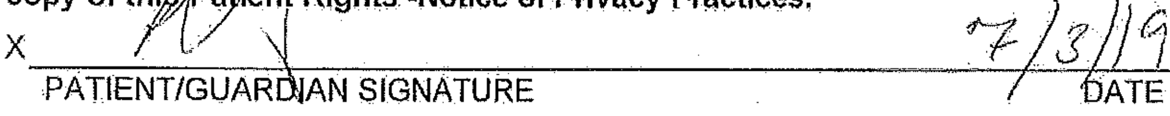


X ______ 7/3/19

PATIENT/GUARDIAN SIGNATURE DATE

NOTICE OF PATIENT RIGHTS-NOTICE OF PRIVACY PRACTICES

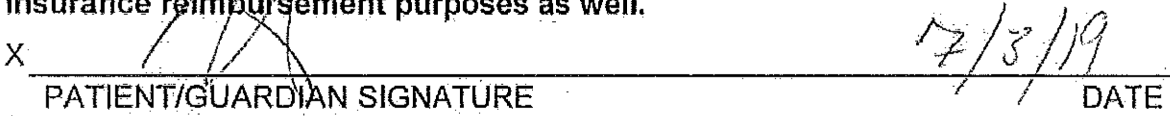
Alssaro Counseling Services, PLLC shall collect acknowledgment of the provision of its Patient Rights -Notice of Privacy Practices to all patients. I acknowledge that I have been provided a copy of this Patient Rights -Notice of Privacy Practices.



X ______ 7/3/19

PATIENT/GUARDIAN SIGNATURE DATE

I have read, understand, agree to and will abide by the Financial Policy. I understand that I am fully responsible and liable for the entire amount of any/all charges for the services rendered which have not been paid by any other source. I also agree that the failure of third-party payer make payments, for whatever reason, will in no way prevent Alssaro Counseling Services, PLLC from enforcing this agreement. I hereby authorize the release of necessary information for insurance reimbursement purposes as well.



X ______ 7/3/19

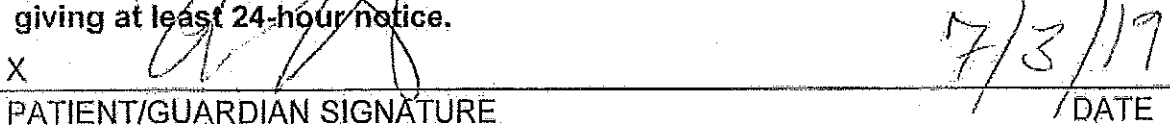
PATIENT/GUARDIAN SIGNATURE DATE

I hereby give Alssaro Counseling Services, PLLC permission for the duration of therapy to examine and treat my son / daughter, ______

X ______ 7/3/19

PATIENT/GUARDIAN SIGNATURE DATE

I understand that I will be responsible for a reserved time, missed appointment fee of $50.00 per appointment made if I decide to cancel, change or no show for my appointment without giving at least 24-hour notice.



X ______ 7/3/19

PATIENT/GUARDIAN SIGNATURE DATE

Alssaro Counseling Services, PLLC

Behavioral Health/Medical Provider Communication Consent Form

PATIENT AUTHORIZATION

I undersigned, understand I may revoke this consent ant any time except to the extent that the action has been taken in reliance upon it and that in any event, this consent shall expired 12 months from the date of signature, unless another date is specified. I have read and understand the above information and give my authorization:

PATIENT, PLEASE CHECK ONE:

[X] To release any applicable medical information to my behavioral and/or medical health provider.

Patient/Guardian Signature ____________________ Date 7/3/19

==

[ ] *I DO NOT* give my authorization to release any information to my medical and/or behavioral provider.

Patient/Guardian Signature ____________________ Date ___/___/___

==

[ ] Patient does not have a medical provider

Patient/Guardian Signature ____________________ Date ___/___/___

==

Patient Information

Patient Insurance ID Number ____________________

Patient Name ____________________ Date of Birth ___/___/___

Patient Street Address ____________________

City ____________________ State __________ Zip Code ____________________

Medical Provider Name/Address/Telephone Number	Behavioral Health Provider
refused to sign consent to share information. Date: 7/3/19	Alssaro Counseling Services, PLLC 481 Main Street Suite 401, New Rochelle, NY 10801 (914) 355-2440 Fax (914)235-0822

OCA Official Form No.: 960 CONFIDENTIAL

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name Charolette Raesenoff	Date of Birth 02/01/2011	Social Security Number
Patient Address 1101 Beach Avenue Larchment NY 10538		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information: Mitch Lieberman - 334 Underhill Rd, Yorktown Hts, NY

8. Name and address of person(s) or category of person to whom this information will be sent: **Alssaro Counseling Services, PLLC 481 Main Street Suite 401 New Rochelle, NY 10801 Telephone: (914)355-2440**

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) ____________ to (insert date) ____________
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☑ Other: **History/Updates**

Include: (*Indicate by Initialing*)

- ______ **Alcohol/Drug Treatment**
- CLK **Mental Health Information**
- ______ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here CLK (Initials) I authorize Mitch Lieberman (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here: Alssaro Counseling Services (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☑ Other: **To facilitate treatment**	11. Date or event on which this authorization will expire: 07/18/2020
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient: Mother

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

[signature] Date: 7/18/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name Charlotte Kassenoff	Date of Birth 02/01/2011	Social Security Number
Patient Address 161 Beach Avenue Larchmont NY 10538		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Alssaro Counseling Services, PLLC 481 Main Street Suite 401 New Rochelle, NY 10801 Telephone: (914)355-2440

8. Name and address of person(s) or category of person to whom this information will be sent:
Mitch Lieberman - 334 Underhill Rd, Yorktown Hts, NY

9(a). Specific information to be released:

☐ Medical Record from (insert date) ________ to (insert date) ________

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☑ Other: **Treatment status/Updates/ Recommendations**

Include: (*Indicate by Initialing*)

CK ____ **Alcohol/Drug Treatment**

CK ____ **Mental Health Information**

____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here CK (Initials) I authorize Alssaro Counseling Service (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

Mitch Lieberman

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☑ Other: **To facilitate treatment**	11. Date or event on which this authorization will expire: 07/18/2020
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient: Mother

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

[signature]

Signature of patient or representative authorized by law.

Date: 7/18/19

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

CONFIDENTIAL

Patient Name	Date of Birth	Social Security Number
Charolette Kassenoff	02/01/2011	
Patient Address		
161 Beach ave Larchmont NY 10538		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Alssaro Counseling Services, PLLC 481 Main Street Suite 401 New Rochelle, NY 10801 T: (914) 355-2440

8. Name and address of person(s) or category of person to whom this information will be sent:
Catherine Kassenoff (161 Beach Ave Larchmont, NY 10583

9(a). Specific information to be released:

☐ Medical Record from (insert date) __________ to (insert date) __________

☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: ______________________

Include: (*Indicate by Initialing*)

_______ **Alcohol/Drug Treatment**
CLK **Mental Health Information**
_______ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here ________ I authorize ______________________
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☑ At request of individual ☐ Other:	11. Date or event on which this authorization will expire: 08/07/2019
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

[signature] Date: 8/7/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Psychotherapy Intake Note

CONFIDENTIAL

Alssaro Counseling Services
481 Main Street Suite 401
New Rochelle, NY 10801
Tel: (914) 355-2440
Label: Psychotherapy Intake Note - 7/3/2019
Note Date: 07/03/2019

Patient: **Charlotte Y Kassenoff**
DOB: 02/01/2011 Age: 8
Female

Session Code

90791 - Psychiatric Diagnostic Evaluation

Presenting Problem

"Parents are getting divorced, feeling sad, parents fight and afraid of father when he yells."

Current Mental Status

Affect
- Neutral

Appearance
- Alert
- Stated Age
- Well developed
- Well groomed
- Well nourished

Attention/Concentration
- Normal

Attitude
- Attentive
- Cooperative
- Friendly
- Interested

Insight
- Good

Judgement
- Good

Memory
- Intact

Mood
- Sad

Motor/Behavior
- Appropriate for age

Orientation
- Person
- Place
- Situation
- Time

Perception
- Appropriate

Speech

Fluent

Thought Content

Congruent

Relevant

Thought Process

Coherent

Logical

Safety Issues

None

Suicidal Ideation

Present

Charlotte experiences passive suicidal ideation as there are times when she "wants to disappear" or "jump out of the window to escape/run away." Charlotte denied any intent/plan. She denied hx of self-injurious behaviors.

Identification

Charlotte is a 8 year old Caucasian, female child currently residing in Larchmont, NY 50% of the time with father and the other 50% with mother (due to domestic violence related incident) and 2 sisters (Alexandra age 10, Josephina age 5).

History of Present Problem

Charlotte was BIB her biological mother self-referred seeking outpatient services. Charlotte reported that her parents are going through a divorce and she has been feeling increasing sad. She stated that although she is sad for her parents to get divorce she believes it is the best because her parents are constantly fighting and yelling with one another. Charlotte reported that she is afraid of her father when he yells and believes he might harm her and/or another member of her family. Charlotte reported that sometimes she "wants to disappear and jump out of the window" to "escape and run away." She has been experiencing the following sxs: distractibility, hopelessness, loneliness, fatigue, withdrawal from people, anxiety/worry/fear, sadness/depression, irritability/anger, sibling conflict and sleep disturbance. Charlotte meets criteria for Adjustment Disorder with depressed and anxious mood.

Past Psychiatric History

Family denied any past psychiatric history.

Trauma History

Emotional abuse by father Domestic violence in the home Parents are in the process of getting a divorce

Family Psychiatric History

Mother - Domestic violence survior, mother is in therapy Alexandra - ODD, ADD, Binge Eating Father - Anger

Medical Conditions & History

Denied any medical conditions. Takes Flintstone vitamins daily. PCP is Dr. Seth Winkler located in Scarsdale, NY Date of last physical exam: 2/2019

Medication(s)

Denied

Substance Use

Denied

N/A

Family History

Charlotte was born to biological mother Catherine (age 50) and biological father (age 46). Charlotte has two siblings which include Alexandra (age 10) and Josephina (5 years old). Parents married in 2006. Mother is requesting a divorce

due to domestic violence related incidents. Mother is a lawyer for the state and father is a patent litigator. Mother's culture is Egyptian and British and father is Jewish. Mother was born in Canada and father was born in US. All children were born in USA. Mother was diagnosed with breast cancer, received chemotherapy and had a bilateral mastectomy.

Social History

Charlotte engages in playing the violin, tennis, soccer, robotics and learning Arabic. Her support system includes her family members, friends, peers at school. Family is spiritual.

Developmental History

Charlotte was born at Columbia Presbyterian Hospital. Mother denied any complications in the birth and/or delivery. Mother denied using any tobacco, medication, street drugs or alcohol while pregnant with Charlotte. Mother reported that Charlotte was born via vaginal birth. She reportedly met developmental milestones within normal limits.

Educational/Occupational History

Charlotte attends the French American School located in Larchmont, NY. She recently finished the 2nd grade and will be attending 3rd grade in the fall. Her grades are excellent, receiving A/B's. There are no behavioral concerns in school. Teachers reported that she is well-behaved and a leader of the classroom. Denied any learning disabilities, IEP and/or 504Plan. Charlotte shared that she has been teased and picked on by a female peer in her school who calls her and her friend negative names.

Legal History

Denied

Department of Social Services/CPS/ACS History

Active

In May 2019, Charlott'es sister Josephina reported a domestic violence incident to school personnel which prompted a CPS case and police involvement. Mother informed therapist that case would be closing as of today 7/3/19 and would notify therapist of the findings. Charlotte's law guardian is Carol Moss. Mother signed consent for therapist and law guardian to communicate.

Military Service History

Not applicable

Strengths/Limitations

Strengths include that Charlotte is intelligent and well-behaved. Her limitations include that she struggles to manage her emotions related to sadness, fear and anxiety and resorts to passive suicidal ideation.

Current Signs and Symptoms

Anger

Depressed mood

Disturbed sleep

Easily distracted

Easily frustrated

Fatigue/Lathargic

Irritability

Peer/Sibling conflict

Poor concentration

Sad/Hopeless

Social isolation

Tension/anxiety

Worried/Fearful

Level of Impairment

Moderate

Length of Time for Current Signs and Symptoms

Few months

Diagnostic Impression ICD-10-CM

F43.23 Adjustment Disorder with depressed mood and anxiety.

Recommendations

Family Therapy

Individual Therapy

Parenting Skills

Play Therapy

Goals

Achieve a level of greater family connectedness.

Alleviate depressed mood and return to previous level of effective functioning.

Decrease overall intensity and frequency of angry feelings, and increase ability to recognize and appropriately express angry feelings as they occur.

Reduce overall frequency, intensity, and duration of the anxiety so daily functioning is not impaired.

Eliminate passive suicidal ideation and/or statements.

Objectives

Describe current and past experiences with depression complete with its impact on function and attempts to resolve it.

Describe current and past experiences with the worry and anxiety symptoms, complete with the impact on function and attempts to resolve.

Identify situations, thoughts, feelings that trigger anger, angry verbal and or behavioral actions and the targets of the action.

Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a DSM diagnosis, the efficacy of treatment, and the nature of the therapy relationship.

Learn calming and coping strategies to manage distressful emotions to prevent passive suicidal ideation statements.

Estimated Completion

6 Months

Does patient/legal guardian understand and consent to proposed treatment plan?

Yes

Signed electronically on Jul 3 2019 2:29PM EST by Jenessa M. Cavallo, LMHC
Signed electronically on Jul 3 2019 2:03PM EST by Jenessa M. Cavallo, LMHC
Signed electronically on Jul 3 2019 1:35PM EST by Jenessa M. Cavallo, LMHC
Signed electronically on Jul 3 2019 2:29PM EST by Jenessa M. Cavallo, LMHC

CONFIDENTIAL

Psychotherapy Progress Note

Alssaro Counseling Services
481 Main Street Suite 401
New Rochelle, NY 10801
Tel: (914) 355-2440
Label: Psychotherapy Progress Note - 7/3/2019
Note Date: 07/03/2019

Patient: **Charlotte Y Kassenoff**
DOB: 02/01/2011 Age: 8
Female

Session Code

90846 Family psychotherapy, without the patient present, 50 minutes (26min-50min)
Total Session Time: 40 mins

Person Present

Parent

Patient Presentation

Not Applicable - Patient not in session

Safety Issues

None

Today's Presenting Issue

Therapist met with Charlotte's mother for a collateral session. Therapist explored reason for referral and mother's concern for Charlotte's emotional well-being. Mother reported that parents separation and father's conduct have been impacting Charlotte. Mother provided clear and concise psychosocial hx as well as court related matters regarding domestic violence. Therapist and mother formulated treatment goals and objective as a way to help drive therapy sessions in order to promote overall emotional stability for Charlotte.

Treatment Strategy/Interventions Provided

Family Therapy
Parenting Skills
Supportive Reflection

Medication(s)

Denied

Treatment Plan Progress

No significant change

Recommendations

Continue Current Therapeutic Focus

Additional Information

Mother participated in session.Signed electronically on Jul 3 2019 2:37PM EST by Jenessa M. Cavallo, LMHC

Psychotherapy Progress Note

CONFIDENTIAL

Alssaro Counseling Services
481 Main Street Suite 401
New Rochelle, NY 10801
Tel: (914) 355-2440
Label: Psychotherapy Progress Note - 7/9/2019
Note Date: 07/09/2019

Patient: **Charlotte Y Kassenoff**
DOB: 02/01/2011 Age: 8
Female

Session Code

90834 Psychotherapy, 45 minutes with patient (38min-52min)
Total Session Time: 40 mins

Person Present

Self

Patient Presentation

Affect
Appropriate
Cognitive functioning
Oriented/Alert
Functional Status
Intact
Interpersonal
Interactive
Mood
Sad

Safety Issues

None

Today's Presenting Issue

Therapist met with Charlotte for an individual session. Charlotte presented with sad mood, affect in full range. Therapist engaged Charlotte in play therapy. The game "The Talking, Feeling, Doing Game" was utilized as a way to build engagement and rapport with Charlotte as this was her first therapy session as well as for her to feel comfortable discussing her feelings related to parents' separation. Through processing, therapist explored her passive SI statements, frequency and duration. Charlotte expressed feeling this way when father yells at her, when she's mad and when her sisters yells or takes her things. Therapist worked with her on utilizing deep breathing and counting to 10 forward and backwards in times of distress. Session addressed goal 5 objective 5.

Treatment Strategy/Interventions Provided

Exploration of Coping Patterns
Exploration of Emotions
Exploration of Relationship Patterns
Play Therapy
Relaxation/Deep Breathing
Supportive Reflection

Medication(s)

Denied

Treatment Plan Progress

No significant change

Recommendations

Continue Current Therapeutic Focus

Additional Information

Charlotte was brought to session by her nanny. Therapist will follow up with mother too address concerns.Signed electronically on Jul 10 2019 12:13PM EST by Jenessa M. Cavallo, LMHC
Signed electronically on Jul 10 2019 12:12PM EST by Jenessa M. Cavallo, LMHC
Signed electronically on Jul 9 2019 11:19PM EST by Jenessa M. Cavallo, LMHC

CONFIDENTIAL

Psychotherapy Progress Note

Alssaro Counseling Services
481 Main Street Suite 401
New Rochelle, NY 10801
Tel: (914) 355-2440
Label: Psychotherapy Progress Note - 7/18/2019
Note Date: 07/18/2019

Patient: **Charlotte Y Kassenoff**
DOB: 02/01/2011 Age: 8
Female

Session Code

90834 Psychotherapy, 45 minutes with patient (38min-52min)
Total Session Time: 40 mins

Person Present

Self

Patient Presentation

Affect
Appropriate
Cognitive functioning
Oriented/Alert
Functional Status
Intact
Interpersonal
Interactive
Mood
Sad

Safety Issues

None

Today's Presenting Issue

Therapist met with Charlotte for an individual session. Charlotte presented with sad mood, affect in full range. Charlotte discussed feeling sad due to change in family environment. Charlotte reported that she feels sad and scared when her father yells at her because he yells a lot and is not patient. Therapist worked with Charlotte on dealing with these distressful emotions and how to mange them in the moment. Therapist engaged Charlotte in a therapeutic art activity of creating a homemade stress ball as a self-soothe coping mechanism. Therapist emphasized using this during any feelings of fear and frustration. Session addressed goal 2,3,4 objective 1,2,3,5.

Treatment Strategy/Interventions Provided

Exploration of Coping Patterns
Exploration of Emotions
Exploration of Relationship Patterns
Other
Relaxation/Deep Breathing
Supportive Reflection
Art therapy

Medication(s)

Denied

Treatment Plan Progress

No significant change

Recommendations

Continue Current Therapeutic Focus

Additional Information

Therapist spoke to mother briefly after session to discuss progress toward treatment goals and objectives. Therapist encouraged mother to help prompt Charlotte in utilization of coping mechanisms during times of distress. Mother agreed.Signed electronically on Jul 18 2019 2:49PM EST by Jenessa M. Cavallo, LMHC
Signed electronically on Jul 18 2019 2:46PM EST by Jenessa M. Cavallo, LMHC

CONTACT NOTE

CONFIDENTIAL

Alssaro Counseling Services
481 Main Street Suite 401
New Rochelle, NY 10801
Tel: (914) 355-2440
Label: Contact Note - 7/22/2019
Note Date: 07/22/2019

Patient: **Charlotte Y Kassenoff**
DOB: 02/01/2011 Age: 8
Female

Contacted Party

Carol Moss

Relationship to Patient

Law Guardian

Method of Communication

Phone

Communication Details

Therapist returned law guardian's phone call and left availability to coordinate on case.Signed electronically on Jul 22 2019 8:19PM EST by Jenessa M. Cavallo, LMHC

CONFIDENTIAL

CONTACT NOTE

Alssaro Counseling Services
481 Main Street Suite 401
New Rochelle, NY 10801
Tel: (914) 355-2440
Label: Contact Note - 7/24/2019
Note Date: 07/24/2019

Patient: **Charlotte Y Kassenoff**
DOB: 02/01/2011 Age: 8
Female

Contacted Party

Carol Most

Relationship to Patient

Law Guardian

Method of Communication

Phone

Communication Details

Therapist spoke to law guardian. Law guardian provided updates regarding this case.Signed electronically on Jul 24 2019 1:07PM EST by Jenessa M. Cavallo, LMHC

PSYCHOTHERAPY PROGRESS NOTE

CONFIDENTIAL

Alssaro Counseling Services
481 Main Street Suite 401
New Rochelle, NY 10801
Tel: (914) 355-2440
Label: Psychotherapy Progress Note - 7/24/2019
Note Date: 07/24/2019

Patient: **Charlotte Y Kassenoff**
DOB: 02/01/2011 Age: 8
Female

Session Code

90846 Family psychotherapy, without the patient present, 50 minutes (26min-50min)
Total Session Time: 60 mins

Person Present

Parent
Father

Patient Presentation

Not Applicable - Patient not in session

Safety Issues

None

Today's Presenting Issue

Therapist met with father for a collateral session. Father provided therapist with psychosocial history and his perspective of family conflict. Father provided updates on court related matters in regards to custody battle. Therapist provided father updates on Charlotte's progress toward treatment goals and objectives. Session addressed goal 1 objective 4.

Treatment Strategy/Interventions Provided

Family Therapy
Parenting Skills
Informing Gathering

Medication(s)

Denied

Treatment Plan Progress

No significant change

Recommendations

Continue Current Therapeutic Focus

Additional Information

Father participated in collateral session.Signed electronically on Jul 28 2019 9:37PM EST by Jenessa M. Cavallo, LMHC
Signed electronically on Jul 28 2019 9:36PM EST by Jenessa M. Cavallo, LMHC

Alssaro Counseling Services, PLLC

481 Main Street, Suite 401
New Rochelle, NY 10801
Phone: (914) 355-2440
Fax: (914) 235-0822
Email: info@alssaro.com

Confidentiality Notice: Confidential Health Information May Be Enclosed

Protected health information (PHI) is personal and sensitive information related to a person's health care. You, the recipient, are obligated to maintain it safe, secure and confidential manner. Inappropriate re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law.

If you are not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any disclosure, copying or distribution of this information is **Strictly Prohibited.** If you have received this message in error, please notify the sender immediately to arrange for return or destruction of these documents.

Alssaro Counseling Services, PLLC
481 Main Street Suite 401
New Rochelle, NY 10801
Phone (914) 355-2440 Fax: (914) 235-0822

CONFIDENTIAL

REGISTRATION FORM

(Please Print)

Today's Date 6, 20, 19

PATIENT INFORMATION

Patient's Last Name: Kassenoff
First: Josephina
Middle: Y
Marital Status (Circle One): (Single) / Married / Other

Is this your legal name? ☐ Yes ☐ No
If not, what is your legal name?
(Former Name)
Birth Date: 8, 10, 13
Age: 5½
Sex: ☐ M ☑ F

Street Address: 161 Beach Ave.
Apt #
City
State
ZIP Code
Social Security: - -
Home Phone No. ( )

P.O. Box: Larchmont
City: NY
State: 10538
ZIP Code
Cell Phone No. 914 836-5200

Occupation
Employer
Email

CK (Patient/LegalGuardian Initials) I consent to receive text messages from the practice at my cell phone and my number fowarded or transferred to that number or emails to receive communication.

Referred from (Please check one box & list)

☐ Internet/Google ☐ Dept. Of Social Services ☐ Other ____________
☐ Insurance ☐ Primary Care Doctor
☐ CPS/ACS ☐ School ____________

***PLEASE LIST ANY HEALTH PROBLEMS AND CURRENT MEDICATIONS YOU ARE TAKING:

PARENT/ GUARDIAN INFORMATION

Name: Catherine Kassenoff

Relationship to Patient:
Biological father - (Mother) Legal Guardian - Foster Parent - Other:

Marital Status of Parents/Legal Guardians:
Single – Married – Live-In Partner - Separated
Divorced -Widowed

If divorced: Joint Custody – Mother Sole Custody- Father Sole Custody
Please provide legal custody documentation

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE OFFICE MANAGER)

Insured's Name
Insured's S.S. #
Birth Date / /

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home or Cell Phone No.	Alternative Phone No.
Lily Becker 917-710-0021			

Alssaro Counseling Services, PLLC
REGISTRATION FORM
(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY

***What to Expect in Your Initial Session**

During the first meeting, your therapist will ask you to complete some paperwork about your history. In order to determine the best way to help you, he or she will also ask you questions about your history and why you're seeking treatment. The intake process is vital to the formation of any counseling relationship. Keep in mind that the initial appointment consists of both the written information and the verbal exchange.

I understand that I am fully responsible and liable for the entire amount of any/all charges for the services rendered which have not been paid by any other source. I also agree that the failure of third-party payer to make payments, for whatever reason, will in no way prevent Alssaro Counseling Services, PLLC from enforcing this agreement. I hereby authorize the release of necessary information for insurance reimbursement purposes as well.

X [signature] 6/20/19

PATIENT/GUARDIAN SIGNATURE DATE

NOTICE OF PATIENT RIGHTS-NOTICE OF PRIVACY PRACTICES

Alssaro Counseling Services, PLLC shall collect acknowledgment of the provision of its Patient Rights -Notice of Privacy Practices to all patients. I acknowledge that I have been provided a copy of this Patient Rights -Notice of Privacy Practices.

X [signature] 6/20/19

PATIENT/GUARDIAN SIGNATURE DATE

I have read, understand, agree to and will abide by the Financial Policy. I understand that I am fully responsible and liable for the entire amount of any/all charges for the services rendered which have not been paid by any other source. I also agree that the failure of third-party payer make payments, for whatever reason, will in no way prevent Alssaro Counseling Services, PLLC from enforcing this agreement. I hereby authorize the release of necessary information for insurance reimbursement purposes as well.

X [signature] 6/20/19

PATIENT/GUARDIAN SIGNATURE DATE

I hereby give Alssaro Counseling Services, PLLC permission for the duration of therapy to examine and treat my son / daughter, ______________________

X [signature] 6/20/19

PATIENT/GUARDIAN SIGNATURE DATE

I understand that I will be responsible for a reserved time, missed appointment fee of $50.00 per appointment made if I decide to cancel, change or no show for my appointment without giving at least 24-hour notice.

X [signature] 6/20/19

PATIENT/GUARDIAN SIGNATURE DATE

Aissaro Counseling Services, PLLC

Behavioral Health/Medical Provider Communication Consent Form

PATIENT AUTHORIZATION

I undersigned, understand I may revoke this consent ant any time except to the extent that the action has been taken in reliance upon it and that in any event, this consent shall expired 12 months from the date of signature, unless another date is specified. I have read and understand the above information and give my authorization:

PATIENT, PLEASE CHECK ONE:

[ ] To release any applicable medical information to my behavioral and/or medical health provider.

Patient/Guardian Signature____________________ Date___/___/___

==

[ ] *I DO NOT* give my authorization to release any information to my medical and/or behavioral provider.

Patient/Guardian Signature [signature] Date 6/20/19

==

[ ] Patient does not have a medical provider

Patient/Guardian Signature____________________ Date___/___/___

==

Patient Information

Patient Insurance ID Number____________________

Patient Name ____________________ Date of Birth ___/___/___

Patient Street Address____________________

City__________ State_____ Zip Code__________

Medical Provider Name/Address/Telephone Number	Behavioral Health Provider
Client/Guardian refused to sign consent to share information. Date: 6/20/19	Aissaro Counseling Services, PLLC 481 Main Street Suite 401, New Rochelle, NY 10801 (914) 355-2440 Fax (914)235-0822

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

CONFIDENTIAL

Patient Name Josephina Kassenoff	Date of Birth 08 10 2013	Social Security Number
Patient Address 161 Beach Avenue Larchmont NY 10538		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Alssaro Counseling Services, PLLC 481 Main Street Suite 401 New Rochelle, NY 10801 Telephone: (914)355-2440

8. Name and address of person(s) or category of person to whom this information will be sent:
Mitch Lieberman - 334 Underhill Rd, Yorktown Hts, NY

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) ________ to (insert date) ________
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☑ Other: **Treatment status/Updates/ Recommendations**

Include: (*Indicate by Initialing*)

- ____ **Alcohol/Drug Treatment**
- CLK **Mental Health Information**
- ____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here CLK (Initials) I authorize Alssaro Counseling Services (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☑ Other: **To facilitate treatment**	11. Date or event on which this authorization will expire: 07 18 2020
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient: Mother

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

[signature]
Signature of patient or representative authorized by law.

Date: 7/18/19

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name Josephina Kassenoff	Date of Birth 08/10/2013	Social Security Number
Patient Address 161 Beach Avenue Larchmont NY 10538		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Mitch Lieberman - 334 Underhill Rd. Yorktown Hts, NY

8. Name and address of person(s) or category of person to whom this information will be sent:
Alssaro Counseling Services, PLLC 481 Main Street Suite 401 New Rochelle, NY 10801 Telephone: (914)355-2440

9(a). Specific information to be released:
- ☐ Medical Record from (insert date) ________ to (insert date) ________
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☑ Other: **History/Updates**

Include: (*Indicate by Initialing*)
- ______ **Alcohol/Drug Treatment**
- CJK **Mental Health Information**
- ______ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here CJK (Initials) I authorize Mitch Lieberman (Name of individual health care provider)
to discuss my health information with my attorney, or a governmental agency, listed here:
Alssaro Counseling Service
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☑ Other: **To facilitate treatment**	11. Date or event on which this authorization will expire: 07/18/2020
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient: Mother

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

[signature]
Signature of patient or representative authorized by law.

Date: 7/18/19

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

CONFIDENTIAL

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Josephina Kassenoff	8/10/2013	
Patient Address: 161 Beach ave Larchmont NY 10538		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Alssaro Counseling Services, PLLC 481 Main Street Suite 401 New Rochelle, NY 10801 T: (914) 355-2440

8. Name and address of person(s) or category of person to whom this information will be sent:
Catherine Kassenoff (161 Beach Ave Larchmont, NY 10583

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) ________ to (insert date) ________
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: ________

Include: (*Indicate by Initialing*)

- ____ **Alcohol/Drug Treatment**
- CKK ✓ **Mental Health Information**
- ____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here ________ (Initials) I authorize ________ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

________ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☑ At request of individual ☐ Other:	11. Date or event on which this authorization will expire: 08/07/2019
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

[signature]
Signature of patient or representative authorized by law.

Date: 8/7/19

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

CONFIDENTIAL

Psychotherapy Intake Note

Alssaro Counseling Services
481 Main Street Suite 401
New Rochelle, NY 10801
Tel: (914) 355-2440
Label: Psychotherapy Intake Note - 6/20/2019
Note Date: 06/20/2019

Patient: **Josephina Kassenoff**
DOB: 08/10/2013 Age: 5
Male

Session Code

90791 - Psychiatric Diagnostic Evaluation

Presenting Problem

"Josephina's parents are going through a divorce, on the heels of a CPS investigation into father's conduct. Josephina witnessed father's conduct and father denies it. Her statements were given to school personnel, CPS and police. Mother worries that she is fearful."

Current Mental Status

Affect
- Neutral

Appearance
- Alert
- Well groomed
- Well nourished

Attention/Concentration
- Normal

Attitude
- Attentive
- Cooperative
- Friendly

Insight
- Good

Judgement
- Good

Memory
- Intact

Mood
- Anxious

Motor/Behavior
- Appropriate for age

Orientation
- Person
- Place
- Situation
- Time

Perception
- Appropriate

Speech

Fluent

Soft

Thought Content

Relevant

Thought Process

Logical

Safety Issues

None

Josephina denied current and/or past SI/HI intent/plan.

Identification

Josephina is a 5 year old Caucasian, female child currently residing in Larchmont, NY 50% of the time with father and the other 50% with mother (due to domestic violence related incident) and 2 sisters (age 10, 8.5 yrs).

History of Present Problem

Josephina was BIB her biological mother self-referred seeking outpatient services for Josephina. Mother reported that there was a domestic violence incident that occurred perpetrated by father which required mother and sister Alexandra to receive medical care. On May 11, 2019 Josephina reported the incident to school personnel which prompted a CPS case and police involvement. There was an OP placed against father, although, now has been lifted by the Judge in order to access rights to father. Mother is in the home for 3 days, then father is in the home the next 3 days and so forth to care for the children. Josephina reported that she witnessed her father throwing her mother across the room and physically harming her sister Alexandra. Josephina expressed fearing her safety and her mother's safety. She has been distracted, having nightmares related to the incident, crying spells, isolation, anxiety/worry and fear, sadness and sleep disturbance In addition, Josephina reported that she experiences flashbacks of the incident a couple x per week. She meets criteria for PTSD.

Past Psychiatric History

Mother denied past psychiatric history.

Trauma History

Josephina witnessed domestic violence where father was the perpetrator and mother the victim. She also witnessed father becoming physical with sister Alexandra.

Family Psychiatric History

Mother - Domestic violence, mother is in therapy (PTSD) Alexandra - ODD, ADD, Binge Eating Father - Anger

Medical Conditions & History

Dr. Seth Winkler located in Scarsdale, NY Hx of stomach aches Date of last physical exam: 2018

Medication(s)

Denied

Substance Use

Denied

Family History

Josephina was born to biological mother Catherine (age 50) and biological father (age 46). Josephina has two older siblings which include Alexandra (age 10) and Charlotte (age 8.5 years old). Parents married in 2006. Mother is requesting a divorce due to domestic violence related incidents. Mother is a lawyer for the state and father is a patent litigator. Mother's cultural is Egyptian and British and father is Jewish. Mother was born in Canada and father was born in US. All children were born in USA. Mother was diagnosed with breast cancer, received chemotherapy and had a bilateral mastectomy.

Social History

Josephina is learning to play the violin, swims, plays soccer and tennis. Her social support system involves her friends, family members, and peers at school. Family is spiritual. Mother reported that she and Josephina like to engage in yoga together.

Developmental History

Josephina was born at Columbia Presbyterian Hospital. Mother denied any complications in the birth and/or delivery. Mother denied using any tobacco, medication, street drugs or alcohol while pregnant with Josephina. Mother reported that Josephina was born via vaginal birth, weighing about 8 lbs. Josephina has delays in regards to not rolling over, not standing and/or walking. She currently receives OT and PT.

Educational/Occupational History

Josephina currently attends Pre-K at Happy Harbor Play located in Mamaroneck, NY. Mother stated that Josephina has excellent grades and behavior at school. Mother denied any IEP and/or 504 Plan.

Legal History

Denied

Department of Social Services/CPS/ACS History

Active

Josephina reported to school personnel about the domestic violence in her home which prompted a CPS case.

Military Service History

Not applicable

Strengths/Limitations

Strengths include that she is friendly and active. Her limitations include her difficulty dealing with emotions related to domestic violence.

Current Signs and Symptoms

Crying spells

Disturbed sleep

Easily distracted

Flashbacks

Hyper-vigilance

Other

Persistent nightmares/night terrors

Poor concentration

Sad/Hopeless

Tension/anxiety

Worried/Fearful

Fear for safety and mother's safety

Level of Impairment

Moderate

Length of Time for Current Signs and Symptoms

Approximately 1-2 months

Diagnostic Impression ICD-10-CM

F43.10 PTSD

Recommendations

Family Therapy

Individual Therapy

Parenting Skills

Play Therapy

Goals

Rebuild sense of self-worth and overcome the overwhelming sense of fear, shame, and sadness.

Reduce the negative impact that the traumatic event has had on many aspects of life and return to the pre-trauma level of functioning.

Educate parents on how trauma impacts children.

Objectives

Identify negative automatic thoughts and replace them with positive self-talk messages to build self-esteem.

Learn and implement calming, and coping strategies to manage challenging situations related to trauma.

Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a DSM diagnosis, the efficacy of treatment, and the nature of the therapy relationship.

Estimated Completion

6 Months

Does patient/legal guardian understand and consent to proposed treatment plan?

Yes

Signed electronically on Jun 25 2019 12:10PM EST by Jenessa M. Cavallo, LMHC
Signed electronically on Jun 24 2019 3:28PM EST by Jenessa M. Cavallo, LMHC
Signed electronically on Jun 25 2019 12:10PM EST by Jenessa M. Cavallo, LMHC
Signed electronically on Jun 20 2019 11:01PM EST by Jenessa M. Cavallo, LMHC

CONFIDENTIAL

Psychotherapy Progress Note

Alssaro Counseling Services
481 Main Street Suite 401
New Rochelle, NY 10801
Tel: (914) 355-2440
Label: Psychotherapy Progress Note - 7/3/2019
Note Date: 07/03/2019

Patient: **Josephina Kassenoff**
DOB: 08/10/2013 Age: 5
Male

Session Code

90834 Psychotherapy, 45 minutes with patient (38min-52min)
Total Session Time: 40 mins

Person Present

Self

Patient Presentation

Affect
Appropriate
Cognitive functioning
Oriented/Alert
Functional Status
Intact
Interpersonal
Interactive
Mood
Euthymic
Nervous

Safety Issues

None

Today's Presenting Issue

Therapist met with Josephina for an individual session. Josephina presented with euthymic and nervous mood, affect in full range. Therapist engaged Josephina in non-directive play therapy. Josephina requested to play with dolls and the dollhouse. Themes observed by therapist in play were safety/security and desire for family cohesion. This brought up dialogue regarding her own lack of family cohesion which prompted Josephina to discuss her feelings of guilt and feeling responsible for parents' separation. Therapist challenged her faulty cognitive distortions and reinforced her protection for mother and sister. Session addressed goal 2 objective 1.

Treatment Strategy/Interventions Provided

Exploration of Coping Patterns
Exploration of Emotions
Exploration of Relationship Patterns
Play Therapy
Supportive Reflection

Medication(s)

Denied

Treatment Plan Progress

No significant change

Recommendations

Continue Current Therapeutic Focus

Additional Information

Therapist met with mother briefly before session and she provided updates on court related matters.Signed electronically on Jul 3 2019 2:52PM EST by Jenessa M. Cavallo, LMHC
Signed electronically on Jul 3 2019 2:51PM EST by Jenessa M. Cavallo, LMHC

CONFIDENTIAL

Psychotherapy Progress Note

Alssaro Counseling Services
481 Main Street Suite 401
New Rochelle, NY 10801
Tel: (914) 355-2440
Label: Psychotherapy Progress Note - 7/9/2019
Note Date: 07/09/2019

Patient: **Josephina Kassenoff**
DOB: 08/10/2013 Age: 5
Male

Session Code

90834 Psychotherapy, 45 minutes with patient (38min-52min)

Total Session Time: 40 mins

Person Present

Self

Patient Presentation

Affect

Appropriate

Cognitive functioning

Oriented/Alert

Functional Status

Intact

Interpersonal

Interactive

Mood

Anxious

Safety Issues

None

Today's Presenting Issue

Therapist met with Josephina for an individual session. Josephina presented with anxious mood, affect in full range. Therapist engaged Josephina in reading the book "A Terrible Thing Happened" which was a story for children who have witnessed violence or trauma. Josephina was able to identify various aspects in the book where she was able to relate to main character. Josephina reported experiencing self-blame and therapist utilized cognitive challenging to help her understand that her trauma was not her fault. Session addressed goal 2 objective 2.

Treatment Strategy/Interventions Provided

Cognitive Challenging

Exploration of Coping Patterns

Exploration of Emotions

Exploration of Relationship Patterns

Other

Play Therapy

Bibliotherapy

Medication(s)

Denied

Treatment Plan Progress

No significant change

Recommendations

Continue Current Therapeutic Focus

Additional Information

Josephina was brought to session by her nanny. Therapist will follow up with mother to address any concerns.Signed electronically on Jul 10 2019 12:26PM EST by Jenessa M. Cavallo, LMHC
Signed electronically on Jul 10 2019 12:25PM EST by Jenessa M. Cavallo, LMHC
Signed electronically on Jul 9 2019 11:20PM EST by Jenessa M. Cavallo, LMHC

Psychotherapy Progress Note

CONFIDENTIAL

Alssaro Counseling Services
481 Main Street Suite 401
New Rochelle, NY 10801
Tel: (914) 355-2440
Label: Psychotherapy Progress Note - 7/18/2019
Note Date: 07/18/2019

Patient: **Josephina Kassenoff**
DOB: 08/10/2013 Age: 5
Male

Session Code

90834 Psychotherapy, 45 minutes with patient (38min-52min)
Total Session Time: 40 mins

Person Present

Self

Patient Presentation

Affect
Appropriate
Cognitive functioning
Oriented/Alert
Functional Status
Intact
Interpersonal
Interactive
Mood
Anxious
Fearful

Safety Issues

None

Today's Presenting Issue

Therapist met with Josephina for an individual session. Josephina presented with anxious mood, affect in full range. Josephina continues to report feelings of fear when father yells. She explained that she saw a man that resembled father on the street and experienced physiological response to fear and anxiety. Therapist engaged Josephina in a therapeutic art activity of creating a homemade stress ball as a self-soothe coping mechanism. Therapist emphasized using this during any feelings of fear and frustration. Session addressed goal 2 objective 2.

Treatment Strategy/Interventions Provided

Exploration of Coping Patterns
Exploration of Emotions
Exploration of Relationship Patterns
Other
Relaxation/Deep Breathing
Supportive Reflection
Art therapy

Medication(s)

Denied

Treatment Plan Progress

No significant change

Recommendations

Continue Current Therapeutic Focus

Additional Information

Mother participated in collateral session. See collateral note.Signed electronically on Jul 30 2019 10:55AM EST by Jenessa M. Cavallo, LMHC
Signed electronically on Jul 30 2019 10:54AM EST by Jenessa M. Cavallo, LMHC
Signed electronically on Jul 18 2019 2:51PM EST by Jenessa M. Cavallo, LMHC

CONFIDENTIAL

Psychotherapy Progress Note

Alssaro Counseling Services
481 Main Street Suite 401
New Rochelle, NY 10801
Tel: (914) 355-2440
Label: Psychotherapy Progress Note - 7/18/2019
Note Date: 07/18/2019

Patient: Josephina Kassenoff
DOB: 08/10/2013 Age: 5
Male

Session Code

90846 Family psychotherapy, without the patient present, 50 minutes (26min-50min)

Total Session Time: 30 mins

Person Present

Parent

Mother

Patient Presentation

Not Applicable - Patient not in session

Safety Issues

None

Today's Presenting Issue

Therapist met with Josephina's mother for a collateral session. Therapist provided updates toward progress in treatment in relation to treatment goals and objectives. Therapist worked with mother and provided ways to help Josephina during times of fear and anxiety and various coping mechanisms that are being taught in treatment. Therapist encouraged mother to practice with children and reinforce at home during times of distress. Session addressed goal 3, objective 3.

Treatment Strategy/Interventions Provided

Family Therapy

Parenting Skills

Psychoeducation

Medication(s)

Denied

Treatment Plan Progress

No significant change

Recommendations

Continue Current Therapeutic Focus

Additional Information

Mother participated in session.Signed electronically on Jul 30 2019 10:59AM EST by Jenessa M. Cavallo, LMHC

CONTACT NOTE

CONFIDENTIAL

Alssaro Counseling Services
481 Main Street Suite 401
New Rochelle, NY 10801
Tel: (914) 355-2440
Label: Contact Note - 7/22/2019
Note Date: 07/22/2019

Patient: **Josephina Kassenoff**
DOB: 08/10/2013 Age: 5
Male

Contacted Party

Carol Most

Relationship to Patient

Law guardian 914-997-9181

Method of Communication

Phone

Communication Details

Therapist returned law guardian's phone call and left availability to coordinate on case.Signed electronically on Jul 22 2019 8:20PM EST by Jenessa M. Cavallo, LMHC

CONTACT NOTE

CONFIDENTIAL

Alssaro Counseling Services
481 Main Street Suite 401
New Rochelle, NY 10801
Tel: (914) 355-2440
Label: Contact Note - 7/24/2019
Note Date: 07/24/2019

Patient: **Josephina Kassenoff**
DOB: 08/10/2013 Age: 5
Male

Contacted Party

Carol Most

Relationship to Patient

Law Guardian

Method of Communication

Phone

Communication Details

Therapist spoke to law guardian. Law guardian provided updates regarding this case.Signed electronically on Jul 30 2019 1:57PM EST by Jenessa M. Cavallo, LMHC

CONTACT NOTE

CONFIDENTIAL

Alssaro Counseling Services
481 Main Street Suite 401
New Rochelle, NY 10801
Tel: (914) 355-2440
Label: Contact Note - 8/1/2019
Note Date: 08/01/2019

Patient: **Josephina Kassenoff**
DOB: 08/10/2013 Age: 5
Male

Contacted Party

Allan Kassenoff

Relationship to Patient

Father

Method of Communication

Phone

Communication Details

Therapist returned father's phone call and left a voicemail message.Signed electronically on Aug 1 2019 7:03PM EST by Jenessa M. Cavallo, LMHC

CONTACT NOTE

CONFIDENTIAL

Alssaro Counseling Services
481 Main Street Suite 401
New Rochelle, NY 10801
Tel: (914) 355-2440
Label: Contact Note - 8/1/2019
Note Date: 08/01/2019

Patient: **Josephina Kassenoff**
DOB: 08/10/2013 Age: 5
Male

Contacted Party

Carol Most

Relationship to Patient

Law Guardian

Method of Communication

Phone

Communication Details

Therapist returned law guardian's phone call and left a voicemail message with contact information provided.Signed electronically on Aug 1 2019 7:08PM EST by Jenessa M. Cavallo, LMHC

CONTACT NOTE

CONFIDENTIAL

Alssaro Counseling Services
481 Main Street Suite 401
New Rochelle, NY 10801
Tel: (914) 355-2440
Label: Contact Note - 8/5/2019
Note Date: 08/05/2019

Patient: **Josephina Kassenoff**
DOB: 08/10/2013 Age: 5
Male

Contacted Party

Carol Most

Relationship to Patient

Law Guardian

Method of Communication

Phone

Communication Details

Therapist spoke with law guardian to discuss case.Signed electronically on Aug 5 2019 3:53PM EST by Jenessa M. Cavallo, LMHC

PSYCHOTHERAPY PROGRESS NOTE

CONFIDENTIAL

Alssaro Counseling Services
481 Main Street Suite 401
New Rochelle, NY 10801
Tel: (914) 355-2440
Label: Psychotherapy Progress Note - 8/7/2019
Note Date: 08/07/2019

Patient: **Josephina Kassenoff**
DOB: 08/10/2013 Age: 5
Male

Session Code

90846 Family psychotherapy, without the patient present, 50 minutes (26min-50min)
Total Session Time: 30 mins

Person Present

Parent

Mother

Patient Presentation

Not Applicable - Patient not in session

Safety Issues

Other

Today's Presenting Issue

Therapist met with Josephina's mother for a collateral session. Mother presented with concerns related to therapist case transfer. Therapist discussed her agreement with therapist case transfer due to this writer's lack of availability for weekday evenings and weekend appointment in order to accommodate father's participation in sessions. Mother was concerned about transitioning Josephina to new therapist. Therapist normalized case transfers and explained ways to discuss with Josephina therapist transfer. Therapist recommended mother schedule session with new therapist this week as Josephina has not been in therapy for the past few weeks.

Treatment Strategy/Interventions Provided

Family Therapy

Medication(s)

Denied

Treatment Plan Progress

No significant change

Recommendations

Continue Current Therapeutic Focus

Additional Information

Case will be transferred to a therapist with open weekday evenings and weekend availability as this therapist does not have available weekday evening appointments or weekends.Signed electronically on Aug 7 2019 1:56PM EST by Jenessa M. Cavallo, LMHC
Signed electronically on Aug 7 2019 1:41PM EST by Jenessa M. Cavallo, LMHC