BEHAVIORAL HEALTH CENTERS
WHAT TO EXPECT

What is the behavioral health center?

The center is a place where your child can meet with mental health professionals (board certified child and adolescent psychiatrist, licensed mental health counselors, care coordinators) to evaluate your child and provide recommendations, resources and support.

This is a short-term program, that will help you connect to long term providers for ongoing care. This may include:

- Individual Counseling
- Specialized testing (ADHD, Autism etc)
- Medication Management
- Support groups
- Family therapy

Based on your child's needs the team may recommend our short-term programs such as for school avoidance or anxiety.

To make an appointment:
Mineola: (516) 321-5770
Rockville Centre: (516) 927-1630
Commack: (631) 775-3280
Riverhead: (631) 803-3116
Mount Kisco: 914-864-0312

Northwell Health®

How do I make an appointment?

Please call the center based on your district listed on the website (use QR code) below. We cannot schedule an appointment without a legal guardian.

Before you arrive:

Please complete the paperwork in your email prior to coming. You will need to bring:

- Guardian ID
- Insurance Card*

*You will be charged your regular co-payment amount, Please call us if there is an issue with insurance so we can assist.

When you arrive:

You will be asked to complete a school consent form. This form is optional however it is requested to help your school best support your child. We will never send your personal records or confirm your attendance without your consent. Please see the example on the back

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At your Visit

You and your child will meet with a Child and Adolescent Psychiatrist and/or Psychologist and/or Licensed Mental Health Counselor separately. Our team will work together to identify what resources will be most helpful and you will be assigned a care coordinator to help support the next stage of connecting with ongoing care based on recommendations.

After your Visit

Your care coordinator will work on identifying long term providers who

- Accept your insurance
- Have current availability
- Specialize in what your child needs
- Is accessible to you

You will receive details about identified resources in an email. Once you receive this email, please follow instructions and call providers immediately as their availability can change rapidly. Please note care coordination can take 1-3 weeks in effort to find you someone who meets the above criteria

Important Phone Numbers to Know

•South Oaks Hospital Admissions: 631-608-5885

•Cohen Children's Medical Center Pediatric Behavioral Health Urgent Care: 718-470-3148

•Cohen Children's Medical Center Pediatric Emergency Behavioral Health: 718-470-3768

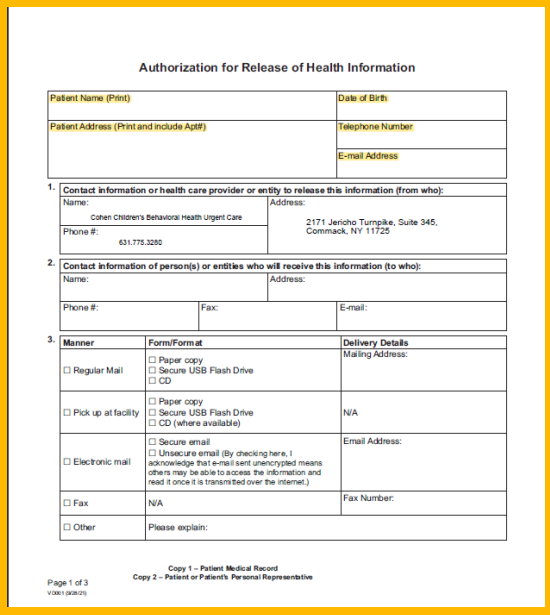
•Long Island Crisis Center: 516-679-1111

• Hudson Valley Crisis Center: Dial 211

•Center for Hope: 516-216-5194

•National Suicide Prevention Lifeline: Call or text 988

What does a consent look like?



Authorization for Release of Health Information

Patient Name (Print)	Date of Birth
Patient Address (Print and include Apt#)	Telephone Number
	E-mail Address

1. **Contact information or health care provider or entity to release this information (from who):**

Name:	Address:
Cohen Children's Behavioral Health Urgent Care	2171 Jericho Turnpike, Suite 345, Commack, NY 11725
Phone #: 631.775.3280	

2. **Contact information of person(s) or entities who will receive this information (to who):**

Name:		Address:
Phone #:	Fax:	E-mail:

3.

Manner	Form/Format	Delivery Details
☐ Regular Mail	☐ Paper copy ☐ Secure USB Flash Drive ☐ CD	Mailing Address:
☐ Pick up at facility	☐ Paper copy ☐ Secure USB Flash Drive ☐ CD (where available)	N/A
☐ Electronic mail	☐ Secure email ☐ Unsecure email (By checking here, I acknowledge that e-mail sent unencrypted means others may be able to access the information and read it once it is transmitted over the internet.)	Email Address:
☐ Fax	N/A	Fax Number:
☐ Other	Please explain:	

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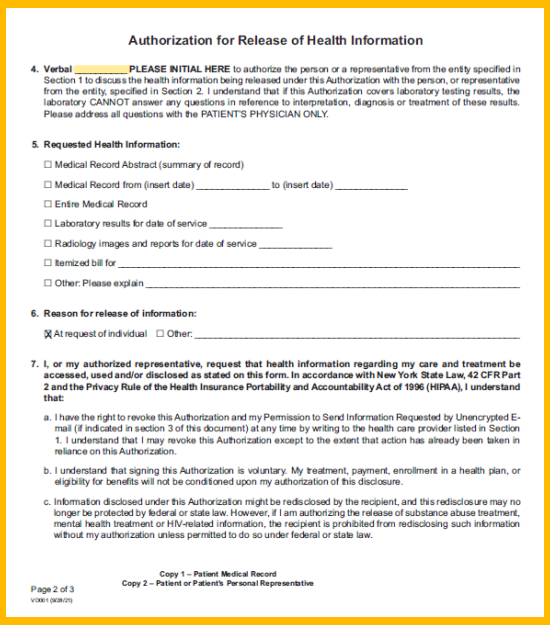
Copy 1 – Patient Medical Record
Copy 2 – Patient or Patient's Personal Representative



Authorization for Release of Health Information

4. **Verbal _____PLEASE INITIAL HERE** to authorize the person or a representative from the entity specified in Section 1 to discuss the health information being released under this Authorization with the person, or representative from the entity, specified in Section 2. I understand that if this Authorization covers laboratory testing results, the laboratory CANNOT answer any questions in reference to interpretation, diagnosis or treatment of these results. Please address all questions with the PATIENT'S PHYSICIAN ONLY.

5. **Requested Health Information:**

☐ Medical Record Abstract (summary of record)
☐ Medical Record from (insert date) _____ to (insert date) _____
☐ Entire Medical Record
☐ Laboratory results for date of service _____
☐ Radiology images and reports for date of service _____
☐ Itemized bill for _____
☐ Other: Please explain _____

6. **Reason for release of information:**

☒ At request of individual ☐ Other: _____

7. **I, or my authorized representative, request that health information regarding my care and treatment be accessed, used and/or disclosed as stated on this form. In accordance with New York State Law, 42 CFR Part 2 and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:**

a. I have the right to revoke this Authorization and my Permission to Send Information Requested by Unencrypted E-mail (if indicated in section 3 of this document) at any time by writing to the health care provider listed in Section 1. I understand that I may revoke this Authorization except to the extent that action has already been taken in reliance on this Authorization.

b. 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.

c. Information disclosed under this Authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law. However, if I am authorizing the release of substance abuse treatment, mental health treatment or HIV-related information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.

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