

# PSYCHOANALYTIC CONSULTATION AND TREATMENT SERVICE (CTS)



Psychoanalytic  
Association of  
New York

One Park Avenue, 8<sup>th</sup> Floor • New York, NY • 10016  
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Email: [nyu.pi@nyulangone.org](mailto:nyu.pi@nyulangone.org)

## HOW TO SUBMIT YOUR APPLICATION:

Email: [nyu.pi@nyulangone.org](mailto:nyu.pi@nyulangone.org)

Fax: 646-754-9540

**Mail:** We are unable to receive mailed applications at this time, please submit by email or fax.  
*Treatment services are not provided at our administrative offices.*

The Psychoanalytic Association of New York abides by HIPAA privacy guidelines, which means that after we receive your application, we will treat it with the utmost care in order to respect your privacy. As an applicant to our Treatment Services, you may email your application to our office, with the understanding that email is not a private or secure system.

You may fax your application to our confidential, private fax line. We will begin to process your application upon receipt.

## HOW TO PAY THE \$50 APPLICATION FEE:

*The fee is waived for members of the NYU community; please indicate this on your application.*

Your \$50 application fee covers the processing of your application by PANY and an in-person consultation, if referred to one of our therapists. If the consultation becomes extended because of missed appointments, cancellation on short notice, or significant lateness, the consulting therapist may charge a mutually agreeable fee for any additional session(s) needed to complete the consultation. The therapist who performs the consultation will discuss this with you if the situation arises.

### Pay online (PayPal, credit, debit, via Paypal link):

Go to our website <https://www.pany.org/reduced-fee-treatment-application>

Click "Pay Now" and follow the instructions indicated on the PayPal website.

### Pay by check or money order:

- We are unable to accept checks or money orders at this time.

## AFTER WE RECEIVE YOUR APPLICATION & PAYMENT:

Once we receive your application and payment, a member of our faculty will review your application and refer you to a member of our Institute for an initial consultation. If we feel we need additional information before making a treatment referral, the initial contact may be by phone.

This process should take 1-2 weeks from the time we receive your application and payment. Please understand that it may not always be possible for us to offer you services *through our Institute*. If this is the case, it is not a reflection of your ability to be helped by treatment, and we will make every effort to provide you with a suitable referral that best meets your needs.

Also note that we are not set up to provide immediate care. **If you need treatment urgently please go to the nearest emergency room or the nearest hospital outpatient facility.**

## APPLICATION FOR CONSULTATION & TREATMENT SERVICE

Date of Application:

**Are you a COVID-19 Healthcare Responder?**

### PERSONAL INFORMATION

First Name:

Last Name:

Date of Birth:

Gender:

Place of Birth:

Pronouns:

(i.e. She/her/hers, He/him/his, They/them/theirs, etc.)

Address:

City/State/Zip:

Home Telephone:

Work Telephone:

Cell:

Preferred number for us to reach you:

Email:

Is it ok to receive mail from us pertaining to your application/treatment at the email and address listed above? (check one)    **Yes**     **No**

Occupation:

Business or School:

Marital Status:

Number of Children:

### SYMPTOMS OR PROBLEMS

Briefly describe the symptoms or problems that have led to your interest in treatment.

**BACKGROUND AND HISTORY**

Please write a short autobiographical sketch.

If you have had any previous psychiatric, psychotherapeutic, or psychoanalytic treatment please indicate the names of the treating physicians or therapists, the length of time you were seen and the frequency of visits. Include name, when treatment occurred, length of time and frequency of visits.

Medical History: List any important illnesses, medications, surgery, or accidents, including childhood illnesses. Include dates.

The information requested below about fee, scheduling, and location will help us match you to a therapist, subject to availability.

## LOCATION

Psychoanalysis and psychotherapy can often be offered in Manhattan, Brooklyn, Long Island, and Westchester, at the private offices of the treating clinicians. Whenever possible we will try to match you to a therapist in terms of location.

Please indicate preferred locality:

What areas would *not* be possible for you?

## SCHEDULING

Please indicate the times you are available for treatment on each day:

Mon:

Tues:

Wed:

Thurs:

Fri:

Sat:

## FEES & INSURANCE

Per session fees will be jointly determined by you and your therapist based on your income, insurance and other resources. Fees for psychoanalysis, due to its higher frequency of sessions per week, may in some instances, be less. Please note that we do not accept Medicare or Medicaid.

Are you currently employed?  Yes  No

What is your monthly income (before taxes)?

Do you currently have savings?

If so how much?

Do you have other means of support (e.g. Family)?

Do you have mental health coverage through an insurance program?  Yes  No

If yes, with what insurance program?

If you have **out of network** mental health insurance, please call your insurance company to obtain the terms of your coverage and list them in the spaces provided below:

## TERMS OF OUT OF NETWORK COVERAGE

Annual out of network deductible:

Percentage of fee covered:

Annual out of network maximum:

Number of sessions covered:

Additional comments:

**How did you hear about the Consultation and Treatment Service?**

<input type="checkbox"/> Referred by doctor:		
<input type="checkbox"/> Referred by hospital or clinic:		
<input type="checkbox"/> Referred by friend/family	<input type="checkbox"/> PANY advertising	<input type="checkbox"/> NYU Langone Health
<input type="checkbox"/> Internet Search	<input type="checkbox"/> By mail	
<input type="checkbox"/> Google Sponsored Links	<input type="checkbox"/> NYU Counseling & Behavioral Services	
<input type="checkbox"/> Other:		<input type="checkbox"/> Don't Recall

**CONSENT FORM**

I understand and agree that information derived from my consultation and treatment under the auspices of Psychoanalytic Association of New York (PANY) Consultation and Treatment Service, with appropriate concealment of my identity, may be shared for educational purposes within the Psychoanalytic Association of New York.

I understand that application to the Consultation and Treatment Service does not guarantee treatment by a member of the Institute. Acceptance for psychotherapy or psychoanalysis is subject to the educational criteria of PANY as well as therapist or analyst availability.

I understand that the Psychoanalytic Association of New York will arrange a referral for consultation with a private practitioner who is presently a training candidate at this Institute. The referral process will be supervised by a PANY faculty member. This consultation may result in a recommendation for treatment with a PANY training candidate, which may or may not be supervised. PANY is acting as a referral source and makes no representation with regard to the outcome of my psychotherapy or psychoanalysis. I will be seen in the private office of the training candidate, who will be responsible for my treatment.

I understand that the electronic submission by email is equivalent to my signature.

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<b>Signature</b> Please type in your name if you submit by email.	<b>Date</b>
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