PANY Faculty Referral Service

Psychoanalytic Association of New York

One Park Avenue, 8th Floor ▪ New York, NY ▪ 10016
Telephone: 646-754-4870 ▪ Confidential Fax: 646-574-9540
Email: nyu.pi@nyulangone.org

HOW TO SUBMIT YOUR APPLICATION:

Email: nyu.pi@nyulangone.org	**Fax: 646-754-9540**
Mail:	**Psychoanalytic Association of New York** **NYU Department of Psychiatry** **One Park Avenue, 8th Floor** **New York, NY 10016** *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 Faculty Referral Service, 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. NOTE: during the COVID-19 pandemic we are unable to accept applications by postal mail.

AFTER WE RECEIVE YOUR APPLICATION:

Once we receive your application, a member of our faculty will call you to discuss your interest in treatment.

This process should take 1-2 weeks from the time we receive your application. 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 FACULTY REFERRAL SERVICE

Date of Application:

Are you interested in treatment for yourself or someone else (please specify)?

PERSONAL INFORMATION

First Name:	Last Name:
Date of Birth:	Gender:

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

Address: City/State/Zip:	

Telephone (where we can leave a confidential message):

Phone type: (cell /work/home)

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

Occupation:	Marital Status:

Briefly describe your interest in psychoanalysis or psychodynamic psychotherapy (optional):

OTHER
Please let us know if you have any other specific requests for your treatment.
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 your desired 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
If you would like to see a therapist who is in your insurance network, please note what type of insurance you have:
Most PANY Faculty are considered out of network, in which case you pay fees (arranged privately between you and the therapist) directly to the therapist and then seek reimbursement from your insurance. Reimbursement is based on your specific insurance policy.

Additional comments:		
How did you hear about the PANY Faculty Referral Service?		
☐ Referred by doctor		
☐ Referred by hospital or clinic:		
☐ Referred by friend/family	☐ PANY advertising	☐ NYU Langone Health
☐ Internet Search	☐ By mail	
☐ Google Sponsored Links	☐ NYU Counseling & Behavioral Services	
☐ Other:		☐ Don't Recall
CONSENT FORM		

I understand that application to the Faculty Referral Service does not guarantee treatment by a member of the Institute.

I understand that the Psychoanalytic Association of New York 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 therapist, who will be responsible for my treatment.

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

Signature Please type in your name if you submit by email.	Date: