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IRONBRIDGE COUNSELING & WELLNESS ASSOCIATES

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID/Member# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Primary Care Physician

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Phone Fax

Dear Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In an effort to coordinate care, I want to inform you that your patient (named above) was seen by me on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for treatment of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current recommendations for the type and setting of treatment include:

( ) Individual Psychotherapy ( ) Outpatient

( ) Family Psychotherapy ( ) Intensive Outpatient Program

( ) Group Psychotherapy ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) Medication Therapy (listed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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( ) Other Pertinent communication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If you need any further information, please contact me at 9844 Lori Road, Suite 100, Chesterfield, VA 23832 or (804) 706-1111 Fax No. (804) 706-1185.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner’s Name Signature

**Release for Coordination with Primary Care Physician**

For the purpose of coordinating care, my behavioral healthcare practitioner may wish to release pertinent information about my current treatment to my primary care physician. I hereby authorize the use or disclosure of my individually identifiable health information. This release shall be to my primary care physician. I hereby authorize the use or disclosure of my individually identifiable health information. The release shall be valid until sixty (60) days after my last date of treatment or until the time I revoke this release, which can be done at any time.

**(Check One)** **I do \_\_\_\_\_\_\_\_\_ I do not \_\_\_\_\_\_\_**\_ give permission to the practitioner named above to exchange information about my treatment with my primary care physician.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient (Guardian) Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness Date

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IRONBRIDGE COUNSELING & WELLNESS ASSOCIATES

INFORMATION FORM

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male \_\_\_\_\_ Female\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Confirmation/Reminders will be e-mailed if e-mail address is provided.)

Home Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAYMENT INFORMATION: Who will be responsible for payment of this account?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip

TODAYS APPOINTMENT IS WITH (Check One):

**Amy E. Goodman, LPC \_\_\_\_\_\_\_ Kris Patterson, LRC\_\_\_\_\_\_\_**

**Maureen K. Leister, LPC\_\_\_\_\_\_ R. David Stitt, LPC \_\_\_\_\_\_\_**

**Teresa Mefford, LPC \_\_\_\_\_\_\_\_**

Whom may we thank for referring you here? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY INSURANCE CO:

Policyholder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_

Policyholder’s Address (If different from yours) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip

Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SECONDAY INSURANCE CO (If applicable):

Policyholder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_

Policyholder’s Address (If different from yours) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip

Insurance Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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ADULT INFORMATION

Marital Status: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

Check One Single Married Separated Divorced Widowed Child

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current or past illnesses, injuries, health problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Mental health treatment (therapy, hospitalizations, drug/alcohol rehab. etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Briefly describe why you are seeking counseling and what you hope to get out of it \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please place a check by any symptoms or problems that you are currently experiencing:

\_\_\_DEPRESSION \_\_\_ANXIETY \_\_\_SCHOOL/WORK PROBLEMS

\_\_\_INSOMNIA \_\_\_FEEL TENSE \_\_\_FINANCIAL PROBLEMS

\_\_\_NO APPETITE \_\_\_CONSTANT WORRYING \_\_\_LEGAL PROBLEMS

\_\_\_FATIGUE/LOW ENERGY \_\_\_PANIC ATTACKS \_\_\_MARITAL/FAMILY PROB.

\_\_\_IRRITABILITY \_\_\_EXCESSIVE FEARS \_\_\_PHYSICAL ABUSE

\_\_\_CAN’T MAKE DECISIONS \_\_\_WITHDRAWN \_\_\_EMOTIONAL ABUSE

\_\_\_LOW SELF ESTEEM \_\_\_EXCESSIVE GUILT \_\_\_SEXUAL ABUSE

\_\_\_MOOD SWINGS \_\_\_NIGHTMARES \_\_\_RECENT LOSS

\_\_\_ANGER PROBLEMS \_\_\_STOMACH PROBLEMS \_\_\_ALCOHOL ABUSE

\_\_\_INCREASED APPETITE \_\_\_MEMORY PROBLEMS \_\_\_DRUG ABUSE

\_\_\_SEXUAL PROBLEMS \_\_\_PAST SUICIDE ATTEMPTS \_\_\_OVERLY SUSPICIOUS

\_\_\_OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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IN CASE OF AN EMERGENCY NOTIFY?

1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Ironbridge Counseling and Wellness Associates or the therapist to provide treatment to me (or my dependent). I request that payment of authorized Medicare and other Insurance benefits be made on my behalf to the treating therapist. I authorize my treating therapist to release medical information necessary to process my claims. I agree to pay insurance Co-payments and any insurance deductible AT THE TIME SERVICE IS RENDERED. If my account is referred to a collection agency, I agree to pay all costs of collection and expenses including attorney or agency fees. In the case of divorced parents if the legally responsible party does not respond, the responsibility for the payment of fees falls to the parent who arranged the therapist’s services. If authorizations are required by my insurance, I agree that I must call my insurance company to obtain that authorization prior to or on the date of my initial appointment, otherwise, I accept responsibility for full payment. I agree that a photocopy of this form shall be considered as valid as the original. I acknowledge that I have received a copy of the General Policies of Ironbridge Counseling and Wellness Associates. I agree to the terms and conditions of these policies to include payment for missed appointments if 24-Hour cancellation notice is not given. (Please Note: Insurance Companies Do Not Pay Any Portion of Fees for Missed Appointments).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Responsible Party Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witnessed by Office Staff, Therapist Date

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**Ironbridge Counseling and Wellness**

**Associates**

**Acknowledgment of Receipt of Notice of Privacy Practices**

By my signature I, acknowledge

Client or Client's Representative//Guardian

that I have reviewed a copy of the Notice of Privacy Practices for Ironbridge Counseling and Wellness Associates.

Signature of Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If this acknowledgement is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name:

Relationship to Client:

Please list any persons and their phone numbers that we may contact in case of an emergency or to change your appointment tune. If there are any changes, please contact our office.

**For Office use Only**

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

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**OFFICE POLICIES**

**FEE Examples, which may vary**

Initial Evaluation (60 minutes) ……. $145 Telephone sessions……. $25 per 10 minutes

Psychotherapy (45 minutes………...$105 Letters or reports………. $50 minimum

Psychotherapy (25 minutes) ………. $65 Group Therapy………… VARIABLE

Missed Session/Late Cancel………. $60 Returned check fee……. $35

Court Appearance …………. $500 minimum for first 3 hours including preparation, travel & appearance

**PAYMENT**: All CO-PAYS are due on the date services are rendered. An additional 10% fee may be charged for billed CO-PAYS. If your insurance has a deductible, you are responsible for that portion of your payment. If you should choose to use your insurance, we will file the claim as a courtesy to you. A client information form containing billing and insurance information is completed at the time of your initial appointment. You are required to complete and sign a financial agreement with your therapist and sign a release, which allows us to bill and provide necessary clinical information to your insurance company to qualify for coverage. If you are not using insurance, payment in full is expected at the time of your appointment. Please be aware that you, not the insurance company, are ultimately responsible for payment of all charges.

**\*\*\*CANCELLATION POLICY**

**If you need to change your appointment, at least 24 hours’ notice is required, or you will be charged a $60 fee for the missed session. Monday appointments must be canceled no later than the previous Friday. Please Initial as Acknowledgement\_\_\_\_\_\_\_\_\_\_\_**

**RECORDS RELEASE**: According to the Virginia Code of Law $10.00 for search and retrieval, 0.50 per page up to 50 pages, and 0.25 thereafter plus postage and handling.

**CONFIDENTIALITY**: The information you discuss in therapy is strictly confidential and will not be shared with anyone without your written consent. There are some legal exceptions to this rule. Your therapist is legally bound to break confidentiality in cases where the client may be in danger of harming themselves or another person, a client is gravely disabled, there is suspicion of child or elder abuse, and by order of the court. The HIPAA Notice of Privacy Practices and Policies are provided for your review and explains in detail the ways in which your protected health information may be used and disclosed.

**EMERGENCIES**: Each therapist has emergency availability by phone 24 hours a day, 7 days a week. Discuss procedure and definition of emergency with your therapist. Call 911 for any life-threatening situation.

A new federal law commonly known as HIPAA requires that we take additional steps to keep you informed about how we may use information that is gathered. The Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. The Notice also describes your rights regarding health information we maintain about you and a brief description of how you may exercise these rights. By signing your client information form, you agree that you have read and understand our policies.

If you have any questions about the above policies, please discuss them with your therapist.