Virginia Clinical Therapy Center (VCTC) Intake Form

Client Intake Information: Adult

Name:_____Date: _____

Birth date:_____Age:_____Social Security Number: _____

Address:_____City, State:_____Zip: _____

Phone numbers Home: (_____)-_____Work: (_____)_____- _____

Cell: (_____)_____-_____Email Address_____@_____

Employer: _____

Position:_____For how long?_____Education: _____

Marital status: _ Significant other's name: _ Age:_____Sex:_____Years together: _____

Names and ages of all individuals in the home: _____

Who referred you to VCTC?_____

Who shall we contact in case of emergency?_____Relationship_____(_____)_____- _____

If you do *not* want us to leave a message on your answering machine, please tell us how you want us to reach you:

_____I

Why are you seeking counseling at this time?

_____

_____

Insurance Information

Policy Holder's Name:_____Policy Holder's SSN: DOB: _____

Relationship to Client_____Name of Plan:_____Type of Insuranace_____

Deductible: $_____Has it been met? YES/ NO Copayment (Your portion of each visit) $_____

Who will pay noninsured balance? _____

If you are required to get preauthorization, have you done so?_____# visits authorized: _____

Additional Insurance

Spouse's Insurance (if any): Name of Plan:_____Type of Insurance _____

Spouse's DOB:_____Contract #:_____Group #: _____

Deductible: $_____Has it been met?_____Copayment (Your portion of each visit) $_____

On this line, please indicate the address and telephone number you want us to use to when sending bills or when we need to contact you. If this box is left blank, we will use the address you have provided above.

All clients using health insurance please sign below.

I hereby grant authorization to Virginia Clinical Therapy Center, to release any Protected Health Information that is necessary for billing (except Psychotherapy Notes) to my insurance company, or to process my claim for payment of services. I authorize my insurance company to send payment directly to VCTC for all services provided. I agree that a photocopy of this authorization shall be as valid as the original.

_____ _____

Signature Date

Name:_____Date: _____

List any allergies you have:_____None

Primary Care Physician:_____Phone number: (____) _____

Address: _____

Approximate date of your most recent physical examination: _____

List all current medications and dosages, including supplements:

Name of Medication	**Reason Taking Medication**	**Dosage**	**Prescribing Doctor**	**Date Started**

List all current or past health problems, and any major operations:

Health Problem or Surgery	**Date**	**Currently a problem?**	**Doctor**

List all therapists you have seen, and dates you saw them:

Therapist and location	**Approximate Dates Seen**

List any substance abuse treatment or inpatient psychiatric treatment and dates:

Name of Substance Abuse Program or Psychiatric Hospitalization	**Dates**	**Inpatient/ Outpatient**

Name:_____Date: _____

Name:_____Date: _____

Please indicate if you are currently, or have in the past, experienced any of the following:

Problem	Current	Past Year	More than 1 year ago	Problem	Current	Past Year	More than 1 year ago
Depression				**Anxiety**			
Shortness of breath				Avoid Public Places			
Chronic Sadness				Trembling/Shaking			
Low frustration level				Agitation			
Crying Episodes				Fear of Dying			
Irritability				Panic Attacks			
Hopelessness				Chest Pain			
Thoughts of Suicide				Fearfulness			
Difficulty concentrating				Avoid social situations			
Withdrawing from Others				Fear of leaving home			
Weight Loss				Restlessness			
Difficulty functioning at work				Fear of loss of Control			
Weight gain				Excessive Worry			
Difficulty functioning socially				**Attention**			
Loss of appetite				Difficulty Waiting			
Low energy/fatigue				Don't finish what you start			
Over eating				Racing thoughts			
Reduced interest/pleasure				Constantly moving/pacing			
Nausea/Vomiting				Taking on too much at once			
Feelings of worthlessness/guilt				Difficulty starting a new task			
Difficulty making decisions				Difficulty concentrating			
No interest in daily activities				Difficulty Organizing			
Recurring thoughts of death or dying				Impulsive			
Sleeping too little/too much				Forgetfulness			
Extreme lows/highs				Difficulty following Directions			
Pounding heart/palpitations				**Substance Abuse**			
Difficulty Falling Asleep				Substance use causing problems with friends/family/work			
Eating Problems				Health problems/accidents due to substance use			
Worry about being underweight				Others think I have a substance problem			
Worry about being overweight				Adult child of an alcoholic parent			
Self-induced vomiting				Excessive use of alcohol/drugs			
Laxative use				Fail at effort to reduce use of alcohol/drugs			
Extreme exercising				Use of substances to cope with			
Obsessed with food				Legal problems related to substance use			
Obsessed with weight				Cigarette use causing health problems			
Other Problems not listed:				**Other Problems not listed:**			

Problem	Current	Past Year	More than 1 year ago	Problem	Current	Past Year	More than 1 year ago
Stress/Trauma				**Other Problem Areas**			
Feeling detached from others/life				Grief/Loss			
Flashbacks/reliving bad experiences				Excessive gambling			
Intrusive thoughts or bad memories				Parent-child relationship issues			
Easily startled/upset				Financial concerns			
Nightmares				High risk sexual behavior			
Difficulty concentrating				**Thinking Problems**			
Feeling tense				Hearing voices/seeing things others do not			
Hyper-vigilance				Fearful others are talking about you			
Self-abuse/cutting				Fearful someone is plotting against you			
				Feelings of being followed/stalked			

Personal Drinking Patterns

	Number	Prefer to Discuss in Person
Number of days of the week you drink		
Number of drinks per day you consume		
Total number of drinks per week you consume		
Number of times in the last two weeks you had four or more drinks at a sitting		
Number of times in the last two weeks you had five or more drinks at a sitting		
Number of times in the past 30 days when you drank enough to get drunk		
Approximate number of times each month you have used alcohol in the past year		

Other Drug Use in Past 12 Months

Other Drugs Names:	Several times per day, most days	Several times per day, weekends	1-2 times _____ per week, _____ so	1-2 times _____ per week, _____ mos	3-4 times _____ per week, _____ so	3-4 times _____ per week, _____ mos	More _____ than 5 _____ ti	Prefer to Discuss in Person

ADDITIONAL INFORMATION

Be prepared to describe your problem to your therapist providing as much information as you can including how long the problem has been present.

- Circumstances that may have led up to the problem.
- Information about your family of origin and early years in life.
- Information about any trauma or abuse you may have suffered.
- Whether you have sought counseling or therapy prior to this and the outcome of that therapy.
- Things you have tried to help the problem so far, what worked, and what did not work.
- Your strengths and positive attributes.
- Your support network.
- Who is involved in your problem at the present or in the past.
- Specific questions you have for your therapist about your problem.

Virginia Clinical Therapy Center Practice Policies

This form has two purposes. First, it tells you about our procedures and policies concerning important aspects of your psychotherapy. Please let me know if you have concerns about any of these policies. Your first visit will help us get a general understanding of your situation in order to determine how we might best help you. Because I want you to participate actively in planning your counseling, don't hesitate to ask questions.

Psychotherapy is a way of talking through your problems in order to begin resolving them. You will need to take an active part in psychotherapy by working on and thinking about the things you talk about with your therapist. Psychotherapy has been shown to have many benefits; it can lead to better relationships, solutions to specific problems, and feeling much less distressed. However, there are no guarantees of what you will experience, and at times a psychotherapy session may leave you with unhappy feelings.

Second, this form is an Agreement between you and Virginia Clinical Therapy Center. You may revoke (cancel) this agreement in writing at any time. That revocation will be binding on Virginia Clinical Therapy Center unless we have already relied on this agreement to take action, *or* if your health insurer requires Virginia Clinical Therapy Center to send information needed in order to process claims made for our services, *or* if you have not paid your bill in full.

APPOINTMENTS

Individual and family sessions last 45-50 minutes and can be scheduled through the secretary or your therapist. *If you cancel an appointment, please notify us at least 48 hours before the session, or you will be charged $50 for the time you reserved for the appointment. Insurance does not pay charges for reserved time; you will personally be responsible for any such charges.* However, if you call in advance to cancel an appointment or cancel because you are ill, there will be no charge.

Please initial and date : _____Date:___/_____/_____

TELEPHONE CALLS

Please try to contact me via telephone during normal business hours, Monday through Friday, 9-5. Lengthy telephone consultations may be billed at our standard hourly rate for professional service. ***In emergencies, you may contact your clinician at the number he provides for you****. An emergency is generally a situation in which you are in danger of hurting yourself or someone else. If the emergency is serious and you cannot wait until I can return your call, please call 911 or the Fairfax County 24-hour mental health emergency number, 703-573-5679, or go to the nearest hospital emergency room.*

FEES, HEALTH INSURANCE, AND MANAGED CARE

This packet contains a separate page to clarify fee arrangements. I am always happy to answer any questions and make payment arrangements. If an account is overdue and no provision for payment has been made, we may turn the account over to a collection agency or lawyer and your failure to pay will show up on your credit history.

Please initial and date :_____Date:____/___/_ __

Most group health insurance plans cover *part* of our fee. Insurance claims require a diagnosis, which your therapist will discuss with you. There may be two kinds of noninsured costs to you: (1) a deductible, which is an amount you must pay before your insurance coverage begins to pay; and (2) a copayment, which is a portion of the fee for each visit that you must pay yourself. **Please note that deductibles and copayments are due at the time of each visit**. Virginia Clinical Therapy Center has contracted with some insurance companies to accept less than our standard fee as payment in full. If this is the case, your account balance will be adjusted when we receive payment from the insurance company. However, if the insurance pays less than 100% of the contracted fee, you will owe the balance of the fee up to 100% of the contracted fee. If your insurance is a managed care plan, the insurance company periodically requires that I submit your diagnosis, progress, and treatment plan to their reviewer, who then determines if further treatment is medically necessary. We want you to know that if you have a managed care insurance plan, this information will be released to the reviewers.

HIPAA: Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law

- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date of this Notice: 3/01/2016

_____

Client or responsible party Witness Date

Virginia Clinical Therapy Center Counseling Services
Fee Agreement

1. ***FEE:*** The fee for an initial consultation is $120.00. After that, your fee will be $100.00 per 45-50 minute session. Although health insurance may aid in payment, you are responsible for paying for all services and appointments at Virginia Clinical Therapy Center. ***If you cancel or do not keep an appointment without giving forty-eight hours' advance notice, you must pay for the time you have reserved***. Insurance companies do not pay for canceled appointments. If you are ill and call in advance to cancel your appointment, there will be no charge.

Please initial here _____

Report writing, hospital visits, consultation with other professionals, home visits, telephone counseling, school meetings and any court-related services (such as consultations with lawyers, depositions, or attendance at courtroom proceedings) are **not** covered by insurance. My fee for ***these*** *services is* **$130 per hour**, including travel time to other locations. These services may require payment in advance. Please inform me in advance if you anticipate that you will require my services in a court or school proceeding.

Please initial here _____

If Virginia Clinical Therapy Center has contracted with your insurance company to accept a lower fee, your deductible and any noninsured portion of each session's fee will be based on that contracted amount. If the insurance company decides to increase the fee that Virginia Clinical Therapy Center is allowed to charge, your deductible and any noninsured portion of each session's fee will be based on the increased amount. Sometimes managed care companies will authorize more sessions than your insurance benefits will pay for. If you see your therapist for visits *that are authorized* but not paid for by your insurance benefits, by signing this form you agree to pay Virginia Clinical Therapy Center's fee, as listed above, for each authorized visit that is not covered by your insurance benefits.

If your insurance company requires you to get authorization from them before seeing a therapist and you do not do so, you are responsible for payment in full of the fees listed above.

2. ***PAYMENT ARRANGEMENT***:
All accounts are payable in full within 30 days after billing. Overdue accounts may be charged interest at the rate of 10% per year.
_____STANDARD PAYMENT ARRANGEMENT: Payment for any deductible or noninsured portion of your fee is due at the time of each session.
_____ALTERNATIVE PAYMENT ARRANGEMENT: _____
_____

3. ***COLLECTIONS PROCEDURES***: Virginia Clinical Therapy Center reserves the right to collect any unpaid balance due to them. If a client is not making regular monthly payments on the account balance, Virginia Clinical Therapy Center may use a collection agency or take legal action to secure payment, as authorized by state or federal law, and the collections action will become a part of your credit record. Clients will be notified in writing before Virginia Clinical Therapy Center takes action to collect.

4. ***LIMIT ON UNPAID BALANCE:*** Virginia Clinical Therapy Center may terminate treatment and refer the client elsewhere for continued care if the unpaid balance exceeds $300.00.

I have read and understood the above fee agreement, and I agree to abide by its terms.

_____ _____ _____
Printed Name Signature Date