Family Counseling of Springfield

Client Intake Information: Adolescent

Name: _____Social Security Number: _____-_____-_____Date: _____

Birth date: ___/___/___ Age: ____ Adopted: Yes/No Country: _____Placement age: _____

School Name _____ Grade _____ Counselor _____

Telephone number: (_____) ____ - _____ I**EP**---Yes /No **504 Plan**---Yes /No **OHI**---Yes /No

Area of Disability: ❒ Emotional ❒ Physical ❒ Learning ❒ Processing Problems: (please list)

_____

If parents are **separated or divorced**, who has **legal** custody? _____

Physical custody arrangements: _____

Mother's Name: _____DOB: _____Address: _____

City, State: _____Zip: _____ Email Address _____@_____

Phone: Home: (____) ____ - _____ Work: (___)____ -_____Cell: (____) _____ - _____

Mother's employer: _____ Position: _____For how long?_____

Education: _____Work days and hours: _____

Names and ages of all individuals in mother's home: _____

_____

Father's Name: _____DOB:_____ Address: _____

City, State: _____Zip: _____ Email Address _____@_____

Phone: Home: (____) ____ - _____ Work: (___)____ -_____Cell: (____) _____ - _____

Father's employer: _____ Position: _____For how long?_____

Education: _____Work days and hours: _____

Names and ages of all individuals in father's home: _____

_____

Has your child been involved with the legal system? Yes / No Charge: _____

If yes, name of Probation Officer _____ Phone number _____

Suspended or expelled from school? Yes/ No Reason: _____

Why are you seeking counseling for your child at this time?

_____

_____

If the client is younger than 18, parent or legal guardian please sign below

I hereby consent for Family Counseling of Springfield Counseling Services, Inc., to provide diagnosis, treatment and evaluation to _____ .
(name of child)

_____ _____ _____ _____
Signature of parent Date Signature of parent Date

Name: _____ Date: _____

Insurance Information

Policy Holder's Name: _____ DOB: _____
Policy Holder's SSN: _____ Relationship to Client _____
Deductible: $_____ Has it been met? _____
Copayment (amount *not* covered by your insurance for 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: _____
Spouse's DOB: _____ Contract #: _____ Group #: _____
Other Insurance Type: _____
Deductible: $_____ Has it been met? _____
Copayment (amount *not* covered by your insurance for each visit): $_____

All clients using health insurance please sign below; parent must sign if client is under 18
I hereby grant authorization to Family Counseling of Springfield, 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 Family Counseling of Springfield for all services provided. I agree that a photocopy of this authorization shall be as valid as the original.

_____ _____
Signature Date

Primary Care Physician: _____Phone number _____
Date of child's most recent physical examination: _____ List any allergies: _____

List all current medications and dosages including vitamins and supplements:

Name of Medication	**Reason Taking Medication**	**Dosage**	**Prescribing Doctor**	**Approximate date prescribed**

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

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

List all therapists your child has 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	**Approximate Dates**	**Inpatient/ Outpatient**

Name: _____ Date: _____

TO BE COMPLETED IN PRIVATE BY TEEN: 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			

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, some weeks	1-2 times per week, most weeks	3-4 times per week, some weeks	3-4 times per week, most weeks	More than 5 times per week	Prefer to Discuss in Person

ADDITIONAL INFORMATION

Be prepared to describe your problem to your therapist providing as much information as you can. 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.

Family Counseling of Springfield 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 I may 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 me. 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 Family Counseling of Springfield. You may revoke (cancel) this Agreement in writing at any time. That revocation will be binding on Family Counseling of Springfield unless we have already relied on this agreement to take action, *or* if your health insurer requires Family Counseling of Springfield to send information needed 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 Joan. *If you cancel an appointment, please notify us at least 48 business hours before the session, or you will be charged $50 for the time you reserved for the appointment. Insurance will not reimburse for reserved time; you will personally be responsible for any such charges.* However, if you call 48 hours in advance to cancel an appointment or cancel because of an emergency, 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 Joan at 703-447-4007****. 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 information regarding fee arrangements. I am always happy to answer any questions and make payment arrangements. For problems involving payments and insurance please call Karen, our counseling benefits coordinator, at 703-569-1300 Monday through Friday between 10 am and 6 pm. 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: ___/___/___

I am not an in-network provider for any managed care insurance plans; however our office is willing to submit your claims so that you can get reimbursed if you have out of network benefits. I highly recommend that you contact your insurance company and find out what they will pay for mental health services for a non-participating provider.

Unfortunately managed care will not send checks to the provider, only to the insured, therefore **all fees are due and payable at the time of service.** If you do not receive reimbursement, please contact **Karen, my admin assistant, at 703-569-1300, Monday-Friday between 11am and 7pm.**

HIPAA NOTICE OF PRIVACY PRACTICES

CONFIDENTIALITY AND FILES

This form contains information about a new federal law that affects your privacy rights. This law, called HIPAA (Health Insurance Portability and Accountability Act) regulates the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. HIPAA requires that we give you a Notice of Privacy Practices . The Notice explains HIPAA's application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Please read and sign this notice; I will be happy to discuss any questions you may have about it.

I will maintain a Clinical Record file on your case, which is the property of Family Counseling of Springfield. You may examine and/or receive a copy of your file *if* you request it in writing *and* the request is signed by you *and* dated not more than 60 days from the date it is submitted. There may be a charge for writing reports or for copying materials.

In most situations, Family Counseling of Springfield can release information about your treatment to others *only* if you sign a written authorization form for each release. However, in other situations, Family Counseling of Springfield needs only written, advance consent to release information. **Your signature on this agreement is written, advance consent for the following releases of information**:

• I participate in group supervision with other mental health professionals; if we discuss your case, it is done without revealing your identity. The other professionals are also legally bound to keep the information confidential and I will note all consultations in your Clinical Record. Please let me know if you would prefer that other clinical staff *not* be consulted about your case. I also employ secretarial staff. In most cases, your therapist needs to share information with them for purposes such as billing, scheduling, and quality assurance. All of our staff are bound by the same rules of confidentiality, and all secretarial staff have training in privacy rules and have agreed not to release any information outside of the practice without permission of a professional staff member.

• I may find it helpful to share information with your primary care physician or other health and mental health professionals who are currently treating you. When working with children and adolescents, I am often asked to share information with the school in order to help them provide appropriate education and accommodations for your child. If we determine it would be helpful I will ask you to complete and sign a "Permission to Exchange Information" form, listing the individuals and/or organizations with whom I may exchange information. You may rescind this permission at any time. A record of these disclosures will be kept in your Clinical Record.

• Family Counseling of Springfield uses a benefits coordinator who will help ascertain your insurance benefits. As required by HIPAA, she promises to maintain the confidentiality of protected health information except as required to file your insurance claims.

There are some situations where Family Counseling of Springfield is permitted or required to use or disclose information *without* either your consent or authorization:

• If a client is clearly likely to seriously harm him/herself, we may be required to take action to prevent self-destruction.

• If there is a clear risk that a client plans to seriously harm another person, we may have a duty to warn the potential victim; or disclose the risk to appropriate public authorities.

• If a therapist suspects that abuse of a child or senior citizen may have taken place, the therapist is required to report the suspected abuse to the Department of Child or Adult Protective Services.

• If the client is a minor, both parents have access to the minor client's complete Clinical Record, including Psychotherapy Notes, unless there is a court order prohibiting one of the parents from access. In the case of adolescents I will ask that you sign a form giving the right to confidentiality to the adolescent.

• If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by the therapist/client privilege law. Family Counseling of Springfield cannot provide any information without your (or your personal or legal representative's) written authorization. However, if a court orders Family Counseling of Springfield to disclose information, I am required to provide it. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

• If a government agency (such as Medicare) is requesting the information for health oversight activities, Family Counseling of Springfield may be required to provide it for them.

• If a client files a complaint or lawsuit against Family Counseling of Springfield or any of its staff, Family Counseling of Springfield may disclose relevant information regarding that patient in order to defend itself.

• If a client files a worker's compensation claim, the client must sign an authorization so that Family Counseling of Springfield may release the information, records or reports relevant to the claim.

• Family Counseling of Springfield staff may present disguised case material in seminars, classes, or scientific writings; in this situation, all identifying information and Protected Health Information is removed, and client confidentiality and anonymity is maintained.

• Your health insurance plan has the right to review your Clinical Records for any services you have asked them to pay for. Unless your treatment is being paid for by a Workers Compensation plan, a health insurance company is *not* entitled to see Psychotherapy Notes, which are detailed notes your therapist may make concerning what you have talked about in therapy. However, they *are* entitled to see other Protected Health Information in your clinical record, including information about dates of therapy, symptoms, your diagnosis, your overall progress towards those goals, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS, AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE OF PRIVACY PRACTICES INCLUDED ABOVE.

_____ _____ _____

Client or responsible party Witness Date

Family Counseling of Springfield Counseling Services
Fee Agreement

1. ***FEE:*** The fee for an initial consultation is $135.00. 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 Family Counseling of Springfield. ***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*** _____

Psychological testing, 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 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.
Please initial here _____

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***: Family Counseling of Springfield LLC reserves the right to collect any unpaid balance due to them. If a client is not making regular monthly payments on the account balance, Family Counseling of Springfield 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 Family Counseling of Springfield takes action to collect.

4. ***LIMIT ON UNPAID BALANCE:*** Family Counseling of Springfield 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