FAMILY LIVING INSTITUTE

1307 Jamestown Rd. Suite 202
Williamsburg VA, 23185

Phone: 757-229-7927
Fax: 757-253-8891

DEMOGRAPHIC INFORMATION

THERAPIST: _____

DATE OPENED: _____

CLIENT: _____
Mailing Address: _____
Street Address: _____
City/State: _____ Zip: _____
DOB: _____ SSN: _____
Employer/School: _____
Phone: (Cell) _____ (Home) _____
E-mail: _____

SPOUSE: _____
Mailing Street: _____
Street Address: _____
City/State: _____ Zip: _____
DOB: _____ SSN: _____
Employer/School: _____
Phone: (Cell) _____ (Home) _____

If client is a dependent, please provide the following information:

PARENT/GUARDIAN: _____
Mailing Address: _____
Street Address: _____
City/State: _____ Zip: _____
DOB: _____ SSN: _____
Employer/School: _____
Phone: (Cell) _____ (Home) _____
E-mail: _____

PARENT/GUARDIAN: _____
Mailing Address: _____
Street Address: _____
City/State: _____ Zip: _____
DOB: _____ SSN: _____
Employer/School: _____
Phone: (Cell): _____ (Home) _____
E-Mail: _____

Emergency Contact: _____ Phone number: _____

Referred By: _____ Client's Doctor: _____

Other residents of household	Relationship to client	DOB	Grade School/ Occupation

INSURANCE INFORMATION

Primary Insurance: _____ Insured's Name: _____
Secondary Insurance: _____ Insured's Name: _____

We will be making a copy of your insurance card(s) or military ID. Please provide us with any important information not on your card. Please note that if you have a change in your insurance coverage, it is your responsibility to advise us of this change immediately for billing purposes; otherwise, you will be responsible for the payment of services.

Revised 10/24/2017

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SERVICE AND FINANCIAL POLICY STATEMENT

Name: _____ **PROVIDER:** _____

Business Office Hours: Monday- Thursday 9:00am - 6:00pm
Friday 12pm – 5:00pm.

24-Hour Answering Services:
757-229-7927

Insurance Benefits: Every effort will be made to work with you and your insurance company(s), but remember your insurance policy is a contract between you and your insurance company and your therapist. If for any reason your insurance policy does not cover the service, or IF YOU FAIL TO ADVISE US OF ANY CHANGE IN YOUR INSURANCE COVERAGE, you are responsible for the remaining balance.

PLEASE CHECK ONE OF THE FOLLOWING OPTIONS:

☐ have **NO** insurance coverage. I will pay fully the day of my appointment or complete a payment agreement with my therapist.

☐ FLI will submit claims to my insurance carrier, and I authorize the insurance payments to be paid directly to FLI. I will pay my deductible and/ or co payment at the time of my appointment. I will provide FLI with completed insurance forms if needed. It is my responsibility to negotiate with my insurance carrier if incorrect payment is made to FLI and the balance in question is my responsibility.

☐ I will submit my own insurance claims and have the insurance payments made directly to me. I will pay fully the day of my appointment.

FEES FOR PROFESSIONAL SERVICES

Services	Length	LPC-INS	M.D. INS	Cash - LPC	Cash M.D.
Initial Diagnostic Assessment	45-60 min	$195.00	N/A	$130.00	N/A
Individual, Marital, or Family Psychotherapy	45-60 min 30 min	$165.00 $95.00	N/A	$130.00 $95.00	N/A
Initial Psychiatric Evaluation	45-60 min	N/A	$300.00	N/A	$250.00
Psychiatric Medication Management	15-20 min 21-40 min	N/A	$200.00 $400.00	N/A	$150.00 $250.00
Letters, Reports, and Lengthy Phone Calls	Per 30 mins	$95.00	N/A	N/A	N/A

*Other services based on the individual provider's fee schedule.

Appointment Policy: Please tell the receptionist when you arrive for your appointment. Therapy appointments are scheduled to reserve time for you in a predictable manner. **MISSED** or **CANCELED** appointments will be charged a fee $35 or above per visit, unless a 24 HOUR NOTICE is given. Insurance carriers do NOT cover missed or canceled appointments. **Initial**_____

Balances 60 days past due which are not fully paid within 30 days after completion of therapy will be subject to a 1.5% per month service charge. If the bill is not paid, collection expenses, court costs, and attorney's fees (up to 45%) will be your responsibility and added to your bill. If you have concerns about this policy, discuss them with your therapist in your first session. The parent who brings the child in will be sent the bill and is responsible for the payment; we do not bill other parties such as young adults, or non-custodial parents.

I HAVE READ THIS SERVICE AND FINANCIAL POLICY STATEMENT AND UNDERSTAND ITS CONTENTS AND AGREE TO THE TERMS STATED I PERSONALLY GUARANTEE PAYMENT OF THIS ACCOUNT

Name: _____ Signature: _____ Date: _____

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INSURANCE POLICY AND ASSIGNMENT OF BENEFITS

CLIENT NAME: _____ **THERAPIST:** _____

Please Read and sign below:

I will pay my deductible and/or co-payment at the time of my appointment or complete a payment agreement with my therapist.

I authorize insurance payments to be paid directly to Family Living Institute, and I authorize the release of any treatment information necessary to process claims.

I further understand that Family Living Institute checks on benefits, and files insurance as a courtesy. It is my responsibility to know my policy, any authorization requirements, and to verify the benefits for this type of service.

I hereby acknowledge that is my responsibility to advise Family Living Institute of any insurance coverage changes immediately or accept responsibility for payment of services rendered.

By signing below, I acknowledge that my insurance policy is a contract between me, my insurance company, and my therapist; and it is not a contract between Family Living Institute and my insurance company. If for any reason my insurance company does not pay as expected, I am responsible for the remaining balance.

_____ _____ _____

Print Clients Name Signature Date

_____

Parent/ Guardian Signature
(If required by patient's age or condition)

For any managed care program: Did you get pre-authorization: ☐ Yes ☐ No

Please give your insurance card to the receptionist to photocopy. If **MEDICAID, SENTARA, FAMILY CARE, OR HEALTHKEEPERS PLUS,** please remember to give us your card each month to make a copy. Complete this portion with any information that is not on your card.

	Primary Insurance	Secondary Insurance
Insurance Company:		
Insurance Phone #:		
Subscriber:		
Subscriber #:		
Group/Emp:		

Revised 10/19/2017

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PRIMARY CARE PHYSICIAN (PCP) NOTIFICATION

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state federal regulations. I also understand that I may revoke my consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, _____ _____ hereby authorize Family Living Institute to
Patient Name DOB

☐ Please do not release information to the patient's primary care physician (PCP)

☐ Exchange information listed below with the patient's primary care physician (PCP)

Primary Care Physician's name: _____

Telephone Number: _____ Fax Number: _____

_____ _____
Patient or Guardian Signature Date

_____
Print Guardian Name

Please Do Not Write Below Line

Dear Dr. _____, the patient/family above was recently seen in this office. I trust the following will be helpful in coordinating this patient's care. I'll contact you in the future if there is additional information to share.

Patient Name: _____ Date of Consultation: _____

Provisional Diagnosis: _____

Presenting Problem: _____

_____

Treatment Recommendations/Plan/ Follow-up: _____

_____

_____

Medications: _____

Provider: _____

Signature: _____ Date: _____

Revised 11/01/2017

FAMILY LIVING
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Psychiatric and Counseling Services

757.229.7927

HIPPA NOTICE OF PRIVACY PRACTICES

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.

Family Living Institute has been and will always be totally committed to maintaining clients' confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the psychiatric profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services
Providing treatment services, collecting payment and conducting operations are necessary activities for quality care. State and federal laws allow us to use and disclose your healthcare information for these purposes, even without your specific authorization.

TREATMENT We may need to disclose health information about you to provide, manage, or coordinate your care with other healthcare professionals involved in your care.

PAYMENT Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes.

HEALTHCARE OPERATIONS We may need to use information about you to review our treatment procedures and business activity.

Other uses or disclosures of your information do not require your consent. There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: 1) information about physical or sexual abuse of a minor, 2) if you provide information that you are in imminent and credible danger of harming yourself or others, 3) information to remind you of/or to reschedule appointments, 4) information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order, 5) information about treatment of a minor if requested by a non-custodial parent.

CLIENTS'RIGHTS

Right to request how we contact you

It is our normal practice to communicate with you about such matters as appointment reminders at your home address and daytime phone number you provided us when you scheduled your appointment. Sometimes, we may leave messages on your voice mail. You have the right to request that our office communicates with you in a different way. Please document preferences on the *Client Biographical Form* completed in your initial visit to Family Living Institute.

Rights to release your medical records

You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid if we have already acted in reliance to a previous authorization.

Right to inspect and copy your medical and billing records

You have the right to inspect and obtain a copy of the information contained in our medical records. To request access to your billing or health information, you must do so in writing to the office manager. Under limited circumstances, we may deny your request to inspect and copy the medical records. If you ask for a copy of any information, we may charge a reasonable fee for the cost of copying, mailing, and supplies.

Right to add information or amend your medical records

If you feel that information contained in your medical records is incorrect or incomplete, you may ask us to add information to amend the record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request. We will make a decision on your request within 90 days. Under certain circumstances, we may deny your request to add or amend information. If we deny your request, you have the right to file a statement that you disagree. Your statement and our response will be added to your record.

Right to an accounting of disclosure

You have the right to request an accounting of disclosures of releases we have made to others.

Right to request restrictions on uses and disclosures of your health information

You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request and we will tell you if we do not.

Right to complain

If you believe your privacy rights have been violated, please contact your individual provider or office manager personally and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health Services. An individual will not be retaliated against for filing such complaint.

Rights to receive changes in policy

You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.

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NOTICE OF PRIVACY RIGHTS AND CLIENT RIGHTS

I/We have received and read a copy of the Notice of Privacy Practices and Client Rights document and agree to abide by its terms during our professional relationship

_____ _____

Signature of Patient (If 16 or older) Date

_____

Print Name of Patient

_____ _____

Signature of Guardian or Representative
(If required due to patient's age or condition) Date

_____

Print Name of Guardian or Representative
(If required due to patient's age or condition)

_____ _____

Provider/Witness Signature Date