FAMILY FOCUS COUNSELING SERVICES, PC
INTAKE PACKET – ALL CLIENTS

170 West Shirley Avenue Suite 206 Warrenton, Virginia 20186	7350 Heritage Village Plaza Suite 102 Gainesville, Virginia 20155	767 Madison Road Suite 112 Culpeper, Virginia 22701

Patient Information

Date: _____

Name: _____

Address: _____ City: _____

State: _____ Zip: _____

Home Telephone Number: _____Work Telephone Number: _____

Cellular Telephone Number: _____ Which number is the best one to contact you?_____

May we call your work number if necessary? Y N

E-mail Address: _____

Birthdate: _____/_____/_____ Age: _____ Sex/Gender: _____ Single / Married / Separated / Divorced
Please circle one

Employment Information (If client is a minor, use parent's employment)

Client/Guardian Place _____ Phone _____

Insurance Information

Primary Insurance _____ Phone number of back of the card _____

Contract/ID Number _____ Group/Acct. Number _____

If TRICARE Insurance → Name of Primary Care Doctor and Telephone Number

_____ _____
Primary Care Doctor's Name Primary Care Doctor's Telephone Number

Subscriber's Name _____ Subscriber's Date of Birth _____ Relationship to the Client _____

Subscriber's Social Security Number: _____
Secondary Insurance _____Phone number of back of the card _____

Contract/ID Number _____ Group/Acct. Number _____

Subscriber's Name _____ Subscriber's Date of Birth _____ Relationship to the Client _____

Person responsible for payment: _____

I attest that I am the person responsible for payment on the abovementioned person's account.

X

Signature of Responsible Party: (*Must be signed for services to begin*)

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Consent for Release of Information

I, _____, authorize the communication of clinical information between Family Focus Counseling Services, P.C. and: (fill in all that apply)

		Telephone:
Primary care physician:	_____	(____)_____
Psychiatrist:	_____	(____)_____
Individual therapist:	_____	(____)_____
Family/couples therapist:	_____	(____)_____
Other ( ):	_____	(____)_____
Other ( ):	_____	(____)_____

Communication may include: direct verbal communication, clinical documentation (including inpatient and outpatient treatment notes), discharge summaries, testing results, and similar clinically relevant materials.

I understand that I may withdraw this consent at any time by submitting a request in writing to Family Focus Counseling Services, P.C. Please note that once the requested information is disclosed pursuant to this Authorization, Family Focus Counseling Services, P.C. will no longer have control over the information and there is a potential that it may be re-disclosed by the recipient and will no longer be protected by the privacy rules under the Health Insurance Portability and Accountability Act.

_____ _____
Signature of Client or Legal Representative Date Signed

_____ _____
Print Client Name Date of Birth

_____ _____
Print Name of Legal Representative Relationship to Client

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Financial Policy

The clinicians who house their practice at Family Focus Counseling Services, P.C. (hereafter referred to as the clinic) are committed to providing caring and professional mental health care to all of our clients. As part of the delivery of mental health services we have established a financial policy which provides payment policies and options to all consumers. The financial policy of the clinic is designed to clarify the payment policies as determined by the management of the clinic.

As a service to you, the clinic will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered, and it is not responsible for the collection of such payments. In some cases insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. We charge our clients the usual and customary rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The Person Responsible for Payments will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 120 days are subject to collections. A 5% per month interest rate is charged for accounts over 60 days.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g. if there were previous visits to another mental health provider since January of the current year that were prior to the first session at the clinic), this amount will be collected by the clinic until the deductible payment is verified to the clinic by the insurance company or third-party provider.

All insurance benefits will be assigned to this clinic (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

Clients are responsible for payments at the time of services. The adult accompanying a minor is responsible for payments for the child at the time of service. Unaccompanied minors will be denied non-emergency services unless charges have been pre-authorized to an approved credit plan, charge card, or payment at the time of services.

Missed appointment or cancellations, less than 24 hours prior to the appointment, are charged at a rate noted in the clinician's office policy. Payment methods include check, cash, or the following charge cards: VISA and/or MasterCard. Clients using charge cards may either use their card at each session or sign a document allowing the clinic to automatically submit charges to the charge card after each session.

Questions regarding the financial policies can be answered by your clinician.

I (we) have read, understand, and agree with the provisions of the Financial Policy.

_____ Date: ____/____/____

Person responsible for account

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Optional Credit Card Form

Type of Card (VISA or MasterCard) _____

Expiration Date: _____

Name as it appears on the Card: _____

Account number on the Card: _____

3 DIGIT CV Code: _____

Client's Name: _____

Amount Charged: $ _____

Card member acknowledges receipt of goods and/or services in the amount of the total shown hereon and agrees to perform the obligations set forth by the card member's agreement with the issuer. My signature, as found, grants permission to my counselor at Family Focus Counseling Services, P.C. for using the provided credit card information in order to pay for services rendered.

Signature of Cardholder: _____ Date: _____

Transaction completed by (please initial): _____

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NOTICE OF PRIVACY PRACTICES

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

Family Focus Counseling Services, P.C. has a duty to maintain privacy of your health information and to provide you with this notice. You will be asked to sign a Consent Form. Once you have signed the Consent Form, Family Focus may use or disclose your Protected Health Information for purposes of diagnosis, treatment, obtaining payment, or to conduct healthcare operations. For example, if you choose to use insurance, to receive payment Family Focus must provide information about you to your insurance company.

Other permitted and required uses and disclosures that may be made without your consent, authorization or opportunity to object:
Abuse or Neglect: If Family Focus suspects abuse or neglect of a child or elder, Family Focus is mandated to make a report to the appropriate public authorities.
Danger: If Family Focus suspects you are in imminent danger of harming yourself or someone else, Family Focus is mandated to make a report to the person at risk and to the public authorities.
Legal Proceedings: Family Focus may disclose Protected Health Information in response to a court order or subpoena or in certain other legal proceedings.

You have the following rights regarding health information I maintain about you:
Right to Inspect and Copy: You have the right to inspect and request copies of information that may be used to make decisions about your care. Usually this includes demographic and billing records but does not include psychotherapy notes. To inspect and/or receive copies of information, you must submit a request in writing. If you request a copy of information, Family Focus may charge a fee for the cost of copying, mailing or other supplies associated with your request. Family Focus must respond to your request within fifteen days of receipt.
Right to Amend: If you feel that health information about you is incorrect or incomplete, you may ask Family Focus to amend the information. You have the right to request an amendment for as long as the information is kept by Family Focus. Your request for amendment must be in writing and must provide reason supporting your request.
Right to an Accounting of Disclosures: You have the right to request an Accounting of Disclosures Family Focus has made of information about you. You must submit your request in writing to the above address. Your request must state a time period for the disclosures, which may not be longer than six years and may not include dates before April 14, 2010.
Right to Request Restriction on Uses and Disclosures: You may request that disclosure of confidential information be limited. If Family Focus is unable to agree to the restriction, Family Focus can discuss other options, such as referral to another counselor.
Right to Limit Reception of Confidential Information: For example, you may request that Family Focus contact you at a certain telephone number or address. You do not have to give a reason for your request.
Right to a paper copy of this Notice.

Other uses and disclosures of Protected Health Information and any disclosure of Psychotherapy Notes will be made only with your written authorization. After such authorization is given, you may revoke that authorization at any time. This Notice may be amended as needed to comply with Federal, State and professional requirements.

If you believe your privacy rights have been violated, please let Family Focus know either in writing or by talking with us. Such a complaint will not result in any retaliation by Family Focus. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

_____ _____
Signature of Client / Custodian Parent / Guardian Date

_____
Printed Name of Client

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Patient Notification

Welcome to the office of Family Focus Counseling Services, P.C. Your signature below indicates your understanding and agreement to the following important factors, as such affects your treatment.

The clinician that you are working with owns his/her own practice/business at Family Focus Counseling Services, P.C., rather than being an employee of Family Focus Counseling Services, P.C. Your therapist houses his/her clinical practice within the offices of Family Focus Counseling Services, P.C., whereby various administrative functions are provided to benefit the operation of that clinician's private practice and your case management. These functions require the sharing of your health information to effectively bill, administer, and seek payment for services received. Also, at times, and only in the form of peer consultation, other sharing of information may occur, in order to facilitate your treatment.

The treatment record that your therapist produces at Family Focus Counseling Services, P.C. remains in your clinician's physical property. In the event that your therapist moves his or her practice to a different location and you choose to continue therapy with that therapist, you authorize the transition of that file with the therapist.

Because Family Focus Counseling Services, P.C. is not the employer of your therapist, you agree not to hold liable and indemnify Family Focus Counseling Services, P.C. for any claim of malpractice or other form of legal action with respect to care received.

Signature: _____

Date: _____

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PRACTICES, POLICIES, AND PROCEDURES

This document outlines and explains the practices, policies, and procedures followed while receiving counseling services with Family Focus Counseling Services, P.C. Please read this document carefully and contact us if any further explanation of these guidelines is necessary. Once these guidelines are agreed to and this document is signed, you will receive a copy for your records.

GENERAL INFORMATION

Clinicians located at Family Focus Counseling Services, P.C. provide outpatient mental health counseling and assessment. Counseling sessions are generally scheduled once a week for 50 minutes, and a given hour is considered blocked for a particular client. Thus, a late cancellation results in an open hour, inconvenience, and a loss of revenue. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation (unless you and your clinician both agree that you were unable to attend due to circumstances beyond your control). If it is possible, your clinician will try to find another time to reschedule this appointment. If you arrive late for a scheduled appointment, only the remainder of the 50 minute session will be available. If your clinician is running late with a prior appointment for some reason, you will still receive the full 50 minutes. If local schools are closed due to weather conditions, please check your clinician's answering machine to see if they will be in the office. They may need to reschedule your appointment. Initial: _____

ATTENDANCE AND FEE POLICY

If an appointment is missed without notice ("no-show") or cancelled with less than a 24 hour notice, you will be charge the full rate ($60) for that session. It is your responsibility to contact your clinician to schedule any further appointments according to current schedule availability. Fees for late cancellations and "no-shows" are not reimbursable, and are not covered by the client's insurance. NOTE: Late cancellation fees may be waived, at Family Focus Counseling Service's discretion, for unavoidable circumstances such as inclement weather, sudden illness, or family emergencies.

Fees, deductibles, and co-pays, when sessions are covered by insurance, will be dictated by your insurance company. If no insurance is used (self-pay), intake sessions and subsequent/regular sessions are decided between you and your clinician. Occasionally, clients may request telephone consultations, the completion of associated paperwork, such as letters or reports, or other services which occur outside normally scheduled sessions and are not covered by insurance. Please consult with your clinician for their individual fees for these type of services.

The $60.00 missed appointment / late cancellation fee is an out-of-pocket expense that cannot be submitted to your insurance company. You are responsible for the full amount. Initial: _____

PAYMENT OF SERVICES

Payment for services is due at the time services are rendered, unless other arrangements are made and approved. Any fees due, while the client is unavailable (such as missed appointments and late cancellations), shall be charged against the client's credit card on file, if such credit card information has been recorded. Any balance not paid within 120 days of the service rendered will be referred to a collection agency. Initial: _____

FORENSIC AND LITIGATIVE SERVICES

Family Focus Counseling Services, P.C. clinicians do not participate in lawsuits of any type on a plaintiff's behalf, unless compelled to do so by subpoena or court order. If you become involved in legal proceedings that require their participation, you will be expected to pay for all of their professional time, including preparation, deposition, telephone time, transportation costs, court appearance, report writing, consultation and supervision, even if they are called to testify by another party. Because of the complexity of legal involvement, they charge $250 per hour for preparation and attendance at any legal proceedings. Initial: _____

CONTACTING YOUR CLINICIAN

Due to your clinician's work schedule, they are often not immediately available by telephone. While they are usually in their office during normal business hours, they will not answer their phone if they are with a client. When they are unavailable, please leave a message on their voice mail. They will make every effort to return your call on the same day you make it, with the exception of days they are not in the office, weekends, and holidays. If you are difficult to reach, please inform them of some time when you will be available. If you are unable to reach them and feel that you can't wait for their return call, contact your family physician or the nearest emergency room. Initial: _____

CONFIDENTIALITY

In general, the law protects the privacy of all communications between a client and a counselor, and your clinician can release information about their work to others only with your written permission. But there are a few exceptions.

There are some situations in which they are legally obligated to take action to protect others from harm, even if they have to reveal some information about a client's treatment. For example, if they believe that a child, elderly, or disabled person is being abused, your clinician is required to file a report with the appropriate state agency. If your clinician believes that a client is threatening serious bodily harm to another, they may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself or herself, they may be obligated to seek hospitalization for him or her or to contact family members or others who can help provide protection. They will make every effort to fully discuss it with you before taking any action.

Your clinician may occasionally find it helpful to consult other professionals about a case. During a consultation, they make every effort to avoid revealing the identity of their client. The consultant is also legally bound to keep the information confidential. Initial: _____

EMERGENCIES

Sometimes, emergencies arise that cannot be planned for. In case of an emergency, contact 911 and notify your clinician, as well. If your clinician leaves town, another clinician will be on call for them in case of an emergency, and that information will be left on their voice mail.

_____ _____

Client / Parent / Guardian Signature Date

_____ _____

Printed Name of Client / Parent / Guardian Relationship to Client

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NOTIFICATION OF CLIENT RIGHTS

As a client of Family Focus Counseling Services, you are assured of the following Rights:

- Impartial access to services regardless of race, religion, sex, ethnic background, or handicap.
- Participation in the development and completion of your treatment plan.
- Written information on program policies and procedures, fee schedules, reimbursement policies, and rules of conduct.
- Confidential maintenance of all information regarding you and the services you receive within the confines of the law.
- The option to inspect, copy, or correct the above written information, at your expense.
- To be treated with dignity and respect at all times.
- The human, civil, and legal rights granted to all citizens.
- In addition, at no time will rights granted to you by the law be restricted without due process.
- If you need assistance in understanding any of the rights, you or your authorized representative are encouraged to seek help from any staff member.

If you feel that any of these Rights are being violated or infringed upon, you are encouraged to bring your concern to the attention of any staff member with whom you work; the Case Manager, the Clinician, or the Director of the program you attend, or any other employee of Family Focus Counseling Services. Complaints brought to our attention will be addressed in a timely manner and resolved as quickly as possible. If unresolved to your satisfaction, an appeal may be made directly to the Local Human Rights Committee. Full details of the complaint procedures may be obtained from any staff member.

If you need further assistance, the Virginia Department of Mental Health and Mental Retardation provides an Advocate for you. This person will assist you in further understanding of your rights and, if necessary, will assist in an inquiry as to your concern. You may contact this person at:

Rappahannock – Rapidan Community Services
Laurie Dodson
P.O. Box 1568
Culpeper, VA 22701
(540) 825-3100

I have received a copy of this notification of my rights and have been offered assistance in understanding them.

_____ _____

Signature of Client ***Date***

_____ _____

Staff signature ***Date***