Williamsburg Centre for Therapy
217 McLaws Circle, Suite 2
Williamsburg, Virginia 23185
Phone 757/253-0371

SSN:_____ **TODAYS DATE**:_____

PATIENT LAST NAME:_____ FIRST:_____M:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

PHONE H:_____C:_____GENDER:_____DOB:_____

MARITAL STATUS:_____EMAIL:_____

PLACE OF EMPLOYMENT:_____PHONE:_____

ADDRESS:_____

OCCUPATION:_____HIRE DATE:_____

SPOUSE'S NAME:_____SPOUSE'S SSN:_____

ADDRESS IF DIFFERENT FROM ABOVE:_____

CITY:_____STATE:_____ZIP:_____

SPOUSES EMPLOYER:_____OCCUPATION:_____

EMERGENCY CONTACT:_____PHONE:_____

NAME AND ADDRESS OF FATHER AND MOTHER (IF MINOR OR STUDENT)

MOTHER:_____ADDRESS:_____

_____PHONE H:_____W:_____

FATHER:_____ADDRESS:_____

_____PHONE H:_____W:_____

FAMILY/PERSONAL PHYSICIAN:_____

WERE YOU SEEING A THERAPIST PRIOR TO COMING HERE? ☐Y☐N. IF YES, PLEASE PROVIDE NAME AND ADDRESS OF THERAPIST:_____

INSURANCE INFORMATION:

NAME OF INS:_____

SUBSCRIBER NAME:_____DOB:_____

SUBSCRIBER SSN:_____POLICY ID #:_____GROUP #:_____

SUBSCRIBER EMPLOYER:_____

EMPLOYER ADDRESS:_____

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NO SHOW POLICY – PLEASE KEEP THIS COPY

If, for any reason, you are not able to keep your appointment, please call our office to reschedule or cancel at least 24 hours in advance so that someone else may benefit from the appointment slot. Failing to call in a cancelation results in unnecessary downtime for our therapists and prevents other patients from being seen. Therefore, the following policy has been implemented.

FAILURE TO CALL OR CANCEL AN APPOINTMENT WITHIN A 24-HOUR TIME FRAME WILL RESULT IN A $65 CHARGE.

THIS CHARGE IS NOT COVERED BY MEDICAL INSURANCE.

If you have questions regarding your late fee charge or feel you are being charged unfairly, please contact our office manager at 757-253-0371.

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PRIVACY & CONFIDENTIALITY

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the added terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

As a general rule, we will disclose no information obtained during your therapy relationship with us, or the fact that you are our patient, except with your written consent. However, if we believe that you are at imminent risk for harming yourself or someone else, we will disclose information to the extent needed for ensuring your safety or others.

Other possible exceptions to confidentiality include the following:

1. Virginia laws require therapists to release information in certain circumstances:
   a) Virginia therapists are required by law to report certain information. Suspicion of abuse or neglect of a child or of an aged or incapacitated adult must be reported to the Department of Social Services. If you provide me with information that someone licensed by a Health Regulatory Board is engaging in illegal practice or unprofessional conduct, then I must advise you of your right to report such misconduct to the Department of Health Professions. Psychologists must report to the

Board of Psychology any known or suspected licensed psychologist who has violated Virginia laws or regulations governing the practice of psychology. If the Board of Medicine licenses you, I am to report that you are receiving therapy if I believe that your condition places the public at risk.

b) Virginia law imposes upon therapists the legal duty to protect other members of society from harmful actions by their patients. Voiced threat or direct harm to another person can result in the notification of the potential victim, law enforcement officers, and/or others as specified by statute.
c) In Virginia court cases, exceptions to therapist-patient may apply in a criminal case, a child abuse case, and court case in which your mental health issue and/or any case in which the judge "in the exercise of sound discretion, deems it necessary to the proper administration of justice'' that information communicated to a therapist be admitted as evidence. This means that others may sometimes issue a subpoena seeking either treatment records or testimony from your present or former therapist as evidence in a course case (including child custody cases). If I receive a subpoena, I will inform you immediately and, with your consent, will cooperate with your attorney in filing motions to quash the subpoena and requesting that the therapy relationship be protected. However, only the judge may decide whether or not the requested information or records must be disclosed.
d) Virginia law also allows certain others to request access to information or treatment records in specific circumstances. These include Protective Service Workers to whom I have reported abuse or neglect, if they so request; Court-Appointed Special Advocates in child abuse or neglect proceedings, if the court so orders; and evaluators for minors' involuntary commitment to inpatient treatment. In such cases, I will make every attempt to limit the information disclosed by substituting an oral or written report.
e) If you are under 18 years of age, Virginia law allows your parents to request information and/or records related to your treatment, however, the Federal Drug Abuse Office and Treatment Act protects the privacy of alcohol and treatment records for every state.

2. Business and operational activities may, at times, involve providing your protected health information to others:
   a) When I am on vacation or away from the office for extended periods of time, a colleague may cover my practice and take emergency calls. If s/he needs information about you in order to be prepared to assist you in my absence, you and I will discuss that plan in advance.
   b) To ensure that I am providing quality care, I sometimes meet with an office colleague to get additional ideas on how to enhance treatment effectiveness.
   c) I may call you by name in the waiting room when I am ready to see you.
   d) WCFT office staff have access to the information necessary for preparing monthly statements, submitting insurance claims, and treatment reports to insurance company reviewers.
   e) We may contact you by phone or e/mail to remind you of your appointment or to reschedule you for a different appointment time.
3. You must decide whether to give consent for me to release information to an insurance company (or other third-party payor) in order to receive reimbursement. I am required to provide information about dates of treatment, type of treatment, treatment goal, and the nature of your problem (diagnosis). Subsequently, I may be required to submit Treatment Reports. I will be happy to review these with you at your request, during our treatment sessions. I will submit them only with your consent. Requests for further information will be discussed with you as they arise. You should be aware that, once part of the insurance company files, in all probability some of it will be computerized. I have no control over how that information might be used or re-released. In some cases, the information about your treatment may be shared with a national medical information data bank. Virginia law also allows third party payors to re-release certain information to others in certain circumstances without your consent, potentially including the employer who provides your health care plan.

PATIENT INFORMATION

I am a licensed therapist in the Commonwealth of Virginia practicing at Williamsburg Centre For Therapy. The following information describes our office policies and specifies the terms of our agreement for the provision of psychological services.

CONFIDENTIALITY: AS a general rule, I will disclose no information obtained during your contract with me, or the fact that you are my patient, except with your written consent. However, there are certain limits to this rule of confidentiality, as described on pages 2 and 3, or as otherwise specified by law.

PAYMENT FOR SCHEDULED SESSIONS (see page 5): You are expected to pay for each session at its scheduled time, unless you have medical insurance coverage which requires another arrangement. **Co-payments are due at each visit.** Other payment arrangements require prior written agreement with Williamsburg Centre For Therapy. If you fall behind in your payments and have not made any other arrangements with Williamsburg Centre For Therapy, we will contact our collection agency and provide them with information necessary for recovering the balance due. If this occurs, you will be responsible for paying all nonpayment fees and interest costs that accrue.

CANCELLATIONS AND NO-SHOWS: If, for any reason, you are not able to keep your appointment, please call our office to reschedule or cancel at least 24 hours in advance so that someone else may benefit from the appointment slot. Failing not to call in a cancellation results in unnecessary downtime for our therapists and prevents other patients from being seen.

OUR POLICY IS: Failure to call to cancel an appointment at least 24 hours in advance will result in a $65 charge. This is NOT covered by medical insurance. If you have questions regarding your no-show charge or feel you are being charged unfairly, please contact our office manager at 757-253-0371.

There are fees for several additional services including assessing school learning or behavioral problems, writing reports, protecting your confidential information from a legal discovery process, court testimony and consultation. If desired, please ask for a copy of our professional fees.

TELEPHONE CONTACT: I can be contacted for consultation regarding a personal or family crisis or other matters related to your treatment. However, there can be a charge for this Professional Service (see attached fee schedule). Scheduling concerns, billing, and payments, etc. can be discussed with the office manager, other office staff or in person with me, during our sessions.

I can be reached at Williamsburg Centre For Therapy on weekdays at (757) 253-0371. If I am in session our office staff will accept your message. If I am unable to promptly return your call it will be due to my full schedule or situations that require me to be away from the office. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the doctor on call. If I am unavailable for an extended time, I will provide you with the name of a colleague at Williamsburg Centre For Therapy to contact, if necessary.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to your therapist to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $_____ for each page, $_____ per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we disclosed your protected health information for purposes other than treatment payment, health care operations and certain other activities after April 14, 2003. After April 14, 2009, accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your protected health information, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you want amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosure of that information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human services.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S Department of Health and Human Services.

Name of contact person: Gwyn Guertin, Office Manager, 217 McLaws Circle, Suite 2, Williamsburg, VA 23185, (757)-253-0371, Fax:(757) 253-8063.

DOCUMENTATION OF PATIENTS INFORMED CONSENT FOR TREATMENT AND RESPONSIBILITY FOR PAYMENT OF SERVICES RECEIVED

Your first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what your work may include. You should evaluate this information along with your own assessment about whether you feel comfortable working with me.

I understand that we will begin with an evaluation of my needs, and that my therapist is not obligated to accept a referral. I understand that psychotherapy is not an exact science, and that no guarantees are being made as to the result or evaluation of my treatment. As a participant in my treatment, I share the responsibility for the process, including goal setting and termination. I understand that, through the process of treatment, I may be working toward changes which may cause me to experience many different intense feelings, some of which may be painful. Also, I understand that when I make changes in myself, I may experience changes in other areas of my left (i.e., family, work, social life, etc.). I am aware that every change potentially has positive and negative effects, and that an important part of treatment will be to clarify and evaluate potential effects of changes before undertaking them.

I understand that therapy involves a large commitment of time, money, and energy, and therefore it is important to select a therapist carefully. I know that if I have any questions about my therapist's policies or procedures, I can discuss them whenever they arise and that, if I request it, my therapist will help me to secure an appropriate consultation with another mental health professional.

I agree that I am personally responsible for the payment of any balance remaining on my account after payment toward said account by my insurance company. In the event that there is no insurance coverage or if for any reason my insurance company refuses to pay any charges reflected on my account, I agree that I am personally responsible for the entire amount of my account. I understand that I will be billed for a missed session if not canceled or rescheduled **24 hours** prior to the appointment time and that my insurance company will not pay for any missed sessions. I am aware that Gwyn, from this office, will file claims with my insurance company and oversee all other billing. If my account becomes delinquent for a period of 90 days, I understand that a collection agency may be contacted to obtain the full balance and that this will necessitate providing the agency with information necessary to recover the balance. If my account becomes assigned to a collection agency, I understand that interest charges and or nonpayment fees will be added to the original balance owed on my account.

By signing below, I agree to begin treatment, and accept responsibility for payment for services provided, I have read about the potential limits of confidentiality as described on the sheet entitled PRIVACY AMD CONFIDENTIALITY including those imposed by Williamsburg Centre For Therapy's office policies and by state law and I understand the policies described on the PATIENT INFORMATION SHEET. I accept these as conditions of receiving psychological services. I understand that I can discuss these or any other concerns with my therapist at any time.

Signed_____Date_____

DOCUMENTATION OF PATIENTS INFORMED CONSENT FOR RELEASE OF INFORMATION TO OBTAIN REIMBURSEMENT FROM A THIRD PAYOR

I hereby authorize the release of the information necessary to process insurance claims. I request that payment be sent directly to Williamsburg Centre For Therapy of benefits otherwise payable to me.

Patient Signature (or guarantor) _____Date_____

I UNDERSTAND THAT MY INSUARNCE COMPANY WILL NOT PAY FOR SESSION THAT ARE MISSED OR NOT CANCELLED WITHIN 24 HOURS OF MY SCHEDULED APPOINMENT TIME AND THAT I WILL BE HELD FINANCIALLY RESPOSIBLE FOR THE FULL AMOUNT OF SAID SESSION. _____INITIAL

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTOOD THE NOTICE.

_____ _____

Patient Name **Date**

_____

Parent or Authorized Representative (if applicable)

_____

Signature

Williamsburg Centre for Therapy
217 McLaws Circle, Suite 2
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Phone 757/253-0371

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize_____ and/or his/her staff to disclose my confidential health information to_____.
This authorization is voluntary. I understand that the information disclosed may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Patient Name: _____Date of Birth:_____

Persons/organizations receiving this information:

Name:_____

Organization_____

Phone: _____Fax:_____

Specific description of information to be used or disclosed_____

_____

I understand that I may revoke this authorization at any time by notifying Williamsburg Centre For Therapy in writing, but if I do, it will not have any effect on any actions taken before receipt of my revocation.

I understand that this authorization will expire_____initials_____

Must be completed if a therapist at Williamsburg Centre For Therapy has requested the authorization.

The patient or the patient's representative must read and initial the following statements:

a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. _____: Initials
b. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. _____: Initials

_____ _____
Signature Date

Printed name of patient's representative (if applicable) _____
Relationship to the patient (if applicable) _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
IF YOU ARE NOT MAKING THIS REQUEST YOURSELF