

DISCOVERY COUNSELING & CONSULTING

Please complete the entire form and bring to your first appointment

Today's Date: _____
 First Name: _____ Last Name: _____ Gender: _____
 Preferred First Name (if applicable): _____
 Social Security #: _____ Age: _____ Date of Birth: _____
 Marital Status: _____
 Address: _____
Street address is required. If you have a P.O. Box, we will use it for correspondence.
 City: _____ State: _____ Zip: _____
 Home phone # _____ Cell # _____ Work # _____
 Email address: _____
 Is it ok to leave medical or confidential information in a *voicemail* at the above #'s? _____
 Employer or School _____ May we contact you at work? _____
 Emergency Contact Information:
 Name: _____ Phone #: _____ Relationship: _____

Responsible Party, if client is a minor (under 18 years of age)

The information below must be the parent/guardian who is present at the appointment.

First Name: _____ Last Name: _____
 Social Security #: _____ Date of Birth #: _____
 Relationship to client: _____
 Address (if different): _____
 City: _____ State: _____ Zip: _____
 Home phone # _____ Cell # _____ Work # _____
May we contact you at work? _____
 Employer _____
Other Parent/Guardian:
 Name: _____ Primary phone number: _____

INSURANCE INFORMATION (PLEASE COMPLETE THIS EVEN THOUGH WE MAY HAVE A COPY OF YOUR CARD)

Insurance Company: _____ Phone #: _____
 Member ID #: _____ Group #: _____
 Subscriber First Name: _____ Subscriber Last Name: _____
 Subscriber Address: _____
 Subscriber Phone #: _____ Subscriber Employer: _____
 Subscriber Social Security #: _____ Subscriber Date of Birth: _____
 Relationship to client: _____

X _____
 (Signature of Responsible Party) (Print name) (Date)

DISCOVERY COUNSELING & CONSULTING

Consent for Treatment

(Please complete section A or B and sign below as indicated)

A. I, the undersigned, do voluntarily consent to behavioral health assessment and/or treatment for myself by _____.
(Name of DC&C clinician)

B. I, the undersigned, am the legal guardian of (child's name) _____, date of birth _____, a minor child. I do voluntarily consent to his/her behavioral health assessment and/or treatment by _____.
(Name of DC&C Clinician)

Consent for treatment

- I understand that behavioral health is not an exact science and no guarantees are being made as to the results of assessment and/or treatment.
- I am aware that I am an active participant in my treatment and that I share the responsibility for the treatment process.
- I understand that assessment and/or treatment will be kept confidential with the exception of legal limitations of confidentiality. In addition, I am aware that, although the above-named clinician is clinically independent, consultations with other clinicians are sometimes advisable, and my signature below gives the above-named clinician permission to do that.
- I understand that when the above named clinician is unavailable, another behavioral health provider may be providing emergency coverage. I understand that the clinician providing coverage may be given access to relevant information in order to provide the best interim care possible.
- I authorize the release of any information necessary to process any insurance claims. This would include an ongoing release of information to meet managed care review requirements.
- Discovery Counseling & Consulting has a "Grievance Procedure" which is available on request to all clients.
- If you are a member of a Managed Care Organization a "Members Rights and Responsibilities" document may be available to you.
- Discovery Counseling & Consulting has provided me with the opportunity to read the Notice of Privacy and all of my questions have been answered.
- You have the right to revoke this consent in writing and terminate services with the above named clinician at any time. In that event, your clinician or other Discovery Counseling & Consulting staff are willing to help you locate alternative resources in the community.

I have read and understand the information on this sheet. My signature indicates my *informed consent* with the above-named clinician. If you have any questions about this form, please discuss them with your clinician.

X _____ (Date)

(Signature)

Relationship to client:

In order to provide the best care possible, your behavioral health care clinician would like to be able to communicate with your Primary Care Physician (PCP). Many insurance companies require this information.

Please check one of the following: I DO or

I DO NOT, give DC&C permission to exchange my protected health information / or my child's protected health information with my PCP.

(signature of client or parent/guardian)

(Date)

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***Please read this notice carefully and keep attached client copy for your records.**

BILLING: Our clinicians participate with many insurance companies and in most cases we will bill your insurance company for you. However, you are ultimately responsible for your bill. If you have not already done so, contact your insurance company to find out what your mental health benefits are, including deductibles, copayments, requirements for preauthorization, and any limitations to your coverage.

IT IS YOUR RESPONSIBILITY TO OBTAIN ANY INITIAL PREAUTHORIZATION REQUIRED BY YOUR INSURANCE COMPANY. FAILURE TO DO SO BY THE END OF THE BUSINESS ON THE DAY OF YOUR INITIAL APPOINTMENT MAY RESULT IN DENIAL OF COVERAGE AND LEAVE YOU RESPONSIBLE FOR PAYMENT OF THE FULL FEE.

Fees not covered by your insurance are due at the time of service. These fees include, but are not limited to, copayments or co-insurance, deductibles, charges for telephone consultation, school meetings, educational testing and services, most court-ordered services, letter and report writing, prescription refills in between appointments, and depositions/ court appearances.

Returned checks will be charged a \$30 fee.

COLLECTION PROCEDURES: Unless arrangements have been made, bills that are more than 90 days delinquent will be turned over to an attorney. In that event, you will be liable for any attorney's fees in the amount of 33% of the current balance. You will also be responsible for an interest rate charge of 1½ % per month on the unpaid balance. If you are unable to afford the cost of treatment, your clinician will assist you with a referral to your community mental health center.

CHANGE IN INSURANCE: It is your responsibility to notify both your clinician and the billing office of any changes in your insurance and to provide us with a copy of any new insurance card(s). It is also your responsibility to contact your new insurance company to obtain any preauthorization that may be required. Failure to do so may result in denial of coverage and may leave you responsible for payment for the full charges.

CANCELLATION POLICY: YOU ARE REQUIRED TO GIVE AT LEAST 24-HOUR NOTICE WHEN YOU NEED TO CANCEL AN APPOINTMENT. MONDAY APPOINTMENTS MUST BE CANCELLED BY THE APPOINTMENT TIME ON THE PRECEDING FRIDAY. IF YOU CANCEL AN APPOINTMENT WITH LESS THAN 24-HOUR NOTICE, OR IF YOU FAIL TO SHOW UP FOR YOUR APPOINTMENT, YOU WILL BE CHARGED A FEE, WHICH IS NOT COVERED BY INSURANCE.

If you arrive late for your appointment, your clinician may see you only for the remainder of your scheduled appointment time or may request that you reschedule if insufficient time remains. While we make every effort to begin appointments on time, other client needs do sometimes result in your clinician running behind schedule. When this happens, you will generally be offered the option to run late and still be seen for a full appointment or to reschedule.

TELEPHONE CALLS: Please try to keep telephone calls brief; try to save any questions that you have for your clinician and ask them during your scheduled appointment times. Except for emergencies, your clinician will charge the regular hourly rate for telephone calls that are longer than fifteen minutes and for frequent phone calls.

CLOSED CASES: Accounts will be considered closed if the last visit was more than 6 months ago.

OTHER RESPONSIBLE PARTIES: To avoid confusion, the person consenting to treatment will be responsible for all fees not covered by insurance. If another party is legally responsible for medical bills not covered by insurance (for example, in case of divorced parents, your child's other parent) we will provide you with whatever documentation you need in order to get reimbursed by that person. We will not bill that party directly however.

(Client Name- please print)

(Responsible Party Name- please print)

(Signature of Client or Responsible Party)

(Date)

DISCOVERY COUNSELING & CONSULTING

Written Acknowledgement Form

Our **Notice of Privacy Practices** provides information about how we may use and disclose Personal Healthcare Information about you. As provided in our Notice (see attached colored copies), the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I, _____ (Please print **client name**) have received a copy of Discovery Counseling & Consulting's Notice of Privacy Practices. (see attached color copies)

I understand that I may ask questions of the Privacy officer at (804) 591-0002, if I do not understand any information contained in the Notice of Privacy Practices.

X _____
(Client signature)

X _____
(Parent or Guardian signature if under 18)

X _____
(Date)

EMAIL CONSENT FORM

Printed name _____

Patient address _____

Patient e-mail address _____

1. RISK OF USING E-MAIL

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before using e-mail. These include, but are not limited to, the following risks:

- a. E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
- b. E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- c. E-mail senders can easily misaddress an email.
- d. E-mail is easier to falsify than handwritten or signed documents.
- e. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
- f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
- g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- h. E-mail can be used to introduce viruses into computer systems.
- i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions:

- a. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- b. Although Provider will endeavor to read and respond promptly to an e-mail from the patient, Provider cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail for medical emergencies or other time sensitive matters.
- c. If the patient's e-mail requires or invites a response from Provider, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
- d. The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.

- e. The patient is responsible for informing Provider of any types of information the patient does not want to be sent by e-mail, in addition to those set out in 2(e) above.
- f. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
- g. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
- h. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between Provider and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient signature _____

Date _____

DISCOVERY COUNSELING & CONSULTING

People that I give permission to disclose information regarding my treatment at Discovery Counseling & Consulting (*a separate Release of Information form will need to be signed for each person/agency listed below*).

Person/Agency Name	Relationship to Client
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

X _____
(Client signature)

X _____
(Parent or Guardian signature if under 18)

X _____
(Date)

DISCOVERY COUNSELING & CONSULTING

Fee Schedule

Unless noted otherwise, fees for services are as follows:

SELF PAY RATES (IF NOT COVERED BY INSURANCE):

Initial Therapy Appointment	\$125.00
Ongoing Therapy Appointment (45-50 min)	\$100.00
Group Therapy Appointment	\$50.00
Extended Therapy Appointment (70-90 min)	\$150.00

FEES NOT COVERED BY INSURANCE:

Psychological or Educational Testing (includes Administration, scoring, report writing)	\$125.00/hr.
School Meetings (includes travel time)	\$100.00/hr.
Deposition/ Court Appearance (includes travel Time)	\$250.00/hr.
Letter	\$50.00
No Show or Late Cancellation Fee	\$50.00
Group No Show or Late Cancellation Fee	\$25.00
Telephone calls (more than fifteen minutes and Non emergency)	\$100.00/hr.
Completion of Health Disability Forms	\$20-\$50
Copy of Medical Record Processing Fee (plus \$0.50 per page up to 50 pages and \$0.25 per page thereafter)	\$10.00

X _____
(Client signature)

(Date)