

# DISCOVERY COUNSELING & CONSULTING

Please complete the entire form and bring to your first appointment

Today's Date: \_\_\_\_\_  
First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Gender: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Marital Status (select one): \_\_\_\_\_  
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 # \_\_\_\_\_  
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: \_\_\_\_\_

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## **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: \_\_\_\_\_

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## **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 (circle one): \_\_\_\_\_

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## **EAP**

Are these visits covered by an Employee Assistance Program (EAP)?

If YES, name of program and phone \_\_\_\_\_

Authorization # \_\_\_\_\_ # of visits \_\_\_\_\_

(An EAP is a benefit provided by SOME employers that is in addition to your health insurance)

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X \_\_\_\_\_  
(Signature of Responsible Party) (Print name) (Date)

# DISCOVERY COUNSELING & CONSULTING

Primary Care Physician (PCP): \_\_\_\_\_ Phone # \_\_\_\_\_

Date and purpose of last visit: \_\_\_\_\_

Current Medications	Doctor prescribing	Dose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who/How were you referred you to our practice? \_\_\_\_\_

Have you received any counseling, psychological, or psychiatric services in the past? Y or N

If yes, Professional's name \_\_\_\_\_

Date began: \_\_\_\_\_ Date ended: \_\_\_\_\_

**Please check any of these which have been a problem in the last *six months*:**

- |                      |       |                        |       |
|----------------------|-------|------------------------|-------|
| Anxiety              | _____ | Concentration problems | _____ |
| Excessive worrying   | _____ | Memory problems        | _____ |
| Panic attacks        | _____ | Educational problems   | _____ |
| Extreme fears        | _____ | Work/career problems   | _____ |
| Shyness              | _____ | Legal problems         | _____ |
| Loneliness           | _____ | Financial problems     | _____ |
| Unhappiness          | _____ | Alcohol use            | _____ |
| Depression           | _____ | Substance abuse        | _____ |
| Suicidal thoughts    | _____ | Sexual problems        | _____ |
| Inferiority feelings | _____ | Marital problems       | _____ |
| Lack of energy       | _____ | Separation/ divorce    | _____ |
| Indecisiveness       | _____ | Loss of family member  | _____ |
| Lack of motivation   | _____ | Problems with children | _____ |
| Self-harm            | _____ | Gay/ Lesbian issues    | _____ |
| Excessive energy     | _____ | Problems with Friends  | _____ |
| Anger problems       | _____ | Headaches              | _____ |
| Impulsivity          | _____ | Health problems        | _____ |
| Nightmares           | _____ | Major illness          | _____ |
| Sleep problems       | _____ | Eating problems        | _____ |
| Intense emotions     | _____ | Other _____            | _____ |

Reasons for seeking help at this time:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please add any other information that you believe may be important:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# 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 \_\_\_\_\_ (Signature) \_\_\_\_\_ (Date)

Relationship to client (circle one):

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 our PCP.

(signature of client or parent/guardian) \_\_\_\_\_ (Date) \_\_\_\_\_

# DISCOVERY COUNSELING & CONSULTING

**\*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.

**COLLECTION PROCEDURES:** Unless arrangements have been made, bills that are more than 90-days delinquent will be turned over to a collection agency. In that event, you will be liable for an additional collection cost 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)

**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

## AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH CARE INFORMATION

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_  
(Client name) (DC&C Clinician name)

To release/request my medical/behavioral health records (including drug and alcohol related information) to/from:

\_\_\_\_\_  
(Person/Agency/Provider) (Address) (Phone #)

Information to be disclosed/requested:

- Intake/Assessment
- Progress notes
- Other (please specify) \_\_\_\_\_

This authorization expires on: \_\_\_\_\_

Information may be released/requested via:  phone  fax  email  mail

As the person signing this authorization, I understand that I am giving my permission to the above named individual/agency for the disclosure of confidential health care records. I also understand that I have the right to revoke this consent at any time.

The person/agency who receives the records to which this consent pertains may not redisclose them to anyone else without my separate written consent unless the recipient is a provider who makes disclosure as permitted by law.

\_\_\_\_\_  
(Client signature) (Date)

\_\_\_\_\_  
(Parent/legal guardian) (Date)

Client Date of Birth: \_\_\_\_\_ Last 4 digits of client social security number: \_\_\_\_\_

# 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	\$70.00
No Show or Late Cancellation Fee	\$50.00
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)