# DISCOVERY COUNSELING & CONSULTING



Please complete all pages and bring to your first appointment

**Today's Date:**_____ **PIN #** (4 digit code used to identify self when calling the office): _____

**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:**_____

**How were you referred you to our practice?**_____ **Name:** _____

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

*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:**

---

**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 DCC permission to exchange my/my child's protected health information with my/my child's PCP.**

**PCP Name:** _____ **Phone #:** _____

**PCP Address:** _____ **Fax #:** _____

_____

_____

**X**_____ _____

**Client/Parent/Legal Guardian Signature** **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.**

**B. ☐ I, the undersigned, am the parent/legal guardian of (child's name)_____, a minor child. I do voluntarily consent to his/her behavioral health assessment and/ or treatment.**

**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 understand that the purpose, potential risks and benefits, and alternatives to any treatment, as well as risks of not having treatment will be explained to me upon my request and that I can always decline 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.
- 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.
- 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 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*. <u>If you have any questions about this form, please discuss them with your clinician.</u>**

**X** _____ _____

(Client/Parent/Guardian Signature) **(Date)**

**Relationship to client:** _____ _____

# DISCOVERY COUNSELING & CONSULTING

## Consent for *Telehealth* Treatment

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

**A. ☐ I, the undersigned, do voluntarily consent to telehealth behavioral health assessment and/or treatment for myself.**

**B. ☐ I, the undersigned, am the parent/legal guardian of (child's name)_____, a minor child. I do voluntarily consent to his/her behavioral health assessment and/or treatment.**

**Consent for treatment**

- I understand that this service is provided through technology, potentially including video conferencing, telephone, text, and email. As such, services may not include direct face-to-face communication with my provider.
- I understand that exchange of information and paperwork will likely be via electronic means, or via mail or fax.
- I understand that there are risks to electronic transmission of data, including, but not limited to, possible confidentiality breaches and theft of personal data.
- I understand that it is my responsibility to maintain privacy on my end, in terms of communication and data storage. This includes but is not limited to: ensuring that I can hold telehealth sessions in a private space, using a secure internet connection, using security features such as password protection on devices and email accounts.
- I understand that technology is subject to periodic technical difficulties and service disruptions. I will establish a plan with my therapist for how to respond if a technical issue interferes with services.
- I understand that it is my right to discontinue telehealth services at any time.
- I understand that my therapist may determine that telehealth treatment is not the appropriate method of service delivery for me. If the determination is made that telehealth services are no longer appropriate, my therapist will discuss this decision with me, and provide me with alternate referrals and resources, as needed.
- If a need for direct, face-to-face services arises, it is my responsibility to contact providers in my area to arrange an appointment (e.g., primary care physician, psychiatrist, emergency services).
- I understand that I will be required to maintain an active credit card on file for purposes of billing for telehealth sessions.
- The laws and professional standards that apply to in-person psychological services also apply to telehealth services. I understand that this document does not replace other agreements, such as documentation of informed consent.
-

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

**X** _____ _____

(Client/Parent/Guardian Signature) **(Date)**

**Relationship to client:** _____

# DISCOVERY COUNSELING & CONSULTING

***Please read this notice carefully***

**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.

ALL 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, back balances, charges for telephone consultation, school meetings, educational testing and services, most court-ordered services, letter and report writing, and depositions/court appearances.

**RETURNED CHECKS**: There is a $37.50 fee for all returned checks. We reserve the right to refuse payment in the form of check after multiple returned checks from the same individual.

**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 chances 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.

C**ANCELLATION POLICY:** YOU ARE REQUIRED TO GIVE AT LEAST 24-HOURS' NOTICE WHEN YOU NEED TO CANCEL AN APPOINTMENT. MONDAY APPOINTMENTS MUST BE CANCELLED VIA EMAIL OR VOICE MAIL MESSAGE AT LEAST 24 HOURS PRIOR TO THE APPOINTMENT. IF YOU CANCEL AN APPOINTMENT WITH LESS THAN 24-HOURS' NOTICE, OR IF YOU FAIL TO SHOW UP FOR YOUR APPOINTMENT, YOU WILL BE CHARGED A FEE, WHICH IS **NOT** COVERED BY INSURANCE. BY SIGNING THIS FORM YOU AGREE TO PAY ALL FEES SPECIFIED UNDER THIS POLICY, THIS INCLUDES MEDICARE RECIPIENTS.

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. As previously stated, these calls are not covered by insurance and you will be responsible for the full cost of telephone calls.

**COURT TESTIMONY:** The fee for any requested court deposition or court testimony, regardless of whether the clinician is served a subpoena or requested to testify by one of the parties is $250.00 per hour with a minimum charge of $1000.00 (for up to four hours). This includes times needed for preparation and travel. Additional fees may be assessed if travel outside of the immediate area is required. Payment in full for depositions and court testimony is required 5 business days in advance of the scheduled hearing. In the event that a deposition or hearing is canceled 3 days or less in advance, a charge of $250.00 will be assessed. Responsibility for the payment in full for any court testimony is ultimately yours regardless of which party may have been issues a subpoena. Fees for depositions and court testimony are not covered by insurance.

**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 signing this form and 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

**Fee Schedule Effective 4/26/21**
**Unless noted otherwise, fees for services are as follows:**

| **SELF PAY RATES (IF NOT COVERED BY INSURANCE):** | |
|---|---|
| Initial Intake Therapy Appointment | $185.00 |
| Individual Therapy Appointment (90837, 90847, 90846) | $165.00 |
| Individual Therapy Appointment (90834) | $110.00 |
| Individual Therapy Appointment (90832) | $85.00 |
| Group Therapy Appointment | $60.00 |
| Therapy Appointment Extension (30 min intervals) | $85.00 |
| **FEES NOT COVERED BY INSURANCE:** | |
| Dialectical Behavior Therapy (DBT) Program Fee | $250.00 |
| Psychological or Educational Testing (includes Administration, scoring, report writing) | $200.00/hr |
| School Meetings (includes travel time) | $165.00/hr |
| Deposition/ Court Appearance (includes travel Time) | $250.00/hr |
| Letters and form completion | $100.00/hr |
| No Show or Late Cancellation Fee | $85.00 |
| Group No Show or Late Cancellation Fee | $35.00 |
| Telephone calls (more than fifteen minutes and non-emergency) | $165.00/hr |
| Copy of Medical Record Processing Fee (plus $0.50 per page up to 50 pages and $0.25 per page thereafter) | $10.00 |

By signing below, I acknowledge that I have read and understand this financial agreement.
I hereby request that payment of authorized insurance benefits, including Medicare, be made on my/my child's behalf to DCC for any services provided to me/my child by DCC. I authorize release of any medical or other information by DCC necessary to process my/my child's claims. I understand that I am financially responsible for any charges not covered by my/my child's insurance. I understand that as a part of utilizing my health insurance benefits, there may be times where my health insurance company requests copies of my medical records for the purposes of standard audits and reviews. I understand that DCC is required to submit this documentation in order to remain in compliance with health insurance contracts and I will not necessarily be notified when this information is disclosed.

Client Name:_____

Responsible Party Name: _____

Relationship to Client: _____

Responsible Party Signature: _____ Date: _____

# DISCOVERY COUNSELING & CONSULTING

## Payment Authorization Form

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our clients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of charges for services I receive from Discovery Counseling & Consulting (DCC) including those covered by my insurance. As a convenience, DCC will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.
2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if DCC determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.
3. DCC may deny service or charge a service fee for failure to pay a co-pay at the time of service.
4. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.
5. I agree to provide DCC and/or its designated payment agent with my debit/credit card or ACH information.
6. I understand that my signature and payment information will be maintained on file digitally for future use by DCC. The applicable payment card or ACH information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card or ACH Information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone.
7. If warranted, DCC may offer the option of paying my share of costs via an automated payment plan. I understand that I may incur some interest expense beyond my balance in exchange for this convenience. I can avoid interest charges by paying my bill immediately if required or by its due date.
8. I authorize DCC and/or its designated payment agent to apply charges to my payment card and/or ACH account for all amounts owed to DCC for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by DCC for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
9. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.
10. Transaction receipts will be maintained in the client file or will be emailed to me if I provide and maintain a valid email address.
11. I authorize DCC and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to DCC. Authorization for services already rendered cannot be canceled or refunded. I agree to notify DCC in writing of any changes in my payment or other information.

_____ _____

Name as it Appears on Card/ACH Account Email Address

_____

Billing Address City State Zip Code

_____

Phone Number

AUTHORIZED SIGNATURE_____ DATE _____

# DISCOVERY COUNSELING & CONSULTING

## Credit Card Payment Form

(This form will be destroyed after the information is input into the system)

1. Client name:_____
2. Name on credit card if different from above: _____
3. Credit card number: _____
4. Credit card expiration date: _____
5. Credit card CVV (3 digit code on back of card): _____
6. Billing zip code: _____

# DISCOVERY COUNSELING & CONSULTING

Patient Portal

Patient Portal is now available at Discovery Counseling & Consulting. With Patient Portal you will be able to update demographic and insurance information in just a few easy steps. We are asking for all clients to set up a Patient Portal account.

Please speak with one of the administrative staff at the front office to get started with setting up your Patient Portal account.

We also now have the option to send you automated appointment reminders. If you are interested in receiving appointment reminders please fill out the information below. This service is free of charge to you, but please be aware that any data or text rates/charges with your phone plan may apply.

Client Name: _____

Preferred Method of Contact: (select only one)

_☐_ Text Message: (Phone Number) _____

_☐_ Phone Call: (Phone Number) _____

_☐_ Email: (Email Address) _____

Client Signature:_____Date: _____

# DISCOVERY COUNSELING & CONSULTING

HIPAA Email Consent

HIPAA stands for the *Health Insurance Portability and Accountability Act*

HIPAA was passed by the U.S. Government in 1996 in order to establish privacy and security protections for health information

Information stored on our computers is encrypted

Most popular email services (i.e. Gmail, Hotmail, Yahoo) **do not** utilize encrypted email

**When we send you an email, or you send us an email, the information that is sent is not encrypted. This means that a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it**.

Email is a popular and convenient way to communicate for many people so in their latest modification to the HIPP act, the U.S. Government provided guidance on email and HIPAA

The information is now available in a pdf on the U.S. Department of Health and Human Services website.

The guidelines state that if a client has been made aware of the risks of unencrypted email, and that same client provides consent to receive health information via email, then a health entity may send that client personal medical information via unencrypted email.

**Please sign below if you wish to communicate with your therapist or office staff via email and/or allow for email transmission of your personal health information.**
**ALLOW** UNENCRYPTED EMAIL:
I understand the risks of unencrypted email and do hereby give permission to Discovery Counseling & Consulting to send me personal health information, including billing information, via unencrypted email.

Signature of Client: _____ Date: _____
(Parent or Guardian if client is a minor)

Email Address: _____

# DISCOVERY COUNSELING & CONSULTING

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH CARE INFORMATION

I,_, hereby authorize _____
(Client name) (DCC Clinician name)
To release/request my medical/behavioral health records (including drug and alcohol related information) to/from:

_____ _____ _____
(Person/Agency/Provider) (Address) (Phone #)

_____ _____
Relationship to Client (Fax #)

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 re-disclose them to anyone else without my separate written consent unless the recipient is a provider who makes disclosure as permitted by law.
I understand that I have the right to access my medical records in accordance with the law. I understand that Virginia law allows DCC to charge me a fee of $10.00 for search and handling, postage and shipping costs, and $0.50 for the first 50 pages and $0.25 per page thereafter. Insurance does not cover this cost.
I understand DCC has the right to deny me access to my records in certain circumstances in accordance with the law. If DCC denied me access to my medical information, I understand it will provide me with the reasons for the denial in writing and describe whether I have the right to have a review of the denial performed by a licensed health professional.
Please note that information disclosed to pursuant to this request is no longer under the control of DCC and may no longer be protected by federal or state law.

_____ _____
(Client signature) (Date)

_____ _____
(Parent/legal guardian signature) (Date)

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

Discovery Counseling & Consulting
7760 Shrader Rd.
Suite B
Henrico, VA 23228
(804) 591-0002
(804) 501-0101- fax

# DISCOVERY COUNSELING & CONSULTING

Brief clinical info- will be provided to your clinician at intake

**Have you received any counseling, psychological, or psychiatric services in the past?** _____
**If Yes, Professional's Name** _____

| **Current Medications** | **Dose** | **Doctor prescribing** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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

- ☐ Anxiety
- ☐ Intense emotions
- ☐ Panic attacks
- ☐ Extreme fears
- ☐ Excessive worrying
- ☐ Shyness
- ☐ Loneliness
- ☐ Unhappiness
- ☐ Depression
- ☐ Suicidal thoughts
- ☐ Inferiority feelings
- ☐ Lack of energy
- ☐ Grief/Loss
- ☐ Lack of motivation
- ☐ Self-harm
- ☐ Excessive energy
- ☐ Anger problems
- ☐ Impulsivity
- ☐ Nightmares
- ☐ Sleep problems
- ☐ Concentration
- ☐ Memory problems
- ☐ Educational problems
- ☐ Career problems
- ☐ Legal problems
- ☐ Financial problems
- ☐ Alcohol abuse
- ☐ Substance abuse
- ☐ Sexual problems
- ☐ Parenting issues
- ☐ Separation/divorce
- ☐ LGBTQ issues
- ☐ Problems with friends
- ☐ Headaches
- ☐ Health problems
- ☐ Major illness
- ☐ Eating problems
- ☐ Gender Identity
- ☐ Chronic pain
- ☐ Domestic violence

**Reasons for seeking help at this time:**

_____
_____
_____
_____

Please complete the questionnaire on Lifestyle Changes.
Please circle the answer that best describes how much or how often you have been bothered by each problem over the last 2 weeks.

-During the **past two (2) weeks** how much or often have you been bothered by sleep problems that affected your overall sleep quality?

| None | Slight, less than a day or two | Mild, several days | Severe, nearly every day |
|---|---|---|---|
| (0) | (1) | (2) | (3) |

-During the **past two (2) weeks** how much or often have you engaged in social activities?

| None | Slight, less than a day or two | Several days | Nearly every day |
|---|---|---|---|
| (0) | (1) | (2) | (3) |

-During the **past two (2) weeks** how much or often have you smoked cigarettes, pipe, cigar, or smokeless tobacco?

| None | Slight, less than a day or two | Mild, several days | Severe, nearly every day |
|---|---|---|---|
| (0) | (1) | (2) | (3) |

# DISCOVERY COUNSELING & CONSULTING

# The CAGE and CAGE-AID Questionnaires

| Item | Text |
|---|---|
| 1. | Have you ever felt you ought to cut down on your drinking *or drug use*? Select Yes or No |
| 2. | Have people annoyed you by criticizing your drinking *or drug use*? Select Yes or No |
| 3. | Have you ever felt bad or guilty about your drinking *or drug use*? Select Yes or No |
| 4. | Have you ever had a drink *or used drugs* first thing in the morning to steady your nerves or to get rid of a hangover? Select Yes or No |

*Note*. The plain text shows the CAGE questions. The italicized text was added to produce the CAGE-AID. For this study, the CAGE-AID was preceded by the following instruction: "When thinking about drug use, include illegal drug use and the use of prescription drugs other than as prescribed."



# The CAGE and CAGE-AID Questions

The original CAGE questions appear in plain type. The CAGE questions Adapted to Include Drugs (CAGE-AID) are the original CAGE questions modified by the *italicized text.*

The CAGE or CAGE-AID should be preceded by these two questions:

1. Do you drink alcohol? Select Yes or No
2. Have you ever experimented with drugs? Select Yes or No

If the patient has experimented with drugs, ask the CAGE-AID questions. If the patient only drinks alcohol, ask the CAGE questions.

## *CAGE and CAGE-AID Questions*

1. In the last three months, have you felt you should cut down or stop drinking or *using drugs?*
   Yes ☐ No ☐
2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or *using drugs?*
   Yes ☐ No ☐
3. In the last three months, have you felt guilty or bad about how much you drink *or use drugs*?
   Yes ☐ No ☐
4. In the last three months, have you been waking up wanting to have an alcoholic drink or *use drugs*?
   Yes ☐ No ☐

**Each affirmative response earns one point. One point indicates a possible problem. Two points indicate a probable problem.**

Reference: The Society of Teachers of Family Medicine. Project SAEFP Workshop Materials, Screening and Assessment Module, page 18. Funded by the Division of Health Professionals, HRSA, DHHS, Contract No. 240-89-0038. Used with permission.