DISCOVERY COUNSELING & CONSULTING

CLIENT INFORMATION

Today's Date: _____ PIN # (4 digit code used to identify yourself): _____

First Name: _____ Last Name: _____

Preferred First Name (if applicable): _____ Marital Status: Select...

Legal Gender (listed on insurance, license, etc.): Select... Gender Identity: Select...

Date of Birth: _____ Age: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred phone #: _____ Type (cell/home/work): _____

May we leave confidential information on a voicemail at the above number? Select...

Email address: _____

Employer or School: _____

Emergency Contact Name: _____

Emergency Contact Phone #: _____ Relationship: _____

How were you referred to our practice? Select...

Is client a minor: Select... If yes, complete next section. If no, skip to insurance section

RESPONSIBLE PARTY INFORMATION- Complete if client is a minor ***(under 18 years of age)***-

*********<u>***Information listed below must be the parent/guardian who is present at the first appointment***</u>********

First Name: _____ Last Name: _____

Relationship to client: _____

Date of Birth: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred phone #: _____ Type (cell/home/work): _____

May we leave confidential information on a voicemail at the above number? Select...

Name of other parent/guardian: _____

INSURANCE INFORMATION *(Check here if self-pay and not using insurance ☐)*

Insurance Company: _____ Insurance Phone #: _____

Member ID #: _____ Group #: _____

Subscriber First Name: _____ Subscriber Last Name: _____

Subscriber Phone #: _____ Relationship to Client: _____

Subscriber Social Security #: _____ Subscriber Date of Birth: _____

_____ _____

Signature of Responsible Party Date

DISCOVERY COUNSELING & CONSULTING

Policies and Services Agreement

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.

COLLECTION PROCEDURES: Unless arrangements have been made, bills that remain unpaid for more than 90-days will be turned over to an attorney for collection. In that event, you will be liable for and you agree to pay any attorney's fees in the amount of 33% of the current balance. You will also be responsible for and agree to pay interest at a rate of 1½ % per month on the unpaid balance. If you are unable to afford the cost of treatment, your Provider may provide you with information about community mental health centers.

CHANGE IN INSURANCE: It is your responsibility to notify both your provider 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-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 policy applies to all patients including, but not limited to Medicare recipients.

If you arrive late for your appointment, your provider may see you only for the remainder of your scheduled appointment time or decline to proceed with the appointment and request that you reschedule. Full regular fees will apply to appointments if you arrive late, whether your provider sees you for only a partial time or declines to proceed with the appointment. While we try to begin appointments on time, other client needs do sometimes result in your provider 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 provider and ask them during your scheduled appointment times. Except for emergencies, your provider will charge the regular hourly rate for telephone calls that are longer than fifteen minutes and for frequent phone calls. Calls are typically not covered by insurance and you will be responsible and agree to pay DCC its full regular fee for telephone calls.

COPIES OF RECORDS: 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 fees for copying and postage associated with records requests and I acknowledge that 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 denies 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.

COURT TESTIMONY: The fee for any requested court deposition or court testimony, regardless of whether the provider 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) for services provided by a LCSW, LCP, LMFT, or LPC and $500.00 per hour with a minimum charge of $2000.00 (for up to four hours) for services provided by a PMHNP. This includes time 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 for services provided by a LCSW, LCP, LMFT, or LPC and $500.00 for services provided by a PMHNP. I agree to pay all fees for any court testimony regardless of which party may have issued a subpoena, and regardless of whether my treatment is continuing with DCC. 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.

TERMINATION: Any of the below may result in my non-voluntary discharge from treatment:

- Exhibiting physical violence, physical or emotional intimidation, verbal abuse of any kind, including phone calls/messages.
- Bringing weapons into the clinic or engaging in illegal acts of any kind.
- Refusing to comply with clinic rules, refusing to comply with treatment plans/recommendations, or failure to make a payment and/or payment arrangements in a timely manner.
- Repeatedly canceling, late canceling, or no showing for appointments.

OTHER RESPONSIBLE PARTIES: To avoid confusion, each 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 reserve the right to bill the undersigned directly and by signing below, you agree to pay all invoices submitted; we may elect not to bill third parties directly.

PRIVACY POLICY: I understand that as part of my mental health care, DCC originates and maintains paper and/or electronic records describing treatment, testing results and forms, correspondence, and insurance information. I have read and agree to DCC's Notice of Privacy Practices.

My signature below indicates that I have read, understand, and agree to all of the terms set forth above.

_____ _____

Client Name- Printed Minors: Parent/Legal Guardian Name- Printed

_____ _____

Signature of Responsible Party Date

DISCOVERY COUNSELING & CONSULTING

7760 Shrader Rd. Ste B. Henrico, VA 23228 Phone: (804) 591-0002 Fax: (804) 501-0101

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name: _____ Client Phone #: _____

Client Date of Birth: _____ Last 4 digits of SSN: _____

Client Address: _____

_____

I hereby give Discovery Counseling & Consulting (DCC) authorization to:

☐ Release information to: ☐ Obtain information from:

Person/Provider/Company Name: _____

Relationship to Client: _____

Person/Provider/Company Address: _____

_____

Person/Provider/Company Phone Number: _____

Person/Provider/Company Fax Number: _____

Information Requested (please indicate all that apply):

☐ Intake/Assessment
☐ Progress notes
☐ Treatment summary
☐ Billing/Payment information
☐ Other (specify) _____

Purpose of Disclosure:

☐ Coordination of care
☐ Payment of services
☐ Insurance
☐ Legal or Disability
☐ Other _____

I understand that I may refuse to sign this Authorization and that DCC will not condition treatment on my agreeing to this Authorization unless the sole reason for treatment is to create health information to be disclosed to a third-party, in which case, failure to sign this Authorization may allow DCC to refuse to treat me or may prevent DCC from disclosing my health information to the intended third-party recipient. I also understand that I may request to receive a copy of the signed Authorization. I understand that information used or disclosed by DCC under this Authorization might be re-disclosed by a recipient and may, as a result, no longer be protected to the same extent to which it is protected by law while solely in the possession of DCC.

As the person signing this Authorization, I understand that this authorization will expire upon termination of my services with DCC unless otherwise indicated here: _____.
I also understand that I have the right to revoke this Authorization at any time, except to the extent that DCC has already acted pursuant to the Authorization.

_____

Printed Name of Client

_____ _____

Signature of Client/Responsible Party Date

DISCOVERY COUNSELING & CONSULTING

Fee Schedule

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
Initial Psychiatric Evaluation (up to 60 minutes)	$225.00
Medication Management Follow-up Appointment (up to 45 min)	$104.00-$206.00
Medication Management Therapy Add-On	$80.00
FEES NOT COVERED BY INSURANCE:	
Dialectical Behavior Therapy (DBT) Program Fee	$250.00
Medication refill requests between appointments	$25.00
Therapy Appointment Extension (30 min intervals)	$85.00
Psychological or Educational Testing (includes Administration, scoring, report writing)	$200.00/hr
School Meetings (includes travel time)	$165.00/hr
Deposition/ Court Appearance (LCP, LCSW, LPC, LMFT includes travel time)	$250.00/hr
Deposition/ Court Appearance (PMHNP includes travel time)	$500.00/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 the following terms:

I, the undersigned, am ultimately responsible for payment of charges for services provided by Discovery Counseling & Consulting (DCC) including those covered by my insurance. As a convenience, DCC may submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine and I agree to pay all fees for services by DCC.

DCC may require and I agree to pay some amount as determined by DCC 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 or if DCC determines other payments to be appropriate. I understand that this situation may happen if, for example, my deductible with my insurer is not yet satisfied.

DCC may deny service or charge a service fee for failure to pay a co-pay at the time of service.

It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.

I agree to provide DCC and/or its designated payment agent with my debit/credit card or ACH information. 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.

If DCC determines it to be 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.

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.

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 interest charges by DCC on the balance.

Transaction receipts will be emailed to me if I provide and maintain a valid email address.

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

_____ _____

Signature of Responsible Party Date

DISCOVERY COUNSELING & CONSULTING

Credit Card Payment Form

Primary Card

Client Name: _____

Name on Card: _____

Email address for receipts:_____

Credit Card #:_____

Expiration Date:_____

CVV Code: _____

Billing Address: _____

Billing City and State: _____ _____

Billing Zip Code:_____

Card Type: (Circle One) ☐ **HSA/FSA** ☐ **Debit** ☐ **Credit Card**

Card Type: (Circle One) ☐ Visa ☐ MasterCard ☐ Discover ☐ AmEx

Back Up Card

(Required if listing an HSA/FSA above)

Name on Card: _____

Email address for receipts:_____

Credit Card #:_____

Expiration Date:_____

CVV Code: _____

Billing Address: _____

Billing City and State: _____ _____

Billing Zip Code:_____

Card Type: (Circle One) ☐ **HSA/FSA** ☐ **Debit** ☐ **Credit Card**

Card Type: (Circle One) ☐ Visa ☐ MasterCard ☐ Discover ☐ AmEx

DISCOVERY COUNSELING & CONSULTING

Appointment Reminders

We 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. Please be aware that it is your responsibility to attend scheduled appointments or cancel with more than 24 hours' notice to avoid a fee, regardless of whether you receive an appointment reminder. Failure to receive an appointment reminder will not constitute reason to not be charged a late-cancellation fee if you do not attend the appointment.

Client Name: _____

Preferred Method of Appointment Reminder: (select only one)

- ☐ _ Text Message: (Phone Number) _____
- ☐ _ Phone Call: (Phone Number) _____
- ☐ _ Email: (Email Address) _____

_____ _____

Signature of Responsible Party Date

DISCOVERY COUNSELING & CONSULTING

Client Consent to Allow PHI by Email or Text Message

You may give permission to Discovery Counseling & Consulting (DCC) to communicate with you by unencrypted email and by text messages (also known as SMS; this does not include any other sort of messaging such as WhatsApp, Facebook Messenger, etc.). The primary purpose of these communications will be for DCC to inform you of appointment schedules and reminders, to check in periodically, and to provide other information about services that you obtain.

1) Some risks of using unencrypted email and text messages: The use of unencrypted email and text message has several risks that you should consider. These risks include, but are not limited to, the following:
   a) Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   b) Senders can accidentally send or forward an email or text to an undesired recipient.
   c) Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted their copy.
   d) Emails and texts can be intercepted, altered, forwarded, or used without authorization or detection.
   e) Cell phones and other personal devices containing emails and texts can be lost or stolen resulting in disclosure of messages to unauthorized individuals.
2) Conditions for the use of email and text messages: DCC cannot guarantee but will use reasonable means to maintain security and confidentiality of email/text information sent and received. You must acknowledge and consent to the following conditions:
   a) IN AN EMERGENCY, DO NOT USE EMAIL, CALL 911. Do not use email/text for urgent problems. Please call your provider or 911 in the event of a psychiatric emergency. Urgent messages or needs should be relayed to us by using regular telephone communication and may include text messages.
   b) Emails/texts to us should not be time sensitive. While we try to respond to email messages daily, we cannot guarantee that any particular email will be read and responded to within any particular period of time. If you have not heard back from us within three days, call us once to follow up if we have received your email.
   c) You should use your best judgment when considering the use of email or text messages for communication of sensitive medical information. DCC and its personnel are not responsible for the content of messages you send.
   d) DCC is not liable for breaches of confidentiality caused by you or any third party.
   e) It is your responsibility to follow up with your provider if warranted.
   f) I understand that message and data rates from my cell phone service provider may apply.
3) Withdrawal of consent: I understand that I may revoke this consent at any time by so advising DCC in writing. My revocation of consent will not impact my ability to obtain future health care, nor will it cause the loss of any benefits to which I am otherwise entitled.

Client Acknowledgement and Agreement

I acknowledge and agree that by providing my email address and/or cell phone number to DCC I am consenting and agreeing to receive unencrypted email and/or text messages at the email address/telephone number provided, and such messages may include information relating to my health and healthcare, including appointment schedules and reminders, and other information about the services I obtain from DCC. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of unencrypted email and text messaging as a form of communication between DCC and me, and consent to the conditions and instructions outlined, as well as any other instructions that DCC may impose to communicate with me by email or text message.

_____ _____

Signature of Client/Responsible Party Date

_____

Client/Responsible Party email address

DISCOVERY COUNSELING & CONSULTING

Brief Clinical Info

Have you received any counseling or psychiatric services in the past? ☐ Yes ☐ No

If yes: Names of professionals: Approximate date last seen:

_____ _____

_____ _____

_____ _____

Please list any current medications you are taking:

Medication Name	Dosage	Prescribed By	Purpose

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

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

Please describe your reasons for seeking help at this time:

_____

_____

_____

_____

_____