Clinical Psychology Services, Inc.
11325 Random Hills Road, Suite 360
Fairfax, VA 22030

Clinical Psychology Services, Inc.

"The Professionals' Professionals"

Dedicated to Providing the Highest Quality Psychological Services

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Thank you for choosing Clinical Psychology Services, Inc. This packet contains registration information (including demographics, insurance and referral information), a review of HIPPA, our practice financial policies, and informed consent to treatment. Please complete the registration packet <u>in full</u> and provide signatures on the following pages:

Consent, Authorization, and Assignment Agreement: This form verifies that Clinical Psychology Services, Inc. may submit insurance claims on your behalf for services rendered.

HIPPA Privacy Rule: This form verifies that you have been provided with information regarding how Clinical Psychology Services, Inc. implements HIPPA Privacy Rules.

Financial Policy: This form explains payment policies, insurance information, requests for records, telephone calls, missed visit policies, and more.

Informed Consent to Treatment: This form provides information on treatment, referrals, emergency and on-call phone services, termination of treatment, confidentiality, and more.

After completion of this packet in its entirety, please provide office staff with your insurance card, so long as we are submitting for you, and driver's license, so they can make a copy for their records. Your signatures will be reviewed at this time. After verification that the packet is complete, you will be provided with copies of all practice policies and forms for your records.

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Registration

Please Print Clearly

1. Tell Us About Yourself

First Name _____ M.I. _____ Last Name _____

Home Address- Street _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Sex _____

Social Security Number _____ Marital Status _____

Home Phone _____ Work Phone _____

Cell Phone _____ Other Phone _____

Employer _____

Employer Address _____

Highest Grade Completed _____ Diploma or Degree _____

Emergency Contact- Name _____ Emergency Contact- Relationship _____

Emergency Contact- Phone _____ Religious Preference (Optional) _____

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Registration

Please Print Clearly

2. Tell Us About Your Spouse

Spouse's Name _____ Work Phone _____

Employer _____

Employer Address _____

3. Financially Responsible Party

☐ Self ☐ Spouse ☐ Parent ☐ Other

Financially Responsible- Name _____ Financially Responsible- Date of Birth _____

Financially Responsible- Address _____

Financially Responsible- Employer _____

Work Phone _____ Cell Phone _____

4. Family Members With Whom You Are Living

Name Relationship Age _____

Name Relationship Age _____

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Name	Relationship	Age
Name	Relationship	Age

5. Family Physician

Name _____ Phone _____

Address _____

6. Current Health Problems ☐ Yes ☐ No

If yes, please specify _____

7. Major Surgery ☐ Yes ☐ No

If yes, please specify _____

8. Previous Mental Health Care

Doctor's Name or Hospital _____ Dates _____

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Previous Mental Health Care

Doctor's Name or Hospital	Dates

9. Current Medications

Medication	Dose	Reason

10. Allergies ☐ Yes ☐ No

If yes, please specify

11. Health Insurance Information

Primary Insurance Company Name

Complete Address

Subscriber ID Number	Group Number

Primary Subscriber- Name	Primary Subscriber- Date of Birth

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Secondary Insurance Company Name

Complete Address

Subscriber ID Number | Group Number

Secondary Subscriber- Name | Secondary Subscriber- Date of Birth

12. Workers' Compensation Cases

Date of Accident | Claim File Number | Employer at Time of Accident

Complete Name, Address, and Telephone Number of Insurance Company

Case Worker (If Applicable)

13. Automobile or Liability Cases

Date of Accident | Policy Number | Claim Number

Name of Policy Holder

Name of Person Liability is Against (If Applicable)

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_____

Attorney's Name, Address, and Telephone Number

14. How Did You Learn About Our Services?
I was referred by:

☐ Friend _____
Name Address Phone

☐ Doctor _____
Name Address Phone

☐ Insurance _____
Name Address Phone

☐ Attorney _____
Name Address Phone

☐ Minister _____
Name Address Phone

☐ School Counselor _____
Name Address Phone

☐ Website _____
Name Address Phone

☐ Other _____
Name Address Phone

May we thank them for referring you? ☐ Yes ☐ No

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15. Anything Else You Would Like Us to Know?

_____

_____

_____

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Consent, Authorization, and Assignment Agreement

I, _____ (*client or responsible party*), hereby authorize Clinical Psychology Service, Inc. to apply for benefits on my behalf for services rendered. I request that payment be made directly to Clinical Psychology Services, Inc. I affirm that the information provided regarding insurance coverage is true and accurate. I further authorize the release of any necessary medical or other information for this or any related claim to any insurance company. A copy of this Consent, Authorization and Assignment Agreement may be used in place of the original. This agreement will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges, whether or not paid by insurance. I agree to assume responsibility for all charges incurred should collection of this balance become necessary, including court costs and attorney's fees. I also understand that I will be charged $25 for any checks returned by my bank.

Signature of Client or Responsible Party

Printed Name

Date

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HIPAA Privacy Rule

Effective April 14, 2013, the federal government has required that all health care providers be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 C.F.R. parts of 160 and 164). The form you are being given today provides you the notice regarding how we at Clinical Psychology Services, Inc. will implement this rule.

Your signature below indicates that you have been given a copy of our notice form.

Signature

Printed Name

Date

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Financial Policy

Thank you for choosing Clinical Psychology Services, Inc. We are committed to providing you with the most successful treatment possible. We consider the payment of fees to be part of the treatment process, and want to provide you with informed consent regarding our financial policies. You will receive a copy of this policy for your records.

Our standard policy is to expect payment, in full, at the time of service. For your convenience, we accept cash, checks, Visa, and MasterCard. We charge a $25 fee for all returned checks. Each psychologist participates with some insurance plans; please ask the receptionist if your plan is one of those with which your psychologist participates. If they do participate with your insurance, then we will explain the aspects of our financial policy which are unique to your plan.

We are aware that during a course of treatment there may be times when payment may be a problem. We want to work with you, if such times occur, but need you to discuss this with us and make specific arrangements.

At any time that payment is not made at the time of service, we will institute a billing fee of $10 per month to cover our administrative costs in maintaining an open account. If you would like for us to submit claims to your insurance for you and you are out of network, we will be happy to do that, for the $10 monthly charge.

Any amount that is past due for a period greater than ninety (90) days will be turned over to our collections agency and all collection fees (50-100% of the outstanding balance, depending on the level of effort required to collect the account) will be added the account. All legal fees will be charged to your account as well. It is our policy to report all accounts that are turned over to our collections agency to credit bureaus, which will adversely affect your credit.

Regarding Insurance

Psychological services are offered to you, the client. Responsibility for payment rests with you, not your health insurance company. We cannot accept responsibility for collecting payment from your insurance company.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. For some insurance plans, we are required to submit for you.

Ask the receptionist if that is the case for your plan. In those instances, we are submitting to your insurance plan either due to our contract with them, or because you have asked us to submit for you for the $10 monthly charge for filing out of network claims.

On occasion, we may bill you for services which are not covered by your insurance policy and we will expect those services to be paid by you at the time of the services, or at the time of the denial of the claim by the insurance company.

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UCR (Usual, Customary and Reasonable)

Some insurances will deny reimbursement for a portion of the bill because they will claim the charge exceeds the usual, customary and reasonable charge they have established for that service. Such rates vary from company to company and are often based on outdated surveys.

That information is generally not available to us, nor do companies usually provide information about how such rates are established. We are committed to providing you quality service at a fair price, and we will expect you to pay the bill in full regardless of the insurance company's determination of UCR rates.

Additional Charges Which May Be Added to Your Account

a. Insurance Company Requests for Information

Occasionally, insurers ask us for additional information to process your claims. Because it takes a great deal of our staff time, and generally takes the time of the psychologist, we have found it necessary to charge for such information. When we receive a request, we will automatically send a form back to the insurance company informing them that we will provide the requested information. While most insurance companies recognize and pay these claims, some companies do not. If your company denies a request to pay for such information, the amount of that charge will be added to your bill. Our office staff will be happy to provide you with information about how we establish these charges, but they are generally based on the amount of time, either clerical or professional, required to process requests.

b. Requests for Records

From time to time, we receive requests for records from other sources such as attorneys and other health care providers. We will charge a reasonable amount for providing records and for the staff time required to gather and send these requests. If a separate and new report must be prepared by your psychologist, we may bill you at the psychologist's normal hourly rate for the preparation of the report. Such charges are rarely reimbursed by insurance. We will require payment of such fees prior to the release of records.

c. Charges for Telephone Calls

We encourage our clients to be in touch with us when they feel the need to, and therefore do not usually charge for telephone calls. If a call exceeds fifteen (15) minutes, we reserve the right to charge you at our regular hourly rate. It is up to the discretion of the psychologist to charge you for phone sessions.

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d. Charge for Missed Appointments

All appointments that are not cancelled at least twenty-four (24) hours prior to the scheduled time may be billed to you at the full hourly rate. Most insurance companies will not reimburse you for missed appointment charges. Therefore, these charges will be your responsibility. Payment for missed appointments will be expected prior to, or at the time of, the next visit- unless other arrangements have been made between you and your psychologist.

By signing this form, I agree that I have read and accept the financial policies of Clinical Psychology Services, Inc.

Signature of Client or Financially Responsible Party

Printed Name

Date

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Informed Consent to Psychotherapy

Welcome to Clinical Psychology Services, Inc. This handout is designed to answer some frequently asked questions about our services. Please read the document in its entirety before you sign the agreement and/or enter therapy.

Psychological Treatment and Referrals:

Therapy is a collaborative process that depends on your active involvement in expressing how you think, feel, and behave. We encourage you to ask questions about the therapeutic process. Both you and your doctor share responsibility for evaluating your progress in therapy. If at any time, you feel that you could be better served by another professional, we encourage you to mention any these concerns to your doctor. You also have the right to ask your doctor about other available treatments for your condition. Your doctor has the obligation to refer you if another professional would better address your concerns. Similarly, if treatment is not progressing well, your doctor may suggest consultation with a different professional. Please be aware, your doctor does not prescribe medication, but if consultation is needed, he or she will provide you with a referral.

After Hours and Emergency On-Call Services:

For after hours and weekends, an answering machine is used to receive your messages. The number is 703-691-1326.

This practice also offers 24-hour on-call services for emergency care. An emergency is a life-threatening or very serious situation that requires immediate attention. To reach the on-call psychologist, dial 703-691-1326 for further instructions.

The on-call psychologist will generally be able to return your call within 30 minutes. If your call is not returned within 30 minutes, call the emergency number and leave a second message, taking care to speak slowly and clearly. If you are unable to wait for a return call, you should go to the nearest hospital emergency room.

Termination:

Termination of therapy should not be done casually, as it is a critical part of the therapeutic process. You or your doctor may terminate sessions if it is agreed that it is in your best interest. Your doctor needs to meet with you for at least one session after you wish to terminate to review your accomplishments, goals, work together, any further work to be done, and options. You have a right to review your case records with your doctor upon request. Your case records will be kept in a secure place by Clinical Psychology Services, Inc.

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Confidentiality:

In general, the law protects the confidentiality of all communications between a patient and a psychologist, and the doctor may only release information about their work to others with your written permission. Here are several matters concerning confidentiality:

1. Any release of records will require written consent by the patient or the appropriate guardian. Patients may be charged an appropriate fee for the preparation of such records.

2. If a client uses third party reimbursement, our practice is required to provide the insurer with a clinical diagnosis and, sometimes, a treatment plan or summary. If a client requests it, we will provide a copy of any report that is submitted.

3. If the client is under 18 years of age, the specific content of client and doctor communications is confidential. However, the clients' parents or legal guardian have a right to receive general information on the progress of treatment.

4. In group therapy, family therapy and marital therapy, all participants are required to consent to the release of information. One marital partner may not waive the confidentiality privilege for another. In cases of marital therapy, therefore, the record may be released only if both parties waive privilege by written consent or if release of the record is court ordered.

5. Your doctor may occasionally need to consult another professional about your case. The consultant, like the doctor, is legally bound to maintain confidentiality. Consultation with another doctor occurs if 1) the doctor needs a second opinion, 2) the doctor is referring the client to another professional – in this case, they must have a signed release of information from the client 3) if your doctor is away from the office for a few days and a trusted fellow therapist is "covering" for them. This therapist is available for emergencies and thus may need to know certain information about clients.

There are also a few exceptions to confidentiality, however:

In most judicial proceedings, you have a right to prevent your doctor from testifying. However, in child custody proceedings, adoption proceedings, and proceedings in which your emotional condition is of relevance, the court may require your doctors' testimony in order to reach a resolution in your case. If you are involved in litigation, or are anticipating litigation, and you choose to include your mental or emotional state as part of the litigation, your doctor may be required to reveal part or all of your treatment or evaluation records.

There are some circumstances when a doctor is required to breach confidentiality without the client's permission. This occurs when 1) the doctor suspects the abuse of a minor- in which case the doctor must file a report with the appropriate agency, 2) if a doctor concludes that the patient threatens serious harm to themselves or another- in which case the doctor may notify the police, warn the intended victim, and/or inform family members of seeking the patient's hospitalization.

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A psychologist has both a legal and ethical responsibility to take action to protect endangered individuals from harm when the doctor's professional judgment indicates that such danger exists. Fortunately, these situations rarely arise in our practice.

While this summary of exceptions to confidentiality should prove helpful in informing you about potential problems, you should be aware that the laws governing these issues are complex, and we are mental health professionals, not attorneys. Active discussions of these issues with your doctor is encouraged**.** However, if more specific advice is needed, feel free to contact formal legal consultation.

I have read the above, and can further discuss with my provider the various aspects of the psychotherapy contract. This can include a discussion of his/her evaluation and diagnostic formulation, as well as the method of treatment. The nature of the treatment should be described, including the extent, its possible side effects, and possible alternative forms of treatment. I fully understand the limits of confidentiality in this relationship, and the circumstances in which confidential communications may need to be breached. I understand that I may withdraw from treatment at any time after first notifying and discussing this with my doctor.

My provider can further discuss with me scheduling policies, fees to be charged, policies regarding missed appointments, matters related to insurance, and, if applicable, pre-authorization and utilization review issues.

Signature of Client or Responsible Party

Printed Name

Date