

Clinical Psychology Services, P.C.
11130 Fairfax Blvd, Suite 305 | Fairfax, VA 22030

REGISTRATION *(please print clearly)*

1. TELL US ABOUT YOURSELF

First Name	M.I	Last Name	Social Security Number	
Address		City	State	Zip
Date of Birth	Age	Sex	Home Phone	Marital Status
Employer		Work Phone		
Employer Address		City	State	Zip
Highest Grade Completed	Diploma or Degree		Religious Preference (optional)	
Emergency Contact (First, Last)			Emergency Contact Phone Number	

2. TELL US ABOUT YOUR SPOUSE (if applicable)

Spouse's Name (First, Last)			Phone Number	
Employer				
Employer Address		City	State	Zip

3. FINANCIALLY RESPONSIBLE PERSON

Self Spouse Parent Other

First Name	Last Name		Phone Number	
Address		City	State	Zip
Employer				

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4. FAMILY MEMBERS WITH WHOM YOU ARE LIVING

Name (First, Last)	Relationship	Age
Name (First, Last)	Relationship	Age
Name (First, Last)	Relationship	Age
Name (First, Last)	Relationship	Age
Name (First, Last)	Relationship	Age

5. FAMILY PHYSICIAN

Name (First, Last)	Phone Number		
Address	City	State	Zip

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 (First, Last)	Dates
Doctor's Name (First, Last)	Dates

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9. CURRENT MEDICATIONS

Medication	Dose	Reason
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Medication	Dose	Reason
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10. ALLERGIES

Yes No

If yes, please specify

11. HEALTH INSURANCE INFORMATION

Primary Insurance Company Name

Address	City	State	Zip
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ID Number	Group Number	Subscriber
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Secondary Insurance Company Name

ID Number	Group Number	Subscriber
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12. WORKERS' COMPENSATION CASES

Date of Accident	Claim File Number	Employer (at time of accident)
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Name of Insurance Company	Phone Number
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Address	City	State	Zip
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Case Worker (if applicable)

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13. AUTOMOBILE OR LIABILITY CASES

Date of Accident	Policy Number	Claim Number	
Name of Policy Holder (First, Last)			
Name of Person Liability is Against (First, Last) (if applicable)			
Attorney's Name	Phone Number		
Insurance Company Address	City	State	Zip

14. ANYTHING ELSE YOU WANT US TO KNOW?

15. HOW DID YOU LEARN ABOUT OUR SERVICES?

- Friend Doctor Insurance Attorney School Counselor Minister
 Website Other _____

May we thank them for referring you? Yes No

Name (First, Last)

Address	City	State	Zip
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CONSENT, AUTHORIZATION and ASSIGNMENT AGREEMENT

I, _____, hereby authorize Clinical Psychology Services, P.C. to apply for benefits on my behalf for services rendered. I request that payment be made directly to Clinical Psychology Services, P.C. 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 I will be charged \$25 for any checks returned by my bank.

Signature

Date

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INFORMATION FOR CLIENTS

Payment for psychological services is expected at the time of your session. If you wish to make other arrangements for payment, or if you have questions about your insurance coverage, please talk to your doctor or the office staff.

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 from your insurance company.

We request 24-hour notice when you must cancel or miss an appointment. Your doctor reserves the right to bill you at the full fee for sessions that are missed or canceled. Ideally, you and your therapist will agree to end therapy at a point when you have achieved your goals. If you decide that you would like to end your therapy sessions, we ask that you discuss this in person during a session with your doctor.

Client of Responsible Party Signature

Date

Doctor Signature

Date

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HIPAA

Effective April 14, 2003, 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, P.C. will implement this rule.

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

Signature

Date

Printed Name

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CLINICAL PSYCHOLOGY SERVICES FINANCIAL POLICY

Thank you for choosing Clinical Psychology Services, P.C. 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 as such want to provide you with informed consent regarding our financial policies. You will receive a copy of this policy for your records.

Each patient is required to complete a registration form.

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 in some insurance plans; please ask the receptionist if your plan is one of those with which we participate. If it is, 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 that 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, 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 collection 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 to 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 collection agency to credit bureaus and this will adversely affect your credit.

Regarding Insurance

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. Again, ask the receptionist if that is the case for your plan. In those instances, where we are submitting to your insurance plan, either because of our contract with them, or because you have asked us to submit for you for the \$10 monthly charge, if the insurance has not paid the claim in forty-five (45) days we will require you to pay the balance. Virginia has a law which requires an insurance company to pay a claim in a "reasonable" time and that is defined in Virginia as forty-five (45) days.

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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.

UCR (Usual, Customary, and Reasonable)

Some insurance 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 a UCR rate.

Additional Charges Which May Be Added To Your Account

A. Insurance Company Requests for Information

From time to time insurers ask us for additional information to process your claim. Because it takes a great deal of our staff time, and generally take the time of the psychologist, we have found it necessary to charge for such information. When we receive such a request, we will automatically send a form back to the insurance company informing them that we will provide the requested information after they pay the preparation charges. While most insurance companies recognize such claims, and pay them, some companies do not. If your company denies such 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 such charges, but they are generally based on the amount of time, either clerical or professional, required to process such requests.

If you are having difficulties with your insurance company, please let us know, and we will be glad to try to help you. Because we have dealt with many insurance companies, we can often guide you in ways to speed the settlement of your claims.

We can provide you with a list of questions to ask your insurance company prior to treatment so that you may find out how much they will reimburse you for your treatment.

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 copying such records and for the staff time required to gather and send such requests. If a separate and new report is must be prepared by your psychologist, we will bill you at the psychologist's normal hourly rate for the preparation of the

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report. Such charges are rarely reimbursed by insurance. We will require payment of such fees prior to the release of such 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.

D. Charge for Missed Appointments

All appointments that are not cancelled at least twenty-four (24) hours prior to the scheduled time will be billed to you at the full hourly rate. Most insurance companies will not reimburse you for missed appointment charges, therefore, such 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, P.C.

Signature of Client or Financially Responsible Party Date

Print Name

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INFORMED CONSENT TO PSYCHOTHERAPY

Welcome to Clinical Psychology Services, P.C. This handout is designed to answer some frequently asked questions about our services. Please read all of it 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 such concerns to your doctor. A list of other qualified therapists is available upon request. 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 condition. 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 it is in your best interests. Your doctor needs to meet with you for at least one session after you wish to terminate to review your work together, goals, accomplishments, 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, P.C.

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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 will 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.

Signature:

I have read the above, and fully discussed with my provider the various aspects of the psychotherapy contract. This has included a discussion of his/her evaluation and diagnostic formulation, as well as the method of treatment. The nature of the treatment has been 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 has further discussed with me scheduling policies, fees to be charged, and policies regarding missed appointments, matters related to insurance and, if applicable, pre- authorization and utilization review issues.

Signature

Date

Print Name