BLUE RIDGE
PSYCHOLOGICAL CENTER

PATIENT INFORMATION (PLEASE PRINT):

Full Name_____
Last First MI
Home Address_____

City, State, Zip_____

Email:_____

Home Phone_____Cell Phone_____Work Phone_____

Male_____Female_____Birth Date_____

Marital Status: Single Married Divorced Separated Other_____

Employer_____Job Title_____

Emergency Contact_____Phone_____Relationship_____

How did you hear about us?_____

INSURED/SUBSCRIBER INFORMATION:

Subscriber Name:_____Relationship to Patient_____

Subscriber's Date of Birth_____Employer_____

Subscriber SS#_____Subscriber Phone Number:_____

Subscriber Home Address_____
(If different from above)

Primary Insurance Company_____ID #_____Group #_____
***Please note we do not file to secondary insurance companies
***Please note we are not contracted or affiliated with MEDICARE

Primary Care Physician Information:

Primary Care Doctor/Pediatrician_____

Office Location_____

Phone_____Fax (if known)_____

BLUE RIDGE

PSYCHOLOGICAL CENTER

Consent to use and disclose your health information

This form is an agreement between you,

_____

(Adult Patient/Parent/Legal Guardian Name)

and, Blue Ridge Psychological Center. When we use the word "you," below, it will mean your child, relative, or other person if you have written his or her name here:

_____

(Minor Patient Name)

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment using a third party payer.

By signing this form you are agreeing to let us use your information for the above referenced purposes. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent Form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future if we change how we use and share information, the changes will be included in our new Notice of Privacy Practices. If we do change it, you can get a copy by calling us at 571-248-2358, or in person from our privacy officer when you come to the office.

If you are concerned about some of your information, you have the right to ask us not to use or share a portion of your information for treatment, payment, or administrative purposes. You will have to specify specifically in writing to tell us what you do not want disclosed. Although, we want to respect your wishes, we are not required by law to agree to these limitations. However, if we do agree, by signing a copy of your specific limitations, we will comply with your written restrictions.

After you have signed this consent, you have the right to revoke it at anytime (by providing us with a written statement telling us that you no longer consent to our use) and we will comply with your written directions. However, such limitation will be forward looking and will not create any liability for our use of the information prior to the revocation. Additionally, if you revoke our right to use the information for insurance billing purposes you agree that you will pay all charges on your account.

_____

Printed Name of Patient/Parent/Legal Guardian

_____

Signature of Patient/Parent/Legal Guardian

Date_____

I have had access to a copy of BRPC's Notice of Privacy Practices _____ (Please Initial)

Patient Name_____

Informed Consent for Treatment

I,_____consent to participate in behavioral health services offered at and provided by Blue Ridge Psychological Center, LLC, behavioral health care providers. I understand I am consenting and agreeing only to those services that the provider is qualified to provide within the scope of the provider's license, certification, and training. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody or guardianship of this individual and I am legally authorized to initiate and consent to treatment on behalf of this individual.

Length and Cost of Services (Non-Legal)

Initial Evaluation and Diagnosis; 45 minutes: $150.00;
Subsequent Individual Counseling Sessions; 45 minutes: $120.00
Subsequent Marriage and Family Sessions; 45 minutes: $125.00
Ancillary Service : $120.00/hour billed in 15 minute increments of time
Request a copy of Medical Records: $25

Cancellation Policy

All appointments must be canceled 24 hours prior the scheduled appointment. Failure to do so will result in a missed appointment charge of **$75.00**. By signing this form, I acknowledge that I have read and fully understand BRPC's policy for cancelation of appointments.

Billing and Insurance Policy

1. I authorize the release of information to my insurance company(s).
2. I understand that I am responsible for the full amount of my bill for services provided including if the insurance company refuses to pay any amount.
3. I authorize direct payment from my insurance provider directly to my service provider and BRPC.
4. I agree a copy of this form is equally valid for all purposes as an original and may be used in place of an original.
5. It is your responsibility to pay any deductible, co-pay, coinsurance, or any other balance not paid by your insurance company
6. Co-pay/Co-insurance/Deductibles are due at the time of service. Failure to pay your co-pay at the time of service may result in additional fees.
7. There will be a $35.00 service charge on all returned checks.
8. In the event we feel a need to turn your account to a collection agency, attorney or our own collections department you agree that 30% of the outstanding balance shall be added to your bill as a collection fee, and you agree this is a reasonable and necessary cost and will pay it.

I understand and accept all of the above terms regarding billing, payment, insurance, use of private medical information and the BRPC cancellation policies.

_____
Printed Name

_____ _____
Signature of Patient/Parent/Guardian Date

Blue Ridge Psychological Center
7520 Gardner Park Drive, Gainesville, VA 20155
*Tel. 571-248-2358 * Fax. 571-248-2359*

Clients are strongly discouraged from having their therapist subpoenaed. If you are in the midst of court involvement, it is in your best interest to seek services from a therapist who has additional training in court/legal matters (Forensic Psychology). If there is a chance you will need court involvement, please let your therapist know and we are happy to refer to a practice that offers that specialty. Please note, that if you subpoena a therapist, the requesting person will be responsible for all fees incurred. Please also note, that there is NO guarantee that the therapists testimony will be in the clients favor. The therapist will only testify toward the facts that were presented by their patient and will not provide any professional opinion regarding any matters, including, but not limited to custody.

Court Action / Legal Fees

* Preparation time (including submission of records): $300/hr
* Phone calls: $300/hr
* Depositions: $300/hour
* Time required in giving testimony: $300/hour
* Mileage: $0.54/mile
* Time away from office due to depositions or testimony: $300/hour
* All attorney fees and costs incurred by the therapist as a result of the legal action.
* Filing a document with the court: $150
* The minimum charge for a court appearance: $3,000.00

_____
PATIENT NAME

_____
PATIENT / GUARDIAN SIGNATURE

_____
DATE

Insurance Information

This information must be obtained prior to your initial appointment.

When you call you insurance company, please specify that you need your OUTPATIENT MENTAL HEALTH BENEFITS.

Name of Mental Health Insurance Carrier:_____

Please be aware that your medical insurance provider may not be the same insurance company that provides your mental health benefits.

Insurance Contact Number: ( ) _____

Questions to ask:

Do you have an annual deductible? Y N If yes, amount: $_____

Have you met your deductible? Y N If no, how much is left? $_____

Co-pay/Co-Insurance Amount: $_____/ _____%

Number of visits allowed?_____

Is your number of visits limit per calendar year or contract year?

If contract year, when does your contract year start? _____

Does your insurance require pre-authorization? Y N

If yes: Authorization Number_____

# of Authorized Visits Approved:_____

Start Date of Authorization_____

Expiration Date of Authorization_____

REMINDER OPTIONS

_____ Please send me a reminder for my upcoming appointment. I understand that electronic communications sometimes have transmission difficulties, therefore, if I do not receive a reminder, I am still expected to attend my appointment. If I do not cancel with 24 hours notice, I will be responsible for any associated fees.

_____ Cell Phone: _____

_____ Please DO NOT send me any reminders

CREDIT/DEBIT OPTION

BRPC contracts with the company, "Instamed," which allows us the the ability to keep credit/debit cards on file. All applicable copays and coinsurance will be charged to this card. Any balance that is more than 30 days delinquent will also be charged to this card (unless other financial arrangements have been made). I further understand that if I do not wish to utilize this credit/debit option, I will be expected to pay all balances at the time of my visit (or when a statement is received) by check or cash

_____ Please keep my credit/debit information on file

_____ DO NOT keep my information stored, I will pay by check or cash at the time of my visit or when statement is received

_____
PATIENT NAME (PRINTED)

_____
SIGNATURE (OF PATIENT OR LEGAL GUARDIAN)

_____
DATE

Blue Ridge Psychological Center

*Name*_____

*Date*_____

In order to get the most of our first session together, I would appreciate knowing more about the concerns that bring you in at this time. Below is a checklist that may help you describe what you're experiencing. Please check any items on the list that you have concerns about.

- ☐ Abuse (physical/emotional/sexual)
- ☐ Adultery
- ☐ Agression/Violence
- ☐ Alcohol/Drug Use
- ☐ Anger, hostility, arguing, irritability
- ☐ ADD/ADHD
- ☐ Appetite change (more/less)
- ☐ Career or work related concerns
- ☐ Childhood issues
- ☐ Concentration difficulty
- ☐ Codependence
- ☐ Decision making
- ☐ Defiance of rules/norms
- ☐ Depression, low mood, tearful, sad
- ☐ Delusions
- ☐ Divorce
- ☐ Eating disorders/problems
- ☐ Fears
- ☐ Financial problems
- ☐ Grief
- ☐ Guilt
- ☐ Hallucinations
- ☐ Health problems
- ☐ Heart racing
- ☐ Hopelessness
- ☐ Impulsivity
- ☐ Irresponsibility
- ☐ Legal problems
- ☐ Low energy
- ☐ Low motivation
- ☐ Mood swings
- ☐ ObsessionsParenting
- ☐ Perfectionism
- ☐ Procrastination
- ☐ Racing thoughts
- ☐ Relationship problems
- ☐ Risk taking
- ☐ Self esteem
- ☐ School problems
- ☐ Self control
- ☐ Sleep disturbance
- ☐ Social problems
- ☐ Stress
- ☐ Thoughts about death/dying
- ☐ Thoughts of hurting yourself or someone else
- ☐ Trembling/Shaking
- ☐ Weight/dieting issues
- ☐ Withdrawal/Isolation
- ☐ Worthlessness