Virginia Beach
Counseling and Wellness

Welcome! We are glad you have decided to make an appointment at Virginia Beach Counseling and Wellness.

Our office is located at 1553 Bradford Rd. Ste. 102, Virginia Beach, VA 23455.

Please bring to your first appointment:

1. Your completed new client paperwork
2. Photo ID
3. Insurance card
4. Credit card (**cardholder** must complete authorization)
5. **For minors** – If parents/guardians are divorced, we require a copy of the legal documents indicating the custody agreement and who has the legal right to consent to medical treatment. In cases of joint custody, we require the signature of both parents at the time of the first session, unless your custody agreement specifies otherwise.

Please provide at least 24 hours notice if you need to cancel or reschedule your appointment. Monday appointments must be canceled by Friday at 5PM.

Please give us a call at 757-453-2144 if you have any questions about your appointment or why we need these items. We will look forward to seeing you.

Information and Consent Form

The purpose of this document is to give you more information about your therapist, our policies and practices, and your rights and responsibilities. Your first session gives us a chance to get to know each other and to find out more about the challenges you are facing. If we decide to continue working together, we will further discuss the goals, focus, risks and benefits of treatments, the approximate time commitment involved, costs and other aspects of your particular situation. Periodically, we will evaluate our progress and, if necessary, redesign our treatment plan, goals, and methods. We may also discuss ways you can implement our work between sessions. This work can help you gain valuable skills and growth while you are in counseling.

Virginia Beach Counseling and Wellness is a group practice consisting of a team of independent contractor practitioners. Our clinicians work collaboratively and may consult on your care.

About our therapists:

-Our therapists are independently licensed professional counselors and social workers in the state of Virginia and are contracted with Virginia Beach Counseling and Wellness to provide mental health counseling services. Their full bio and credentials can be viewed on our website, vabeachcounseling.com.

Missed Appointment Policy

- The missed appointment fee is $90 (the average insurance reimbursement) OR your full session fee if you do not use insurance (up to $165).
- To avoid missed appointment fees, **please cancel with at least 24 hours notice and by Friday at 5PM for Monday appointments.**
- Fees will be charged to the card on file at the time of the missed appointment.
- Your account must be paid in full before rescheduling.

Confidentiality and Records

Virginia Beach Counseling and Wellness will maintain records in accordance with HIPAA and Virginia law.

Generally, we will tell no one what you tell us without your written consent, unless you are under the age 18, in which case, we will discuss the legal rights your parent(s)/ guardian(s) have to your records.

There are two primary circumstances in which we cannot guarantee confidentiality, legally or ethically: (1) when we believe you intend to harm yourself or another person; and (2) when we believe a child or elder person has been or will be abused or neglected. In rare circumstances, a counselor can be ordered by a judge to release information.

Disclosure may be required by your health insurance carrier. This includes your diagnosis and, in some cases, your entire clinical record. By signing this agreement, you agree that I can provide requested information to your insurance carrier.

Records are stored in a secure Electronic Health Record. Staff and clinicians have access to the full practice schedule within the Electronic Health Record. Clinicians contracted with the practice may collaborate and consult with each other on your care. Only the clinicians assigned to your care will have access to your notes and full records.

In keeping with standards of practice, your therapist may consult with other mental health professionals, outside of the practice, regarding care and management of cases. The purpose of this consultation is to ensure quality of care. Your therapist will maintain complete confidentiality and protect your identity by not using real names or any identifying information.

Working with Multiple Providers

In some cases, you may work with more than one provider at our practice. For example, if you are seeking individual therapy and couples therapy. Any providers assigned to your care will work collaboratively and will have access to your records. Please ask your clinician if you have any questions about this policy.

Explanation of Dual Relationships

Although you may share very private thoughts and emotions with your therapist, it is important for you and your therapist to maintain a professional rather than social relationship. Contact is limited to scheduled appointments and we do not participate in social media relationships.

Appointment Guidelines

Sessions are 45 to 53 minutes in duration. Starting and ending appointments on time allows us to best utilize your time. If you arrive more than 15 minutes late, we are not able to bill your insurance. Your appointment will be rescheduled and you will be charged the full fee for a missed appointment.

Fees, Method of Payment, and Insurance

$165 per intake assessment
$145 per 45-53 minute individual, couples or family session

Reduced fee appointments available with some clinicians.
Agreed upon fee: _____

Payment is required at the time of service. We keep a credit card on file for ease of payment but also accept cash and checks.

Any unpaid balance will be charged to the card on file. If you accrue an outstanding balance or missed appointment fee, payment must be received prior to scheduling your next appointment.

Fees are subject to change and you will be given at least 30 days of notice of any changes.

We reserve the right to use the services of a collection agency for unpaid balances.

Account statements are available upon request.

Insurance

We accept several insurances and can discuss the details of your particular plan. The client is responsible for any fees not covered by their insurance.

Please note that any insurance quotes provided are an estimate based on information provided to us by the insurance company. We strongly encourage you to speak with your insurance company to fully understand your benefits as they apply to mental health services.

Non-therapy Services Including Services Related to Court and Legal Issues

Prep time, administrative time, time spent writing reports or assessments, phone calls and other correspondence will be billed at the amount of $165 per hour.

We do not take part in any court cases unless subpoenaed. The charge for court is a minimum nonrefundable fee of $1200, paid in advance, regardless of whether we actually testify or appear in court. The first $1200 applies to a maximum of four hours of our time at an out-of-office courtroom rate of $300 per hour. Expenses we may incur such as parking, travel time, telephone calls, and time spent preparing documents will be charged at $350 an hour and are in addition to the $1200 minimum fee. If we are required to be on call beyond the first four hours for a court appearance, an additional $1200 minimum fee will be incurred, even if we must remain "on call" one minute, one hour, or all four hours beyond the first four, whether we are actually called to testify or not. If a client wants us to speak, meet, or correspond in any way with any other person to include but not limited to an attorney, probation officer, CPS worker, physician, etc., the client will be billed for the therapist's time.

Clients should consider whether or not they want to issue a subpoena for a therapist to testify in court. The process is always expensive to the client, and there is no guarantee that what the therapist will say will be of benefit to the client's case. In some cases a therapist's testimony may be detrimental to the client's case.

Termination of Treatment

If you are out of contact with your therapist for 30 days at any time your case will be considered closed.

Messages

Messages for us can be left on voice mail 757-453-2144. Some of our clinicians are in the office part-time and may not be available to return calls every day. Please ask your clinician about their availability and the best way to reach them.

Emergency Contact

We offer outpatient care and do not have 24 hour emergency care. If you experience a psychological emergency, please contact your therapist at 757-453-2144. If we are not available:

1. call the 24-hour crisis line at VBDHS 757-385-0888, **or**
2. call the Virginia Beach Psychiatric Center's 627-LIFE crisis line, **or**
3. call 911/ go to the nearest Emergency Room for immediate treatment

Complaint Procedures

If you are not satisfied with any aspect of our work, please inform your therapist so that we can work with you to resolve the concern. You may also bring concerns to our practice manager.

If you think that you have been treated unfairly or unethically, by our therapists or any other licensed therapist and cannot resolve this problem with the practice, you can contact:

Commonwealth of Virginia - Department of Health Professions
6606 West Broad Street, Fourth Floor, Richmond, Virginia 23230-1717 phone (804) 662-9575

Email and Texting Policy

- While we make every effort to protect text and email, we can provide no assurance confidentiality or security.
- The standard email you use at home or work is most likely not HIPAA secure and could be vulnerable to unauthorized access.
- Electronic communications are not appropriate if you are experiencing a crisis.
- We may not check my email or texts every day.
- **Our main office number is a landline and does not accept text messages.** Please check with your individual therapist about whether they are willing to communicate via text message.
- With your consent, we may send automated email or text appointment reminders.

Each client must weigh the benefits against the potential risk and determine the communication types they are comfortable using.

Please sign below that you understand and agree with the above policy.

I consent to using email communication: ____ Y _____ N

I consent to using text message communication: ____ Y _____ N

Please carefully read the statement below and initial:

_____ I consent for myself (or my child) to receive behavioral health services at Virginia Beach Counseling and Wellness.

_____ I have read, understand, and agree to comply with the fee policy and the **Missed Appointment Policy.**

_____I have reviewed the Notice of Privacy Practices (HIPAA) located in the
(Located in waiting room, please ask if you would like a copy for your records)

_____ **I will use my insurance benefits.** I understand that I am responsible for all co-payments, cost share payments, or out of pocket payments for services provided to me. I authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan.

_____I understand that I am responsible for any fees denied or not covered by my insurance company.

OR

___ I will pay for services out of pocket and will not use insurance or will submit my own receipts for out of network reimbursement. I understand that I am responsible for all fees for services provided to me.

I have read and understand the conditions outlined above:

Client's signature _____ Date _____

Parent/Guardian _____ Date _____

Therapist _____ Date _____

Credit Card Authorization

This form is necessary even if you do not intend to use credit card payment so we have a backup for any missed session fees, forgotten payments, etc.

By signing this agreement, I am authorizing Virginia Beach Counseling and Wellness to bill my credit card for professional services rendered to
(client name) _____. I agree that I will not dispute valid charges, which may include:

- Agreed upon fees for services
- A missed session fee if the client does not show up for a scheduled appointment or cancels with less than 24 hours notice
- Checks that are returned will incur the check amount and a $25 bank fee
- Disputed cc charges which are found to be valid will incur a $35 administrative fee for time spent responding to the dispute
- Co-pays, cost-shares, deductibles, or any fee not covered by your insurance

You may also choose to use another form of payment at the time of service.
Unpaid balances will be charged to the card on file.

CARDHOLDER INFORMATION

Name: _____Relationship to client: _____

Billing Street Address:

City: _____ State: _____ Postal Code: _____

Email: _____ Telephone: _____

CREDIT CARD INFORMATION
Credit Card Type: □ MasterCard □ Visa □ Discover Card

Last 4 digits: _____Expiration Month: _____Expiration Year: _____
Is this an HSA or HRA card? □ yes □ no

Cardholder Signature _____ Date _____

Complete if cardholder is NOT the client.

I, (client name)_____, authorize Virginia Beach Counseling and Wellness to disclose billing information to the above named cardholder.

Client signature _____ Date _____

New Client Information

Name: _____ Gender: _____ Age: _____ Date of Birth: _____

Address: _____

May we *discretely* contact you at this address? □ yes □ no

Cell Phone: _____ May we *discretely* contact you at this number? □ yes □ no

Home phone: _____ May we *discretely* contact you at this number? □ yes □ no

Email Address: _____

Would you like to be added to the practice email newsletter? □ yes □ no

Marital/relationship status: _____ Ethnic/Cultural Background: _____

Education: _____ Occupation: _____ Employer: _____

Emergency Contact:

Name/phone_____ Relationship: _____

How did you find out about this counselor? □ Google/online search □ Psychology Today □ Insurance

□ Referred by provider. Name of referring provider: _____ □ Other

Primary Insurance Information

Name of Insurance Company: _____

Policy Owner's Name: _____

Policy Owner's Date of Birth: _____

Policy Owner's SS#: _____

Insurance ID #:_____

Policy Owner's Address (only if different than above):

_____

Do you have secondary insurance? ____y ____n

We do not bill secondary insurance and will provide you with the necessary forms to submit to your insurance company.

Please be prepared to provide our office staff with your insurance card and photo ID so that we may make a copy.

Current Concerns

Please provide a brief description of what made you decide to seek counseling at this time:

_____

_____

_____

In what areas do your problems impact your life: (Check all that apply)

□ Lifestyle □Activities

□ Relationships □Eating

□Sleeping □Mood

Have you ever attempted suicide? □ Yes □ No If yes, when? _____

Have you currently been thinking about suicide? □ Yes □ No

Have you ever thought about harming or killing someone else? □ Yes □ No

If yes, when? _____

Have you currently been thinking about harming or killing someone else? □ Yes □ No

Do you use drugs or alcohol? □ Yes □ No If yes, what type and how often?

_____

_____

Have you ever received treatment for substance abuse? □ Yes □ No If yes, when?_____

Family history of substance abuse? □ Yes □ No

Additional information:_____

Treatment History

Are you currently being treated by a mental health professional or physician for the problems noted above? □ Yes □ No

Name of Professional/Practice, Contact Information, Treatment Type (counseling, therapy, medication, etc.)

_____

_____

_____

Current medications:

_____

_____

Previous mental health treatment:

Date(s) Name of Professional, Treatment Type, Why treatment ended

_____

_____

_____

Have you ever been hospitalized for mental health treatment? □ Yes □ No

Date(s) Name of Hospital or Facility, Reason for Hospitalization

_____

_____

_____

Health Information

Name, Practice Name, and contact information for your Primary Care Physician:

_____

_____

When were you last seen by your physician?_____

Current health problems:

_____

_____

If you have an eating disorder, is your physician aware? □ Yes □ No

Have you ever had any health problems related to an eating disorder? □ Yes □ No Additional details:

_____

_____

Client's signature _____ Date _____

Parent/Guardian _____ Date _____

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Please complete this form if you would like us to communicate with your primary care physician. Extra copies are available for psychiatrists or other providers involved in your care.

Please initial below if you would prefer that we not communicate with your primary care physician.

_____ I **do not** consent to coordination of care with my primary care physician.

DATE:_____

CONTACTED PARTY:
Name: _____ Fax: _____

Address: _____ Phone: _____

_____

CLIENT INFORMATION:
Name: _____ DOB: _____

INFORMATION TO BE RELEASED BY THE THERAPIST:
Information pertinent to outpatient individual, family, and/or group psychotherapy to include mental health conditions and/or substance use._____
_____

INFORMATION TO BE RELEASED BY THE CONTACTED PARTY:
Any information pertinent to the client's recovery process with regards to his/her mental health, and/or substance use._____
_____

SPECIFIC PURPOSE FOR WHICH INFORMATION IS REQUIRED:
To facilitate coordination of care and assist in the client's recovery process._____

_____
Client Date

_____
Parent/legal guardian Date

_____
Therapist Date

I authorize the release of information from the above named party to Virginia Beach Counseling and Wellness, LLC 1553 Bradford Rd. Ste. 102 (757) 453-2144 **AND** I authorize Virginia Beach Counseling and Wellness to release information to the above named party.

This authorization will expire 90 days after your last date of service.

NOTE: I understand that I have the right to revoke this release of information at any time. Revocation must be submitted in writing. A revocation will not apply to information that has already been released. Virginia Beach Counseling and Wellness and its contracted clinicians are not responsible for confidential information, which is passed on to any party named in this release.
To the party receiving the information: This information has been disclosed to you from records whose confidentiality is protected under Federal Law. Federal Regulations (HIPAA, 42 CFR Part 2) prohibit you from making any further disclosure without the written consent of the person to whom it pertains. A general authorization for the release of medical or other information is not sufficient for this purpose.

For office use only:

Virginia Beach
Counseling and Wellness

Date_____

Practice:_____

Provider: _____

Address:_____

_____

Fax: _____

I am writing to coordinate care for our mutual patient, _____ who was seen for an intake assessment on _____.

Therapist: _____

Diagnosis: _____

Treatment plan: □ individual therapy □ couples therapy □ family therapy

□ other _____

Recommended frequency: □ twice a week □ weekly □ every other week

□ other _____

Additional information: _____

_____

Please let me know if there are any changes in his/her medical status that that may impact treatment. Records can be faxed to 866-337-6301.

Please let me know if I can provide any additional information and I will look forward to collaborating on this patient's treatment.

Sincerely,

Virginia Beach Counseling and Wellness is a multispecialty counseling center offering individual, couples, and family therapy to clients ages 4+. We have a special focus on trauma, eating disorders, and the LGBT community.