Riverside Counseling, PLLC
Phone: (540) 373-1200 Riversidecounseling.org Fax: (540) 373-1283

Counseling Registration and History

Patient Information

Today's Date			
Client Name			
Client is a Minor	☐ Yes ☐ No		
Parent/ Legal Guardian	Name:	Relationship:	
Address			
City			
State			
Zip Code			
Home phone	**( )**	☐ Okay to call	☐ Don't call
Cell phone	**( )**	☐ Okay to call	☐ Don't call
Work phone	**( )**	☐ Okay to call	☐ Don't call
E-mail			
Gender	☐ Male	☐Female	☐Choose not to disclose
Status	☐Single	☐Married	☐Other
Age			
Birthdate			
Employer			
Occupation			
Emergency Contact	Name: Phone:	Relationship:	
Whom may we thank for referring you?			

IS THIS COURT ORDERED Yes_____ No_____?

Which counselor will you be seeing today? _____

Insurance Information if Applicable (Don't need to complete if card has been scanned)

Who is responsible for this account?	
Relationship to Client	
Employer of Insured	
Insurance Co.	
Insurance ID#	
Group #	
Covered by additional insurance?	☐ Yes ☐ No
Subscriber's Name	
Birthdate	
SS#	

May we contact your physician?	☐ Yes ☐ No
Reason for today's visit:	
Health Concerns:	
Mental health condition(s) you are currently experiencing (e.g., depression, anxiety, PTSD, eating disorder, etc.)	
Medication currently being taken and reason for the prescription:	1. Reason: 2. Reason: 3. Reason: 4. Reason: 5. Reason: 6. Reason:
Additional information you feel may be helpful for your treatment:	

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Riverside Counseling, applicable insurance benefits, if any, payable for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named counselor may use my health care information and may disclose such information to the above-name insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits for related services. This consent will end when my current treatment plan is completed.

I also acknowledge I have received the HIPAA Notice of Privacy and understand my rights contained in the notice.

_____

Signature of Client, Parent, Guardian and/or Personal Representative

_____

Printed name of Client, Parent, Guardian and/or Personal Representative

_____

Relationship to Client Date

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Information and Consent Form

Welcome to Riverside Counseling. It is important to know that your treatment is based on full disclosure. We want you to feel informed and knowledgeable of your rights as a client and to know the potential risks, legal and ethical obligations we have in treating you.

Counseling is a real commitment of time and energy. At any time, should you decide to terminate counseling for any reason, you have the right to end the therapeutic relationship. As well, if your counselor feels it is in your best interest, she/he has the right to end the counseling relationship and make appropriate referrals.

As a client of this practice, you have the right to be treated with dignity and respect regardless of your race, gender, religion, age, sexual preference or ethnicity. You have the right to participate in the planning of your treatment.

There are potentials risks to counseling. Therapy may be painful, and you may experience periods of unpleasant emotions. Generally, the discomfort is short-lived and will pass with the resolution of your problems. Please bring any concerns you see with the process or with your treatment to the attention of your counselor. If you have a problem with the service, please feel free to contact the owner of Riverside, Andrew Roberts.

As a client you have the right to privacy and confidentiality concerning with you disclose in therapy. Communication between you and your counselor is considered privileged and is legally protected. According to Federal Law, this practice cannot disclose information regarding your treatment without your written permission. This protection does have limitations, however. In cases of suspected or reported elder or child abuse or neglect, we are mandated reporters for the state of Virginia and must report the situation to the appropriate government agency.

If you should threaten to harm an identifiable third party, it is required that notification be given to local law enforcement agencies and the person in potential danger. If you should threaten to harm yourself in a clear and planned manner, it is required by law to take necessary steps to protect your life. The results could include insistence on voluntary inpatient hospitalization, notification of local law enforcement agencies, or the initiation of involuntary commitment procedures. Also, in rare cases, the court can require that notes be turned over.

Riverside Counseling requires the collaboration effort of both you and your clinician. When you miss your scheduled appointment, or cancel without the required 24-hour notice, you miss an opportunity for treatment and prevent someone else from having the opportunity to receive counseling. You are responsible for keeping your appointment within the 24-hour window. Late cancellations and missed appointment will be charged the full fee of $50-$125 depending on which therapist you are seeing. Payment will be expected on or before your next scheduled appointment.

It is a privilege to have you come to this practice. Please feel free to ask any questions about these topics or any other area of concern or interest. Please sign below if you are satisfied and agree to abide by the information provided above.

_____ _____

Signature of Client, Parent, Guardian and/or Rep Date

_____

Printed name

Check all symptoms that apply (helpful information – can be discussed with the counselor and the paperwork completed in session)

	Depressed mood		Numbness/tingling
	Decreased interest in activities		Chills or hot flashes
	Weight gain or loss		Afraid to leave the house
	Difficulty sleeping		Repetitive behaviors (e.g., hand washing)
	Sleeping too much		Mental acts that must be performed (e.g., counting)
	Feelings of worthlessness nearly everyday		Recurrent and persistent thoughts
	Excessive or inappropriate guilt nearly everyday		Recurrent and persistent impulses
	Diminished ability to think or concentrate		Recurrent and persistent images
	Recurrent thoughts of death		Restrictive eating
	Recurrent thoughts of suicide		Compulsive eating
	Suicidal thoughts		Binge eating
	Suicidal plan		Purging
	No suicidal plan		Food rituals
	Suicide attempt in the past		Substance/Alcohol use
	Excessive anxiety and worry		Inflated self-esteem
	Difficulty controlling the worry		Decreased need to sleep
	Restlessness		More talkative than normal/pressure to keep talking
	Easily fatigued		Excessive involvement in harmful activities
	Difficulty concentrating		Trouble wrapping up details of a project
	Irritability		Difficulty organizing things
	Muscle tension		Difficulty adjusting to new situations
	Sleep disturbance		Life and death traumatic experience
	Fear of social situations		Sexual abuse
	Fear of performance situations		Raped
	Heart racing		Childhood physical/emotional abuse
	Sweating		Childhood verbal abuse
	Trembling/shaking		Adult physical abuse
	Sensation of shortness of breath		Adult verbal/emotional abuse
	Feelings of unreality; detached from oneself		Conflict avoidant
	Fear of losing control		Anger issues
	Fear of dying		Co-dependency tendencies (put another before self)

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Health Insurance and Payment Explanations

Riverside Counseling will submit claims to your insurance company on your behalf. We try our best to give you the most accurate information provided to us by your insurance carrier regarding your coverage. Based upon this information, we will provide a good faith estimate of your payment responsibility. However, if your insurance company does not pay as expected or if the policy changes, **you are ultimately responsibility for any balance due on your account.** We encourage all clients to contact your insurance company to obtain benefits coverage. All co-pays, deductibles and co-ins that apply must be paid at the time of services.

By signing below, I certify that I, and/or my dependents have insurance coverage and I authorize that my insurance benefits, if applicable, be paid directly to Riverside Counseling. I also authorize the clinician or insurance company to release any information required to process my claims. I may revoke this authorization in writing at any time. I understand that I am financially responsible for any balances due.

Referrals:
I understand that it is my responsibility to obtain a referral if it is required by my insurance company. **I will be responsible for all charges if I am seen without a referral.**

Riverside Counseling does not participate with Medicare or any Medicaid Plans.

_____ _____
Client's Signature *Date*

_____
Printed Name of Client

For patients under the age of 18: [ ] parent [ ] legal guardian must sign this consent for any minor child.

_____ _____
Parent, Guardian, or Power of Attorney's Signature *Date*

_____ _____
Printed Name of Parent, Guardian, or POA *Relationship to Client*

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Fee Agreement

Missed/ Cancelled Appointments: Riverside Counseling charges $50.00 per missed or cancelled appointment made less than 24 hours of the scheduled time. If there are more than two of these events, clients will be charged $125.00 per missed/cancelled appointment thereafter.

Testing: A fee of $100.00 will be charged if a testing appointment is missed or cancelled less than 24 hours of scheduled time. This fee must be paid in order to reschedule any more testing dates.

Subpoenas/Attorney's Fees: Riverside Counseling charges a fee of $1500.00 per day if a clinician is required to be away from the practice for court related cases. Payment is due two weeks prior to court date. This is Non-refundable regardless if case is settled and/or continued.

For over the phone conference, face-to-face and/or depositions with attorney(s) the fee is $200.00 an hour (minimum 1 hour). This must be cancelled 72 hours in advanced in writing to receive a refund.

Form/Letter Fee: If a client requests letter(s) and or form(s) to be completed by their counselor a fee of $50.00 will be charged.

Medical Records Request: VA Law allows for copy charges consisting of the following: $10.00 administrative fee Plus $0.50 per page for the first 50 pages and $0.25 per page thereafter, and $1.00 per page of microfilm/fiche.

_____ _____
Printed Name of Client Date

_____
Signature of Client

If client is under the age of 18: A [ ] parent [ ] legal guardian must sign this consent for any minor child.

_____ _____
Parent/Guardian printed name Date

_____
Parent/ Guardian Signature

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HIPAA NOTICE OF PRIVACY ACKNOWLEDGEMENT

I acknowledge that I have read the HIPAA Notice of Privacy and understand my rights contained in the notice.

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health information for the purpose of treatment, payment, insurance inquiry, legal inquiry and health care operations as described in the privacy notice.

_____ _____

Printed Name of Client Date

_____

Signature of Client

If client is under the age of 18: A [ ] parent [ ] legal guardian must sign this consent for any minor child.

_____ _____

Parent/Guardian Printed Name Date

_____

Parent/ Guardian Signature