Riverside Counseling, PLLC

Phone: (540) 373-1200 Riversidecounseling.org Fax: (540) 373-1283

Counseling Registration and History

Today's Date			
Client Name			
Client is a Minor	☐ Yes ☐ No		
Parent/ Legal Guardian	Name:	Relationship:	
Address			
City			
State			
Zip Code			
Home phone	( )	☐ Ok to call	☐Ok to leave messages
Cell phone	( )	☐ Okay to call	☐ Ok to leave messages
Work phone	( )	☐ Okay to call	☐ Ok to leave messages
E-mail			
Administrative Sex (for insurance purposes)	☐ Male ☐Female ☐Other		
Gender Identity			
Status	☐Single ☐Married ☐Other		
Birthdate		Age:	
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, including the potential risks and the 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 also 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 what you disclose in therapy. Communication between you and your counselor is considered privileged, and it 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 we 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 subpoena our therapy records.

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. You also prevent someone else from having the opportunity to receive counseling at that scheduled time. Therefore, you are responsible for keeping your appointment within the 24-hour window. Late cancellations and missed appointments 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		Fear of dying
	Decreased interest in activities		Fear of social situations
	Weight gain or loss		Afraid to leave the house
	Substance/Alcohol use		Fear of performance situations
	Difficulty sleeping or sleep disturbance		Fear of losing control
	Decreased need to sleep		Repetitive behaviors (e.g., hand washing)
	Sleeping too much		Mental acts that must be performed (e.g., counting)
	Diminished ability to think or concentrate		Recurrent and persistent images
	Feelings of worthlessness nearly everyday		Recurrent and persistent thoughts
	Excessive or inappropriate guilt		Recurrent and persistent impulses
	Excessive anxiety and worry		Restrictive eating
	Recurrent thoughts of death		Binge eating
	Recurrent thoughts of suicide		Compulsive eating
	Suicidal plan		Food rituals
	Suicide attempt in the past		Purging
	Chills or hot flashes		Difficulty organizing things
	Restlessness		Difficulty adjusting to new situations
	Easily fatigued		Trouble wrapping up details of a project
	Difficulty concentrating		Excessive involvement in harmful activities
	Irritability		More talkative than normal/pressure to keep talking
	Muscle tension		Conflict avoidant
	Heart racing		Co-dependency tendencies (put another before self)
	Trembling/shaking		Feelings of unreality; detached from oneself
	Sensation of shortness of breath		Gaps in memory or lost time
	Sweating		Interpersonal conflict
Are there any other symptoms you would like to notify your therapist? Feel free to list them here.			
Are there any traumatic incidents in your past that you would like to disclose to your therapist on this form? Feel free to state them here.			

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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. 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 appointments within 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 before the scheduled time. This fee must be paid in order to reschedule.

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 the court date. This is non-refundable, regardless of whether the 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 in writing 72 hours in advance in order 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