BLUE RIDGE

PSYCHOLOGICAL CENTER

PATIENT INFORMATION (PLEASE PRINT):

Full Name_____
Last First MI

Home Address_____

City, State, Zip_____

Email:_____
*By providing your email address you agree to receive emails from our practice.

Home Phone_____Cell Phone_____
*Please note that we will send appt reminders via text to the cell phone provided. If you would like to opt out or use a different phone number, please let your provider know.

Birth Date_____Male_____Female_____

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 or MEDICAID

Primary Care Physician Information:

Primary Care Doctor/Pediatrician_____

Office Location_____

Phone_____Fax (if known)_____

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 here. Our Notice of Privacy Practices (attached to clipboard) 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 we may change how we use and share information and so may our 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.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although, we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us why you no longer consent) and we will comply with your wishes using and sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

_____

Printed Name of Patient/Parent/Legal Guardian

_____

Signature of Patient/Parent/Legal Guardian

Date_____

Informed Consent for Treatment

I,_____consent to participate in behavioral health services offered at and provided by Blue Ridge Psychological Center, behavioral health providers. I understand I am consenting and agreeing only to those services that the provider is qualified to provide, within the scope of the providers 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 of this individual and am authorized to initiate and consent to treatment, and I am legally authorized to initiate and consent to treatment on behalf of this individual.

Length and Cost of Routine Services
(Non-Legal)

Initial Evaluation and Diagnosis; not exceeding 45 minutes: $150.00
Subsequent Counseling Sessions; not exceeding 55 minutes: $150.00
Subsequent Counseling Sessions; not exceeding; 45 minutes: $120.00
Ancillary Service : $150.00/hour billed in 15 minute increments of time
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.
3. I authorize direct payment to my service provider and BRPC.
4. I permit a copy of this form to be used in place of an original.
5. It is my 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. Any fee that remains unpaid after 45 days will incur a $25 late fee, per month, until the balance is paid or other financial arrangements have been agreed upon.
9. All accounts that are over 90 days delinquent will be forwarded to a collections company and will incur an additional 35% fee.

Credit Card Policy

I understand that when using a credit card at BRPC, my card will be kept securely on file. Any applicable copays, deductibles, coinsurance or missed appt fees will be charged at the time of visit. BRPC reserves the right to use this credit card to process any balance due at the time of session or to pay any balance that is >30 days delinquent. Any accounts not paid within 30 days will have a $25 late fee added, monthly until the balance is paid or a financial arrangements have been made. All accounts that are over 90 days delinquent will be forwarded to a collections company. If you have questions about a balance, please promptly notify your provider before your card on file is charged. By signing below, I acknowledge this credit card policy and understand that I am able to pay by cash or check if I choose to not want my credit / debit card kept on file.

I understand and accept all of the terms regarding payment, billing, insurance, and cancellation policies.

_____
Patient Name (Printed)

_____ _____
Signature of Patient/Parent/Guardian Date

Court Action / Legal Fees

Patients 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 will be happy to referral you to a practice that offers that specialty. Please note, that if you subpoena a therapist or require any court mandated and/or legal services, you will be responsible for all fees in accordance with this policy. Please also note, if a therapist is subpoenaed to appear in court, there is NO guarantee that the therapists testimony will be in the favor of the patient. The therapist will only testify toward the facts that were presented by their patient and will not provide their professional opinion regarding any matters, including, but not limited to custody.

- Preparation time (including submission of records: $300 / hr.
- Phone calls: $300 / hr.
- Depositions: $300 / hr.
- Time required in giving testimony: $300 / hr.
- Mileage: $0.54 / mile
- Time away from office due to depositions or testimony: $300 / hr.
- All attorney fees and costs incurred by the therapist as a result of legal action: $300 / hr.
- Filing a document with the court: $150
- The minimum charge for a court appearance: $3,000

_____
Patient name (printed)

_____
Signature of patient / parent / legal guardian

_____
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, IN AN OFFICE SETTING.**

Name of **MENTAL HEALTH** Insurance Carrier:_____

*Please be aware that your insurance carrier may utilize a different company for mental health benefits. In order to use "in network" benefits, your provider must be in network with the company that provides your mental health benefits

Insurance Phone Number (Provider Number): ( ) _____

Questions to ask:

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

Have I met my deductible? Y N If no, how much is left? $_____

Co-pay Amount: $_____

Coinsurance Amount: $ _____

Does my insurance require pre-authorization? Y N

Please note that ALL EAP services require the patient to obtain authorization. In order to use EAP services at your initial appointment, you are required to complete the information below.

EAP Company: _____
(This is often different that your medical insurance company)

Authorization Number_____

# of Authorized Visits Approved:_____

Start Date of Authorization_____

Expiration Date of Authorization_____

SYMPTOMS / CONCERNS

In order to get the most out of our first session together, I would appreciate knowing more about the concerns that bring you in today. Below is a checklist that may help you describe what you are experiencing. Please check any items that concern you or feel free to add any that are not included.

___ Abuse (Physical/Emotional/Sexual)	___ Hopelessness
___ Adultery	___ Impulsivity
___ Aggression / Violence	___ Irresponsibility
___ Alcohol / Drug Use	___ Low energy
___ Anger, arguing, irritability	___ Low motivation
___ Anxiety	___ Mood swings
___ ADD / ADHD	___ Obsessions / Compulsions
___ Appetite change (more / less)	___ Parenting concerns
___ Career / Work related concerns	___ Perfectionism
___ Childhood issues	___ Procrastination
___ Concentration difficulty	___ Racing thoughts
___ Codependence	___ Relationship problems
___ Decision making	___ Risk taking / Self control
___ Defiance of rules / norms	___ Self esteem
___ Depression, low mood, tearful, sad	___ Sleep disturbance
___ Delusions / Hallucinations	___ Stress
___ Divorce / Separation	___ Thoughts about hurting self / others
___ Eating disorder / problems	___ Worthlessness
___ Fears	***Please lis any other concerns below***
___ Financial problems	
___ Grief	
___ Guilt	
___ Health problems	
___ Heart racing	