Blue Ridge Psychological Center
7520 Gardner Park Dr., Gainesville, VA 20155
7982 Donegan Dr., Manassas, VA 20155
(p) 571.248.2358 | (f) 571-248-2359

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_____Work Phone_____

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:

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

Subscriber Name:_____Relationship to Patient_____

Subscriber's Date of Birth_____Employer_____

Subscriber SS#_____Subscriber Phone Number:_____

Subscriber Home Address_____
(If different from above)

Primary Care Physician Information:

Primary Care Doctor/Pediatrician_____

Office Location_____

Phone_____Fax (if known)_____

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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 (available online and by request) 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, on our website at www.brpcva.com 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

_____
Signature of Patient or Legal Guardian (if patient is a minor)

_____
Printed name of Legal Guardian (if applicable)

_____
Date

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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

MINORS AND PARENTS

Patients under the age of 18 years of age who are not emancipated, and their parents should be aware that the law may allow parents to examine their child's record. Privacy and establishing a trusting environment in psychotherapy is crucial to the therapeutic process and its effectiveness. For this reason, it is our policy to require an agreement from parents that they give up access to the minor's record. By signing this consent to treatment, it is understood that the minor's record and content of sessions will be kept confidential. We will provide parents with general information about our work together, unless we feel there is a high risk that the minor will seriously harm himself/herself or someone else. In that case, the provider will notify the parent(s) of their concern. Any other communication will require the child's authorization. Before giving parents any information, the provider will discuss the matter with the child, if possible, and do their best to handle objections that he/she may have.

Length and Cost of Routine Services (Non-Legal)

Initial Evaluation and Diagnosis; not exceeding 45 minutes: - $175.00 (Master's Level Clinicians

Subsequent Counseling Sessions; not exceeding 55 minutes: $150.00 (Master's Level Clinician)

Subsequent Counseling Sessions; not exceeding; 45 minutes: $120.00 (Master's Level Clinician)

Ancillary Service : $150.00/hour billed in 15 minute increments of time (Master's Level Clinician)

Medical Records: $25

Participation in Litigation / Legal Fees

BRPC and its providers will not voluntarily participate in any litigation or custody dispute involving a client. We have a policy of not communicating with clients' attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in a legal matter. BRPC and its providers will generally not provide records or testimony unless compelled to do so by the court. Should BRPC or its' providers be issued a subpoena in any action involving a client, the client and/or the requesting party agrees to reimburse BRPC for any time spent as outlined in this agreement. A summons to appear for court testimony, including depositions or administrative hearings, requires a flat, non-refundable fee of **$2,500.00 per day, per individual or entity named**,

pre-paid two (2) weeks in advance. In addition, we will charge **$300 per hour** for anything related to the subpoena, including, but not limited to, preparation time, phone calls, travel time, expenses/lodging, testimony, etc. These charges will apply even if BRPC and/or its providers are ultimately excused from testifying. Should it become necessary for BRPC to initiate collections proceedings or retain an attorney to collect any fees hereunder, you and/or the requesting party agree to pay all associated fees required for collection.

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 30 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.
10. I understand the outlined fee schedule for legal fees and also understand these are services not covered by insurance.

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Credit Card Policy

CREDIT CARD ON FILE: I understand that when using a credit card at BRPC, my card will be kept securely on file. I, hereby, authorize BRPC to charge the card that has been supplied for payment, wether listed below or given to BRPC in person / phone for all services and fees. Any applicable copays, deductibles, coinsurance, missed appt fees and ancillary fees will be charged at the time of visit / service. Any accounts not paid within 30 days will have a $25 late fee added, monthly until the balance is paid or financial arrangements have been made. All accounts that are over 90 days delinquent will be forwarded to a collections company. By signing below, I acknowledge this credit card policy and understand that I will pay by cash or check at the time of service, if I prefer to not keep my credit / debit card on file. This credit card authorization can be revoked at any time by submitting a written request to BRPC.

Credit Card Company: Visa MC Amex Discover HSA:_____

Cardholder Name (as written on card):_____

Card Number:_____

Expiration Date:_____

Security Code / CVV:_____

Billing Information

Address:_____

City:_____ State:_____ Zip:_____

_____
Printed Name of Patient

_____
Signature of Patient or Legal Guardian (if patient is a minor)

_____
Printed Name of Legal Guardian (if applicable)

Telehealth / Teletherapy

Definition of Services:

By signing this form I am consenting to engage in teletherapy with my provider at Blue Ridge Psychological Center (BRPC). Teletherapy is a form of psychological service provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually. Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions.

I understand that I have the following rights with respect to teletherapy:

1. I, the client, need to be a resident of Virginia and be located in Virginia at the time of the teletherapy service.

2. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

3. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy follows the same guidelines that I have previously agreed to when signing the general informed consent paperwork at BRPC.

4. I understand that there are risks and consequences when participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my provider, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

5. There is a risk that services could be disrupted or distorted by unforeseen technical problems.

6. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that if my provider believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area.

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7. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may even get worse.

8. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency department for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support. Clients who are actively at risk of harm to self or others may not suitable for teletherapy services. If this is the case or becomes the case in future, my provider may recommend more appropriate services.

9. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of the psychological treatment provider to do the same on their end.

I understand and accept all of the terms regarding consent to treat (including telehealth), payment, billing, insurance, and cancellation policies.

_____
Printed Name of Patient

_____
Signature of Patient or Legal Guardian

_____
Printed Name of Legal Guardian (if applicable)

_____
Date

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Insurance Information

This information must be obtained prior to your initial appointment. When you call you insurance company, please specify that you need your

ROUTINE OUTPATIENT MENTAL HEALTH BENEFITS

MENTAL HEALTH Insurance Company:_____

***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.**

***BPRC does not participate with any Employee Assistance Programs (EAP)**

Insurance Phone Number (Provider Number): _____

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 / Coinsurance amount per session _____

Are Telehealth services covered? Y N

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INSURANCE CARD

In the area below, please copy an image of the FRONT and BACK of your INSURANCE CARD