Adult Client Paperwork Instructions

Print the paperwork below, fill it out and bring it to your appointment.
You may fax it prior to your appointment. Fax #: (757) 490-6995
***If you are being seen for couples counseling both of you will need to fill out a packet.

If you are not able to fill out the paperwork please arrive 30 minutes early to fill it out in the office.

For all appointments in our VIRGINIA BEACH office during the day (9am-5pm) please arrive 10 minutes early for check-in.

For questions regarding the attached paperwork, directions, or insurance please contact us at (757) 490-6960.

If unable to make this scheduled appointment, please call as soon as possible to reschedule.

We look forward to meeting you!

Associated Counselors of Tidewater, Inc.

Adult Client Information

SECTION 1: CLIENT INFORMATION

Today's Date: ____________________

Legal Name: First ____________________________MI ____________Last ___________________________________

Nick Name: _____________________ Age: _______ Birthdate: ______________ S.S.#: ____________________

Address: ____

Cell Phone (____)________________ Home Phone (____)________________ Work Phone (____)________________

Employer Name: ____Occupation:______________________________

Spouse's Name: ____ Age: ______ Birthdate: ________________

Spouse's Employer: ____ Occupation: ______________________

Emergency Contact: __________________________ Phone: (____)_______________ Relationship: ___________

Children's Names	Age	Birthdate	Relationship to you	Lives with you
				YES NO
				YES NO
				YES NO
				YES NO

List all other members (other than spouse & children) living in your home (family and/or friends):				
Name	Age	Birthdate	Relationship to you	Occupation

SECTION 2: PRESENTING INFORMATION

Describe the reason you are seeking counseling: ____

___# years you have lived in this area ___ # of years in present relationship ___ # of prior marriages

Present relationship/marriage is: ____ very happy ____ pleasant ____ tolerable ____ poor

Have you had suicidal thoughts in the past? ___ Never ___ Sometimes ___ Often

Do you currently have suicidal thoughts? ___ Never ___ Sometimes ___ Often

Have you ever attempted suicide? ___ yes ___ no if yes, please explain ____

____

Rate the following on how often it is difficult to function at your normal level: Never = 0 Sometimes = 1 Often = 2

___ Anxiety ___ Manic states ___ Anger ___ Depression ___ Concentration

Rate the problems that apply to you: No Problem = 0 Mild = 1 Moderate = 2 Severe = 3

___ Nervousness ___ Depression ___ Fears ___ Shyness ___ Sexual problems

___ Drug use ___ Separation ___ Divorce ___ Memory ___ Alcohol use

___ Friends ___ Anger ___ Self control ___ Health problems ___ Stomach problems

___ Relaxation ___ Headaches ___ Tiredness ___ Work ___ Legal matters

___ Stress ___ Sleep ___ Energy ___ Insomnia ___ Making decisions

___ Loneliness ___ Inferiority ___ Pain ___ Education ___ Concentration

___ Nightmares ___ Temper ___ Appetite ___ Unhappiness

SECTION 3: CLIENT HEALTH INFORMATION

Height _________ Weight_________ Physical condition: ____ Excellent ____ Good ____ Fair ____ Poor

Name of Primary Care Physician ____

Most Recent doctor Visit (when & why) ____

List any health problems for which you are currently receiving treatment: __________________________________

____

Do you have a physical fitness program? ____ Not at all ____ Occasionally ____ Regularly

Do you have any Allergies? ____yes ____ no if yes, please explain _________________________________

Any major surgical operations? ____yes ____ no If yes, for what & when? ______________________________

Current Medications:

Name	Start Date	Dosage/Frequency	Taken For

Sleeping Habits: __ No problems _____ Difficulty falling asleep _____ Early morning waking

_____ Nightmares/dreams _____ Insomnia _____ Restless _____ Sleep too much

Eating Habits: Eating problems? ____ yes ____ no # meals you normally eat daily? ____ # snacks daily? ___

Do you have, or have you had in the past, any eating disorders**?** ____ yes ____ no

If yes, please explain ____

Sexual History: Please describe any sexual problems that you have experienced in the past or are currently experiencing:

____

Drug/Alcohol History: Do you ever drink alcohol ____ yes ____ no If yes, how often? ________________

Do you drink alcohol to alter behavior/mood? ____ yes ____ no If yes, how often? ___________________

Do you use drugs to alter behavior/mood ____ yes ____ no If yes, how often? ________________________

Have you ever received treatment for alcohol/drug use? ____ yes ____ no If yes, when? _________________

Have you ever been charged with a DWI/DUI? ____ yes ____ no If yes, when? _________________________

Do you now or have you ever attended AA/NA/ALANON? ____ yes ____ no If yes, when? _________________

Counseling History Have you received previous psychiatric/psychological help or counseling? ___Yes ___No

Date(s)	Name of therapist/doctor	Name of Practice & location

Have you ever been hospitalized for substance abuse, eating disorder or other psychiatric problems? ___Yes ___No

Date (s)	Reason	Name of Hospital & location

SECTION 4: CLIENT EDUCATIONAL AND VOCATION INFORMATION

Education - Indicate your highest level of education:

____ Grade school # of years completed ____

____ High school # of years completed ____

____ College # of years completed ____ area of study ____________________________________

____ Advanced degree # of years completed ____ area of study ____________________________________

Describe any specialized skills for which you have training: certification or licensure: _______________________________

____

School has been ____ easy ____ fairly easy ____ difficult ____ very difficult

Any specific area of difficulty? ____

Areas of Achievement: ____

Vocation - Describe your employment history for the past five years beginning with your current position:

Employer	Position	Time on job	Reason for leaving
____________________________	___________________________	_____________	________________________________
____________________________	___________________________	_____________	________________________________
____________________________	___________________________	_____________	________________________________
____________________________	___________________________	_____________	________________________________
____________________________	___________________________	_____________	________________________________

Has your employer/supervisor ever expressed any of these concerns? (Check all that apply)

____ Missing too much work ____ Assigned tasked ____ Irresponsibility

____ Poor/bad attitude ____ late too often ____ Increased errors

____ Difficulty getting along with other workers/supervisors Other ____

Military History

Have you ever served in the military service? ____ yes ____ no If yes, branch of service: _________________________

Age at enlistment: _______ Rank at discharge: _______________________________ Any combat? ____ yes ____ no

If yes, please describe: ____

Financial History

Do you have a system of saving money? ____ yes ____ no

Are you currently, or have you ever been, in a financial crisis? ____ yes ____ no

Explain: ____

For couples, do you divide your income and bills ______ or do you combine and share income and bills? _______

Spiritual History

Do you expect your spiritual life to be included in therapy? ____ yes ____ no

Were you brought up in any religious tradition? ____ yes ____ no

What is you current affiliation? ____

Do you attend services? ____regularly ____ most of the time ____ occasionally ____ never

SECTION 5: CLIENT BACKGROUND INFORMATION

Family History

Mother: Name ____________________________________ Age _______ (if deceased, when?) _____________________

Nationality _____________________________Highest level of education__________________________________

Occupation _____________________________Abilities/special interests __________________________________

General Health Status: Physical __________________________Emotional: _______________________________

Describe your relationship with her: ____

Father: Name __________________________________ Age _________ (if deceased, when?) _______________________

Nationality _______________________________Highest level of education _______________________________

Occupation _______________________________Abilities/special interests ________________________________

General Health Status: Physical ___________________________Emotional: ______________________________

Describe your relationship with him: ____

Brothers & Sisters Names & Ages:

____

____

____

Where did you grow up? ____

With whom did you live during your childhood? (Check all that apply)

___ Mother & Father ___ Mother only ___ Father only ___ Mother & Stepfather

___ Father & Stepmother ___ Relatives ___ Foster Parents Other: ____

Describe you childhood: ___Very happy ___Pleasant ___Bearable ___Unhappy ___Mixed

Please explain ____

Describe you adolescence: ___Very happy ___Pleasant ___Bearable ___Unhappy ___Mixed

Please explain: ____

Check all that apply: ___I was not abused as a child ___ I witnessed abuse in the home

___I was emotionally abused ___I was physically abused ___I was sexually abused as a child

Please explain: ____

Any family history of alcohol and/or drug abuse? ___yes ___no If yes, who, explain? ________________________

____

Have any of your family members ever received counseling? ____ **yes** ____ **no** if yes, who and for what reason?____

Any Addition Comments: ____

____

Associated Counselors of Tidewater, Inc.

Insurance Information

Client's Name: ____

Employee Assistance Program (EAP) Company (if applicable): ______________________

Employee Name: ______________________ SS#: ____________ DOB: ______

Employer: ______________________ Patient Relationship to Employee: ________

EAP Phone #: ______________________ Authorization #: ________________

Primary Insurance Company Name:______________________________

Full Name of Insured (employee):______________________________

Policy Number (ID #): ________________ Group Number: ____________________

Insured Date of Birth: ________________ Insured's Social Security #: ______________

Insured's Employer: ______________________________________

Patient Relationship to Insured: ______________________________

Insured's Address (if different than client): ________________________

Secondary Insurance: We normally do no submit claims to Secondary Insurance Companies. If you have a secondary insurance then you will be responsible for your primary insurance co-insurance/co-pay unless you have made other arrangements with us. We can give you a statement showing that you paid and then you can submit that along with the primary insurance EOB (explanation of benefits) to your secondary insurance for reimbursement. There are some primary insurance companies like Medicare that will automatically forward claims to the secondary.
Secondary Insurance Company Name:______________________________

Full Name of Insured (employee):______________________________

Policy Number (ID #): ________________ Group Number: ____________________

Insured Date of Birth: ________________ Insured's Social Security #: ______________

Insured's Employer: ______________________________________

Patient Relationship to Insured: ______________________________

Insured's Address (if different than client): ________________________

ASSIGNMENT OF BENEFITS AUTHORIZATION:

I hereby assign to Associated Counselors of Tidewater any insurance or other third-party benefits available for psychiatric/counseling care provided to me. I understand that Associated Counselors of Tidewater Practice has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Associated Counselors of Tidewater, I agree to forward to Associated Counselors of Tidewater all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

RECORD RELEASE AUTHORIZATION:

I hereby authorize Associated Counselors of Tidewater to furnish medical information to my insurance carrier(s).

______________________ ______________________ __________

Signature of Patient/Legal Guardian Printed Name Date

PLEASE GIVE THE OFFICE STAFF/YOUR THERAPIST YOUR INSURANCE CARD(S) TO COPY.

Associated Counselors of Tidewater, Inc.

POLICIES & PROCEDURES

Associated Counselors of Tidewater, Inc. is committed to providing professional services to the highest quality and standards. In order to serve our clients efficiently and responsibly we require agreements be made as to the following policies.

Fees for services:

As a client of Associated Counselors of Tidewater, Inc., you will be required to pay for each session at the time of the each visit.

Diagnostic Interview (1st session): $150.00
Individual/Family Therapy (45 minutes): $125.00
Individual/Family Therapy (60 minutes): $165.00
Group Therapy: $55.00

Court Appearance (including travel): $200.00/hour, $400.00 advanced deposit
Drug Test: $30.00
Typed Letter or Report: $25.00
Release of Records: $25.00

Missed appointments/Late Cancellation: $60.00*
We accept checks, cash, & credit/debit cards. There is a $1.00 convenience fee if you use a credit/debit card.

CLIENTS WITH INSURANCE

Your copay and deductible are quoted by your insurance company but does not guarantee claim payment. We suggest that you also call to very your benefits for out-patient mental health and verify whether or not pre-authorization is required. As a client of Associated Counselors of Tidewater, Inc., you will be required to pay your co-pay at each visit. You will also be required to pay any deductible amount at each visit until the deductible is met. You will be responsible for any denied payments from your insurance company.

CLIENTS WITHOUT INSURANCE

You will be required to pay for each session at the time of the each visit. Self-pay rates are as follows:
Diagnostic Interview (1st session): $90.00
Individual, Couple, or Family Therapy (45 minutes): $70.00
Individual, Couple, or Family Therapy (60 minutes): $90.00
Group therapy: $35.00

COLLECTIONS FEES:

ONCE YOU STOP RECEIVING SERVICES HERE, IF YOU HAVE A BALANCE WE WILL SEND YOU ONE STATEMENT. IF YOU DO NOT MAKE A PAYMENT THEN YOUR ACCOUNT WILL BE TURNED OVER TO A COLLECTIONS AGENCY AND A FEE OF 35% OF YOUR BALANCE WILL BE ADDED.

TERMINATION POLICY

You are under no obligation to continue services should you decide to terminate at any time. However, we strongly urge that the counselor be notified in person regarding this decision so that it can be discussed openly to help your situation.

CANCELLATION POLICY

CANCELLATIONS MUST BE MADE BY **4:00PM THE DAY BEFORE** YOUR SCHEDULED APPOINTMENT. THIS ALLOWS US TIME TO TRY TO FILL THE SLOT WITH SOMEONE ELSE. YOU WILL BE RESPONSIBLE FOR THE PAYMENT OF THE **$60.00 FEE** FOR ANY MISSED APPOINMENTS OR LATE CANCELLATIONS.
Insurance companies will not cover missed or canceled appointments.
If we are not available to answer the phone you can leave a message any time and any day letting us know you need to cancel.
More than two (2) late canceled or missed appointments represent a break in the contract and could lead to termination of services.

I understand and have received a copy of these **POLICIES & PROCEDURES** and the **Notice of Privacy Practices**.
I give my consent for treatment.
Printed Name of Client: ______________________________
Signature of Client: ______________________________ **Date:** ____________
For child or for adults when someone other than the client is responsible for payment list below:
Printed Name of Responsible Party: ______________________________ **Relationship to client:** ____________
Signature of Responsible Party: ______________________________ **Date**: ____________

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Client Copy

Associated Counselors of Tidewater, Inc.

NOTICE OF PRIVACY PRACTICES

Effective Date: *January 1, 2005*
THIS NOTICE DESCRIBES HOW PSYCHIATRIC INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. If you have any questions about this notice, please contact Associated Counselors of Tidewater.
WHO WILL FOLLOW THIS NOTICE.
This notice describes our practice's privacy practices and that of:
•Any counselor authorized to enter information into your psychiatric chart.
•All departments and units of the practice.
•All employees, staff and other office personnel.
•All these individuals, sites and locations follow the terms of this notice. In addition, these individuals, sites and locations may share psychiatric information with each other or with third party specialists for treatment, payment or office operations purposes described in this notice.
OUR PLEDGE REGARDING PSYCHIATRIC INFORMATION:
We understand that psychiatric information about you and your health is personal. We are committed to protecting psychiatric information about you. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements.
This notice applies to all of the records of your care generated by our office.
This notice will tell you about the ways in which we may use and disclose psychiatric information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of psychiatric information.
We are required by law to:
•Make sure that psychiatric information that identifies you is kept private;
•Give you this notice of our legal duties and privacy practices with respect to psychiatric information about you; and follow the terms of the notice that is currently in effect.
HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU
The following categories describe different ways that we use and disclose psychiatric information. Not every use or disclosure in a category will be listed.
However, all of the ways we are permitted to use and disclose information will fall within one of the categories.
• **For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to the practice's office personnel who are involved in taking care of you at the office or elsewhere. We also may disclose medical information about you to people outside our office who may be involved in your care after you leave the office, such as family members or others we use to provide services that are part of your care provided you have consented to such disclosure. These entities include third party physicians, hospitals, nursing homes, pharmacies or clinical labs with whom the office consults or makes referrals.
• **For Payment.** We may use and disclose psychiatric information about you so that the treatment and services you receive at our office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your psychiatric plan information about treatment you received at the office so your behavioral health plan will pay us or reimburse you for the services. We may also tell your behavioral health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
• **Appointment Reminders.** We may use and disclose information to contact you as a reminder that you have an appointment for treatment at the office.
• **Treatment Alternatives.** We may use and disclose psychiatric information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
• **Individuals Involved in Your Care or Payment for Your Care.** We may release psychiatric information about you to a friend or family member who is involved in your care provided you have consented to such disclosure. We may also give information to someone who helps pay for your care.
In addition, we may disclose psychiatric information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
• **As Required By Law.** We will disclose psychiatric information about you when required to do so by federal, state or local law.
• **To Avert a Serious Threat to Health or Safety.** We may use and disclose psychiatric information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
SPECIAL SITUATIONS
Health Oversight Activities. We may disclose psychiatric information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose psychiatric information about you in response to a court or administrative order. We may also disclose psychiatric information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release psychiatric information if asked to do so by a law enforcement official:

- ❖ In response to a court order, subpoena, warrant, summons or similar process;
- ❖ To identify or locate a suspect, fugitive, material witness, or missing person;
- ❖ About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- ❖ About a death we believe may be the result of criminal conduct;
- ❖ About criminal conduct at the office; and
- ❖ In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding psychiatric information we maintain about you:

• **Right to Inspect and Copy.** You have the right to inspect and/or receive a copy of your psychiatric information that may be used to make decisions about your care. To inspect and/or receive a copy of psychiatric information that may be used to make decisions about you, you must submit your request in writing to **Associated Counselors of Tidewater, Inc.** If you request a copy of the information, we may charge a fee for the costs of copying and mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain limited circumstances.

• **Right to Amend.** If you feel that psychiatric information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office.

To request an amendment, your request must be made in writing and submitted to your counselor. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- ❖ Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- ❖ Is not part of the psychiatric information kept by or for our office;
- ❖ Is not part of the information which you would be permitted to inspect and copy; or is in accurate and complete.

• **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list of accounting of disclosures, you must submit your request in writing to the **Associated Counselors of Tidewater, Inc. Office Manager.**

Records Department. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12 month period will be free. For additional lists, we may charge you a fee for the costs of copying and mailing or other supplies associated with your request. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

• **Right to Request Restrictions.** You have the right to request a restriction or limitation on the psychiatric information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the psychiatric information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to **Associated Counselors of Tidewater, Inc.** In your request, you must tell us: **(1)** what information you want to limit; **(2)** whether you want to limit our use, disclosure or both; and **(3)** to whom you want the limits to apply, for example, disclosures to your spouse.

• **Right to Request Confidential Communications.** You have the right to request that we communicate with you about psychiatric matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the **Associated Counselors of Tidewater, Inc., Office Manager.** We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

• **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for psychiatric information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office. The notice will contain on the first page, in the top left-hand corner, the effective date. In addition, each time you register we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a written complaint with Associated Counselors of Tidewater, Inc.
287 Independence Blvd., Pembroke 2, Ste. 219, Virginia Beach, VA 23462, Phone (757) 757-490-6960. Or you can file your complaint with the office of Civil Rights within the Department of Health and Human Services by visiting their Web site at www.hhs.gov/ocr/hipaa. All complaints must be submitted in writing.

You will not be penalized or retaliated against for filing a complaint.

OTHER USES OF PSYCHIATRIC INFORMATION

Other uses and disclosures of psychiatric information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose psychiatric information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose psychiatric information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Client Copy