Total Life Counseling, Inc.
5401 Fallowater Lane, Suite C, Roanoke, VA 24018

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations. For example:

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Total Life Counseling, Inc."*

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

If payment is not made as arranged, our office may utilize an outside collection agency, credit reporting agency, or other means of collecting an outstanding debt. Your file, containing protected health care information, may be reviewed by the designated collection agency or authority.

Workers' Compensation
If applicable, we may disclose your health information as necessary to comply with state Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify, or assist in notifying a family member or another person responsible for your care, about your medical condition in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury, or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner, and government benefit purposes.

Other Communications

We may contact you for such activities as confirming or scheduling appointments, as described below: (example)

> *"As a courtesy or to confirm/schedule an appointment or to follow-up on a missed appointment, we may call your home. If you are not at home, we may leave a reminder message on your answering machine or with the person answering the phone. No protected health information will be disclosed during this call other than the date and time of your scheduled appointment and a request to call our office if you need to cancel or reschedule your appointment."*

Change of Ownership

In the event that Total Life Counseling, Inc. is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Heath Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised however, that Total Life Counseling, Inc. is not required to agree to the restriction you requested.

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information.

- You have a right to request that Total Life Counseling, Inc. amend your protected health information. Please be advised, however, that Total Life Counseling, Inc. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with this denial.

- You have a right to receive an accounting of disclosures of your protected health information made by Total Life Counseling, Inc.

- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Total Life Counseling, Inc. reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, Total Life Counseling, Inc. is required by law to comply with this notice.

Total Life Counseling, Inc. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: The Privacy and Security Officer by calling this office at (540) 989-1383. If the Privacy and Security Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your privacy rights or how Total Life Counseling, Inc. has handled your health information should be directed to The Privacy and Security Officer by calling this office at (540) 989-1383. If The Privacy and Security Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____/_____/_____.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Total Life Counseling, Inc. with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

_____
Patient's Name (print)

_____ _____
Patient's (or Parent/Guardian) Signature Date

Total Life Counseling, Inc.

5401 Fallowater Lane, Suite C, Roanoke, VA 24018

CONSENT FOR TREATMENT: I consent to outpatient treatment and testing and, if necessary, emergency medical care.

Signed_____Parent/Guardian _____Date_____
(if client is under 18 years old)

The following is a summary of our office policies and our financial agreement with you as the client/patient/responsible party.

_____ (client initial) INSURANCE & PAYMENTS:

We file primary insurance as a service to our clients/patients. We do not file secondary insurance, as this is the responsibility of the client/patient. Although we may estimate what your insurance carrier might pay, it is the insurance company that makes the final determination of your eligibility**.**

It is the client's/patient's responsibility to determine if his/her insurance provider is in network with Total Life Counseling and the individual counselor and to know his/her individual co-payment/deductible amount before the initial visit.

All copays/deductibles are due at the time of service.

- **Failure to provide timely and accurate information about your health insurance as well as any updates can result in you being totally responsible for the cost of services provided. Many insurances require billing to be done in a "timely manner" and will not pay claims submitted after the allotted time.**

You can choose to complete payment by cash, check, VISA or MasterCard, Discover on the day treatment is rendered. We do not accept post-dated checks.

Unless we approve other arrangements in writing, the patient balance on your statement is due and payable when the statement is issued and is past due if not paid by the end of the month.

_____ (client initial) REFERRALS/AUTHORIZATIONS:

If your insurance company requires a referral from your physician or an authorization to begin treatment, please get the required information before the initial visit. Total Life Counseling may not be able to re-submit claims if complete information is not given.

_____ (client initial) MISSED APPOINTMENTS:

We require a 24-hour notice if you are unable to keep your appointment. This is a charge that your insurance company does not cover. A late cancellation or missed appointment charge is $55.00.

_____ (client initial) OPTIONAL SERVICES:

As a service to our clients/patients, optional services are offered by counselors and staff at Total Life Counseling, but may not be covered by your insurance company. Examples include, but are not limited to: counseling sessions by telephone, request for letters written on behalf of a current client, request for forms, request for copies or request to appear in court. The fee schedule is listed at Total Life Counseling, as needed. All fees are due at or before the time of the service.

MONTHLY STATEMENT:

If you have a balance on your account, we will send you a monthly statement. It will show a previous balance, any new charges to the account and any payments or credits applied to your account during the month.

PAST DUE ACCOUNTS:

Outstanding balances over 90 days may result in a referral to our collection procedure. If we turn the account over to our collection process, any fees, including court costs, attorney fees, and collection fee of $40, accumulated as a result of failure to pay will become the client's responsibility.

DIVORCE:

In the case of divorce or separation, the party responsible for the account prior to the divorce or separation, remains the responsible party for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

WAIVER OF CONFIDENTIALITY:
If we are forced to submit a past-due account to our collection agency, or if past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

CHARGES:
Charges range from $105.00 to $120.00 per session, depending on the length of your session. Sessions typically are 45 minutes to 60 minutes in length depending on which counselor you see and the immediacy of the problem. Charges for resident counseling sessions are $50.00.

TESTING:
The cost for psychological tests ranges from $30.00 to $75.00**. Some insurance policies will not cover testing therefore the patient will be responsible for the fee.** The test, PREPARE/ENRICH, used for premarital counseling and marriage enrichment, has a different fee schedule. The cost of this test is typically not covered by insurance.

HOSPITALIZATION:
For acute mental and emotional problems, inpatient hospitalization may be necessary. Persons requiring intensive treatment can be evaluated for admission to our Partial Day Psychiatric Hospitalization Program. Our brochure gives more detail about our partial day program.

RETURNED CHECKS:
There is a $35.00 fee for returned checks plus any additional fees charged by banks or lending institutions.

TRANSFERRING OF RECORDS:
We will, with a properly signed release of information, release copies of records to another counselor, doctor, attorney, court, or insurance company. Your authorization allows us to include all relevant information, including your payment history. If you are requesting your records be transferred to us, you authorize us to receive all relevant information, including your payment history. There is a fee for this service.

CO-SIGNATURE:
If another person signs this agreement, or another financial policy, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with future charges.

THIRD-PARTY BILLING:
A signed release of information must be on file and a letter of commitment from the third party must be received before we can bill a third party.

EFFECTIVE DATE:
Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

I acknowledge that I have read this summary and agree to its conditions.

I also grant permission to exchange information necessary for reimbursement with my insurance company and I understand that I am responsible for any charges not covered by insurance. I also authorize my insurance company to pay directly to TOTAL LIFE COUNSELING, INC., reimbursement of charges for services rendered.

If I am not filing insurance, I understand that I am responsible for all charges applied to this account.

PATIENT'S NAME (please print) _____

RESPONSIBLE PARTY (if not the patient) _____

SIGNATURE_____DATE_____

_____ (client initial) *Would you like a copy of this Consent to Treat and Payment Agreement for your records? __yes __no*

OFFICE COPY 11/17

Total Life Counseling, Inc.

5401 Fallowater Lane, Suite C, Roanoke, VA 24018
PHONE: (540) 989-1383 - FAX: (540) 989-8092 - totallifecounselinginc.com

DATE: _____/_____/_____

PATIENT NAME: _____ NAME YOU GO BY: _____
First Middle Last

SS#: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

BEST PHONE # (____) _____ SECONDARY PHONE # (____) _____

MARITAL STATUS OF PATIENT: _____ BIRTHDATE: _____/_____/_____ AGE: _____ SEX: M/F

EMPLOYER: _____ (full/part-time) OCCUPATION: _____

SCHOOL ATTENDING NOW: _____ (full/part-time) YEAR: _____

Mr./Mrs._____ has permission to make/schedule/change my appointments.
Relationship to client: _____. (Client initial) _____

PRIMARY INSURANCE INFORMATION – ALL INFORMATION REQUIRED

(Total Life Counseling, Inc. does not bill secondary insurance)

PRIMARY INSURANCE COMPANY: _____

ID NUMBER: _____ GROUP NUMBER: _____

(If patient is not the Policy Holder, please include the following information.)

INSURED'S NAME: _____ SS#: _____

ADDRESS: _____CITY: _____STATE: _____ZIP: _____

BIRTHDATE: _____/_____/_____ RELATIONSHIP TO PATIENT:

_____

EMPLOYER: _____ (full/part-time) OCCUPATION: _____

Guarantor's signature_____
(adult responsible for payments)

IF PATIENT IS UNDER 18 YEARS OF AGE, PROVIDE THE FOLLOWING INFORMATION

Father of Minor: _____ SS #: _____

Address: _____ City: _____ State: _____ Zip: _____

Marital Status: _____ Birthdate: _____/_____/_____

Best phone # (____) _____ Secondary phone # (____) _____

Employer: _____ (full/part-time) Occupation: _____

Mother of Minor: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Marital Status: _____ Birthdate: _____/_____/_____

Best phone # (____) _____ Secondary phone # (___) _____

Employer: _____ (full/part-time) Occupation: _____

WITH WHOM DOES THE MINOR LIVE? _____

IN AN EMERGENCY, NOTIFY:

Name: _____ Relationship: _____

Primary phone # (____) _____ Secondary phone # (____) _____

Name: _____ ____Relationship: _____

Primary phone # (____) _____Secondary phone # (____) _____

GENERAL INFORMATION

HOW WERE YOU REFERRED TO OUR PRACTICE (Please note if referred by physician) _____

( ) Check to be added to our email list for upcoming events. EMAIL: _____

Please describe your reasons/concerns for seeking counseling at this time:
_____
_____
_____

When did you first notice the problem? _____
_____

What changes would you like to see as a result of counseling? _____
_____

Please check and/or list your goals for counseling:

_____ Feel, think, and act constructively
_____ Attain balanced living
_____ Improve communication
_____ Improve relationships
_____ Manage fear
_____ Live in the present
_____ Express emotions constructively
_____ Practice forgiveness
_____ Strengthen identity
_____ Decrease depression
_____ Reduce stress
_____ Deal with past hurts
_____ Reduce guilt
_____ Manage time
_____ Practice contentment
_____ Confront lovingly

Have you ever had a severe emotional upset? (If yes, please explain): _____
_____
_____
If you have had psychotherapy or counseling before, please include the following information: Dates: _____
Counselor or Therapist: _____
Practice/Clinic Name: _____
What was the outcome? _____
_____

SOCIAL & FAMILY HISTORY

Please note any significant social events in your past which have had a profound effect on you, good or bad. (Examples: accidents, relationships, graduation, etc.) _____
_____
_____
_____

Check and briefly explain any that apply to your family history.
Abuse: _____
Alcoholism: _____
Divorces: _____ Stepparents: _____
Poor Relationship(s) Today: _____

Is there any family history of mental illness? _____ (If yes, please explain): _____
_____
_____

How many older: Brothers _____ Sisters_____ Relationship Today: _____
How many younger: Brothers _____ Sisters_____ Relationship Today: _____

MARITAL INFORMATION

Marital Status (check all that apply):
Single_____Dating_____Separated_____Married_____Divorced_____Widowed_____*Remarried_____
Date of Marriage: _____ How long did you know your spouse before marriage? _____
Length of Steady Dating and/or Engagement period: _____
Have you ever been separated? _____ If yes, when: _____
Have either of you ever filed for divorce? _____
*If you have been married before, please provide any significant information: _____
_____
_____

SPOUSE INFORMATION:
Name of Spouse: _____ Occupation: _____ Spouse's Age: _____
Education (in years): _____ Is your spouse willing to come to counseling? ____Yes ____ No
Has spouse been married before? _____ If yes, please provide any significant information: _____
_____
_____

FAMILY INFORMATION

CHILDREN:

Name	Age	Sex	Education	Marital Status	Living in Household
					Yes/No
					Yes/No
					Yes/No
					Yes/No

Total Number of Pregnancies: (Including those not carried full-term) _____

Please list other people living in your household not mentioned above:

NAME RELATIONSHIP TO YOU
_____
_____
_____
_____

EDUCATION/OCCUPATION

Highest Level of Education Completed: _____ Other Training: _____

Occupation: _____ Employer: _____

Job Satisfaction: _____ Military Experience: _____

RELIGION

Religious Affiliation: _____ Church Attending: _____

Attendance per month (Please circle): 1-3, 4-7, 8-10, 11+ Church Attended in Childhood: _____

Religious Background of Spouse (if married): _____ Do you attend church together now? Y N

Explain any recent changes in your religious life, if any: _____

_____

HEALTH INFORMATION

Rate your health: Very Good Good Average Declining Other

List all important present or past medical conditions, injuries, or disabilities: _____

_____

_____

List any Chronic Medical Conditions or Communicable Diseases: _____

_____

Your Physician: _____ Address: _____

Date of Last Medical Examination: _____ Findings: _____

Would you like us to contact your physician to coordinate your care? (Yes) (No)

Prescription and Non-Prescription medications taken in the last six months:

DRUG	DOSAGE	PURPOSE/REASON FOR MEDICATION	PHYSICIAN	DATE	DATE MEDICATION CHANGED OR DISCONTINUED

List Medication and/or Other Allergies: _____

_____

_____

List Any Adverse Medication Reactions In The Past: _____

_____

_____

List Any Medications Taken Previously Which Have Proven To Be Ineffective: _____

_____

_____

Medical/Physical Symptom Checklist

Please check all that apply:

____ Insomnia (cannot sleep) or Hypersomnia (excessive sleeping) nearly every day
____ Sleep Disturbance (difficulty falling asleep, difficulty staying asleep)
____ Eating/Appetite (Increase/Decrease)
____ Weight Change (Increase/Decrease) +/- ____ lbs. Current Weight: ____lbs.
____ Pleasure (Increase/Decrease)
____ Sex Drive (Increase/Decrease)
____ Energy Level (Increase/Decrease)
____ Productivity (Increase/Decrease)
____ Psychomotor Agitation or Retardation
____ Periods of High Energy and Productivity, Then Depression
____ PMS
____ Nervous (Panic Attacks)
____ Heart Palpitations
____ Muscular Aches (Headaches, Back, Neck, Chest, Pain)
____ Gastrointestinal Distress (Pain, Diarrhea, Constipation, IBS)
____ Poor Nutritional Habits/Irregular Eating Times
____ Other: _____
____ Caffeine Intake: _____
____ Alcohol Consumed Weekly: _____
____ Cigarettes Smoked/Other Tobacco used Daily/Weekly: _____
____ Drugs Used Recently: _____

Symptoms have been present for: ☐ Less than one month ☐ 1-6 months ☐ 7-11 months ☐ One year or more

Mental Concerns

____ Confusion about time and place
____ Not caring about appearance
____ Speaking/Communication difficulties
____ Difficulties in getting point across or putting thoughts into words
____ Something affecting me and I don't know what it is
____ Worries (List): _____
_____
____ Angers (List): _____
_____
____ Guilts (List): _____
_____

____ Esteem issues
____ Memory loss
____ Obsessions (spiders, cleanliness)
____ Perfectionism
____ Paranoia
____ Bizarre thoughts
____ Difficulty concentrating
____ Difficulty making decisions
____ Compulsions (hand-washing, locking doors)
____ Phobias
____ Mind playing tricks

____ Homicidal thoughts (Describe): _____
____ Suicidal thoughts (Describe): _____
____ Thoughts of death (Describe): _____

Symptoms have been present for: ☐ Less than one month ☐ 1-6 months ☐ 7-11 months ☐ One year or more

If you would like to explain any symptoms, write here:

_____

_____

_____

THIS PAGE FOR OFFICE USE ONLY

Initial Session: Date _____

Name: _____

Individuals Present: _____

Follow up care:

Therapist Signature: _____

THIS PAGE FOR OFFICE USE ONLY

PATIENT NAME _____ **DATE** _____

Coordination of Care

Would you like us to contact any other provider's of care? (physician, psychiatrist, etc.) **YES / NO**
If yes, an "Authorization To Release Information" will need to be completed.

Contact documentation:
Date: _____

_____
_____
_____
_____

Substance Abuse Assessment

List any current or past substance abuse/treatment: (If under 12, list substance abuse/history in family)

_____
_____
_____
_____

If screening is positive, document further assessment including assessment tool/tools utilized and results:

_____
_____
_____
_____

Treatment Recommendations/Referrals:

_____
_____
_____
_____

Lifestyle Assessment

Assess following areas and circle those of concern:
(tobacco use - sleep habits - diet/eating habits - exercise/activity level - social activity/hobbies/stress mgmt./spiritual activities)

List specific issues in areas of concern and corresponding treatment/recommendations:

_____
_____
_____
_____
_____
_____