CHILD INFORMATION SHEET

PATIENT'S NAME:____
(FIRST) (MIDDLE) (LAST)
SOCIAL SECURITY NUMBER:____

DATE OF BIRTH:___________________________AGE:__________________________SEX:____________________

( )PART TIME STUDENT ( ) FULL TIME STUDENT ( ) DISABLED

ADDRESS:____
STREET CITY ZIP
HOME #:____________________________ CELL #:_______________________ALT.#:________________________

NAME OF SCHOOL CHILD ADTTENDS:____

IN CASE OF AN EMERGENCY, FAMILY MEMBER TO CONTACT:

NAME:____RELATIONSHIP:_____________________________

ADDRESS:____PHONE NUMBER:________________________

IF APPLICABLE, WHO HAS LEGAL CUSTODY?____

FATHER'S NAME:__________________________________HOME #:___________________WORK #:____________

MOTHER'S NAME:_________________________________HOME #:__________________WORK #:_____________

STEP-FATHER:_____________________________________HOME #:________________WORK #:_______________

STEP-MOTHER:____________________________________HOME #:________________WORK #:_______________

RESPONSIBLE PARTY:____________________________________RELATIONSHIP:___________________________

SOCIAL SECURITY NUMBER:_________________________________DATE OF BIRTH:_________________________

( ) SINGLE ( )MARRIED ( )SEPARATED ( )DIVORCED ( )WIDOW ( )FULL TIME STUDENT ( ) PART TIME STUDENT ( )DISABLED

ADDRESS:____
STREET CITY ZIP
HOME #:____________________________WORK #:__________________________CELL #:___________________

PLACE OF EMPLOYMENT:____DEPT:__________________________

SPOUSE'S INFORMATION: NAME:____

SOCIAL SECURITY NUMBER:____________________________________DATE OF BIRTH:______________________

( )SINGLE ( )MARRIED ( )SEPARATED ( )DIVORCED ( )WIDOWED ( )FULL TIME STUDENT ( )PART TIME STUDENT ( )DISABLED

ADDRESS:____

HOME #:___________________________WORK #:_________________________CELL #:_____________________

PLACE OF EMPLOYMENT:____DEPT:_________________________

I AGREE TO ASSUME FULL RESPONSIBILITY FOR ALL CHARGES INCURRED FOR SERVICES RENDERED TO THE PATIENT REGARDLESS OF INSURANCE COVERAGE. IT IS FURTHER UNDERSTOOD AND AGREED THAT ANY FAILURE TO COMPLY WITH THIS AGREEMENT WILL RESULT IN A COLLECTION EFFORT, BE THAT OF A COLLECTION AGENCY OR SMALL CLAIMS COURT. THE FEES INCURRED FOR THIS COLLECTION EFFORT WILL BE AT THE GUARANTOR'S EXPENSE. FOR ANY MANAGED INSURANCE CARRIERS, GUARANTOR WILL BE RESPONSIBLE TO LET THE OFFICE KNOW OF ANY SESSIONS OR LAB WORK DONE OUTSIDE OF OUR OFICE. YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL FOR ANY SESSIONS NOT NOTED.

GUARANTOR____DATE____________________________

INSURANCE INFORMATION

Your insurance policy is a contract between you and your insurance carrier. Even though we have agreed to work with your insurance, we will still look to you for final payment. To avoid any misunderstandings the patient and/or responsible party is requested to complete the following:

1. **PRIMARY INSURANCE:** ____

   Insurance Company Address: ____

   ____

   Policyholder's Name:______________________________**DOB:** __________

   ID Number: ______________________________ **Group Number:**__________

2. **SECONDARY INSURANCE:**____

   Insurance Company Address:____

   ____

   Policyholder's Name:______________________________ **DOB:** __________

   ID Number:______________________________ **Group Number:**__________

3. **ADDITIONAL INSURANCE:**____

   Insurance Company Address:____

   ____

   Policyholder's Name:______________________________ **DOB:** __________

   ID Number:______________________________ **Group Number:**__________

I request that Payment of Authorized Benefits be made on my behalf to my provider for any services rendered. I authorize the release of any medical information necessary to determine these benefits payable for related services.

____

Guarantor's Signature Date

olonial Psychiatric Associates of Williamsburg, LLC

1318 Jamestown Rd Suite 101◆Williamsburg, Virginia, 23185

Phone (757)645-4715 ◆Fax (757)645-4720

FINANCIAL POLICY

You are responsible for all charges incurred by you for professional service rendered by your provider at Colonial Psychiatric Associates of Williamsburg, LLC whether or not the services are covered by health benefits. Your insurance benefits are a contract between you and your insurance company. Your insurance company is responsible to you, not your provider. We will bill your insurance at no additional charge for services rendered at this office. We will not accept responsibility for collecting or negotiating insurance claims. You are responsible for payment within a reasonable time, regardless of the status of a claim. If your insurance company has placed your claim in a "pending" status that results in a delay in payment, you are to establish a payment plan. The charges for services are as follows:

Initial Visit	$195.00	Medication Management Visit	$80.00
Initial Psychiatric Visit	$250.00	Letters/forms filled out /phone calls	$95.00 / 30 min
Individual Therapy	$195.00	Medical Record copies	$15.00
Family Therapy	$165.00	Missed appointment fee	$80.00
Psychological Testing	$190.00/hr	Group Therapy	$125.00

Appointments are scheduled and expected to be kept unless **24 hour advanced** notice has been given. After office hours, there is an answering machine available to leave a message. This allows us to fill appointments from our waiting list. Insurance companies do not cover missed appointments. This will be your responsibility. Repeated missed appointments could result in your provider referring you to another provider outside our office.

The undersigned states they have read, or had read to them, this Financial Policy and they understand that payment is due when services are rendered unless prior arrangements are made. Upon default of payment, the undersigned agrees to pay all reasonable legal fees and costs of collection to the extent permitted by law.

I, AUTHORIZE, any physician, medical practice, hospital, clinic or other medically related facility, insurance or reinsuring company, consumer reporting agency, social services or employer having information available as to diagnosis, treatment, prognosis and/or benefit coverage with respect to any physical or mental condition and/or treatment of me or anyone I am signing for as their Legal Representative to give a representative of Colonial Psychiatric Associates of Williamsburg, LLC or my provider any and all information required to properly process claims arising from treatment and care provided at Colonial Psychiatric Associates of Williamsburg, LLC by my provider. A copy of this document shall serve with the same force as the original. This release includes information concerning alcohol or drug abuse as well as information concerning Hepatitis A, B, or C and HIV status that may be included in my medical records.

__________________________ ____________________________________

Print Patient Name | Patient/Guardian Signature | Date

__________________________ ____________________________________

SSN | DOB | Age

Client's Name:____Therapist:_________________________________

CLIENT'S INFORMED CONSENT

I have chosen to receive treatment services by the above provider. My choice has been voluntary and I understand that I may terminate therapy at any time.

I understand that CPA of Williamsburg, LLC provides administrative services only and that my provider is responsible for treatment.

I also understand that the providers rotate emergency and after hours call.

I understand that psychotherapy is a cooperative effort between me and my therapist and that I need to work to resolve my own difficulties with my therapist's guidance and assistance. I understand that my improvement cannot be guaranteed but will be the mutual goal between me and my therapist.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that mental health professionals are not allowed to release any information about clients unless they sign a "Release of Information" from which permits the transfer of specific information to a specified individual or organization. This form is valid for the time specified on the form.

There are certain situations in which information about clients may be released with or without their permission. The law requires therapist:

1. To report suspected child physical or sexual abuse or neglect to the proper authorities.
2. To report suspected abuse or neglect of a vulnerable adult.
3. To take action when a client is a danger to himself/herself or to another identified
4. To respond when a court of law orders the release of inform
5. To share, upon request, information and/or records about a minor child's treatment with the non-custodial parent.

In addition, it is important to understand that your insurance company may request information in order to approve reimbursement for sessions. Your use of your policy constitutes consent to provide this information.

I understand that if my insurance refuses to approve sessions, but if I wish to continue therapy, then I will be personally responsible for payments. Additional services, such as letters and reports for attorneys, court, and schools, lengthy telephone consultations or educational evaluations not covered by insurance, and fees for missed appointments may be charged to my account. I understand that I will be personally responsible for any of these charges not covered by my insurance.

EMERGENCY COVERAGE

Your therapist can be reached during office hours at 645-4715. After hours you can reach the therapist or doctor on call by calling the same number and following the instructions of emergencies. Other emergency resources include your family physician, a local hospital emergency room, or mental health center.

I HAVE READ AND UNDERSTAND THE ABOVE CONSENT.

____

Client's Signature (Parent/Guardian Signature if Client is a Minor) Date

olonial Psychiatric Associates of Williamsburg, LLC

1318 Jamestown Rd Suite 101◆Williamsburg, Virginia, 23185

Phone(757)645-4715◆Fax (757)645-4720

PRIMARY CARE PHYSICIAN NOTIFICATION

Authorization of Release of Information:

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke my consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months for the date signed.

I, ____, hereby authorize Colonial Psychiatric Associates of Williamsburg, LLC and my provider:

Please check one:

- o To exchange any applicable information with (my or my child's) primary care physician (PCP).
- o Please DO NOT release to (my or my child's) primary care physician (PCP).

Patient's Name (please print): ____Date of Birth:________________

Signature of patient or guardian: ____Date: _________________

Relationship to patient (circle one): self parent/guardian other _____________________

Primary Care Physician's Name:_____________________________ Tel. #: _______________ Fax #:_______________________

PLEASE DO NOT WRITE BELOW THIS LINE:

Dear Dr.__________________________________ this patient/family was recently seen in this office. I trust that the following information will be helpful in coordinating this patient's care. I'll contact you in the future if there is further information to share.

Patient's name: ______________________________________ Date of initial consultation: _______________

Provisional Diagnosis: ____

Presenting Problem: ____

____

____

Treatment Recommendations/Plan/Follow-up: ____

____

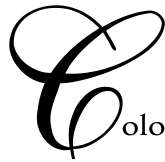
____

Medications: ____

Please call if additional information would be helpful at this time:

Provider's Name____

Provider's Signature ____ Date ________________

olonial Psychiatric Associates of Williamsburg, LLC

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Phone(757)645-4715◆Fax (757)645-4720

HIPAA ACKNOWLEDGEMENT

I/We have read and/or received a copy of the Notice of Privacy Practices. This notice describes how Protected Health Information (PHI) about patients and their family members may be used or disclosed and how you can access this information.I understand according to the notice that limitations may be imposed on confidentiality for service rendered and accept those limitations and consent to receive services under these conditions.

____________________________________ ______________________
Signature of Patient (if age 16 or older) Date

____
Please print Patient Name

____________________________________ ______________________
Signature of Patient’s Parent/Guardian Date

____
Please print Name of Parent/Guardian

CPA NOTICE FORM

Notice of Colonial Psychiatric Associates Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOUCAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

CPA (CPA refers to the health care providers, employees and staff of Colonial Psychiatric Associates of Williamsburg) may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions.

- "***PHI***" refers to information in your health record that could identify you.
- " ***Treatment, Payment and Health Care Operations***"
  Treatment is when your therapist provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when your therapist consults with another health care provider, such as your family physician or another psychologist.
  Payment is when your therapist obtains reimbursement for your healthcare. Examples of payment are when your therapist discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  Health Care Operations are activities that relate to the performance and operation of CPA. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "***Use***" applies only to activities within CPA such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "***Disclosure***" applies to activities outside of CPA, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

- Your therapist may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when your therapist is asked for information for purposes outside of treatment, payment, and health care operations, your therapist will obtain an authorization from you before releasing this information. Your therapist will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes your therapist has made about your conversation during a private, group, joint, or family counseling session, which your therapist has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.
- You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) your therapist has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

I will also obtain an authorization from you before using or disclosing:

- PHI in a way that is not described in this Notice.
- PHI for marketing purposes.

III. Uses and Disclosures with Neither Consent nor Authorization

Your therapist may use or disclose PHI without your consent or authorization following circumstances:

- **Child Abuse:** If your therapist has reason to suspect that a child is abused or neglected, he/she is required by law to report the matter immediately to the Virginia Department of Social Services.
- **Adult and Domestic Abuse:** If your therapist has reason to suspect that an adult is abused, neglected or exploited, he/she is required by law to immediately make a report and provide relevant information to the Virginia Department of Welfare or Social Services.
- **Health Oversight:** The Virginia Board of Psychology has the power when necessary to subpoena relevant records should your therapist be the focus of an inquiry.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and your therapist will not release information without written authorization of you or your legal representative, or a subpoena (of which have been served, along with the proper notice required by state law). However if you move to quash (block) the subpoena, your therapist is required to place said records in a sealed envelope and provide them to the clerk of court of the appropriate jurisdiction so that the court can determine whether the records should be released. The Privilege does not apply when you

are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advanced if this is the case.

- **Serious Threat to Health or Safety:** If your therapist is engaged in his/her professional duties and you communicate to him/her a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and he/she believes you have the intent and ability to carry out that threat immediately or imminently, your therapist must take steps to protect third parties. These precautions may include (1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18; or (2) notifying a law enforcement officer.
- **Worker's Compensation:** If you file a worker's compensation claim, your therapist is required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.
- When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-define disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and nation security and intelligence.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions*- You have the right to request restrictions on certain uses and disclosures of PHI about you. However, your therapist is not required to agree to a restriction your request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*- You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a therapist. Upon your request, CPA will send your bills to another address.)
- *Right to Inspect and Copy*- You have the right to inspect or obtain a copy (or both) of PHI is maintained in the record. Your therapist may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, your therapist will discuss with you the details of the request and denial process.
- *Right to Amend*- You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your therapist may deny your request. On your request, your therapist will discuss with you the details of the amendment process.
- *Right to an Accounting*- You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request your therapist will discuss with you the details of the accounting process.
- *Right to Paper Copy*- You have the right to obtain a paper copy of the notice from CPA upon request, even if you have agreed to receive the notice electronically.
- *Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket.* You have the right to restrict disclosures of PHI to a health plan when you pay out-of-pocket in full for services.
- *Right to Be Notified if There is a Breach of Your Unsecured PHI.* You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) our risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Health Care Provider Duties:

- CPA is required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.
- CPA reserves the right to change the privacy policies and practices described in this notice. Unless CPA notifies you of such changes, however, CPA is required to abide by the terms currently in effect.
- If CPA revises its policies and procedures, you will be notified at your next appointment or by telephone or mail depending on the importance of the change.

V. Complaints

If you are concerned that your therapist and/or CPA have violated your privacy rights, or you disagree with a decision made about access to your records, you may contact our office manager at (757) 645-4715.
You may also send a written complaint to Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003

CPA reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that CPA maintains. CPA will provide you with a revised notice by your next appointment or by phone or mail depending on the importance of the change.