

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

**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: Telehealth sessions, 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 \$125.00 to \$145.00 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.

**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 \_\_\_\_\_



**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? \_\_\_\_\_

\_\_\_\_\_

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 & FAMILY 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: \_\_\_\_\_

**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/past medical conditions, chronic illnesses, communicable diseases, injuries, or disabilities:

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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
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List Medication and/or Other Allergies: \_\_\_\_\_

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List Any Adverse Medication Reactions In The Past: \_\_\_\_\_

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

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## 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
- \_\_\_ Homicidal thoughts (Describe): \_\_\_\_\_
- \_\_\_ Suicidal thoughts (Describe): \_\_\_\_\_
- \_\_\_ Thoughts of death (Describe): \_\_\_\_\_
- \_\_\_ Difficulty concentrating
- \_\_\_ Difficulty making decisions
- \_\_\_ Compulsions (hand-washing, locking doors)
- \_\_\_ Phobias
- \_\_\_ Mind playing tricks

**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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**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.

**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, issues related to your account, and/or any billing inquiries.



**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 Health 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 to receive a copy of your health information.
- You have the 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 the reason(s) for the denial and information about how you can disagree with this denial.
- You have the right to receive an accounting of disclosures of your protected health information made by Total Life Counseling, Inc.
- You have the 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