RIVERSIDE
COUNSELING CENTER

44084 Riverside Parkway, Suite 240, Leesburg, Virginia 20176 - (703) 724-0200

PATIENT INFORMATION

Patient Name: _____ Preferred Name: _____ Birth Date: _____

Home Address: _____
(street) (city) (state) (zip)

Home Telephone: _____ Work Telephone: _____

Cellular Phone: _____ Social Security Number: _____

Email: _____ Okay to use email to inform me of *Riverside* seminars? Y / N

Employer/School: _____ Sex: M / F

RESPONSIBLE PARTY (circle one: patient /parent / guardian / other responsible party)

Name: _____ Relationship to You: _____

Social Security Number: _____ Home Phone: _____

Home Address: _____

EMERGENCY CONTACT

Name: _____ Relationship to You: _____

Home Phone: _____ Cell Phone: _____

REFERRED BY _____

☐ Doctor/Counselor ☐ Friend ☐ School ☐ Clergy ☐ Internet ☐ Insurance ☐ Other

CONFIDENTIALITY PLEDGE

As a client of Riverside Counseling Center, one of your most important rights is that of confidentiality. Communications between client and clinician will be confidential and not disclosed to anyone without your written permission, except as required by state law and professional ethics.

Payment Information (*choose one*)

If you are seeing a Psychiatrist, Psychologist, Nurse Practitioner, Out-of-Network Therapist:

☐ PRIVATE PAYMENT - I do not intend to use medical insurance to pay for my services at Riverside Counseling Center (RCC). I understand that I am responsible for full payment for services at each visit.

☐ OUT-OF-NETWORK INSURANCE – I intend to use out-of-network insurance benefits to cover my services. I understand that I am responsible for full payment for services at each visit and will use clinic receipt to seek reimbursement from my insurance company. I recognize that insurance companies vary in the percentages of reimbursement provided. While RCC staff is available to assist in obtaining preauthorization from my insurance company, I recognize that it is primarily my responsibility to secure this preauthorization.

If you are seeing an In-Network Therapist:

☐ IN-NETWORK INSURANCE – I intend to use in-network insurance coverage benefits to cover my services at Riverside Counseling Center (RCC). I understand that it is my responsibility to obtain necessary referrals from my primary care doctor when needed and the co-payment amount for my visit is due at the time of service. I authorize Riverside Counseling Center to apply for benefits on my behalf for services rendered to me. I request that payment from my insurance company, if any, be made to RCC, unless otherwise indicated on the claim. I authorize the release of any necessary information, including medical information, for this or any related claim, to my insurance carrier. In making this assignment, I understand that I am financially responsible for any charges not paid under this insurance policy. I further understand that RCC will not file for secondary insurance.

Policy Holder's Name: _____ Employer: _____

Policy Number (or SSN): _____ Date of Birth: _____

Policy Holder's Relationship to Patient: Self _____ Spouse ____ Child ____ Other _____

Insurance Company Name: _____ Telephone # _____

Insurance Company Address: _____

Guarantee of Payment to Riverside Counseling Center, PLLC – For and in consideration of services rendered, or to be rendered to the below named patient, I guarantee payment of all said charges occurred in accordance with the policy payment of bills. In the event the account must be placed with an attorney or collection agency to obtain payment, I agree that jurisdiction for said collection shall be Loudoun County, Virginia; that I shall pay all allowable costs associated with attorney's fees, collections costs, and all court costs and interest on the total unpaid balance at the rate of 1.5% per month.

By signing below I indicate agreement to the terms of treatment stated above.

Patient Name: _____ Date: _____

Responsible Party's Name: _____ Signature: _____

Witness: _____ Date: _____

Billing Policies

Late Cancelation Policy: I recognize that if I am unable to keep an appointment, it is my responsibility to cancel at least 24 business hours in advance, exclusive of weekends and holidays, by calling RCC at 703-724-0200. I understand that insurance companies do not pay for missed appointments and that my failure to give 24 hours notice may result in my being charged the clinic's usual full visit fee for that session.

Tricare Non-Participation: I realize that due to changes in Tricare policies, *Riverside* is no longer seeing patients who use Tricare Insurance. If I begin Tricare insurance in the future, I will notify my therapist/doctor right away.

Medicare Restrictions:

All Medicare patients will be required to pay the usual full fee at time of service. Medicare will not reimburse for services at this office.

LCSW therapists do not see Medicare patients at this office.

LPC and Residency Therapists may see Medicare patients but Medicare will not reimburse for services.

MD and NP medical staff may see Medicare patients under opt-out status. This means patients may not bill Medicare for services. Patients seeing MD, NP, and LPC providers may request reimbursement from secondary insurance companies. *Riverside* does not directly bill secondary insurances.

If Seeing Resident in Counseling: I understand that my therapist has Masters Degree in counseling and is working toward state licensure as LPC under the supervision of Dan Towery, LPC. I understand that my counselor is providing reduced-fee services and that medical insurance will not reimburse for these sessions.

Fee for Medication Prior Authorizations Required by Insurance Companies: Many medical insurance companies are now blocking access to new medications. This often requires physicians to complete lengthy Prior-Authorization (PA) processes. For PAs requiring less than 15 minutes to complete, no fee will be charged by our office. For PA's taking longer than 15 minutes, the doctor's usual hourly fee will be charged in 15 minute increments.

By my signature, I affirm my agreement with Riverside Counseling Center's Billing Policies as noted above.

Patient/ Responsible Party: _____

Relationship to Patient (*if patient is a minor*): _____

Signature: _____ Date: _____

Witness: _____ Date: _____

HIPPA Notification

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment for third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by *Riverside Counseling Center* of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that *Riverside* has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this clinic at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

By my signature:

I affirm my agreement with Riverside Counseling Center's Late Cancelation Policy as noted above.
I understand my HIPPA rights as stated above.

Patient/ Responsible Party: _____

Relationship to Patient (*if patient is a minor*): _____

Signature: _____ Date: _____

Witness: _____ Date: _____

MEDICAL HISTORY Name _____

Reason for Visit (1-2 sentences in your own words)

Goals for Your Visit:

Please Note Any Current Stressful Circumstances in Your Life:

Please List all Major Medical Problems:

Medical Problem	Date of Onset		Medical Problem	Date of Onset

History of Any of the Following:

☐ Head Injury	☐ Thyroid Abnormality	☐ High Blood Pressure	☐ Heart Problems
☐ Seizures	☐ CT or MRI of Brain	☐ Diabetes	☐ Shortness of Breath
☐ Movement Disorder	☐ Digestive Problems	☐ Liver or Kidney Disorder	☐ NONE OF THESE

Females Only:

Planning Pregnancy Y / N Currently Pregnant Y /N

Current Medications: Name _____

Medication	Dose		Medication	Dose

Past Psychiatric Medications Used (e.g. Antidepressants, Sleep or Anxiety Meds, Other)

Medication	Problem with Med ?		Medication	Problem with Med ?

Substance Use History:

	Past Use	Most Recent Use	Maximum Amount / Day
Alcohol	Y N		
Marijuana	Y N		
Cocaine	Y N		
Amphetamines/Stimulants	Y N		
Sedatives (Valium, Xanax. Other)	Y N		
Heroin or Prescription Pain Medication	Y N		

Allergies to Medication:

Medication(s)		

Name _____

Psychological History

Hospital-Based Treatment:

	Reason for Treatment	Date(s)	Name of Facility
Emergency Room Evaluation for Mental Health Issue			
Outpatient Substance Abuse Treatment			
Residential Substance Abuse Treatment			
Inpatient Psychiatric Treatment			

Outpatient Mental Health Services:

	Reason for Treatment	Date(s)	Name of Provider
Psychiatric Evaluation			
Psychological Testing			
Individual Counseling			
Marital / Family Counseling			

Family History (of any of the following):

		Relationship(s) to You
Diabetes	Y N	
Thyroid Disorder	Y N	
Depression	Y N	
Anxiety Problems	Y N	
Suicide	Y N	
Bipolar Disorder	Y N	
Alcohol or Drug Problems	Y N	