Bright Horizons Counseling Services, LLC
556 Garrisonville Road, Suite 212
Stafford, VA 22556
(P) 540-602-7615; (F) 540-628-0446

TODAY'S DATE:	CONTACT: RELATIONSHIP TO PATIENT:

NEW PATIENT INFORMATION

PATIENT NAME (FIRST, MIDDLE, LAST)	DATE OF BIRTH	AGE	SEX
HOME PHONE	WORK PHONE	CELL PHONE	PH PREFERENCE
STREET ADDRESS	CITY	STATE	ZIP CODE
OCCUPATION/EMPLOYER	EMPLOYER ADDRESS & PHONE #	RELATIONSHIP TO PATIENT	
EMAIL ADDRESS	TREATMENT: Individual, Group, Family Therapy	REASON (S) FOR TREATMENT	

INSURANCE INFORMATION

DO YOUR WANT YOUR CLAIMS TO BE SUBMITTED THROUGH INSURANCE? _____Y/N. IF YES, PLEASE FILL OUT THE FOLLOWING INFORMATION AND PROVIDE A COPY OF YOUR INSURANCE CARD.

PRIMARY INSURANCE COMPANY NAME/PLAN	INSURANCE ID#	GROUP #	PATIENT SS#
INSURED'S NAME	ADDRESS (IF OTHER THAN PT)	DOB (IF OTHER)	SUBSCRIBER'S SS#
SECONDARY INSURANCE COMPANY NAME/PLAN	INSURANCE ID#	GROUP #	PATIENT SS#
PATIENT RELATIONSHIP TO SUBSCRIBER	___SELF	___SPOUSE	___PARENT

Informed Consent to Treatment

Date: ___________

I, ______________________________, (name of client or guardian as applicable), agree and consent to participate in behavioral health care services offered and provided by Bright Horizons Counseling Services and the following Clinicians.

PLEASE INTITIAL:

_____ Kristin Gartner, LPC, NCC a licensed professional counselor

_____Gail Grandela, LPC, CCM, NCC a licensed professional counselor

_____Danielle Mosser, LPC a licensed professional counselor

_____ Elena Monti, LCSW a licensed clinical social worker

_____ Nadia Speziale, LPC a licensed professional counselor

_____Jorge E. Grandela, PsyD, LPC, LMFT, LSATP a licensed professional counselor, marriage and family therapist and substance abuse provider

_____Kandra Orr, MS, ATR, a board-certified art therapist

_____ Rebecca Kaufman, LPC a licensed professional counselor

_____Heather Fitz-Randolph, M.Ed who is currently undergoing her supervision hours to obtain her licensure for Virginia.

_____James Kasten, M.A. is currently undergoing his licensure for Virginia.

HIPAA Privacy (1 of 4)

With your consent, the practice is permitted by federal laws to make uses and disclosures of your health information treatment, payment, for purposes of and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnosis, treatment and applying for future care treatment. It also includes billing documents for those services.

Example of use of your health information for treatment purposes:
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share this information with such specialist and obtain input.

Example of use of your health information for payment purposes:
We submit a request for payment to your health insurance company. The health insurance company request information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of your information for health care operations:
We obtain services from our insures or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol, and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insures or other business associates as necessary to obtain these services.

<u>Your Health Information Rights</u>
The health record we maintain and billing records are the physical property of the practice. The information in it, however belongs to you, you have the right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you will be allowed to inspect and copy your health record and billing record-you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances.
- Request that your health record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to your office. An accounting will not include internal uses of information for treatment, payment or operations, disclosures made to you or made at your request, or disclosures made to family members or friends during providing care;
- Request that communication of your health information be made by alternative means or at an alternative means or an alternate location by delivering the request in writing to our office and revoke authorization that you made

HIPAA Privacy (2 of 4)

previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact our administrator, in person or in writing, during normal hours. She/he will provide you with assistance on the steps to take to exercise your rights.

Our responsibilities

The practice is required to

- Maintain the privacy of your health information as required by Law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable request regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. Lf our information practices change, we will amen our notice. You are entitled to receive a revised copy of the notice by calling and requesting a copy of our notice or by visiting our office and picking up a copy.

To request information or file a complaint
If you have any questions, would like additional information, or want to report a problem regarding the handling of your information, please contact our director, Kristin Gartner, LPC, NCC.

Department of Health Professions Complaint Process
The department of Health Professions receives complaints about health care practitioners who may have violated a regulation or law. Complaints for all licensing and regulatory Boards are received and processed by the Enforcement Division. For information about each of the 14-individual licensing and regulatory Boards under this agency's authority, visit the Licensing Boards Page. You can find this under the Virginia Department of Health Professionals website. On this page you may also find a list of mental health care practitioners and facilities regulated by this agency. You may also find a detailed explanation of the Disciplinary Process for Licensed Health Professionals here.

Complaint Form
NOTE: The department of Health Professionals cannot guarantee anonymity. Information regarding your report, including information provided by you, may be shared with the subject of the report (practitioner or licensee). If you wish to submit an anonymous report, do not include any information on the complaint form, envelope, email or supplemental documents that reveal your identity.
Download Complaint Form

* Fillable Word Version
* PDF Version

1. Provide your name, address, and telephone number (unless anonymous)

HIPAA Privacy (3 of 4)

2. Identify the practitioner you are reporting
3. Provide a detailed summary of your concerns.
4. Attach copies (not originals) of documents relating to your concerns, if applicable.
5. Return the completed Complaint Form to the Enforcement Division.

Please select the "Option" button and select "enable this content" to allow typing in the Word version. If you do not have Microsoft Word, you can get the Microsoft Word Viewer to view and print documents.

How to file a complaint

Complaints may be submitted to the Enforcement Division in writing, by telephone, fax, email, or in person.

NOTE: The department of Health Professionals cannot guarantee anonymity. Information regarding your report, including information provided by you, may be shared with the subject of the report (practitioner or licensee). If you wish to submit an anonymous report, do not include any information on the complaint form, envelope, email or supplemental documents that reveal your identity.

Virginia Department of Health Professionals
Perimeter Center
9960 Maryland Drive, Suite 300
Henrico, VA 23233-1560

Telephone: 1-800-533-1560 or (804) 367-4691
Fax: (804) 527-4424
Email: enfcomplaints@dhp.virginia.gov

Other disclosures and Uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to products and products defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

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HIPAA Privacy (4 of 4)

Workers Compensations
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with the laws relating to Workers Compensation.
Public Health
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Abuse & Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcements
We may disclose your protected health information for law enforcements purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcements.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight activities.
Judicial/Administrative Proceedings
We may disclose your protected health information during any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures besides those identified in this notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website
If we maintain a website that provides information about our entity this notice will be on the website.

Effective date: 04/01/2012

I ___________________________, hereby acknowledge that I have received a copy of this practice notice of privacy practices. I have been given opportunity to ask any questions I may have regarding this notice.

____ ______________________________

Name Date

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FINANCIAL POLICY

The *Person Responsible for Payment of Account* is required to sign this form, which explains the fees and collection policies of this office. At the beginning of treatment, you can make a choice to pay for services out-of-pocket or to file through insurance. If you choose to file claims through insurance, this office will submit insurance claims, on your behalf, for those insurances in which Bright Horizons participates and for those services which have been determined to be covered under your insurance policy. Bright Horizons will not submit claims for services that are not covered by your insurance, and those fees will be due at time of the service. If Bright Horizons does not participate with your insurance carrier, we will provide you with appropriate documentation so that you may file claims under an Out of Network benefits. If your Insurance Does Not cover your services with us for any reason, client or client's guardian is responsible for any amounts billed, for services rendered.

Insurance deductibles and co-payments are due at the time of the service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g. if their previous visits to another mental health clinic since January of the current year prior to our first session), this amount will be collected by this office until the deductible payment is verified to this office or by third-party payer.

Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company. As a service to you, this office will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered, and is not responsible for the collection of such payments. In some cases, insurance companies or other third-party payers may consider certain services not reasonable or necessary or may determine that services are not covered. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 120 days are subject to collections. A 5% per month interest rate is charged for accounts over 60 days. All insurance benefits will be assigned to this office (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

CLIENTS ARE RESPONSBILE FOR PAYMENTS AT THE TIME OF SERVICES. The adult accompanying a minor is responsible for payment for the child at the time of the service. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved credit plan, charge card, or payment at the time of service. Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate noted in the clinician's office policy. Payment methods include check, cash and most credit/debit cards. Please initial the appropriate selections:

______(Initial) I chose to pay fee for services and do not wish to have claims submitted to my insurance. I understand what the fee per session is and understand that Bright Horizons Counseling Services, LLC does not accept my insurance.

_______(Initial) I provide permission to Bright Horizons Counseling Services, LLC to submit insurance claims on my behalf and to provide the necessary information to file claims appropriately for in-network benefits. I provide Bright Horizons with permission to release information to my insurance company as deemed necessary for Out-of-Network/In-Network benefits.

I (we) have read, understand, and agree with the provisions of this Financial Policy.

Person Responsible for Account ______________________________________Date____/______/______
Co-responsible Party for Account ____________________________________Date____/______/______

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Release of Information (OPTIONAL)

Client's Name: ________________________________DOB:______________________________

I, ______________________________, authorize Bright Horizons Counseling Services, LLC

to: _____(send)_____(receive)_____(send/receive) information from:

Name: ____

Address: ________________________City: _______________State: __________Zip: __________

Phone: _________________________ Fax: ______________________________

Please check all that apply:

__________Treatment Information (Verbal) __________Psychological Testing Results (Verbal)
__________Treatment Information (Written) __________Psychological Reports (Written)
__________Entire record, except progress note _________ *Psychotherapy Notes
__________Other, specify ____
____
____

*A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES.

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: _____Self _____Parent/Legal guardian _____Personal representative _____Other (describe)

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of your authorization to receive this protected health information.

Client's Signature: _________________________ Date: ________/____________/____________
Parent/guardian/personal representative (if applicable)

Signature: ______________________________________ Date: ________/____________/____________

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Psychotherapist – Client Contract (1 of 2)

Practice Policies and Procedures

Welcome to Bright Horizons Counseling Services, LLC. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

Meetings

Counseling sessions are generally scheduled once a week for 45-50 minutes, and a given hour is considered blocked for a particular client. Thus, a late cancellation results in an open hour, inconvenience, and a loss of revenue. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control). If it is possible, we will try to find another time to reschedule the appointment. If you arrive late for a scheduled appointment, only the remainder of the session will be available. If the clinician runs late with a prior appointment for some reason, you will still receive the full session. If local schools are closed due to weather conditions, please check the answering machine or website to see if we will be in the office. We may need to reschedule the appointment.

Fees/Billing and Payments/Insurance Reimbursement

Our hourly rate for the intake session (first session) is $200. Fees for following services are $150 per session. In addition to weekly appointments, we charge the same hourly rate for other professional services you may need, though we will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than a few minutes, consulting with other professionals (with your permission), preparation of records or treatment summaries, and the time spent performing any other service you may request. Fees may increase periodically. You will be expected to pay for each session at the time it is held unless we agree otherwise. Cash, checks and most credit/debit cards are acceptable forms of payment. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency, and this could affect your credit. If such legal action is necessary, its costs will be included in the claim. There will be a $50 charge for the return of a check from the bank. Bright Horizons Counseling Services, LLC tries to participate in all insurances. If we do accept your insurance and you would like to file claims through insurance, you can provide permission for us to submit claims on your behalf (see Financial Policy). Even if we are not a participator with your insurance, your insurance company may reimburse you according to guidelines they have established for out of network providers. Your health insurance policy will usually provide some coverage for mental health treatment. Bright Horizons will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of fees. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administration. You should also be aware that most insurance companies require you to authorize Bright Horizons to provide them with a clinical diagnosis. Sometimes we must provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files.

Forensic and Litigative Services

It is the stated philosophy of this practice that **we do not participate** in lawsuits of any type on a plaintiff's behalf, unless compelled to do so by subpoena or court order. If you become involved in legal proceedings that require Bright Horizons participation, you will be expected to pay for all professional time, including preparation, deposition, telephone time, transportation costs, court appearance, report writing, consultation and supervision, even if Bright Horizons is called to testify by another party. Because of the complexity of legal involvement, Bright Horizons charges $500 for preparation (including speaking with attorneys, report writing, and other such duties). **This amount is due two weeks before the trial date.** Bright Horizons charges $1,000.00/half day (4hours) or $2,000.00/full day(8hours) including driving time to and from the office, and attendance at any legal proceeding.

Patient Name: ___________________________

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Psychotherapist – Client Contract (2 of 2)

Contacting Us

Due to our work schedule, we are often not immediately available by telephone. When we are unavailable, please leave a message either with our office manager or on the office voice mail. Your clinician will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please leave some time when you will be available. If you are unable to reach your clinician and feel that you can't wait for a return call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If your clinician will be unavailable for an extended time, he/she will provide you with the name of a colleague to contact, if necessary, and that information will be provided to you prior to any clinician's unavailability. Using text messages to schedule appointments is not permitted. Furthermore, our clinicians primarily use email for exchange of information regarding appointment times. We do not use it for discussion of clinical issues as email is not a secure, confidential form of communication and should not be used for urgent communication.

Professional Records

The laws and standards of this profession require that your clinician keep treatment records. You are entitled to receive a copy of your records, or Bright Horizons can prepare a summary for you instead. Because these are professional records, they can be misinterpreted by and/or upsetting to untrained readers. If you wish to see your records, Bright Horizons recommends you review them in your clinician's presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

Minors

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is Bright Horizons Counseling Services, LLC policy to request that we will provide parents only with general information about our work together, unless your clinician feels there is a high risk that you will seriously harm yourself or someone else. In this case, your clinician will notify them of his/her concerns. Your clinician will also provide them with a summary of your treatment when it is complete. Before giving them any information, your clinician will discuss the matter with you, if possible, and do his/her best to handle any objections you may have about it.

Confidentiality

In general, the law protects the privacy of all communications between a client and a mental health provider (LPC, LCSW), and your clinician can release information about your work to others only with your written permission. But there are a few exceptions. There are some situations in which your clinician is legally obligated to take action to protect others from harm, even if your clinician has to reveal some information about a client's treatment. For example, if your clinician believes that a child, elderly, or disabled person is being abused, he/she is required to file a report with the appropriate state agency. If your clinician believes that a client is threatening serious bodily harm to another, he/she may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself or herself, your clinician may be obligated to seek hospitalization for him or her or to contact family members or others who can help provide protection. Your clinician will make every effort to fully discuss it with you before taking any action. In most legal proceedings, you have the right to prevent your clinician from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order your clinician's testimony if he or she determines that the issues demand it.

Your clinician may occasionally find it helpful to consult other professionals about a case. During a consultation, your clinician will make every effort to avoid revealing the identity of the client. The consultant is also legally bound to keep the information confidential.

Signature:_______________________________________ Printed Name_______________________________ Date:_________________