Prince William Family Counseling 8140 Ashton Ave, Suite 200 Manassas Virginia 20109

Consent for Treatment and Recipient's Rights

Patient Name: _____DOB: _____

I, _____the undersigned, hereby attest that I have Voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at Prince William Family Counseling, hereby referred to as the PWFC. Further, I consent to have treatment provided by a psychiatrist, psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The clinic encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Nonvoluntarily Discharge from Treatment: A patient may be terminated from the PWFC nonvoluntarily. if: (A) the patient exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or (B) the patient refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The patient will be notified of the nonvoluntary discharge by letter. The patient may appeal this decision with the Clinic Director or request to reapply for services at a later date.

Patient Notice of Confidentiality: The confidentiality of patient records maintained by the PWFC is protected by federal and/or state law and regulations. Generally, the PWFC may not say to a person outside the PWFC that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: (1) the patient consents in writing, (2) the disclosure is allowed by a court order, or (3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of federal and/or state law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or state law and regulations do not protect any information about a crime committed by a patient either at the PWFC, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under federal and/or state law to appropriate state or local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the PWFC's duty to warn any potential victim when a significant threat of harm has been made. In the event of a patient's death, the spouse or parents of a deceased patient have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related patient records may be released to substantiate disciplinary concerns. Parents or legal guardians of nonemancipated minor patients have the right to access the patient's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the patient, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Patient data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above-stated policies and agreements with Prince William Family Counseling.

_____ _____

Signature of Patient/Legal Guardian Date

_____ _____

Witness Date

(In a case where a patient is under 18 years of age, a legally responsible adult acting on his/her behalf)

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Financial Policy

The staff at Prince William Family Counseling (hereafter referred to as the PWFC) are committed to providing caring and professional mental health care to all of our patients. As part of the delivery of mental health services, we have established a financial policy that provides payment policies and options to all consumers. The financial policy of the PWFC is designed to clarify the payment policies as determined by the management of the PWFC.

The Person Responsible for Payment of Account is required to sign the form policies and procedures, which explains the fees and collection policies of the PWFC. 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, the PWFC 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 as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. We charge our patients the usual and customary rates for the area. Patients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The Person Responsible for Payment will be financially responsible for payment of such services. 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 1% per month interest rate is charged for accounts over 60 days.

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

All insurance benefits will be assigned to PWFC (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

Patients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of 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 Payment Contract for Services.

Payment methods include check, cash, or charge card. Patients using charge cards may either use their card at each session or sign a document allowing the PWFC to automatically submit charges to the charge card after each session.

Questions regarding the financial policies can be answered by the Office Manager. I have read, understand, and agree with the provisions of the Financial Policy.

Person responsible for account: _____Date:_____/_____/_____

Signature: _____

PWFC

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Privacy of Information Policies

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information. Effective 4.14.03 Updated 9.23.13

Our Legal Duties

State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information

Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a Patient cannot be shared with another party without the written consent of the Patient or the Patient's legal guardian or personal representative. It is the policy of this clinic not to release any information about a Patient without a signed release of information except in certain emergency situations or exceptions in which Patient information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect

When a Patient discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the Patient discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the Patient.

Public Safety

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws. Other Authorizations Required by Law, including: legal proceedings and law enforcement; Workers' Compensation; protected health information related to Inmates; Military, National Security and Intelligence Activities; for the Protection of the President; certain approved research purposes; organ donation; for use by coroners, medical examiners and funeral directors; or any other reason such a disclosure would be required by law.

Abuse

If a Patient states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a Patient is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Patient's Death

In the event of a Patient's death, the spouse or parents of a deceased Patient have a right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings

Health care professionals are required to release records of Patients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor Patients have the right to access the Patient's records.

Other Provisions

Medical Records include both the written record and/or electronic records.

When payment for services are the responsibility of the Patient, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis,

treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the Patient's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the Patient. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about Patients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the Patient, or any identifying information, is not disclosed. Clinical information about the Patient is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the clinic or mental health professional must telephone the Patient for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the Patient (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

Disclosures for which Patient Authorization is Required

The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of protected health information (PHI) for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice. If this clinic intends to send fundraising communications to an

individual, the individual will be informed the intent and the individual has the right to opt out of such fundraising communications with each solicitation. This clinic is required to notify the patient of any breach of his or her unsecured PHI.

Your Rights

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows; You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to choose someone to act for you if you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

If you desire a copy of this notice you may obtain it by requesting a copy at the front desk or accessing it on our website.

Complaints

If you have any complaints or questions regarding these procedures, please contact the Office Manager

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Name of the Patient or Parent/Guardian signing the form: _____

Signature of Patient or Parent/Guardian Date _____

Name of Patient(if not signing form):_____ DOB: _____

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Office Policies and Procedures

Practice Policies and Procedures

Welcome to the office of Prince William Family Counseling (PWFC). This document contains important information about professional services and business policies. Please read it carefully and jot down any questions you might have so you can discuss them with your clinician at your next meeting. When you sign this document, it will represent an agreement between PWFC, your clinician, and you.

The clinician that you will be working with is an independent contractor rather than an employee of Prince William Family Counseling. Your clinician houses his/her clinical practice within the offices of Prince William Family Counseling whereby various administrative functions are provided to benefit the operation of that clinician's practice and your case management. There are functions that require the sharing of your health information to effectively administer, bill, and seek payment for services received.

The treatment record that your clinician produces at Prince William Family Counseling remains the physical property of Prince William Family Counseling. In the event that your clinician moves his/her practice to a different location and you decide to continue therapy with that clinician then or at a different time in the future you can authorize your clinician to copy and/or receive your clinical record.

Because Prince William Family Counseling is not the employer of your clinician you agree not to hold liable and to indemnify Prince William Family Counseling from any claim of malpractice or other form of legal action with respect to the care received.

General

Clinicians at Prince William Family Counseling provide outpatient mental health counseling and assessment. Initial intakes/assessment appointments take approximately 45-50 minutes and primarily involve treatment formulation and paperwork completion. Counseling sessions are generally scheduled once a week for 45 minutes. A late cancellation or no- show 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. If you cancel late or no-show for your appointment your charge will equal the fee that would have been collected by your insurance company or a fee agreed to by you and your clinician. If it is possible, your clinician will try to find another time to reschedule the appointment. If you arrive late for a scheduled appointment, only the remainder of the 45 minute session will be available. If your clinician is running late with a prior appointment for some reason, you will still receive the full 45 minutes.

At times, and only for the purpose of attempting to provide the very best in clinical care, judicious sharing of clinical information in the form of peer consultation may occur to facilitate your or your child's treatment.

Other Professional Services

In addition to weekly appointments, you may find that you need other professional services such as a letter from your clinician. The hourly rate for your clinician is $100. They will charge the same hourly rate for other professional services you may need, though they will break down the hourly cost, in 15 minute increments, if they 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 of your clinician. Fees may increase periodically.

If you or your child is involved in litigation, such as a custody hearing, your clinician will present you with a form that will require you to put down a $2000 deposit as a retainer fee for possible services that will be required of the clinician. Examples of such services: Responding to a subpoena, writing a letter, going to court, deposition. This form will be given to you at your clinicians digression.

Billing and Payments

You will be expected to pay your insurance co-payment for each session at the time it is held. If you do not have insurance or choose not to utilize it, your agreed upon fee will be expected to be paid in full at the time of each session. Cash, check, and credit 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, PWFC has the option of using legal means to secure the payment. This may involve the use of a collection agency, and this could effect your credit. If legal action is necessary, the costs of the collection fees and interest will be included in the claim. There will be a $50 charge for the return of a check from the bank.

Contacting Your Clinician

Due to their work schedule, clinicians are not always immediately available by telephone. While they are usually in the office during regular office hours, they will not answer the phone if they are with a patient. When they are unavailable, please leave a message on their voice mail. They 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 inform them of some times when you will be available. If you are unable to reach them and feel that you can't wait for them to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If your clinician is unavailable for an extended time, they will provide you with the name of a colleague to contact, if necessary, and that information will be on their voice mail. Your clinician only uses email for setting up appointment times or contacting a client who has missed an appointment. They do not use it for discussion of clinical issues. Email is not a secure, confidential form of communication and should not be used for communication related to private information.

Confidentiality

In general, the law protects the privacy of all communication between a client and a clinician, 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 they have to reveal some information about a client's treatment. For example, if they believe that a child, elderly, or disabled person is being abused, they are required to file a report with the appropriate agency. If they believe that a client is threatening serious bodily harm to another, they 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. They will make every effort to fully discuss these issues 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, they

make every effort to avoid revealing the identity of their client. The consultant is also legally bound to keep the information confidential.

Freedom of choice of provider

I understand I have a choice of providers for receiving Mental Health Outpatient Services. I have been made aware that I have a choice of other providers offering this service and have chosen (office) as my provider.

Right to appeal -I also understand that if I have any concerns about decisions that affect my receiving this service I have the right to appeal to DMAS. Upon request, (office) will supply me with all information necessary in accessing my right to a fair hearing. I may appeal any decision by notifying, in writing, the Appeals Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

Human Rights Notification

Each individual who receives services with (Office) shall be assured protection to exercise his/her legal, civil and human rights related to the receipt of services; shall be shown respect for her/his basic dignity; and shall be provided services consistent with sound therapeutic practices.

Every patient receiving (office) services will be treated with dignity and be protected, respected and supported in exercising all of her/his legal, civil and human rights. All staff are prohibited from limiting or taking away these rights for any reason, including a patients disabilities or barriers that may be created due to a disability.

IT IS YOUR RIGHT

- To be treated with dignity and respect
- To be told about your treatment
- To have a say in your treatment
- To speak to others in private Regional Advocates for Virginia:
- To have complaints resolved
- To say what you prefer
- To ask questions and be told about your rights
- To get help with your rights

Charles Collins, contact 540-332-8321 (Staunton Area), Deb Lochart, contact 703-323-2098 (Northern VA), Nan Neese, contact 276-783-1219 (Marion Area), Regional Office, contact 804-524-7247 (Petersburg, Richmond), Reginald Daye, contact 757-253-7061 (Tidewater Area), Sherry Miles, contact 434-947-6214 (Lynchburg Area)

This advocate can assist you if you have reason to believe your rights have been violated.

Upon request you will be given a complete copy of (Office) Human Rights Plan and/or a copy of the Virginia State Human Rights Regulations.

Emergencies

Sometimes, emergencies arise that cannot be planned for. In case of an emergency call 911 and notify your clinician. If your clinician leaves town, another clinician will be on call for them in case of an emergency, and that information will be left on their voice mail.

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Weather

Please do not assume that your clinician follows the PWCPS or Federal Government closure schedules. Contact your clinician in case of inclement weather in order to determine whether your session will be kept or cancelled.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during the professional relationship.

Signature of Patient or Parent/Guardian _____ Date _____/_____/_____

Name of Patient:_____ DOB:_____

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Primary Care Doctor Release of Information

It is often necessary to consult with physicians and nurse practitioners regarding medical/ medication issues pertaining to our patients to insure the highest quality of care. As a result, it is helpful to have a signed release of information to your primary care physician (PCP) or nurse practitioner. In today's world it is typically the role of the PCP to be aware of all treatment you or your child receive to help insure proper coordination of care. Your therapist needs to make your PCP aware of any referrals that need to be made for medication evaluations, to insure the PCP is aware of medication changes, to discuss the need for ruling out medical causes for observed behavioral symptoms, and to make him/her aware of your basic treatment plan (not typically the details of your case, just the general symptom presentation and treatment approach). Also, many insurance companies require that we coordinate care with a patient's PCP as part of treatment and make it a condition of continued authorization for treatment. Your signature on this form indicates that you give consent for your therapist to consult with your PCP/nurse practitioner or your child's pediatrician,(insert name)_____, regarding medication, substance abuse, medical, and mental health issues pertaining to this case.

You hereby give consent for your therapist to exchange verbal information, written information, school records, medical records, and any pertinent substance abuse history with the above named treating primary care medical provider. By signing this form you acknowledge that you understand that you may refuse to authorize release of confidential information to others if you so choose. You understand that you may revoke this consent at any time in writing, except to the extent that action has been taken in reliance on it and that in any event that this consent expires automatically as described below. You are also acknowledging you understand that this information may be subject to re-disclosure by the party receiving the information and may no longer be protected. By signing this form you are allowing your primary care medical provider to accept a copy of this form as a valid consent to release information. This consent includes information, which is placed in the record after the date this consent was signed, unless noted otherwise. Your signature acknowledges that this consent expires when your case is closed OR as specified here on/when

Signature of Patient/Parent or Guardian: _____

Date: _____ Witness Signature _____

Patient Name:_____ DOB: _____

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PHYSICAL RECOMMENDATION

So that we may best serve our patients we recommend that all patients receive a physical examination as soon as possible after beginning services. If a physical examination has been completed within the last year please provide us with appropriate documentation of such physical.

Please check one:

_____ I or my child has received a physical examination within the last year.

Doctors Name:_____ Date of Exam.:_____/_____/_____

_____ I or my child has not had a physical examination within the last year but I agree to set one up. Please let the clinician know if you would like help with this.

_____ I or my child has not had a physical examination and I do not wish for him/her to have one at this time.

PSYCHOLOGICAL/PSYCHIATRIC EVALUATION

So that we may best serve our patients, your clinician MAY recommend that you or your child receive a psychological/psychiatric evaluation upon starting services if you or your child do not currently work with a psychiatrist.

Please check one:

_____ I or my child is currently working with a psychologist/psychiatrist or has been evaluated by a psychologist/psychiatrist within the last year.

Doctors Name:_____ Date of Exam.:_____/_____/_____

_____ I or my child has not seen a psychologist/psychiatrist but I agree to set up an evaluation. Please let the clinician know if you would like help with this.

_____ I or my child has not seen a psychologist/psychiatrist and I do not wish for them to see one at this time.

I understand and agree that by typing in my name, I am creating an electronic agreement that is legally binding upon me and those I represent in the same manner as if I had signed a paper document containing the same terms and conditions.

Signature of Patient or Parent/Guardian_____Date_____/_____/_____

Name of Patient:_____ DOB: _____

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Release of Information

Patient's Name:_____ Phone:_____ DOB:_____

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

I,_____, authorize _____to:
Patient Name/Guardian Clinician/Practice Name/Other

___ (send) ____(receive) _____(from)
Clinician/Practice Name/Other

(Please Provide the name, address and phone number of the person who will be receiving the information)

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

___ Academic testing results
___ Behavior programs
___ Progress reports
___ Intelligence testing results
___ Medical reports
___ Personality profiles
___ Psychological reports
___ Psychological testing results
___ Service plans
___ Summary reports
___ Vocational testing results
___ Entire record, except progress notes
___ *Psychotherapy Notes
___ Other, specify _____

The above information will be used for the following purposes:

___ Planning appropriate treatment or program
___ Continuing appropriate treatment or program
___ Determining eligibility for benefits or program
___ Case review ____ Updating files
___ Other (specify) _____

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 (some states vary,

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usually 1 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 this authorization to receive this protected health information.

Patient's Signature:_____ Date _____

Parent/guardian/personal representative (if applicable) Signature: _____ Date:_____

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No-Show and Cancellation Agreement

In an effort to provide excellent client service to all of our clients, and to provide the best possible therapeutic environment, it is our policy to require a fee for no-show appointments and cancellations made less than 24 hours in advance of the scheduled appointment. *

The fee of $60.00 will be charged to the following credit card:

___ Visa ___ MasterCard

Credit Card #: _____ Expiration Date: ___/___CCV (Credit Card Verification) _____

Name as it appears on Card: _____

I,_____, understand and agree that if I do not show up for my scheduled appointment or if I cancel my scheduled appointment with less than 24 hours notice, the above named credit card will be charged in the amount of $60.00.

Signature _____ Date_____

Printed Name _____

Address: _____ Daytime Ph.: _____

City:_____ Zip:_____

**Exceptions for emergencies are determined by your counselor; and cancellations made 24hrs prior to your time on Monday appointments must occur on Friday as weekend days do not count.*

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Optional CREDIT CARD FORM

Acct Number of Card (MC / Visa OR Debit card): _____

Expiration Date: _____

Name as it appears on the Card: _____

Mailing Address: _____

Contact Phone Number: _____

3 DIGIT CV CODE: _____

Patient's Name: _____

Amount Charged: $_____

Card member acknowledges receipt of goods and/or services in the amount of the total show hereon and agrees to perform the obligations set forth by the card member's agreement with the issuer. My signature as found grants permission to Prince William Family Counseling for using the provided credit card information in order to pay for services rendered.

Maintain card on file: _____ Do Not maintain card on file: _____

Signature of Cardholder: _____ Date: _____

Transaction completed by (please Initial) :

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RELEASE OF MEDICAL INFORMATION

Patient NAME_____ Patient DOB: _____

Date of release: _____/_____/_____

Dear _____,

We are currently working with your patient,_____, in an outpatient mental health setting. Insurance companies require that health information on patients must be obtained. In order to fulfill this requirement, we request that you either mail or fax the patient's latest physical health information.

Your patient is being seen in our (Circle): Gainesville, Manassas, Woodbridge.

Thank you for your prompt attention and your cooperation in this matter. Below, you will find the signatures of the patient and/or his/her parent/guardian indicating agreement with this release.

Signature of Parent/Guardian (if applicable) _____ Date____/___/___

Signature of Patient _____ Date____/___/___

Staff witnessing signature _____ Date____/___/___

Date sent to PCP: _____/_____/_____

Clinician: Please complete this form and either fax or mail a *copy* of this form to the abovementioned doctor. Place this completed form with the date sent in the client's chart.

PWFC