DATE: _____CLIENT ID #: _____THERAPIST INITIALS: _____DSM5/ICD: _____

CHILD FACE SHEET/ BACKGROUND INFO FORM

CHILD'S NAME: _____ DATE: _____

AGE: _____ BIRTHDATE:_____

GRADE:_____TEACHER:_____SCHOOL:_____

ETHNIC BACKGROUND:_____ RELIGION:_____

1. PARENT'S NAME:_____ AGE:_____

ADDRESS: _____

PHONE (HOME):_____ (WORK):_____ (MOBILE):_____

EMAIL:_____

ETHNIC BACKGROUND:_____ RELIGION:_____

HIGHEST GRADE OF EDUCATION: _____

OCCUPATION: _____

2. PARENT'S NAME:_____ AGE:_____

ADDRESS: _____

PHONE (HOME):_____ (WORK):_____ (MOBILE):_____

EMAIL:_____

ETHNIC BACKGROUND:_____ RELIGION:_____

HIGHEST GRADE OF EDUCATION: _____

OCCUPATION: _____

PRESENT MARITAL STATUS:
___Single ___Living together ___Engaged ___Married ___Separated ___Divorced ___Remarried ___Widowed

Number of Years married/living together: _____

Any previous marriages for either spouse: _____ How many?____Duration of each: _____

WHO IS LIVING IN YOUR RESIDENCE?

Name	Age	Relationship

CHILDREN NOT LIVING AT HOME:

Name	Age	Relationship

PREVIOUS TREATMENT:

Has any member of your family applied to or been treated at this office before? _____

Name(s) and Approximate Dates: _____

Has your child been evaluated or received help at some other agency? _____

If yes, where and why? _____

WHY YOU'RE HERE:

What is the problem you seek help for? How long has it existed?

What might contribute to the problem, i.e. the "emotional climate" in the home or community?

Please describe important developments in your child's background:

Unusual events and/or reactions to events (i.e. prolonged separation from parents, divorce of parents, deaths in family, hospitalization of family member):

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DEVELOPMENTAL HISTORY:
Was this a planned pregnancy? _____

Were there any problems during the pregnancy? If yes, what and when? _____

Length of labor: _____ Birth Difficulties: _____

Breast or bottle fed? _____ Any feeding problems during the early years? If yes, what?

Child's health during first year, including allergies? _____

When did your child achieve the following milestones:
Talk: _____ Any difficulties?_____

Walk: _____Any difficulties?_____

Toilet trained_____Any difficulties? _____

MEDICAL HISTORY:
Has your child had any medical problems (i.e. accidents, high fevers, childhood diseases, surgery, hospitalization)? If yes, what and when? _____

Child's Physician's Name: _____ Phone: _____

Is your child taking any medications? If yes, please list Medications and Dosages: _____

Medicating Physicians or Psychiatrist: _____Phone: _____

PRE-SCHOOL YEARS:
Relationship with brothers and sisters:

Relationship with friends:

SCHOOL:
Which school does your child attend and when started: _____

School performance- academic: _____

School performance- social: _____

Other pertinent information:

Name of person filling out form: _____

Relationship to child: _____ Date: _____

In case of an emergency, whom can we notify?
Name: _____ Relationship: _____

Address: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

THANK YOU!

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THE FAMILY CENTER THERAPY AGREEMENT

Welcome to The Family Center. The following sets forth the policies under which we operate. Please read this carefully and feel free to ask your therapist any questions you might have. Please sign the agreement and either bring it with you to your next appointment, or email it back prior to your next session.

Patient/Client Consent to Treatment

Participating in therapy can result in a number of benefits including greater insight, less emotional distress, and resolution of specific emotional, psychological, or behavioral concerns. Benefits may also include improved social skills, increased capacity for intimacy, decreased negative thoughts and behaviors, and improved ability to achieve personal goals. Psychotherapy requires active participation and openness. You are encouraged to give feedback and input about the course of therapy as it proceeds. For the best results, it is often ideal for therapist and patient to collaborate in good faith to meet the patient's goals. Occasionally your therapist might consult with other professionals including other Family Center clinicians, are also bound by rules of strict confidentiality, regarding ideal practice and treatment to enhance effectiveness and quality of services. In this event, names and identifying information are concealed to protect confidentiality. If at any time your therapist believes that they are unable to help you reach your therapeutic goals, they will discuss this with you, and if appropriate, develop a plan for termination and referral to another provider. You have the right to terminate treatment at any time. Therapy never involves social, sexual or business relationships or any dual relationship that may impair the effectiveness of treatment.

Communication: Phone, Email, Texting, TeleHealth, and Emergency Contact

If you need to contact your therapist outside of your regularly scheduled appointment time, you may leave a confidential voice message at (703) 998-5605 ext. ___, or email _____. Some therapists have an alternative phone number and/or are comfortable with text messaging. Please be sure that you and your therapist discuss the ideal way to contact one another. You may also email info@thefamilycenter.com to reach someone on our administrative team.

TeleHealth: Presently, The Family Center is conducting virtually all services via a HIPAA compliant TeleHealth platform, which enabling patients and therapists to see and speak with each other from remote locations. Telehealth involves delivery of healthcare services including assessment, treatment, diagnosis, and education using interactive audio, video, and data communications. Prior to your first appointment, your therapist will provide you with a unique link to click at the time of your weekly appointment. This will connect you to our patient TeleHealth portal. The same link may be used weekly.

Emergencies: If you are experiencing an emergency and cannot reach your therapist, please contact 9-1-1 or your local emergency/crisis center, or go directly to the nearest hospital emergency room and ask for the psychiatrist on-call. If possible once you are safe, then leave your therapist a message that you have done so.

Confidentiality

Confidentiality. Confidentiality is a key component of effective therapy. Knowing that what you share will be kept confidential helps most people to feel more comfortable and develop greater trust in their therapist and the process. With little exception, information that you share in therapy will be kept confidential.

Written Consent Exception. One exception to confidentially is when you have given express written consent to disclose certain information. This would involve you signing a Release of Information Form that sets clear parameters regarding which information may be disclosed to whom. As noted above, our therapists do from time to time collaborate with each other and other professionals in order to provide you with the highest quality treatment. With respect to communications with other Family Center therapists, names and identifying information will be concealed. With respect to communications with professionals outside of The Family Center, you will be asked to sign a Release of Information Form, which you may subsequently revoke at any time as desired.

Safety Exceptions. There are additional exceptions to confidentiality that are important for you to understand before you share information with your therapist. Exceptions to confidentiality are described in greater detail in our Informed Consent for Treatment Form. In essence, any information that you share regarding a plan to inflict harm on yourself or on someone else will require an exception to be made to confidentiality. Please make sure to read and ask any questions you have about confidentially and related exceptions prior to signing the Informed Consent for Treatment. In the event that your therapist is required to break confidentiality, they will make every reasonable effort to talk with you and inform you before doing so.

Policy of Minors in Treatment. Clients who are younger than eighteen years are considered minors and parent(s) or legal guardian(s) sign must sign an informed consent for their treatment As minors, the law may give parents and legal guardians the right to examine treatment records. The Family Center encourages and values open communication and a collaborative approach to working with minors. At the same time, confidentiality is vital in helping minors feel safe to explore feelings they may not be comfortable sharing with other adults. With minors' involvement, therapists will provide parents/legal guardians with general information about sessions, treatment goals, and progress. Further, therapists will work with minors on developing a plan for sharing confidential information with their parent(s) or legal guardian(s) when appropriate and beneficial for treatment progress. If at any time a therapist assesses that there is a high risk a minor may seriously harm themself or another person the therapist will notify the minor's parent(s) or legal guardian(s) immediately of the concern.

The Family Center Professional Rates

Initial Psychotherapy Intake Session	$235.00
Individual Psychotherapy Session	$185.00
Couples and Family Sessions	$235.00
Group Psychotherapy	$100.00
Forensic Evaluations & Court Appearances	$500.00
Psychological-Educational Assessments	$250.00
*Family Mediation	$250.00
*Parenting Coordination	$350.00
*Parental Guidance/Coaching	$150.00
*School Visits	$175.00
*Executive/Accountability Coaching	$150.00

* indicates services not able to be submitted to insurance

Payment is due at the time of service. For allowable services and paneled therapists and supervisees, ***INSURANCE IS BILLED THROUGH OUR OFFICE AS A COURTESY***. Patients are responsible for knowing their own insurance benefits, including copay, deductible, out of pocket maximum amounts, and effective dates. In the event that a patient's insurance provider denies any insurance reimbursement, the ***PATIENT IS ULTIMATELY RESPONSIBLE FOR THE FULL BALANCE ON THEIR ACCOUNT***.

If you need to discuss payment plan options, please let your therapist and/or our front office know as soon as possible. Further, some therapists may be open to discussing a sliding scale fee arrangement.

For patients with out of network insurance benefits, full fees are due at the time of service. Your therapist will provide you monthly with a detailed billing statement including a clinical diagnosis and standard billing codes used by insurance carriers that you may submit directly to your insurance for reimbursement.

Correspondence and related professional services outside of regularly scheduled sessions are billed at our hourly rate of $200.00, billed in 15-minute increments. Examples of these services include report writing (non-assessment related), telephone conversations lasting longer than 10 minutes, consulting with other professionals (with your permission), preparation of records/treatment summaries, and the time spent performing another service at your request.

In legal proceedings of patients that require therapist or mediator participation, patients are responsible for all

professional time and costs, including preparation and transportation costs, and any necessary professional attorney fees, even if the therapist or mediator is called to testify by another party. Because of the complications and difficulty of legal involvement, the hourly professional rate is $500.00, billed in 15-minute increments for preparation, travel, and attendance at any legal proceeding.

Please be aware that practice fees tend to increase between 5-10% every few years, as necessary to offset to increasing cost-of-living expenses and various other practice operating expenses. If and when the practice finds it necessary to raise fees, you will be informed at least one month in advance in order to offer an opportunity to discuss the increase. Please let your therapist know if you feel the increase would cause financial hardship.

Cancellation/Missed Session Policy. In contracting for psychotherapy, you are responsible for the weekly appointment time(s). Advanced notice of 24 hours prior to a canceled session is required to avoid a full fee charge for that session. Cancelled sessions are not billable to insurance. Sessions canceled at the last moment due to illness or emergency will not be charged if the client can make up the missed appointment within 10 days. As a courtesy, group psychotherapy members are allowed to miss 2 sessions at no cost during each semester. Any absences from group beyond 2 missed sessions will be charged at the full fee in order to maintain the client's space in the group. In order to enroll in group, clients must commit to participate for a semester at a time.

Billing and Payments. Patient bills are printed and insurance is submitted, both once monthly. Payment is expected within 20 days of receipt of the bill. Many patients opt to provide on file credit card information so that their copay amount can be run weekly. In circumstances of unusual financial hardship, please let your therapist know to discuss negotiated fee adjustment or installment payment plan.

Late Fee ($25). All bills are due the 20th of each month. A $25.00 late fee will be added for each bill not received by the 20th, and an additional $25.00 will be charged for each billing cycle a balance remains unpaid.

Coordinating with physician and psychiatrists. Physical and psychological symptoms often interact. You are encouraged to seek medical consultation as needed. Medication can be helpful for some psychological concerns. Please let your therapists know of any medical and/or psychiatric concerns you have and a referral can be made where appropriate.

Patient Rights. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides you with the following rights: to request certain amendments to your record; to restrict what Protected Health Information (PHI) information is disclosed to others; to request an accounting of disclosures that have not required your consent; to determine the location(s) where PHI is sent; to have complaints you may make about therapist procedures and policies recorded in your record; to request copies of this notice and the HIPAA notice form. You have a right to review your PHI, except in limited legal and emergency situations, including situations where releasing the information to you might be harmful to you. In this event, it may be appropriate for to provide records to an appropriate mental health professional of your choice to review with you.

Counseling Agreement Consent

Your signing below indicates that you have read in its entirety and understood this Therapy Agreement, that you have had an opportunity to ask questions, and are agreeing to enter into a professional relationship with The Family Center and agree to abide by the terms of this agreement. In the event that a person other than you is responsible for paying the bill, please also have the party read this document and sign. Thank you!

Patient Name: _____ Date: _____
(please print)

Patient Signature: _____ Date: _____
(parent/guardian's signature, if applicable)

Therapist Signature: _____ Date: _____

CONSENT FOR TREATMENT - CHILDREN

Client Name: _____

It is important that you understand the policy and procedures regarding the treatment of minors at the beginning of service so that you can make an informed decision about receiving services.

This information is in addition to the Family Center Therapy Agreement.

• Parents/Guardians are expected to be involved in their child's therapy sessions. All children must initially be brought to therapy sessions by a parent or guardian and that person must remain in the office during the time your child is being see. If an alternate accompanying adult is desired for future sessions, it is important to discuss this option prior to the session.

• A parent or guardian who has legal authority to do so must consent to their child's treatment. A court order to verify that you are the legal parent or guardian may be necessary.

• Virginia Law allows for either parent to have access to their child's records or information, unless there is a court order limiting access or terminating parental rights. If and when a parent makes a request, I will make attempts to notify the other parent. Please understand that I must comply with legitimate requests.

• By signing this statement you agree not to involve this therapist in any type of legal proceedings against a parent or family member. It is important to recognize the importance of the relationship that your child will be developing with their therapist. The trust that is built into the sessions is the foundation for change and growth in your child.

By requesting participation in legal proceedings, you would be asking your child's therapist to betray the trust and relationship that was built/is building with your child.

I acknowledge that I have read and agree to all of the above provisions about seeking services for my child. I certify that I am the legal parent/guardian and have the authority to consent to services

_____ _____

Parent/Legal Guardian Signature Date

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INFORMED CONSENT FOR TREATMENT

PATIENT NAME: _____

I (We) _____, hereby give permission and
(Patient or Legal Guardian)

consent to _____ for treatment. I (We)
(Psychotherapist)

understand that this will encompass the intake, diagnostic assessment, and treatment processes.

I (We) understand and acknowledge that strict confidentiality is practiced and assured, with the following exceptions:

1. I/We have signed a Release of Information Consent Form for specified individuals or agencies;
2. There is an active court order signed by a duly appointed or elected judge for the release of my records or my/our child's records;
3. I am/My child is perceived to be a danger to myself/themselves/or others.
4. I am/My child is suspected of abusing children or other vulnerable individuals
5. Representatives of a funding source for my(our)/my child's services require that my(our)/my child's record(s) be made available with my(our) written consent.

*HIPAA Privacy Rule allows for release to insurance carriers of Protected Health Information (PHI), namely treatment dates, modalities, results of tests, diagnoses, symptoms, treatment plan, prognosis, and progress. PHI does not include Psychotherapy Notes, which may include the content of our conversations and therapist analysis of these conversations. These Notes are the possession of the therapist, and are not released by the therapist. When requested, a summary of Psychotherapy Notes will be provided to the patient, or another party with written consent of the patient or their representative.

I (We) understand that all treatment and evaluation with the Therapist is voluntary, and that I (We) may cease treatment or evaluation at any time. I (We) have read and agree to the Therapy Agreement. I (We) have read and/or had the above explained to me (us), and voluntarily give my (our) informed consent to treatment and/or evaluation.

_____ _____
Patient Signature Date

_____ _____
Parent or Legal Guardian Signature Date

_____ _____
Parent or Legal Guardian Signature Date

ACKNOWLEDGEMENT OF CHILD THERAPY

Client/Patient Name: _____

This release is an acknowledgement that _____is seeing my child in counseling
Therapist Name

and that I am aware of the invitation to participate in this counseling process.

_____ I am in agreement with this process
_____ I am not in agreement with this process
_____ I accept the invitation to participate:
_____ In person
_____ By phone
_____ In writing
_____ I decline to participate

_____

Parent/Legal Guardian Signature Date

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INSURANCE FORM

*PATIENT' NAME: _____ INTAKE DATE: _____

*DOB: _____ SSN#: _____

PRIMARY NAME ON INSURANCE POLICY:

*NAME: _____ SSN#: _____

*DOB: _____ *RELATIONSHIP TO PATIENT: _____

INSURANCE INFORMATION

*INSURANCE ID #: _____

GROUP ID #: _____

*INSURANCE CARRIER: _____

*INSURANCE CLAIMS ADDRESS: _____

INSURANCE PHONE NUMBER: _____

*EFFECTIVE DATE: _____

POLICY RE-STARTS BASED ON: □ CALENDAR YEAR (JAN-1) OR □ CONTRACT YEAR (EFFECTIVE DATE)

DEDUCTIBLE AMT: _____ COPAY AMT: _____ OUT OF POCKET MAXIMUM: _____

LIMIT ON NUMBER OF SESSION ALLOWED PER YEAR? _____ NUMBER ALLOWED: _____

REFERRAL OR AUTHORIZATION REQUIRED? _____

The above information will be disclosed to your insurance carrier and their mental health carrier if applicable in order to obtain eligibility, benefits, authorization/certification, extension of a treatment plan, claim submission, and claims questions.

Your signature below signifies your consent to release this information.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____ DATE: _____

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RELEASE FOR ELECTRONIC DELIVERY OF BILLING INVOICES

I, _____ consent to have The Family Center deliver my billing invoices to the email address provided below. I understand that email communications may not be considered confidential or privileged, and I accept all risk to confidentiality permitted by my consent. I further agree not to hold The Family Center or any of its therapists or office staff liable for any damages incurred as a result of electronic emailing of my billing statements.

_____ _____

Signature Date

_____

Email Address for Billing Invoice (please print clearly)

CREDIT CARD AUTHORIZATION

Please complete this form even if you will not be charging your sessions on a regular basis. Because clients may occasionally forget to leave payment, we appreciate having a card on file, which will not be charged without notifying you.

_____(Initial) I authorize The Family Center to keep my signature on file and to charge my account for services rendered including copays, late cancellation fees, no show charges, and unpaid balances.

I understand that this form is valid for four (4) years unless I cancel the authorization through written notice to The Family Center.

Patient's Name: _____

Card Holder's Name: _____

Card Billing Zip Code: _____

____ Visa _____ MasterCard

Account #: _____

CVV: _____ (3 digits found on the back of the card in the signature line)

Signature: _____Expiration Date:_____

THANK YOU!!

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