WESTHAMPTON FAMILY PSYCHOLOGISTS, P.C.

***** PLEASE RETURN FORM TO FRONT DESK *****

VIRGINIA NOTICE FORM

Notice of mental health professionals' practices and policies in compliance with HIPAA (Health Insurance Portability and Accountability Act) to protect the privacy of your health information

Please read the following information carefully and sign the last page.

I understand that I am financially responsible for my deductible, co-payment, and/or balance remaining after my insurance has paid. In addition, if my insurance carrier does not cover the services provided I understand I am responsible for all charges for care provided.

I understand that as part of my mental health care, Westhampton Family Psychologists, P.C. originates and maintains paper and/or electronic records describing treatment, testing results and forms, correspondence and insurance information. This information cannot be disclosed without my written consent. I may revoke any authorization for disclosure at any time except if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

I understand that information from the medical record may be disclosed without obtained consent for the following conditions:

1. Child Abuse – State law requires that your clinician disclose information regarding suspected harmful actions or neglect towards children.

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2. Adult or Domestic Abuse – State law requires your clinician to report and provide information if there is suspicion of adult abuse, neglect or exploitation.
3. Health Oversight – Regulating Boards have the power to subpoena relevant records if a clinician is the focus of an inquiry.
4. Judicial or Administrative Proceedings – If you are involved in a legal proceeding and your mental health records are requested, the information will not be released except if it is requested by subpoena. If you desire to block (quash) the subpoena then your record will be provided to the clerk of the court in a sealed envelope so that the court can determine whether the records should be released.
5. Serious threat of health or safety – If you have communicated directly to your clinician that you have a specific and immediate plan to cause serious harm or death to an identifiable person and if your clinician has sufficient evidence based on your conversations, history and treatment to believe this threat is real, then the law requires the clinician to take steps to protect the third party. Either the third party can be warned, or their parents warned if they are under 18, or a law enforcement officer may be contacted.
6. Serious threat to yourself – If you have communicated directly to your clinician that you have specific and immediate plans to cause serious harm or death to yourself and if your clinician has sufficient evidence based on your conversations, history and treatment to believe this threat is real, then the law requires the clinician to take steps to protect you by either contacting a significant other or admitting you to an appropriate treatment facility.
7. Worker's Compensation – If you file a worker's compensation claim, the law requires that relevant mental health information be submitted to your employer, insurer or a certified rehabilitation provider.

I understand that I have the following rights:

1. I have the right to request restriction on certain uses and disclosures of my mental health information. Your clinician may or may not be required to agree upon these restrictions.
2. I have the right to request and receive confidential communication by alternative means and at alternative locations (e.g. fax or email).
3. I have the right to inspect and obtain a copy of my mental health record and billing records. The access to this information may be denied under some circumstances. You are entitled to a discussion with your clinician regarding the reasons for limiting access to your records.
4. I have the right to request an amendment to my records, but this request can be denied by your clinician.

I understand that my treating clinician is required by law to maintain privacy of my mental health record and to provide me with notice of their legal duties and privacy practices with respect to my mental health record. The treating clinician has the right to change those privacy policies and practices with notification to you in writing.

I understand that I have the right to disagree with decisions made and I can make formal complaint to Pat, Office Manager, Westhampton Family Psychologists, P.C. who can be reached at (804) 673-0100 x201. A written complaint can be made to the Secretary of the U.S. Department of Health and Human Services.

I understand that this notice is in effect beginning May 15th, 2005. If there are any changes to this notice and I am still in treatment at WFP then I will be notified in person and writing about such changes.

I understand that my clinician may need to contact me. I agree to the following forms of communication knowing that the clinician will leave their name and information about my appointments.

Please check all to which you agree:

Voice mail:	Email:	Verbal message:
☐ home	☐ home	☐ home
☐ work	☐ work	☐ work
☐ cell	☐ cell	☐ cell

I have read and understand this HIPAA policy. Please sign and enter today's date.

_____ _____

Your Name Today's Date

WESTHAMPTON FAMILY PSYCHOLOGISTS, P.C.

FINANCIAL AGREEMENT

Our fees for professional services are as follows:

- The fee for the ***Initial Evaluation is $150.00***.
- The fee for a ***45 minute therapy session is $125.00.***
- The fee for sessions exceeding 45 minutes will be assessed according to the amount of additional time spent in session. Insurance companies typically do not cover additional time beyond the 45 minutes therefore additional time will most often be paid out of pocket.
- The cost of a ***Psychiatric Evaluation*** and office visit with a Psychiatrist (MD) will vary depending on the length of the visit and nature of the appointment.
- ***An initial evaluation with a psychiatrist is $200.00***.
- ***The charge for a medication consultation is $75.00***.
- ***A medication evaluation combined with a therapy visit is $150 for a 45 minute session***.
- There is a charge for ***prescription refills and phone calls with the psychiatrist outside of a scheduled office visits.*** The amount will depend on the length of time involved.
- The cost of a ***Psychological Evaluation*** varies with the tests administered. Depending on your insurance policy, a portion of the charges may be reimbursable. Approval for reimbursement requires a separate pre-authorization which will be completed by the examiner prior to beginning the testing. Testing for educational purposes including achievement testing and assessments to rule out learning disabilities are **not covered** by insurance companies. A summary of individual testing charges is available and you may also feel free to discuss this with the psychologist. In addition to the charges for the evaluation, there is a separate fee for testing and scoring materials that is requested at the time of service. The amount of the charge will vary depending on the test materials used and is not covered by insurance companies.
- ***There is a $75.00 charge for all missed appointments***. A minimum of a 24-hour notice is required to cancel an appointment to enable us to reschedule the time with another person. Failure to cancel within this time or missing without canceling an appointment will result in a charge of $75.00 for which you are responsible. These charges cannot be filed with your insurance company and will be billed to you in full.
- There is no charge for brief ***telephone calls***, though calls regarding treatment or medication issues lasting more than 5-10 minutes will be pro-rated and billed at the regular hourly therapy rate. Insurance policies do not provide coverage for telephone therapy leaving you responsible to satisfy payment of any accrued charges.

- The fee for any requested ***court testimony*** regardless of whether the clinician is served a subpoena or requested by one of the parties is a minimum of $1200.00 for one half day (up to four hours) and $2500.00 for an entire work day. This includes time for transportation and preparation. Additional fees may be assessed if travel outside of the immediate area is required.

- ***Payment in full for court testimony*** is required 5 business days in advance of the scheduled hearing. In the event that a hearing is cancelled within less than 3 business days notice, a charge of $250 will be assessed. Responsibility for the payment in full for any requested court testimony is ultimately yours regardless of which party may have issued the subpoena. If you anticipate that your therapist will be needed in court, please ask us for a copy of our court policy for review.

- Some insurance companies provide what is referred to as ***"out of network" coverage***. In such cases, there is typically a deductible that must be met before the insurance company will provide payment for services. Once you have satisfied your deductible, your co-pay may be a specific percentage of the entire bill. Payment in full of this amount is your responsibility and is required at each office visit.

- ***Payment is due at the time of service for your portion of the bill***. This includes any portion of the bill that is not covered by the insurance company. We ask that prior to beginning services, you contact your insurance company to obtain any needed pre-authorizations and/or referrals. It is your responsibility to contact your insurance company to obtain information regarding the portion of the bill that you are responsible for. Payment in full of your co-pay is due at the time of service. Payment may be made in the form of cash or check. We also accept Visa and MasterCard as forms of payment. You are ultimately responsible for payment of all charges on your account even if your insurance company denies the claim or otherwise refuses to reimburse the charges. To avoid unexpected charges, we ask that you verify your coverage and note any restrictions or limitations prior to beginning treatment.

- ***There is a $25.00 charge for all returned checks.*** You are responsible for these charges.

- A ***service charge*** of 4% may be added to all bills that are 90 days past due. Failure to settle or make arrangements to settle your account will result in a referral to a collection agency. In addition to the sum of the bill, you will be assessed an additional collection fee of approximately 25% in addition to any legal or court fees.

I have read, been informed of and had the opportunity to discuss and ask questions regarding any and all of the above terms and I agree to accept treatment under them.

_____ _____

Date Name of Patient and/or Person Responsible for Payment

_____ _____

Date Signature of Patient and/or Person Responsible for Payment

WESTHAMPTON FAMILY PSYCHOLOGISTS, P.C.

Authorization to Exchange Information

In accordance with HIPAA privacy laws, a signed consent is required to exchange information in any form about your care. Please use the space below to identify any persons with whom you may want us to have contact with. A signed consent is required by law in order for us to communicate in any manner (including billing) with parents of individuals who are 18 or older. This authorization allows us to communicate when needed or requested regarding scheduling, insurance or billing information, as well as routine or emergency contact. This authorization may be rescinded or amended at any time that you so choose.

I, _____certify that I am over the age of 18 and therefore give permission for Westhampton Family Psychologists to communicate with the following persons about my/ my child's treatment.

May speak to about me:

Name	Relationship	Phone #	In Person	By Phone	Emergency **ONLY**
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

_____ _____

Name of Patient Date

_____ _____

Signature of Patient or Guardian (if under 18) Date

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PCP Coordination

To: Dr. _____M.D, Fax # _____, Date: _____

Please enter PCP name & fax # here

Re: Patient Name _____ Date of Birth: _____

In an effort to coordinate treatment, I am informing you that the above individual has requested services through our practice. I look forward to the opportunity to coordinate treatment with you. Please feel free to contact me at 673-0100 if you have any further questions or if I can be of further assistance. I look forward to working with you on this case.

Sincerely,
Westhampton Family Psychologists

PLEASE MARK ALL THAT APPLY

- ☐ Allison Twente, PhD x202
- ☐ Stephen Twente, PsyD x203
- ☐ Shanan Raines, PhD x206
- ☐ Laura Brewer, PhD x215
- ☐ Martha Davidson, MD x210
- ☐ Annette Doll, LPC x213
- ☐ Bruce Hammond, LCSW x211
- ☐ Helen Landry, LCSW x257
- ☐ Sarah McElroy, PhD x212
- ☐ Lara Meili, PsyD x205
- ☐ Laine Sims, LCSW x250
- ☐ Kimberly Nicolas, PhD x214
- ☐ Linda Pattee, Ph.D
- ☐ Karen Zagayko, Ph.D x209

Permission to Exchange Information with your Primary Care Physician

Many insurance companies are now requesting that primary care physicians are contacted in order to coordinate care. It is your choice as to whether we communicate with your or your child's physician. Please indicate whether you authorize or decline this communication.

_____ I do give permission for my therapist to share information regarding my therapy with my primary care physician. I understand that this release shall be valid for ninety (90) days after my last date of treatment. I understand that I may revoke this authorization at any time during the course of my treatment.

_____ I do not authorize my therapist to exchange information about my current treatment with my primary care physician.

Signature of Patient or Guardian: _____

WESTHAMPTON FAMILY PSYCHOLOGISTS, P.C.

Child Intake Information

Patient's Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Sex: ____ S.S. #: _____

Mother/Guardian: _____ _____
Email

Address: _____
Street City State Zip Code

Telephone: _____ _____ _____ _____
Home Work Cell Email

Father/Guardian: _____ _____
Email

Address: _____
Street City State Zip Code

Telephone: _____ _____ _____ _____
Home Work Cell Email

_____
Alternate Emergency Contact Relationship Phone Number Email

School: _____ Grade: ____ Special Education: YES NO

Physician: _____
Name Contact Number

Reason for Referral and Chief Complaint(s):

_____

_____

_____

_____

List all immediate family members in relation to the patient:
Name(s) Relationship Age/Date of Birth Occupation/Education

_____

_____

_____

_____

_____

_____

Marital Status of the child's parents:

____Single ____Married ____Separated ____Divorced ____Widowed

Please complete only if there has been a divorce or marital separation in your child's life:
Separation/Divorce: (when) _____ Mediation? _____

Child lives mainly with: _____

Custody/Visitation: _____

Does your child have a history of criminal behavior? _____ If yes, explain

_____

_____

_____

_____

Is your child currently using alcohol/drugs? ____ If yes, please describe

Type: _____ Frequency: _____ Amount: _____

Does anyone in your family have a history of alcohol/drug use? _____

If yes, please explain: _____

_____

_____

Has your child ever expressed suicidal thoughts? _____ If yes, please explain:

_____

_____

_____

Has your child ever expressed thoughts of hurting /killing other people? If yes, please explain: _____

_____

_____

Following is a series of problems that sometimes run in families. Please note if anyone other than the patient has had any of these. Please put an **X** in the column of the family members who have had each problem. (Others=cousins, aunts, uncles, grandparents)

Problem	Mother	Father	Sibling*Specify	Other
Hyperactivity as a child				
Trouble with reading/math				
Speech problems				
Kept back in school				
In trouble as a teenager				
Childhood behavior problems				
Anxiety, Panic, Phobias				
Depression				
Obsessions, Compulsions				
Alcohol or drug abuse				
Other mental illness (specify)				
Medical illness (specify)				

Has your child ever been sexually/physically abused? YES NO

Has your child ever sexually/physically abused others? YES NO

Does your child have a history of neglect? YES NO

If yes to any of these questions, please describe and note action taken: _____

_____

_____

Note stressful or traumatic events that may have had an impact on your child:

_____

_____

_____

Is your child sexually active? _____ If yes, please describe any known high risk behavior: _____
_____

Please mark all health difficulties experienced by your child. Use an **X** and note appropriate age of occurrence. If there are no difficulties in a particular area, please leave bank.

___ Ear infections_____
___ Rashes or skin problems _____
___ Meningitis _____
___ Seizures _____
___ High fevers (over 103 degrees) _____
___ Pneumonia _____
___ Asthma _____
___ Slow weight gain _____
___ Trouble with hearing or ears_____
___ Trouble with vision or eyes_____
___ Bowel problems _____
___ Hospitalization (s) _____
___ Surgery _____
___ Head injuries/loss of consciousness _____
___ Other serious injury _____
___ Food allergies _____
___ Other allergies _____
___ Anemia _____
___ Lead poisoning _____
___ Other poisoning or overdose _____
___ Heart problems_____
___ Kidney or urinary problems _____
___ Became ill after immunization shot _____
___ Problems with eating _____
___ Problems with sleeping _____

If your child has problems with sleeping please check all that apply

___ Trouble waking in a.m. ___ Trouble falling asleep

___ Excessive tiredness during the day ___ Snoring

Has your child experienced other important illnesses or conditions?

_____

_____

_____

List any medications your child is currently taking or have used over a long period of time (e.g., prescription, dosage, dates):

_____

_____

_____

Please describe any problems related to pregnancy or birth (e.g. miscarriages, infertility, prescribed medications, alcohol/drug use): _____

_____

_____

_____

_____

At what age did your child say his/her first word? _____ String words into sentences? _____ Walk? _____ Toilet trained? _____

Have either the patient or other family members been in therapy before?

_____

If so, when, with whom, and was it useful (specify)? _____

_____

_____

What else would you like your clinician to know about you and your family?

_____

_____

_____

WESTHAMPTON FAMILY PSYCHOLOGISTS, P.C.

Child Symptom Checklist

Patient's Name: _____ Person completing form: _____

CURRENT PROBLEMS: Please indicate any difficulties that your child is experiencing.

Mood Problems:

- ❒ Depressed mood
- ❒ Irritable mood
- ❒ Loss of interest or pleasure in usual activities
- ❒ Loss of appetite
- ❒ Weight loss of ____ pound(s)
- ❒ Weight gain
- ❒ Insomnia
- ❒ Hypersomnia
- ❒ Feelings of hopelessness
- ❒ Low self-esteem
- ❒ Diminished energy
- ❒ Feelings of worthlessness
- ❒ Excessive/inappropriate guilt
- ❒ Concentration difficulties
- ❒ Suicidal ideation
- ❒ Frequent thoughts of being dead
- ❒ Mood swings
- ❒ Feeling on top of the world for no reason
- ❒ Impulsivity
- ❒ Racing thoughts or speech
- ❒ Other: _____

Anxiety Problems:

- ❒ Excessive worry about future/past events
- ❒ Feelings of being on the edge
- ❒ Difficulty concentrating
- ❒ Irritability
- ❒ Shakiness
- ❒ Muscle tension or aches
- ❒ Somatic/bodily complaints without a physical basis
- ❒ Restlessness
- ❒ Inability to relax
- ❒ Insomnia
- ❒ Fatigue
- ❒ Excessive need for reassurance about a variety of concerns
- ❒ Worries about parents
- ❒ Difficulty breathing/shortness of breath
- ❒ Heart palpitations
- ❒ Excessive sweating
- ❒ Cold/clammy hands
- ❒ Dizziness
- ❒ Lightheadedness
- ❒ Dry mouth
- ❒ Nausea
- ❒ Stomach distress
- ❒ Hot flashes
- ❒ Fear of losing control or dying
- ❒ Excessive fears with avoidance
- ❒ Frequent urination
- ❒ Difficulty swallowing
- ❒ Intense anxiety about social/academic/athletic performance
- ❒ Fear of failure/making mistakes
- ❒ Marked self-consciousness
- ❒ Excessive avoidance of people
- ❒ Persistent/intrusive thoughts
- ❒ Preoccupation about "silly worries"
- ❒ Repeatedly checking, washing, or counting
- ❒ Separation problems
- ❒ Clinginess
- ❒ Other: _____

Disruptive Behavior Problems

- ❒ Is often angry and resentful
- ❒ Is easily annoyed
- ❒ Often loses temper
- ❒ Argumentative with adults
- ❒ Argumentative with peers
- ❒ Often blames others for his/her own mistakes
- ❒ Oppositional/negativistic behavior with parents
- ❒ Deliberately annoying behavior
- ❒ Defiance of rules
- ❒ Often swears or uses obscene language
- ❒ Is often spiteful or vindictive
- ❒ Impulsivity
- ❒ Overactivity
- ❒ Other: _____

Social Problems:

- ❒ Increased arguments with family members
- ❒ Social withdrawal
- ❒ Social isolation
- ❒ Having few friends
- ❒ Lack of close relationships
- ❒ Poor judgment in social situations
- ❒ Generalized lack of expressiveness
- ❒ Sexual problems
- ❒ Increased distance and argumentativeness with others
- ❒ Lack of trust in others
- ❒ Fear others are out to harm child
- ❒ Difficulty starting relationships
- ❒ Difficulty maintaining relationships
- ❒ Brief and stormy relationships
- ❒ Fear of rejection/abandonment
- ❒ Difficulty making decisions
- ❒ Excessive dependency
- ❒ Difficulty being alone
- ❒ Excessively trying to please others
- ❒ Lack of assertiveness
- ❒ Verbal aggression
- ❒ Conflict with authority
- ❒ Physical aggression toward others
- ❒ Lack of guilt/remorse after wrong doing
- ❒ Non-conforming behaviors
- ❒ Involvement with the law
- ❒ Other: _____

School Problems:

- ❒ Problems with attention
- ❒ Concentration difficulties
- ❒ Easily distractible
- ❒ Makes careless mistakes
- ❒ Acts impulsively
- ❒ Difficulty completing class/homework assignments
- ❒ Disorganized
- ❒ Forgetful
- ❒ Does not follow instructions
- ❒ Does not seem to listen when spoken to
- ❒ Hyperactive
- ❒ Excessive running/climbing
- ❒ Fidgety
- ❒ Cannot stay seated
- ❒ Difficulty awaiting turn
- ❒ Often interrupts/intrudes on others
- ❒ Excessive shyness with schoolmates
- ❒ Academic underachievement
- ❒ Low academic motivation
- ❒ Cheating
- ❒ Behavior problems at school
- ❒ Refusal to go to school
- ❒ Truancy from school
- ❒ School suspensions
- ❒ Frequent fights at school
- ❒ Math difficulties
- ❒ Written language difficulties
- ❒ Reading problems
- ❒ Other: _____

Eating Problems:

- ❒ Fear of gaining weight/becoming fat
- ❒ Feeling “fat” regardless of weight
- ❒ Using food for comfort when sad/angry
- ❒ Pattern of weight loss and gain
- ❒ Overeating
- ❒ Vomiting
- ❒ Abusing laxatives
- ❒ Other: _____

Alcohol/Drug Problems:

- ❒ Overuse of alcohol/drugs
- ❒ Using more alcohol/drugs than planned
- ❒ Using more alcohol/drugs to get the same effects
- ❒ Unsuccessful attempts to limit intake of alcohol/drugs
- ❒ Morning drinking/drug use to diminish hangover
- ❒ Using alcohol/drugs despite arguments from family or friends
- ❒ Experimentation with alcohol/drugs
- ❒ Other: _____

Other Behavior Problems:

- ❒ Difficulty controlling anger
- ❒ Academic failure
- ❒ Achievement below intellectual ability
- ❒ Sexual problems
- ❒ Sexual abuse
- ❒ Physical abuse
- ❒ Sexual orientation concerns
- ❒ Self-destructive behaviors
- ❒ Legal problems
- ❒ Financial problems
- ❒ Death of a friend/family member
- ❒ Nightmares
- ❒ Seizures/convulsions

Home Problems:

- ❒ Lying
- ❒ Stealing
- ❒ Noncompliance at home
- ❒ Irresponsibility
- ❒ Being argumentative
- ❒ A conflictual relationship with parents
- ❒ A distant relationship with parents
- ❒ Other: _____