Westhampton Family Psychologists, P.C.
1503 Santa Rosa Road | Henrico, VA 23229
P.804.673.0100 | F.804.673.8054
www.wfphelp.com

Child | Adolescent Intake

Patient | Family Information

Child | Adolescent Name: _____ Today's Date: _____

DOB: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Grade: _____ | School _____

Pediatrician: _____

Who referred you to our practice? _____

Parent | Guardian's Name:

_____

Relationship: _____

Home Address: _____
(If different from above)

_____

Phone(Home) _____

Phone (Cell) _____

Phone (Work) _____

Email: _____

Parent's Marital Status: _____

Parent | Guardian's Name:

_____

Relationship: _____

Home Address:_____
(If different from above)

_____

Phone(Home) _____

Phone (Cell) _____

Phone (Work) _____

Email: _____

Date of Divorce if applicable: _____

Legal custody of child(ren): _____

What is the reason for your visit?_____

_____

_____

Have either the patient, or other family members, been seen in therapy before? Yes No

If so, when, with whom, and did you find it useful? Please explain: _____

_____

_____

List all immediate family members in relation to the patient:

Name	Relationship	Age (DOB)	Occupation | Education

Please indicate any additional information you would like your clinician to know about the patient and his | her family: _____

_____

_____

Insurance Information (*Please verify with the Front Desk whether or not your provider participates with your insurance)*

Insurance Company: _____ Policy Holder's Name: _____

Policy Holder DOB: _____ Policy Number: _____ Group Number: _____

Employer: _____ Relationship to patient: _____

Please provide a copy of your insurance card with our billing office

Medical History | Lifestyle Habits

Does the patient have a history of criminal behavior? Yes No

Has the patient ever expressed suicidal thoughts? Yes No

Has the patient ever expressed thoughts of hurting or killing other people? Yes No

Has the patient ever been sexually | physically abused? Yes No

Has the patient ever sexually | physically abused others? Yes No

Does the patient have a history of neglect? Yes No

Is the patient currently using alcohol or drugs (including tobacco)? Yes No

If yes, Type: _____ Frequency: _____ Amount: _____

Would the patient like help | resources on tobacco cessation, or alcohol | drug treatment? Yes No

Does anyone in the patients family have a history of alcohol | drug use? Yes No

If yes, please explain: _____

_____

Is the patient concerned about their weight or physical health? Yes No

Would the patient like help | resources on improving their physical health? Yes No

Does the patient have a regular routine of healthy social activities or hobbies? Yes No

Please explain:_____

_____

Would the patient like help | resources on developing healthy social activities and or hobbies? Yes No

Does the client engage in healthy stress management activities? Yes No

Please explain: _____

_____

Would the patient like help | resources on developing healthy stress management activities? Yes No

Please note any stressful or traumatic events that may have had an impact on the patient: _____

_____

_____

Please list any current prescribed medications the patient is taking, or have used over a long period of time (e.g. prescription, dosage, dates)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any health problems of the patient, current or past, including any hospitalizations, infections, head injuries or accidents

_____

_____

_____

Developmental History

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

_____

At what age did the patient say his | her first word? _____ Walk? _____

String words into sentences? _____ Was Toilet Trained? _____

What are the patient's main interests and hobbies? _____

_____

What are the patient's strengths and greatest accomplishments? _____

_____

Child | Adolescent Symptoms: *Please check all that apply*

Mood Problems:

- ❒ Depressed mood
- ❒ Irritable mood
- ❒ Loss of interest or pleasure in usual activities
- ❒ Loss of appetite
- ❒ Weight loss of ____ pound(s)
- ❒ Weight gain of ____ pound(s)
- ❒ Insomnia
- ❒ Hypersomnia
- ❒ Feelings of hopelessness
- ❒ Low self-esteem
- ❒ Diminished energy
- ❒ Feelings of worthlessness
- ❒ Excessive/inappropriate guilt
- ❒ Concentration difficulties
- ❒ Suicidal ideation
- ❒ 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
- ❒ Shakiness
- ❒ Muscle tension or aches
- ❒ Restlessness
- ❒ Inability to relax

- ❒ Somatic/bodily complaints without a physical basis
- ❒ 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: _____

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: _____

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

Social Problems Cont.

- ❒ 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: _____

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 us to diminish hangover
- ❒ Using alcohol/drugs despite arguments from family or friends
- ❒ Experimentation with alcohol/drugs
- ❒ Other: _____

Home Problems:

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

Other Behavior Problems:

- ❒ Difficulty controlling anger
- ❒ Sexual problems
- ❒ Sexual abuse
- ❒ Physical abuse
- ❒ Sexual orientation concerns
- ❒ Self-destructive behaviors
- ❒ Legal problems
- ❒ Death of a friend/family member
- ❒ Nightmares
- ❒ Seizures/convulsions
- ❒ Encopresis (soiling)
- ❒ Enuresis (wetting)
- ❒ Other: _____

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

Please complete the following by entering the patient's PCP name and fax number, and the patient's name and DOB below:

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

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, PC

Please check all that apply

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

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: _____

Date: _____

Westhampton Family Psychologists, P.C.

Client Services Agreement

Welcome to our practice! This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice). The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will represent an agreement between the client / responsible party and Westhampton Family Psychologists. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PROFESSIONAL FEES

- 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 ***Psychological Evaluation*** varies with the tests administered, age of the client, and reason for the referral.
- **Missed appointment fees are $75.00 per scheduled 45 minute sessions. Co-parenting missed appointments are $75.00 per slot scheduled, which equates to $150.00.** 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.
- Any requests for a ***letter, or other written document***, will be charged at a prorated amount of your provider's hourly rate, with a minimum of $25.00.

- 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 $1,200.00 for one half day (up to four hours) and $2,500.00 for an entire work day. This includes time for transportation and preparation and additional fees may be assessed if travel outside of the immediate area is required. In the event that a deposition or hearing is cancelled less than 3 business days in advance, a charge of $250.00 will be assessed. Depositions or hearings cancelled with less than 24 hour notice will be assessed the full fee as mentioned above. Responsibility for the payment in full for any requested court testimony is ultimately yours regardless of who issued the subpoena.

- ***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 most major credit cards 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.

- **Medical Records Copying / Processing Fee:**

  The following fees are assessed for copying and/or processing client medical records. Medical records will be released once medical record copying / processing fees are paid in full and a current release is on file. We accept cash/charge/check payment. Please allow 15 calendar days for processing.
  - Copying fee of $.50 cents per page up to 50 pages
  - Additional fee of $.25 cents per page for 50 or more pages.
  - Processing fee of $5 if records exceed 15 pages.
  - Processing fee of $10 if records exceed 25 pages.
  - Postage fees (tbd) if records are being mailed

- ***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.

CONTACTING US

When we are unavailable, because we are in session or out of the office, you may leave a message on your clinician's confidential voicemail or may leave a message with one of our Administrative staff. We will make every effort to return your call within 24 hours, with the exception of weekends and holidays. In emergencies, call 911 or go to the nearest emergency room. For urgent calls, please follow instructions on our voicemail system.

LIMITS ON CONFIDENTIALITY – HIPAA (Health Insurance Portability and Accountability Act)

The law protects the privacy of all communications between a client and a therapist. In most situations, we can only release information about your treatment to others if you sign the written Authorization Form that meets legal requirements imposed by HIPAA and/or Virginia law. However, in the following situations, no authorization is required to disclose protected health information:

1. Child Abuse – State law requires that your clinician disclose information regarding suspected harmful actions or neglect towards children.
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 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 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 the Westhampton Family Psychologists, P.C.'s Office Manager 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 if there are any changes to this notice and I am still in treatment at Westhampton Family Psychologists, P.C., 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 forms of communication to which you agree :

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

Your signature below indicates that you have read this agreement and agree to its terms and also serves as an acknowledgement that you have been provided a copy of Health Insurance Portability and Accountability Act).

Both parents must consent to treatment of a minor in cases where parents are in the process of separating, are separated, have joint, or sole legal custody.

_____ _____

Client, or in case of minor, Parent | Guardian (Print) Date

_____ _____

Client, or in case of minor, Parent | Guardian (Sign) Date

_____ _____

Client, or in case of minor, Parent | Guardian (Print) Date

_____ _____

Client, or in case of minor, Parent | Guardian (Sign) Date