Demographic & Intake Information

Patient Name: _____ Patient D.O.B: _____

Address: _____

Gender: Male☐ Female☐ Other ☐

Parent/Guardian Name (if patient under 18): _____

Home Phone No. _____ Mobile Phone No. _____

Email Address: _____

Referral Source: _____

Referred to (CFCG Provider): _____

Does Patient Have: MEDICARE? ☐ TRICARE? ☐

CHILD & FAMILY COUNSELING GROUP
Comprehensive Diagnostic & Therapeutic Services

Acknowledgement Receipt of Notice of Privacy Practices

The undersigned Patient or Guardian of the Patient acknowledges that he or she personally received a copy of Child & Family Counseling Group's Notice of Privacy Policies on the date indicated below.

_____ _____

Patient Name Patient Signature

_____ _____

Parent/Guardian (if patient is under 18) Date

10521 Rosehaven Street Suite 100 • Fairfax VA 22030 • (Phone) 703-352-3822 • (Fax) 703-385-8353

CHILD & FAMILY COUNSELING GROUP
Comprehensive Diagnostic & Therapeutic Services

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your medical information is important to us.

Overview

The law requires us to keep your protected health information ("PHI") private in accordance with this Notice of Privacy Practices ("Notice"), as long as this Notice remains in effect. We are also required to provide you with a paper copy of this Notice, which contains our privacy practices, our legal duties, and your rights concerning your PHI.

From time to time, we may revise our privacy practices and the terms of our Notice at any time, as permitted or required by applicable law. Such revisions to our privacy practices and our Notice may be retroactive. Our Notice will be updated and made available to our patients prior to any significant revisions of our privacy practices and policies.

Our Privacy Practices

Use and Disclosure We may use or disclose your PHI for treatment, payment, or health care operations. For your convenience, we have provided the following examples of such potential uses or disclosures:

> **Treatment** Your PHI may be used by or disclosed to any physicians or other health care providers involved with the medical services provided to you.
>
> **Payment** Your PHI may be used or disclosed in order to collect payment for the medical services provided to you.
>
> **Health Care Operations** Your PHI may be used or disclosed as part of our internal health care operations. Such health care operations may include, among other things, quality of care audits of our staff and affiliates, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Authorizations We will not use or disclose your medical information for any reason except those described in this Notice, unless you provide us with a written authorization to do so. We may request such an authorization to use or disclose your PHI for any purpose, but you are not required to give us such authorization as a condition of your treatment. Any written authorization from you may be revoked by you in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.

Patient Access We will provide you with access to your PHI, as described below in the Individual Rights section of this Notice. With your permission, or in some emergencies, we may disclose your PHI to your family members, friends, or other people to aid in your treatment or the collection of payment. A disclosure of your PHI may also be made if we determine it is reasonably necessary or in your best interests for such purposes as allowing a person acting on your behalf to receive filled prescriptions, medical supplies, X rays, etc.

Locating Responsible Parties Your PHI may be disclosed to locate, identify, or notify a family member, your personal representative, or other person responsible for your care. If we determine in our reasonable professional judgment that you are capable, you will be given the opportunity to consent to or to prohibit or restrict the extent or recipients of such disclosure. If we determine that you are unable to provide such consent, we will limit the PHI disclosed to the minimum necessary.

Disasters We may use or disclose your PHI to any public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Required by Law We may use or disclose your medical information when we are required to do so by law. For example,
your PHI may be released when required by privacy laws, workers' compensation or similar laws, public health laws, court or administrative orders, subpoenas, certain discovery requests, or other laws, regulations or legal processes. Under certain circumstances, we may make limited disclosures of PHI directly to law enforcement officials or correctional institutions regarding an inmate, lawful detainee, suspect, fugitive, material witness, missing person, or a victim or suspected victim of abuse, neglect, domestic violence or other crimes. We may disclose your PHI to the extent reasonably necessary to avert a serious threat to your health or safety or the health or safety of others. We may disclose your PHI when necessary to assist law enforcement officials to capture a third party who has admitted to a crime against you or who has escaped from lawful custody.

Deceased Persons After your death, we may disclose your PHI to a coroner, medical examiner, funeral director, or organ procurement organization in limited circumstances.

Research Your PHI may also be used or disclosed for research purposes only in those limited circumstances not requiring your written authorization, such as those, which have been approved by an institutional review board that has established procedures for ensuring the privacy of your PHI.

Military and National Security We may disclose to military authorities the medical information of Armed Forces personnel under certain circumstances. When required by law, we may disclose your PHI for intelligence, counterintelligence, and other national security activities.

Your Individual Rights

Access and Copies In most cases, you have the right to review or to purchase copies of your PHI by requesting access or copies in writing to our Privacy Officer. Please contact our Privacy Officer regarding our copying fees.

Disclosure Accounting You have the right to receive an accounting of the instances, if any, in which your PHI was disclosed for purposes other than those described in the following sections above: Use and Disclosures, Facility Directories, Patient Access, and Locating Responsible Parties. For each 12-month period, you have the right to receive one free copy of an accounting certain details surrounding such disclosures that occurred after April 13, 2003. If you request a disclosure accounting more than once in a 12-month period, we will charge you a reasonable, cost-based fee for each additional request. Please contact our Privacy Officer regarding fees.

Additional Restrictions You have the right to request that we place additional restrictions on our use or disclosure of your PHI, but we are not required to honor such a request. We will be bound by such restrictions only if we agree to do so in writing signed by our Privacy Officer.

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Alternate Communications You have the right to request that we communicate with you about your PHI by alternative means or in alternative locations. We will accommodate any reasonable request if it specifies in writing the alternative means or location and provides a satisfactory explanation of how future payments will be handled.

Amendments to PHI You have the right to request that we amend your PHI. Any such request must be in writing and contain a detailed explanation for the requested amendment. Under certain circumstances, we may deny your request but will provide you a written explanation of the denial. You have the right to send us a statement of disagreement to which we may prepare a rebuttal, a copy of which will be provided to you at no cost. Please contact our Privacy Officer with any further questions about amending your medical record.

Complaints

If you believe we have violated your privacy rights, you may complain to us or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us by notifying our Privacy Officer.

We support your right to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Us
John W. Wires, Ph.D.
10521 Rosehaven Street Suite 100 - Fairfax, Virginia 22030
Phone (703) 352-3822 Fax: (703) 385-8353

CHILD & FAMILY COUNSELING GROUP
Comprehensive Diagnostic & Therapeutic Services

Surprise Billing Protection Form

This document describes your protections against unexpected medical bills. It also asks if you'd like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider before scheduling care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network and is considered out-of-network. This means the provider or facility doesn't have an agreement with your plan to provide services. **Getting care from this provider or facility will likely cost you more.**

If your plan covers the item or service you're getting, federal law protects you from higher bills when:

- You're getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you're not sure if these protections apply to you.

If you sign this form, be aware that you may pay more because:

- You're giving up your legal protections from higher bills.
- You may owe the full costs billed for the items and services you get.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, you can also ask your health plan if they can work out an agreement with this provider or facility (or another one) to lower your costs.

See the next page for your cost estimate

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Estimate of what you could pay if you give up your protections

Patient name: _____

Out-of-network facility name: Child and Family Counseling Group

Total cost estimate of what you may be asked to pay: see attached financial agreement

- **Review your detailed estimate**. See Page 4 for a cost estimate for each item or service you'll get.
- **Call your health plan**. Your plan may have better information about how much you'll be asked to pay. You also can ask about what's covered under your plan and your provider options.
- **Questions about this notice and estimate?** Contact the Administrative Team at 703-352-3822, or at admin@childandfamilycounseling.com
- Questions about your rights? Contact 1-800-985-3059

Prior authorization or other care management limitations

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover the items or services before you can get them. If your plan requires prior authorization, ask them what information they need for you to get coverage.

Understanding your options

You can get the items or services described in this notice from the following providers who are in-network with your health plan:

More information about your rights and protections

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

By signing, I understand that I'm giving up my federal consumer protections and may have to pay more for out-of-network care.

With my signature, I'm agreeing to receive services from:

- *The Child and Family Counseling Group*

With my signature, I acknowledge that I'm consenting of my own free will and I'm not being coerced or pressured. I also acknowledge that:

- I'm giving up some consumer billing protections under federal law.
- I may have to pay the full charges for these items and services, or have to pay additional out-of-network cost-sharing under my health plan.
- I was given a written notice on _____ *that* explained my provider or facility isn't in my health plan's network, described the estimated cost of each service, and disclosed what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all of the amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You don't have to sign this form. If you don't sign, this provider or facility might not treat you, but you can choose to get care from a provider or facility that's in your health plan's network.

_____	_____
Patient's signature	Guardian/authorized representative's signature
_____	_____
Print name of patient	Print name of guardian/authorized representative
_____	_____
Date and time of signature	Date and time of signature

Keep a copy of this form. It contains important information about your rights and protections.

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Comprehensive Diagnostic & Therapeutic Services

Credit Card Authorization Form

In providing us with your credit card information, you are giving *Child & Family Counseling Group* permission to charge your credit card for all patient(s) you have listed below.

Please complete all information below: (to be completed by cardholder/guardian)

Patient Full Name: _____ Date of Birth: ____/____/____
(Please Print)

Patient Full Name: _____ Date of Birth: ____/____/____

Patient Full Name: _____ Date of Birth: ____/____/____ Ee

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

Cardholder Name (as shown on card): _____

Card Billing Address: _____

Email Address: _____

Phone Number: _____

Card Number: _____

Expiration Date (mm/yy): _____ CVV: _____

_____ _____
Card Holder Signature Date

(To Be Completed by Provider Only)	
Provider Initials:	
Date of Service:	Amount Billed:
Diagnosis Code:	Procedure Code(s):

Electronic Communication Consent & Release

At Child & Family Counseling Group (CFCG), there are various electronic means of communication used to treat and/or coordinate treatment with you and your family. Electronic communication may include, but is not limited to, Cellular phone calls, Text messages, E-mails, Video Conferencing, etc. When I exchange Protected Health Information (PHI) electronically with a clinician from the CFCG office, I am solely responsible for protecting my own privacy and confidentiality, at my own location.

By signing this form, I acknowledge that I understand it is my responsibility alone to ensure the privacy on my end of any electronic communications. I hold CFCG, my therapist and psychiatrists blameless should any violation of my privacy occur due to my error. I acknowledge that I am informed of CFCG, policy and that CFCG, has on file for me to read and possess a copy if I require, a full list of guidelines and regulations for which CFCG, is compliant.

_____ _____

Print Patient Name Patient Signature

_____ _____

Parent/Guardian Signature (IF UNDER 18) Date

Internal Release of Information

Child & Family Counseling Group is an outpatient mental health facility, which has an interdisciplinary staff. Occasionally, staff members need to consult with each other in order to provide the best possible care for their clients. This may necessitate the sharing of client information. When this pertains to you, we require your written permission.

By signing this form, you will be authorizing us to exchange both verbally and in written form any information we have obtained from you and which we have available to use here at Child & Family Counseling Group.

We assure you that all information used and shared will be so judiciously and in the service of providing you better treatment.

_____ _____

Print Patient Name Patient Signature

_____ _____

Parent/Guardian Signature (IF UNDER 18) Date

CHILD & FAMILY COUNSELING GROUP

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Authorization for Release of Information

Patient Name:_____ Date of Birth: _____

Phone #: _____

Child & Family Counseling Group: (Check all that apply):	Outside Person or Organization:
Providers Name: _____ ☐ Release Information ☐ Receive Information ☐ Verbally or Electronically Exchange Information	Name of Person or Organization:
Address: 10521 Rosehaven Street, Suite 100	Address:
Fairfax, VA 22030	City, State, Zip:
Phone: 703-352-3822 Fax: 703-385-8353	Phone # Fax #
Information to Be Released (Check all that apply):	
☐ Billing Information	☐ Behavioral Report
☐ Education/Academic Records	☐ Psychological or Neurological Evaluation
☐ Progress Notes	☐ Psychiatric Records
☐ Teacher's Report	
☐ Other (please specify):	
☐ Entire Medical Record for Specified Date Range:_____to _____	
Purpose of Release:	
☐ Legal	☐ Transfer of care
☐ Continuing Care	☐ Other (Please Specify):
☐ School	
Authorization For General Release of Information:	
I authorize Child & Family Counseling Group to release, receive or exchange information from the above-mentioned patient's medical record as stated. You may amend or revoke this form in writing to Child & Family Counseling Group. ***Note: Please complete form in its entirety, failure to do so may delay or deny processing of your request. Release will remain in effect. from date signed unless otherwise stated here:*** _____	

_____ _____

Patient Signature **Date**

_____

Parent or Guardian Signature (if patient is under 18)

Informed Consent Overview

Process, Benefits, and Risks of Psychotherapy: Participating in individual psychotherapy may results in several benefits including a reduction of problematic behaviors, a greater understanding of the child's strengths and weaknesses, improved awareness of emotional issues, improved self-esteem, and increased availability within the learning environment. However, we cannot guarantee such progress. Working towards these goals requires efforts from the patient and support from the family is essential.

Confidentiality: The laws and standards for mental health professionals require that records be kept regarding the treatment of your child. All information disclosed within sessions and the written records pertaining to those sessions are completely confidential and cannot be revealed to anyone without your written permission, except where disclosure is required by law. Law in the following circumstances will require disclosure:

- When there is reasonable suspicion of child or elder abuse or neglect
- Where the client presents a danger to him/herself or to others
- When disclosure is court-ordered

The reason for such requirements is that mental health professionals have legal and ethical responsibility to take action to protect endangered individuals from harm when there is indication that such a danger exists. Such actions may include notifying the parent/guardian, notifying the potential victim, contacting the police, or seeking hospitalization for the child.

When working with children, the issue of confidentiality is often complicated. For children to relate well to the mental health professional and thereby address their social, emotional, and behavioral goals, children must feel a sense of privacy about the information they decide to share. However, mental health professionals understand and acknowledge that there may be types of information that would be important for the parent or guardian to know, even if it does not fall under the categories listed above.

In addition, children are made aware from the onset of treatment that regular communication with the parent/guardian will occur. They are told that relevant themes and issues will be shared with the parent/guardian, when it seems in their best interest to do so.

Availabilities and Emergency Procedures: I have voicemail that I check periodically throughout the day. In addition, we employ an on-call Emergency Answering Service. This service is for emergencies only, e.g. if the child is experiencing an emotional or behavioral crisis and you feel that he or she is out of your control and at risk of hurting him/herself or someone else. In the event of a life-threatening emergency and I cannot be reached, the parent should immediately call 911 or immediately proceed to the nearest emergency room.

If you have any questions or concerns regarding your Informed Consent, please feel to discuss them with me directly.

The Clinical Staff
Child & Family Counseling Group

CHILD & FAMILY COUNSELING GROUP

Comprehensive Diagnostic & Therapeutic Services

Adult History Form

Form completion date: _____

Please fill out this form to the best of your knowledge. If some questions are not applicable, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.

Name:_____ Date of Birth: _____

Reason for seeking treatment:

_____

_____

_____

How long has this problem existed? (please check one):

☐ 1-3 mos. ☐ 6-12 mos. ☐ 1-2 yrs. ☐ 2-5 yrs. ☐ 10+ yrs.

Prior Therapy? ☐ Yes ☐ No If yes, what was the duration? ☐ Brief ☐ Long Term

Type of environment? (please check one) ☐ Periodic Sessions ☐ Day Treatment ☐ Inpatient

Was it: ☐ Helpful ☐ Not Helpful ☐ Not sure

Current Marital Status: _____ Current Primary Physician: _____

Occupation: _____ Current Employment: _____

High School graduate? (please check one) ☐ Yes ☐ No ☐ GED

College Graduate ☐ Yes ☐ No

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Degree (S)	# of credits	Field of Study

Occupational Training (please explain):

_____

_____

_____

Any Military Service?

_____

_____

Religious Affiliation?

_____

Recreation *(list some usual activities)*

_____ _____

_____ _____

_____ _____

_____ _____

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Have you ever been married? (please check one) ☐ Yes ☐ No

If yes, provide here.	How long did marriage last?

Who is in your household?

Name	Age	Relationship

Do you have children who do not live with you? (please check one) ☐ Yes ☐ No

If yes, please provide name(s) and age(s):

Name	Age

Have there been deaths in your family or among your friends? ☐ Yes ☐ No

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If yes: Who: _____ When: _____

_____ _____

_____ _____

Have you moved recently? ☐ Yes ☐ No

If yes when: _____

Have you moved often? (If yes, please explain) ☐ Yes ☐ No

_____

_____

_____

Do you plan a move soon? (If yes, please explain): ☐ Yes ☐ No

_____

_____

Work history for the past 10 years

Employer	Job Title	Start Date	End Date	Reason for Leaving

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Family of Origin

Please provide data on your mother, father, siblings, and any step or half-family members.

Name & Relationship	Age	Health Status	Occupation	Where they reside	Frequency of Contact

Have you ever separated from family members for a prolonged period? ☐ Yes ☐ No

Where there any separations from your family or either parent when you were a child (i.e. mother hospitalized for 3 weeks when you were 5, etc.)? ☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

Is there any history of mental, emotional, or psychiatric problems in your family? ☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

_____

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Health History

List any medications taken

Medication Name	Dosage	Directions	Check if presently taking	Start date – End date	Reason for discontinuing

Hospitalizations

Date	Medical or Psychiatric	Purpose	Outcome

Please provide a history of each pregnancy (if applicable) (i.e. to term, miscarriage, abortion,)

Date	Outcome

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Please list any chronic health conditions (i.e. asthma, high blood pressure, etc.)

Please list any serious accidents or illnesses for which did not require hospitalization.

What is your current general state of health?

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Symptoms and Behaviors Checklist

Check the box the best describes the symptom

Symptom	None	Low	Medium	High	Extreme
Depression					
Tearfulness					
Feeling lonely					
Feelings Sad					
Withdrawn					
Spending more time alone					
Moody					
Avoiding Friends					
Concerned about injury					
Eating more					
Eating less					
Weight change					
More exercise					
Less exercise					
Decreased interest in sex					
Decreased interest in usual activities					
Tired					
Sleeping more					
Sleeping less					
Walking during the night					
Waking early in the morning					
Sleep walking					
Nightmares/bad dreams					
Headaches					

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Symptom	None	Low	Medium	High	Extreme
Careless about dress/hygiene					
Having trouble concentrating					
Confused					
Distractible					
Impulsive					
Disorganized					
Hearing things other don't hear					
Seeing things others don't see					
Trouble following directions					
Perfectionistic					
Anxious					
Worrying					
Feeling panicky					
Obsessive/ritualistic behaviors					
Critical of others					
Have few friends					
Low self esteem					
Disappointed in appearance					
Disappointed in achievements					
Disappointed in social life					
Legal problems					
Problems at work					
Problems in daily life					
Arguing					
Defiant					
Destroying/damaging property					
Irritable					
Angry					
Easily frustrated					
Giving away belongings					
Threats to one-self					
Wishes to be dead					
Suicidal thoughts					
Suicidal intent					
Homicidal thoughts					

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