FamilyFirst Psychological Services • 8381 Old Courthouse Road, Suite 330, Vienna, VA 22182 • T 703.938.9090 • F 703.938.9091 • familyfirstva.com

Hello and thank you for choosing FamilyFirst Psychological Services.

Our office is located at 8381 Old Courthouse Road, Suite 330, Vienna, VA 22182. **Please complete the attached forms and bring them to your initial consultation appointment.**

1. Client Information Form - *please complete*
2. Services, Policies, and Informed Consent - *please review and sign*
3. Notice of Privacy Practices - please review and keep for your records
4. Authorization to Release Information - if there is anyone (e.g., physician, school) with whom you would like us to consult and/or exchange information, please complete

If you have any questions prior to your appointment, do not hesitate to call your clinician at 703-938-9090 and dial his/her extension. Should you need to reschedule your appointment, please provide your clinician with a 24-hour notice. We look forward to meeting you.

Sincerely,

FamilyFirst Psychological Services, PC

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CLIENT INFORMATION FORM

Name of Client:_____ Today's Date:_____

Date of Birth: _____ Age: _____

Gender: ◯ Male ◯ Female ◯ Transgender ◯ Other _____
◯ Prefer not to disclose

What pronouns do you/your child prefer we use when talking about you/your child?
◯ She/her/hers ◯ He/him/his ◯ They/them/theirs ◯ Other _____

Client's Marital Status: ◯ Never Married ◯ Partnered ◯ Married ◯ Separated
◯ Divorced ◯ Widowed If married, Spouse's Name: _____

Client's Home Address:_____

City:_____ State: _____ Zip Code:_____

Is it okay to send mail to this address? Yes ◯ No ◯

Client Phone (if over 18): _____

Email Address (if over 18): _____

<u>If Client is under 18 years of age:</u>

Name of Parent/Guardian #1: _____ Relationship: _____

Phone: _____ Email Address: _____

Name of Parent/Guardian #2: _____ Relationship: _____

Phone: _____ Email Address: _____

If we need to contact you, which number(s) would you prefer that we use? _____

Is it okay to leave a message at your listed number(s)? Yes ◯ No ◯

Is it okay to communicate with you via text*? Yes ◯ No ◯

Is it okay to communicate with you via email*? Yes ◯ No ◯

Emergency Contact and Phone Number:_____

Referred by:_____

** Please refer to our "Services, Policies, and Informed Consent" form for detailed information about communication via technology, including the security limitations of email and text communications.*

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SERVICES, POLICIES, AND INFORMED CONSENT

Welcome to FamilyFirst. This document contains important information about FamilyFirst's professional services and business policies. Please read it carefully and ask your clinician any questions that arise. When you sign this document, it represents an agreement between FamilyFirst and you and/or your child.

PSYCHOLOGICAL SERVICES

Therapy: Therapy varies depending on the personalities of the therapist and client, and the particular problems you are experiencing. There are many different methods your therapist may use to deal with the problems that you/your child hope to address. Therapy calls for an active effort on your/your child's part.

Your first session will involve an evaluation of your needs. By the end of the intake, your therapist will offer you some impressions of what your work will include and a general treatment plan. During this time, you can both decide if he/she is the best person to provide the services you need. If not, we can refer you to a more appropriate therapist. Therapy involves a commitment of time, money, and energy, so make sure you feel comfortable working with your psychologist. If you have any questions about your work together, please discuss them whenever they arise. Throughout treatment, you and your therapist will assess and/or modify the focus of therapy according to your needs.

Psychological Testing: Testing includes an intake, a customized set of tests that is administered and interpreted by your licensed clinical psychologist, a detailed written evaluation report, and a thorough feedback session that includes explanation of the results and discussion of relevant recommendations and referrals. We will work with you to determine the most appropriate type of testing based on your specific concerns.

CONFIDENTIALITY

The law protects the privacy of all communications between a client and a mental health clinician, which means these discussions are confidential. In most situations, we can only release information about you/your child's treatment to others if you sign an "Authorization to Release Information" form that meets certain legal requirements imposed by HIPAA. There are some situations, however, where we are permitted or required to disclose information without either your consent or authorization. These include the following circumstances:

- if you are in danger of harming yourself or another person
- if you are unable to care for yourself
- if there has been suspected abuse or neglect of a child, older adult (65 or older), or dependent adult
- if we are court ordered to release information as part of a legal proceeding or as otherwise required by law

If any such situation arises, we will make every effort to fully discuss it with you before taking action and we will limit our disclosure to what is necessary. It is important to discuss any questions or concerns you may have about confidentiality as they arise.

Clients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in therapy is often crucial to successful progress, particularly with teenagers, and parental involvement is also essential, we request an agreement with minors and their parents about parental access to information. This agreement provides that during treatment, we will share general information about the progress of the treatment and the minor's attendance at scheduled sessions with parents. Any other communication will require the child's authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents and/or appropriate authorities of our concerns.

In order to provide you/your child with the highest quality care, at times your clinician may discuss aspects of your treatment with other FamilyFirst therapists. We will make every effort to avoid revealing the identity of the client and the consulting clinician is legally bound to keep the information confidential.

PROFESSIONAL FEES

Fees for therapy services will be discussed with your clinician. There will be no charge for brief telephone calls (e.g., phone contact with you, school personnel, other providers, etc.). However, you will be charged the typical session fee (prorated according to length) for any calls longer than 10 minutes.

Given the range of psychological testing batteries, the exact fee for your evaluation will be agreed upon prior to the start of testing depending on your individual needs. One-half of the evaluation fee is due by the first day of testing, and the remaining balance is due no later than the day of the feedback session. Written evaluation reports will not be released to clients until the balance is paid in full. Any requested revisions to the report (e.g., versions of the report for other providers, such as school, doctors, etc.) after the feedback session are charged at our hourly rate.

Fees for other services, such as letter writing, are generally prorated based on our hourly rate. Off-site meetings (e.g., school visits) are charged at the hourly rate, including travel time to and from the FamilyFirst office. There may be a small increase in FamilyFirst fees each year.

PAYMENT

Payments are to be made at the time of service. Payment schedules for other professional services will be agreed upon when they are requested. FamilyFirst accepts cash, checks, and credit cards (Visa, Mastercard, or Discover). There is a $25 fee for returned checks. A $20 late fee will be added for any charges 30 days past due, and additional charges will accrue monthly for any unpaid balances. If your account has not been paid for more than 60 days, we may use legal means to secure the payment. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information we release regarding a client's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order to provide the best care possible, FamilyFirst does not participate directly with any insurance companies. Certain health insurance policies will provide some coverage for "out of network" mental health treatment. However, you (not your insurance company) are

responsible for full payment of our fees. FamilyFirst will provide you with receipts that contain information your insurance company may require, yet we cannot guarantee reimbursement and it is your responsibility to communicate with your insurance provider.

ATTENDANCE
Once a therapy appointment is scheduled, you will be charged the full appointment fee unless you provide a 24-hour notice of cancellation, regardless of the reason for cancellation. Therapy sessions will end 50 minutes after the scheduled appointment time, even if you are late. If (on a rare occasion) your clinician begins a session late, he/she will make up the missed time in some mutually agreeable fashion (e.g., by extending the session, if convenient for you). For evaluations, we require a credit card number at the intake appointment to secure your scheduled testing date(s). In the event that you do not show up or cancel without a 48-hour notice, a nonrefundable $500 charge will be placed on your credit card.

COMMUNICATION VIA TECHNOLOGY
For communication between sessions, we only use email and text communications with your permission and only for administrative purposes. This means that email exchanges and text messages with our office should be limited to administrative matters. This includes things like setting/changing appointments and sending necessary forms. You should be aware that we cannot guarantee the confidentiality of any information communicated by email or text. For instance, emails and text messages may be intercepted during transmission, unencrypted messages (and attachments) can be read, and potentially copied/forwarded, by anyone, and/or may be viewed by someone other than the recipient. We prefer not to discuss clinical information by email or text, and request that you do not do so either.

CUSTODIAL ARRANGEMENTS
If you are seeking treatment for your minor child and parents are separated/divorced, we require that both parents consent to treatment by signing this document. We will not proceed with treatment if there is a joint custody arrangement and one parent does not consent to treatment. While we prefer to treat children with consent from both parents, if one parent has the legal right to make medical decisions for the child, we need you to provide a copy of the most recent custody decree that establishes custody rights for your child or otherwise demonstrates that you have the right to authorize treatment for your child.

COURT-RELATED SERVICES
For professional and clinical reasons, we do not participate in court proceedings of any type, unless compelled to do so by court order. If you become involved in legal proceedings that court-order our participation, you will be expected to pay for any professional time spent in preparation. You also will be expected to pay for our time spent testifying, even if we are called to testify by another party. All court-related participation is charged at the rate of $500 per hour.

CONTACTING YOUR CLINICIAN
If you need to reach your clinician, please contact him/her directly at 703-938-9090 and dial his/her extension. Although your clinician may not be immediately available by telephone, we check voicemail regularly. Your clinician will make every effort to return your

call on the same business day. We are not able to provide 24-hour on-call services. In the event of a crisis or emergency and you are unable to reach your psychologist, please contact your family physician, psychiatrist (if you have one), or the nearest emergency room.

ENDING THERAPY
Therapy may end at any time. Joint discussion about the decision and a final session(s) with your clinician are strongly recommended for closure of your work together.

I have read and understand FamilyFirst's "Services, Policies, and Informed Consent" document and I have had my questions answered to my satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement. I consent to participate in evaluation and/or treatment. I also certify that I have received a copy of FamilyFirst's Notice of Privacy Practices detailing the provisions of HIPAA and my privacy rights and I have been offered a copy of this consent form for my records.

Name of Client: _____

Signature (if over 18): _____ Date: _____

<u>If client is under 18 years of age</u>

Name of Parent/Guardian #1: _____

Signature: _____ Date: _____

Name of Parent/Guardian #2: _____

Signature: _____ Date: _____

Name of Clinician: _____

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPAA) Provisions

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting your privacy. Although mental health professionals have always managed psychological records with great concern for privacy and confidentiality, the rules regarding security of psychological records have been considerably strengthened by the provisions of the Health Insurance Portability and Accountability Act (HIPAA). The following information provides details about the provisions of HIPAA and your rights concerning privacy and your psychological records.

Your Rights Regarding Protected Health Information (PHI) About You

The right to inspect and obtain a copy of your psychological record. Professional records constitute an important part of the therapy process and help with continuity of care over time. According to the rules of HIPAA, your consultations are documented in two ways: 1) The *clinical record* (required) may include the date of your sessions, your reasons for seeking therapy, diagnosis(es), therapeutic goals, treatment plan, progress notes, medical and social history, treatment history, copies of email/text communications, phone call notes, and any records from other providers; 2) *Psychotherapy notes* (optional) consist of the specific content or analyses of therapy conversations, how they impact the therapy (including sensitive information that you may reveal that is not required to be included in your clinical record), and notes of your therapist that may assist in treatment. Psychotherapy notes are kept separately from your clinical record in order to maximize privacy and security.

You have the right to inspect and obtain a copy of your *clinical record*. Viewing the record is best done during a professional consultation in order to clarify any questions that you might have at the time. While clients are entitled to receive a copy of their records, in the event that this will not cause substantial harm to the client, our clinicians strongly recommend that the client receive a treatment summary in lieu of the full record. These are professional records that may be misinterpreted by and/or upsetting to untrained readers, and that may be harmful if released. You may be charged a nominal fee for responding to information requests and/or accessing and photocopying the record. *Psychotherapy notes*, however, if they are created, are not disclosed to third parties, insurance companies, billing agencies, clients, or anyone else. They are for the use of a treating therapist in tracking details of the consultations that are far too specific to be entered into the clinical record.

The right to request a correction or add an addendum to your clinical record. If you believe that there is an inaccuracy in your clinical record you may request a correction. If the information is accurate, however, or if it has been provided by a third party (e.g., previous therapist, primary care physician, etc.), the request may be denied. In this case you will receive an explanation in writing with a full description of the rationale. You also have the right to make an addition to your record if you think it is incomplete.

The right to an accounting of disclosures of your psychological information to third parties. You have the right to know if, when, and to whom your psychological information has been disclosed (exclusive of treatment, payment, and health care operations). However, you likely would already be aware of this, as you would have signed an "Authorization to Release Information" form allowing such disclosures (e.g., disclosures to other therapists, doctors, schools, specialists, etc.). This accounting must extend back for a period of six years.

The right to restrict disclosures when you have paid for your care out-of-pocket. You have the right to restrict certain disclosures of PHI to a health plan when you pay out of pocket in full for our services.

The right to request restrictions on how your information is used. You have the right to request restrictions on certain uses or disclosures of your psychological information. These requests must be in writing. These requests will most likely be honored, although in some cases they may be denied. This office does not use or release your protected health information for marketing purposes or any other purpose aside from treatment, payment, healthcare operations, and other exceptions specified in this notice.

The right to request confidential communications. You have the right to request that your therapist communicate with you about your treatment in a certain way or at a certain location. For example, you may prefer to be contacted at work instead of at home, or you may wish to receive mail at a post office box rather than your home address.

The right to be notified if there is a breach of your unsecured PHI. You have a right to be notified if: a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; b) that PHI has not been encrypted to government standards; and c) our risk assessment fails to determine that there is a low probability that your PHI has been compromised.

The right to receive a copy of this notice upon request. You have the right to a paper copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time.

The right to file a complaint. If you have any questions or concerns about this notice, disagree with a decision your clinician makes about access to your records, or have other concerns about your privacy rights, you may contact FamilyFirst at 703-938-9090 with your complaint. If after discussing your concerns with us, you believe that your privacy rights have been violated, you may file a complaint in writing to FamilyFirst at 8381 Old Courthouse Road, Suite 330, Vienna, VA 22182 and/or the Virginia Board of Psychology at Perimeter Center, 9960 Mayland Drive, Suite 300, Henrico, VA 23233-1463. FamilyFirst believes in your right to protect your privacy and will not retaliate in any way if you choose to file a complaint.

Uses and Disclosures of Personal Health Information (PHI) With Your Consent or Authorization

For treatment. We may use psychological information about you to provide, coordinate or manage your treatment and any related services. This information will not be shared with other health care professionals, however, unless you specifically request or agree to it and sign a consent form to that effect.

For payment. We may use and disclose psychological information about you for billing purposes. This is generally restricted to information provided on your bill for services, and includes your name and other demographic information, diagnostic and treatment codes, and dates of service. Please note: Given that we are out-of-network providers for all insurance companies, our practice will not provide specific information about your treatment to your insurance company without your written authorization.

As required by law. We will disclose psychological information about you when required to do so by federal, state or local law. For example, it is possible (but unlikely) that our compliance with the regulations of HIPAA will be reviewed by the U.S. Department of Health and Human Services.

Business associates. We may contract with a billing agency or attorneys to attend to business aspects on an as-needed basis. In this case, there will be a written contract in place with the agency requiring that it maintain the security of your information, in compliance with the rules of HIPAA.

Health care operations. We may use and disclose psychological information about you to make sure that all of our clients receive quality care, such as to review our services and evaluate our performance.

Other. We will obtain an authorization form from you before using or disclosing your PHI in a way that is not described in this Notice.

Uses and Disclosures of Personal Health Information (PHI) Without Your Consent or Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

Child abuse. If we know, or have reasonable cause to suspect, that a child has been abused or neglected by a parent, guardian, or caretaker, we are required by law to report this information to the appropriate authorities.

Adult and domestic abuse. If we know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been abused, neglected, or exploited, we are required by law to report this information to the appropriate authorities.

Serious threat to health or safety. If you present a specific and immediate threat to cause serious bodily injury or death to yourself, to other individuals, or to society we may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

Health oversight activities. If a complaint is filed against your clinician with the Virginia Board of Psychology, the Board has the authority to subpoena confidential mental health information from us relevant to that complaint.

Judicial or administrative proceedings. If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and we will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

When allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state Department of Health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

Changes to this Notice

Please note that this privacy notice may be revised. You will be notified of changes in the laws concerning privacy or your rights as we become aware of them, and we will provide you with a revised notice by mail or in person. In the meantime, please do not hesitate to raise any questions or concerns about confidentiality with us at any time.

This notice will go into effect on April 14, 2003. Revised on 7/25/22

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AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

I authorize _____ (Clinician Name) at FamilyFirst Psychological Services, PC to exchange information regarding the above named individual as described below.

The type of information to be exchanged is as follows:

_____

This information may be exchanged with the following individual or organization:

Name: _____

Address/Phone: _____

_____

I understand that I have a right to revoke this authorization at any time. My revocation becomes effective when delivered in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire at the end of treatment, unless an expiration date, event or condition is specified as follows: _____

I also understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and therefore: 1) FamilyFirst and your clinician have no responsibility or liability as a result of the re-disclosure, and 2) your information is no longer protected by state or Federal privacy law.

_____

Name of Parent/Guardian (if client is under 18)

_____ _____

Signature of Client (if over 18) or Signature of Parent/Guardian Date