GIFT OF THERAPY AND CONSULTING

CLIENT INFORMATION SHEET

Date: _____

Name _____ Maiden/Other Name _____
LAST FIRST MIDDLE INTIAL

Address _____
STREET APT# CITY STATE ZIP

Age____ Date of Birth _____ [ ] Male [ ] Female Marital Status _____

Home Phone # _____ Social Security # _____

Client's Employer _____ Employer's Phone # _____

Occupation _____ Cell/ # _____

Primary Care Physician _____ Telephone # _____

Address _____
STREET CITY STATE ZIP

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Name _____ Social Security # _____
LAST FIRST MIDDLE INITIAL

Address _____
STREET APT# CITY STATE ZIP

Home Phone # _____ Date of Birth _____

Employer _____ Employer's Phone # _____

Occupation _____ Cel # _____

PRIMARY HEALTH INSURANCE INFORMATION

Company Name _____ Telephone # _____ Effective Date _____

Policy Holder's Name _____ Policy # _____

Policy Holder's Date of Birth _____ Social Security # _____

Client's Relationship to Policy Holder: [ ] Self [ ] Spouse [ ] Child [ ] Other Group # _____

SECONDARY HEALTH INSURANCE INFORMATION

Company Name _____ Telephone # _____ Effective Date _____

Policy Holder's Name _____ Policy # _____

Policy Holder's Date of Birth _____ Social Security # _____

Client's Relationship to Policy Holder: [ ] Self [ ] Spouse [ ] Child [ ] Other Group # _____

CONTACT INFORMATION

Name of Emergency Contact _____

Telephone # /s _____ Relationship _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

THIS IS ***NOT*** A RECORDS REQUEST

FEC CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN (PCP)

Communication between behavioral health provider and your primary care physician is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, an medication if necessary.

Client Name: _____ Client DOB: _____

Client SS#: _____ Military Sponsor #(if applicable): _____

I authorize, for the purpose of coordinating care, the release of information related to my evaluation and treatment to:

Primary Care Doctor: _____ Phone: _____

Primary Care Address: _____
(Street) (City) (State) (Zip)

CONSENT

I, the undersigned, understand that I may revoke this consent at any time to the extent that action has been taken in reliance upon it and that in any event this consent shall expire upon termination of treatment or 9 months from date last seen. I have read and understand the above information and give my consent to:

Client Please Check One & Sign:

{ } To release any applicable mental health/substance abuse information to my PCP
{ } Do Not release any information to my PCP

_____ _____
Client/Parent/Guardian Signature Date Witness Date

Information for PCP:

Date Pt seen: _____ Diagnosis: _____

Treatment Plan:
{ } Individual Therapy
{ } Family Therapy
{ } Weekly Group
{ } Intensive Outclient Group
{ } Referral for Medication Evaluation
{ } Continue Medication Management

Please call me at (757) 419-1871, to discuss this case further or if you need any other information.

_____
Provider Name Signature

Gift of Therapy and Consulting
317 Office Square Lane, Suite B102
Virginia Beach, VA 23462
Phone: (757) 419-1871 • Fax (844)374-3058
Email: dorothymoore@giftoftherapyandconsulting.com Client's Account Number: _____

Gift of Therapy and Consulting, LLC
317 Office Square Lane, Suite B102
Virginia Beach VA 23462
Phone: 757-419-1871 Fax: 844-374-3058

Authorization for Release of Information

Patient Name:_____ SSN:_____ Date of Birth:_____
(PLEASE PRINT)

I hereby authorize: **To:**

Gift of Therapy and Consulting, LLC
317 Office Square Lane, Suite B102
Virginia Beach VA 23462

{ } Obtain information from:
{ } Release information to:
{ } Oral Communication ONLY

Name/Agency: _____

_____
Complete Street Address City State Zip Code

Phone#: _____ Fax# _____

For the purpose of: _____

Specific Information to be released: Service dates of: _____to_____

{ } Psychiatric Evaluation
{ } Psychological Testing/Assessment
{ } MD Progress/Psychotherapy Notes
{ } Substance Abuse Treatment
{ } Lab/Urine Drug Screen Results
{ } Oral Communication
{ } Billing/Insurance
{ } Scheduling
{ } Other (specify) _____

I understand that the medical information and/or records may include information covered by 42 CFR, Part 2: 1) psychiatric and mental health records; 2) records related to alcohol and/or drug abuse/and other conditions that require specific release under State and Federal regulations; 3) and records related to HIV testing, evaluation and treatment.

I understand that I may withdraw this consent at any time (in writing), except to the extent that action has already been taken.
This consent, if not withdrawn, will expire six (6) months from the date last seen.

I further authorized the information to be sent by FAX: { } YES { } NO

(If the patient is under guardianship, proof of court-appointed guardianship is required. Patients 13-17 years of age MUST sign with parent/legal guardian.)

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian Witness

There is a nominal fee of $0.50 per page up to 50 pages and $0.25 a page thereafter and a $10.00 search, postage, and handling fee. **As a courtesy, there will be no charge if records are requested by or sent to another physician. WE REQUIRE 15 BUSINESS DAYS TO PROCESS REQUEST.**

Gift of Therapy and Consulting

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Email: dorothymoore@giftoftherapyandconsulting.com

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change. if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES

May we discuss your medical condition with any member of your family? YES

If YES, please name the members allowed:

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature. _____ Date: _____

Witness: _____ Date: _____

Financial Acknowledgement and Agreement

Clients who carry health insurance should remember that professional services are rendered and charged to the client and not to the insurance companies. Your insurance is a personal contract between you and your insurance company. If you would like us to file your claim for you, please provide your card (proof of insurance) at the beginning of your first session. Without your card or proof of insurance, your claims cannot be filed. Please remember, **Payment is due in full on the date of service**, unless other arrangements have been made or we have a contract stating otherwise with your insurance company. We accept cash, check, Visa, Master Card, and American Express.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services, however, you remain responsible for charges to any service rendered.

_____ Date _____
Signature of Responsible Party

ASSIGNMENT OF BENEFITS: I authorize payment of psychotherapy benefits to Dorothy M. Moore, LPC, ACS. I also authorize the release of any medical or other information necessary to process a claim. To submit a claim to your insurance carrier, there must be complete client and insurance information on file.

_____ Date _____
Signature of Responsible Party

HIPAA Acknowledgement

I have been presented with a copy of the Gift of Therapy and Consulting Client Information Booklet and Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____ Date _____

If not signed by the client, please indicate your relationship to the client: _____

Signature _____ Date _____

Gift of Therapy and Consulting
317 Office Square Lane, Suite B102
Virginia Beach, VA 23462
Phone: (757) 419-1871 • Fax (844) 374-3058
Email: dorothymoore@giftoftherapyandconsulting.com

Credit Card on File

Date: _____ Client Account #: _____

Client Name: _____

Responsible Party Name: (if different from above) _____

Credit Card #: _____

Billing Address: _____

Expiration Date: _____ 3 Digit Code: _____ Zip Code: _____

I hereby give permission to Gift of Therapy and Consulting, LLC to run my credit card for the following charges:

Initial Evaluation: _____ _____

Regular Session: _____

No Show Fee:

CoPay: _____

_____
Signature of Responsible Party

Gift of Therapy and Consulting, LLC

Client Information Booklet

317 Office Square Lane, Suite B102
Virginia Beach, VA 23462
Phone: (757)419-1871
FAX: (844)374-3058

Welcome! I am honored that you have chosen the Gift of Therapy and Consulting to partner with you as you work towards removing barriers that have hindered your gift to live a life of purpose and full of joy.

For most clients, seeking the services of a medical or mental health professional is not always an easy step to take. We acknowledge your courage required in taking this initiative. We will work hard to make this process as smooth as possible, working with primary care physicians or referring agencies, to address any particular concerns with sensitivity and efficiency. Mental health services are provided on a personalized basis. Consistency in delivery is important to forming a positive therapeutic alliance that is at the center of a quality service being provided.

Psychotherapy services usually involve talking with an individual, couple, or other family member(s), to get some understanding of the reported concern, and develop a treatment plan with the client. The plan may involve elements such as talk therapy, coaching, mentoring, or education. For the process to be effective, it is imperative that a collaborative effort with the client be formed by assisting in providing important information, and working as an active partner in the treatment process.

Most of the work done at Gift of Therapy and Consulting is managed through insurance companies, however, services can be provided on a self-pay basis for those without insurance or those who choose not to use their insurance in lieu of a reduced rate.

Office Hours

The office is currently open 10 a.m. until 6 p.m. Tuesday through Friday, and Saturday from 11 a.m. until 2 p.m. However, you can reach me at any time by calling (757) 419-1871, and leaving a message. I will return your call as quickly as possible.

Appointment Scheduling

We will attempt to accommodate your scheduling needs as we speak in session. If you have to cancel or reschedule an appointment, please do so with 24 hours advance notice. Failure to do so or not showing up for your appointment may result in a $50.00 no show/cancellation fee charged to your account. Your insurance will not cover this charge.

Emergencies

If you are experiencing a medical emergency, dial 911 for an emergency operator, otherwise, leave a message on my office telephone.

Notice of Privacy Practices

Attached you will find a copy of Notice of Privacy Policies, entitled "**Your Information, Your Rights, Our Responsibilities.**" Please take some time to read this document to

understand your rights of privacy. The practice is required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy polices and practices that are outlined in this notice.

Billing and Insurance

Payment is expected at the time of service. We accept payment by cash, check, or credit card. If you should have any questions regarding your account, please speak with me in your session or contact me by telephone. Further information can be found in the **Financial Acknowledgement and Agreement**, as part of this package.

Due to the complexity of insurance and managed care requirements for preauthorization of services, please carefully discuss with your insurance company the requirements of your particular insurance. We will make every effort to ensure that services are authorized at the time that they are delivered, however, the final responsibility belongs to the client.

Co-pays and deductibles also vary by insurance company. We will help you establish what your co-payment is, but the ultimate determination of your personal share of the charges is made by your insurance company. You will want to contact your insurance company directly to be certain of your co-payment and deductible responsibility.

In the case of eligible services, we will be happy to file your insurance for you. We must depend on you to provide us with accurate information, and with immediate notice of any change in coverage or your carrier. Without accurate information, the possibility exists that the insurance provider will not cover services.

If your insurance company denies charges, you will be held responsible for the denied charges. Changes made to your insurance coverage, even without your knowledge of said changes, do not excuse your responsibility for services rendered. This can be especially important in divorce situations where your coverage may be provided by a relative living out of the area. Military dependents should also be aware that insurance coverage under Tricare is contingent upon having an up-to-date I.D. card.

Please be sure to notify us of any changes in address, telephone number, or insurance coverage.

Services not Covered by your Insurance Provider

Your insurance company will be billed for services that are determined to be medically necessary and are appropriately documented and authorized. You may have

requirements imposed upon you by a third party, such as the court, an employer, or a school for evaluations, letters, or reports about your progress in treatment, that will not be paid for by your insurance company. Separate charges will be made which will be your responsibility to pay out-of-pocket. I will make every effort to inform you of any such charges when a request for non-covered service is made. Please feel free to inquire about any charges that may be involved in any letter or report that you might request.

By example, the following services are not considered medically necessary and therefore, will not be paid by your insurance provider:

Court Appearance/Subpeonas - $250.00 per hour with a 3 hour minimum, to be paid prior to the court date.

Preparation time for court appearances - $125.00 per hour.

Letters - $125.00 per hour pro-rated for actual time spent.

Copying of Medical Records - $.50 per page.
All postage and shipping costs extra.
Search and handling fee not to exceed $10.00.

No show/late cancellation fee - $50.00.

Your comments and suggestions regarding the content of this information booklet will be greatly appreciated!

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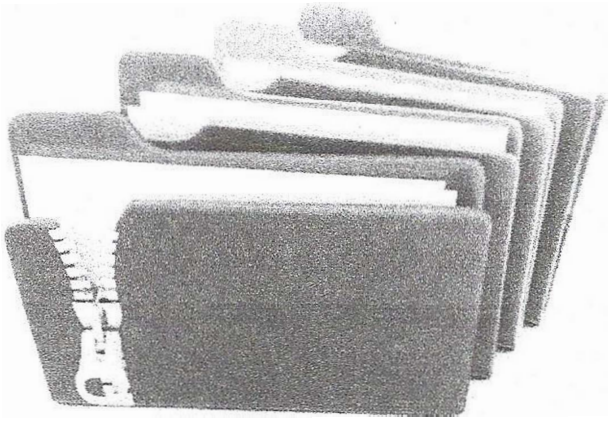

Your Information. Your Rights. Our Responsibilities

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share	◦ You can ask us **not** to use or share certain health information for treatment, payment, or our operations. ◦ We are not required to agree to your request, and we may say "no" if it would affect your care. ◦ If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. ◦ We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	◦ You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. ◦ We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	◦ You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	◦ If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. ◦ We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	◦ You can complain if you feel we have violated your rights by contacting us using the information on page 1. ◦ You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** ◦ We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

[illegible]

We typically use or share your health information in the following ways.

Treat you	We can use your health information and share it with other professionals who are treating you.	*A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*We use health information about you to manage your treatment and services.*
Bill for your services	We can use and share your health information to bill and get payment from health plans or other entities.	*We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	We can share health information about you for certain situations such as: - Preventing disease - Helping with product recalls - Reporting adverse reactions to medications - Reporting suspected abuse, neglect, or domestic violence - Preventing or reducing a serious threat to anyone's health or safety
Do research	We can use or share your information for health research.
Comply with the law	We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	We can use or share health information about you: - For workers' compensation claims - For law enforcement purposes or with a law enforcement official - With health oversight agencies for activities authorized by law - For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: 11/1/17

This Notice of Privacy Practices applies to the following organization:

Gift of Therapy and Consulting, LLC
317 Office Square Lane, Suite B102
Virginia Beach, VA 23462

Dorothy Moore, LPC, ACS Privacy Officer
E-mail: dorothymoore@giftoftherapyandconsulting.com
Phone: (757) 419-1871