First Colonial
PSYCHOTHERAPY SERVICES

First Colonial Psychotherapy Services
1232 Perimeter Parkway Suite 206
Virginia Beach, VA 23454
757-428-7500

CLIENT INFORMATION

First name

Middle name

Last name

Preferred Name

Suffix

Client is a minor?

EMAIL ADDRESS

- ❑ Yes, it's ok to send messages to this email address
- ❑ Yes, send appointment reminders to this email address

CONTACT INFORMATION

Phone number

Phone type

- ☐ Mobile
- ☐ Home
- ☐ Work

☐ Yes, it's okay to send voice messages to this number
☐ Yes, it's okay to send text messages to this number
☐ No, don't send appointment reminders to this number
☐ Yes, send text appointment reminders to this number

ADDRESS

Address, City, State, Zip

ABOUT CLIENT

Birth date (MM/DD/YYYY)

Gender Identity

Sex

Relationship Status

Employment Status

Preferred Language

EMERGENCY CONTACT

First Name

Last Name

Relationship

Phone Number

☐ Yes, it's okay to leave voice messages
☐ Yes, it's okay to leave text messages
☐ Send me text message reminders for appointments
☐ No, don't send me text message reminders for appointments

Email address

❑ Yes, it's ok to send messages to this email address
❑ Yes, it's ok to send appointment reminders to this email address
❑ No, don't send reminders to this email address

Insurance Information

Primary Insurance Company Name:

Member ID:

Group ID:

Plan ID:

Secondary Insurance Company Name:

Member ID:

Group ID:

Plan ID:

INTAKE QUESTIONNAIRE

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can.

What are your goals for counseling?

Have you seen a mental health professional before?

- ❍ Yes
- ❍ No

Specify all medications and supplements you are presently taking and for what reason.

If taking prescription medication, who is your prescribing MD? Please include the type of MD, name and phone number.

Who is your primary care physician? Please include the type of MD, name and phone number.

Do you drink alcohol?

- ❍ Yes
- ❍ No

Do you use recreational drugs?

- ❍ Yes
- ❍ No

Do you have suicidal thoughts?

- ❍ Yes
- ❍ No

Have you ever attempted suicide?

- ❍ Yes
- ❍ No

Do you have thoughts or urges to harm others?

- ❍ Yes
- ❍ No

Have you ever been hospitalized for a psychiatric issue?

- ❍ Yes
- ❍ No

Is there a history of mental illness in your family?

- ❍ Yes
- ❍ No

If you are in a relationship, please describe the nature of the relationship and months or years together.

Describe your current living situation. Do you live alone, with others. With family, etc…

What is your level of education? Highest grade/degree and type of degree.

What is your current occupation? What do you do? How long have you been doing it?

Please check any of the following you have experienced in the past six months

- ❑ Increased appetite
- ❑ Decreased appetite
- ❑ Trouble concentrating
- ❑ Difficulty sleeping
- ❑ Excessive sleep
- ❑ Low motivation
- ❑ Isolation from others
- ❑ Fatigue/low energy
- ❑ Low self-esteem
- ❑ Depressed mood
- ❑ Tearful or crying spells
- ❑ Anxiety
- ❑ Fear
- ❑ Hopelessness
- ❑ Panic
- ❑ Other

Please check any of the following that apply

- ❑ Headache
- ❑ High blood pressure
- ❑ Gastritis or esophagitis
- ❑ Hormone-related problems
- ❑ Head injury
- ❑ Angina or chest pain
- ❑ Irritable bowel
- ❑ Chronic pain
- ❑ Loss of consciousness
- ❑ Heart attack
- ❑ Bone or joint problems
- ❑ Seizures
- ❑ Kidney-related issues
- ❑ Chronic fatigue
- ❑ Dizziness
- ❑ Faintness
- ❑ Heart valve problems
- ❑ Urinary tract problems
- ❑ Fibromyalgia
- ❑ Numbness & tingling
- ❑ Shortness of breath
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Asthma
- ❑ Arthritis
- ❑ Thyroid issues
- ❑ HIV/AIDS
- ❑ Cancer
- ❑ Other _____

What else would you like me to know?

CREDIT CARD AUTHORIZATION FORM

Please complete all fields below. You may cancel this authorization at any time by contacting us.This authorization will remain in effect until canceled.

Credit Card Information
Card Type: ❒ MasterCard ❒ VISA ❒ Discover ❒ AMEX ❒ Other
Cardholder Name (as shown on card): _____
Card Number: _____
CVV (3 digits on the back):
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address):

I,_____, authorize First Colonial Psychotherapy Services to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____

Customer Signature Date

Credit Card Authorization

By your electronic signature of this form, you authorize charges to your credit card through Stripe via SimplePractice for services rendered. These charges will appear on your bank/credit card statement as **First Colonial Psychotherapy Services**. You have the right to request a paper copy of this document.

I authorize **First Colonial Psychotherapy Services** to charge my credit card through Stripe. **CANCELLATION POLICY: I also agree that my credit card can be charged for any session that is not cancelled at least 24 hours prior to the scheduled session.**

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify **First Colonial Psychotherapy Services** in writing of any changes in my account information or termination of this authorization.

I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form. I acknowledge that credit card transactions could be linked to Protected Health Information.

By signing below I am agreeing that I have Read, Understood and Agree to the items contained in this document.

_____ _____

Customer Signature Date

In Case of an Emergency

If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:

Call 911 or 988.

Other resources include:
1. Call the emergency line at Virginia Beach Psychiatric Hospital at 757-627-life or go to the nearest emergency room
2. National Crisis Hotline 1-800-273-8255
3. Local Suicide Hotline 757-385-0888
4. Suicide Text Line- text "EMPATHY" to 741741

There are additional procedures that we need to have in place specific to mental health services. These are for your safety in case of an emergency and are as follows:

You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, you are unreachable via phone/text or in a crisis that we cannot solve, I may determine that you need a higher level of care.

I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please enter this person's name and contact information below.

Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

Please list your Emergency Contact Person here:

Name:

Phone:

Insurance Benefits Disclosure

** indicates a required field*

*** I want to use my insurance benefits for services?** ** Please circle your answer*

YES **NO**

* **If you are using insurance to pay for services, please read carefully before signing. Prior to your first appointment, our office will verify your eligibility and benefits with your insurance company. While we try to be as accurate as possible when verifying benefits, your fees may change depending on your eligibility and benefits during the date of your sessions. We obtain an estimate and we won't know your exact fee until we bill your insurance and get your explanation of benefits back from your insurance company. You are also encouraged to call the number on the back of your card and ask your member representative about your 'mental health, outpatient, office visit benefits. FCPS cannot guarantee any insurance coverage or reimbursement. Please be aware you are ultimately responsible for services rendered and the services will be charged to the card you have placed on file. Insurance may take up to 30 days to process your claim. We understand the complexity of insurance policies, so our office will work with you to pay for services rendered, if needed and discussed with our office. Please plan accordingly, and be sure to discuss any concerns or questions with our office staff.**

BY SIGNING THIS FORM, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS IN THIS FORM.

Signature:_____

Therapist/Counselor Qualifications Consent Form

Charles Liggio, Thomas Baker and Paula Crooks are licensed in the Commonwealth of Virginia as Licensed Clinical Social Workers.

Kathy Baker, Dr. Nicole Wynder, Rebecca Provost, Robert Nixon, Sarah Wampler and Jamie Hayes are licensed in the Commonwealth of Virginia as Licensed Professional Counselors.

Soheila Alizadeh is a Resident in Counseling with a graduate degree in the field of counseling. Sade' Patterson and Tamika Daniel are Supervisee's in Social Work with a graduate degree in the field of clinical social work.

All provisionally licensed counselors (Residents in Counseling and Supervisees in Social Work) are supervised by either Robert Nixon, LPC or Dr. Kenyuatia Gash.

They are provisionally licensed and currently working towards becoming fully licensed in the state of Virginia. If you feel there is a basis for a formal complaint or grievance about anything related to the professional services that we are providing, we invite you to first communicate your concerns with your counselor so that he/she will be informed and have an opportunity to respond and attempt to resolve any misunderstanding. You have the right to file a complaint about any counselor in our office to our licensing board and may do so by contacting the Virginia Board of Counseling, Perimeter Center, 9960 Maryland Drive, Suite 300, Henrico, Virginia 23233- 1463. The complaints phone number is 1-800-533-1560. The website to the Virginia Board of counseling is www.dhp.virginia.gov/counseling.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature:_____

Practice Policies

First Colonial Psychotherapy Services

1232 PERIMETER PARKWAY, STE 206

VIRGINIA BEACH, VA 23454

(757)-428-7500

PRACTICE POLICIES

I hereby authorize First Colonial Psychotherapy Services and their staff to provide psychotherapy services. I understand that this treatment may include face-to face, video and telephone meetings. The standard meeting time for psychotherapy is 45-60 minutes.

APPOINTMENTS AND CANCELLATIONS Please remember to cancel or reschedule 24 hours in advance. There is a fee of $75 if a cancellation is less than 24 hours. You have the option to cancel via your reminder voice/ text message. You may also cancel your appointment directly via the client portal. This option is only available if you are within the time frame of canceling. Otherwise you will need to call the office at 757-428-7500 ext 0.

Late cancellations are subject to a fee of $75 if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. No Call/No Show sessions will be subject to a fee of $90. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you will lose some of that session time.

Consistency in therapy is crucial to your outcome, therefore if appointments are cancelled or missed excessively, even outside the 24 hour cancellation window, you will not be able to book future appointments with our office. If a client is more than 15 minutes late to scheduled appointment time, clinician reserves the right to cancel appointment, and client will need to reschedule.

FEES & FINANCIAL POLICIES

Please understand that although if you use your insurance , that ultimately you are responsible for services rendered and if your insurance denies payment you are responsible and services will be charged to the credit card you put on file. All co-pays, deductible amounts, and self pay fees are due at the time services are rendered, unless other arrangements have been made in advance. A credit card authorization form will need to be completed, which allows us to run your card for payment. If you are a client under MEDICAID and you miss three appointments, you will be terminated from therapy. If you miss appointments, the office will not call to check on client as we believe it is client's responsibility to take ownership of the therapeutic process. Clinician reserves the right to terminate therapy after missed appointments. We are equipped with a confidential voicemail system that allows a client to leave a message at any time. We will make every effort to return calls within 24 hours notice, during business hours, excluding weekends and holidays, but cannot guarantee the calls will be returned immediately. EAP client sessions are allowed once and granted as a new client to establish relationship, after that, the client will either have to use their insurance or self-

pay. You signing this document shows you understand that it is entirely your obligation to ensure payment is made. EAP clients are not allowed to be charged for missed or late canceled appointments while using EAP visits however, you will forfeit that session if the cancellation/missed protocol is not met.

Our self pay rates are:

$230 for intakes with a licensed provider

$165 for sessions with a licensed provider

$180 for couple sessions with a licensed provider

$90 for intakes with a provisionally licensed provider

$85 for sessions with a provisionally licensed provider

$105 for couple sessions with provisionally licensed provider

LETTERS AND PAPERWORK

If you request any letters, forms, or any other paperwork to be completed, such as FMLA or disability forms, please be advised there is a minimum fee of $25 for paperwork. Payment is due at the time of the request for completion of paperwork. This fee may be increased depending on the complexity level of the paperwork. Our therapist will not complete any FMLA, disability, other paperwork or letters of support unless they have met with you for at least 6-8 sessions. They will also not complete any FMLA or disability paperwork if they do not believe they can support it based on what you have presented at intake and during sessions.

COMMUNICATION Secure communications are the best way to communicate personal information, though no method is entirely without risk. Our patient portal via Simple Practice is a secure method for communication. You may also leave a message on your therapists voice mail extension. They are often not immediately available; however, they will attempt to return your call within 48 hours. If a true emergency situation arises, please call 911 or go to the nearest emergency room.

SOCIAL MEDIA AND TELECOMMUNICATION Due to the importance of your confidentiality and the importance of minimizing dual relationships, We do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of your therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

ELECTRONIC COMMUNICATION We cannot ensure the confidentiality of any form of communication through electronic media, including text messages. We cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

MINORS

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

TERMINATION Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. We may terminate treatment after appropriate discussion with you and a termination process if we determine that the psychotherapy is not being effectively used or if you are in default on payment. We will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, we will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

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 at our office.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature:_____

First Colonial
PSYCHOTHERAPY SERVICES

COURT APPEARANCE AND LEGAL FEES POLICY

There may be a time during your treatment at FCPS that your provider may be subpoenaed to court for the purpose of litigation. Please be aware that your provider can only testify to the facts of the case and to their professional opinion. This does not guarantee that testimony will be solely in your favor. The same is true for records requests for the purpose of litigation. Furthermore, when your provider must go to court, all clients that are normally seen that day must be rescheduled, so fees will be assessed to make up for lost revenue. These fees are usual and customary, and within State of Virginia guidelines. None of these fees are billable to your insurance and are the sole responsibility of the client or requestor and/or legal guardian for a minor being treated by our practice.

If the provider is to receive a subpoena, then the attorney or office staff must contact FCPS to set up a time within business hours to serve the subpoena. A minimum of 72 hours will be requested in order to accommodate schedule changes. Any requests with less than 72 hours will be assessed a rush fee of $150.

Fees for the purpose of court action are as follows:

Therapist:	**$400/hour (billable in 15 minute increments)**
Mileage:	**$0.40/mile**
Filing document with the court:	**$150 flat fee**
Retainer (due 72 hours in advance):	**$1500**
Rush Fee (if less than 72 hours notice):	**$150**

Examples of court-related actions:

1. Preparation Time
2. Phone calls
3. Depositions
4. Time required in giving testimony
5. Travel to/from court-related destination
6. Time away from office due to depositions or testimony
7. All attorney/court fees and costs that are incurred by the provider as a result of the legal action.

The retainer will be due 72 hours before any requested court appearance. The remainder will be billed to the client or requestor and is due within 30 days of receipt of invoice. If the full $1500 retainer is not utilized, the credit will be refunded. If the provider is subpoenaed and the case is reset after appointments have been cleared for the day, you will be responsible for an additional $500 to account for lost revenue from those day's appointments. There may be times that your provider will be out of town, and therefore unable to accommodate requests for court appearances.

Client Name (Print)

Legal Guardian (If Applicable)

Client/ Legal Guardian Signature

Date

Notice of Privacy Practices

FIRST COLONIAL PSYCHOTHERAPY SERVICES, 1232 PERIMETER PARKWAY, STE 206, VIRGINIA BEACH, VA 23454

PHONE NUMBER: 757.428.7500

NOTICE OF PRIVACY PRACTICES

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

I. MY PLEDGE REGARDING HEALTH INFORMATION: We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information. We are required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- We can change the terms of this Notice, and such changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. We may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, we may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. We do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is: a. For my use in treating you. b. For our use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy. c. For our use in defending myself in legal proceedings instituted by you. d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA. e. Required by law and the use or disclosure is limited to the requirements of such law. f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes. g. Required by a coroner who is performing duties authorized by law. h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. As psychotherapists, we will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As psychotherapists, we will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, we can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although our preference is to obtain an Authorization from you, we may provide your PHI in order to comply with workers' compensation laws.

10. Appointment reminders and health related benefits or services. We may use and disclose your PHI to contact you to remind you that you have an appointment with our office. We may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that we offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask us not to use or disclose certain PHI for treatment, payment, or health care operations purposes. We are not required to agree to your request, and may say “no” if we believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to You. You have the right to ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and we will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that we have about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 15 days of receiving your written or verbal request, and I may charge a reasonable, cost based fee for doing so.

5. The Right to Get a List of the Disclosures We Have Made. You have the right to request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided us with an Authorization. We will respond to your request for an accounting of disclosures within 30 days of receiving your request. The list I will give you will

include disclosures made in the last two years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that we correct the existing information or add the missing information. We may say "no" to your request, but we will tell you why in writing within 30 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on January 2, 2019

Acknowledgment of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature:_____

Informed Consent for Psychotherapy

FIRST COLONIAL PSYCHOTHERAPY SERVICES, 1232 PERIMETER PARKWAY, STE 206 VIRGINIA BEACH, VA 23454

PHONE NUMBER: 757.428.7500

Informed Consent for Psychotherapy

General Information The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature:_____

PHQ-9

** indicates a required field*

Over the **last 2 weeks**, how often have you been bothered by any of the following?

* 1. Little interest or pleasure in doing things.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

* 2. Feeling down, depressed, or hopeless.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

* 3. Trouble falling or staying asleep, or sleeping too much.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

* 4. Feeling tired or having little energy.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

*** 5. Poor appetite or overeating.**

- Not at all
- Several days
- More than half the days
- Nearly every day

*** 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.**

- Not at all
- Several days
- More than half the days
- Nearly every day

*** 7. Trouble concentrating on things, such as reading the newspaper or watching television.**

- Not at all
- Several days
- More than half the days
- Nearly every day

*** 8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.**

- Not at all
- Several days
- More than half the days
- Nearly every day

*** 9. Thoughts that you would be better off dead or of hurting yourself in some way.**

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly every day

*** If you checked off any problem on this questionnaire so far, 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

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