Pediatric Associates of Alexandria

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PATIENT INITIAL VISIT

PLEASE PRINT –FILL ALL AREAS IN BLACK INK

FIRST NAME	LAST NAME	MIDDLE INITIAL	BIRTHDATE	SEX
				M F

Mailing Address

Home Address		Social Security Number	Home Phone Number ( )
City	State	Zip	Cell Phone Number ( )
Employer name & Address			Work Phone Number ( )

Insurance Information *Insurance info and copy of insurance cards needed to file for benefits – **ALL SESSIONS ARE SELF-PAY UNLESS STATED OTHERWISE.***

Policy Holder's Name & Address		Social Security Number of Subscriber	Co-Payment / Co-Insurance Amount	
Primary Insurance Company	Identification / Policy Number	Sex of Policy Holder ❒Male ❒Female	Birthdate of Policy Holder	Effective Date

PLEASE MAKE SURE FORM IS COMPLETELY FILLED OUT
PAYMENT IS DUE AT TIME OF SERVICE

(TURN OVER)

Read Therapy Agreement on the Back of this Form

THERAPY AGREEMENT

I have brought my child _____, age(at the initial visit) _____, to Pediatric Associates of Alexandria, Inc., for evaluation and/or treatment.

THE PRACTICE

Pediatric Associates of Alexandria, Inc.(PAA) and/or its mental health providers, employees, agents, or assignees will hereafter be referred to as "The Practice."

CONSENT FOR THERAPY

The counseling process is a partnership between your child and Pediatric Associates of Alexandria (Mental Health Providers), facilitated by the minor's parent/s and/or guardians. The undersigned hereby consents to the evaluation and/or treatment required by the mental health providers rendering therapeutic care. The Practice reserves the right only to provide services to established patients. I understand that The Practice's patient at each session is my child – not me, any other sibling, or my spouse. This is factual no matter who pays The Practice for the sessions with my child. I understand that The Practice's primary responsibility is my child's best interest. The Practice may decide to involve the parent(s) in the child's evaluation/treatment at their sole discretion.

APPOINTMENTS

Appointments will ordinarily be 45-50 minutes in duration at the time scheduled; additional sessions may be more or less frequent as needed. The planned time for your appointment is assigned to your child. If you need to cancel or reschedule a session, we ask that you provide 24 hours' notice. If you miss a session without canceling or canceling with less than 24 hours' notice **(please see "Professional Fees" for the fee associated with missed appointments)**. It is important to note that insurance companies do not provide reimbursement for canceled sessions; thus, you will be responsible for the portion of the fee as described below. If it is possible, we will try to find another time to reschedule the appointment. In addition, you are responsible for bringing your child to each session on time; if you are late, the appointment will still need to end on time.

PROFESSIONAL FEES

I understand that I am responsible for and agree to pay a $125.00 Missed Appointment Fee for each scheduled session that my child misses/ that were not canceled with at least 24 hours advance notice. I understand that missing two scheduled sessions may terminate my relationship with the Practice for therapy. I understand that I am responsible for and agree to pay a $20.00 "Emergency After Hours fee" for all after-hours calls to the covering provider. These after-hour calls are considered an emergency and charged to the member's account on the date services were rendered. The after-hour calls are not covered by commercial and or Medicaid policies and are the patient's responsibility. I understand that if payment is not received promptly for services rendered by The Practice to my child, the services may be suspended or terminated at The Practice's sole discretion, according to the ethical guidelines governing psychological care.

AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS

I do hereby authorize The Practice, when applicable, to apply for benefits for services rendered to myself or minor child under any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from my (our) insurance company to The Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.)
I irrevocably authorize all such payments to The Practice. I authorize The Practice to contact the employer or insurance company regarding insurance information, the existence of insurance, and coverage of my (our) benefits.

CONFIDENTIALITY

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. All interactions with The Practice's mental health services, including scheduling of or attendance at sessions, the content of your sessions, progress in counseling, and your records, are confidential. No record of counseling is contained in any academic, educational, or job placement file. In writing, you may request that the mental health providers release specific information about your counseling to persons you designate outside of PAA.

EXCEPTIONS TO CONFIDENTIALITY:

• The counseling staff works as a team. Your mental health provider may consult with other counseling staff, other providers, and staff at PAA to provide the best possible care. These consultations are for professional and training purposes.

• If there is evidence of clear and imminent danger of harm to self and/or others, a therapist is legally required to report this information to the authorities responsible for ensuring safety.

• Virginia state law requires that staff of The Practice's counseling services who learn of or strongly suspect physical, sexual, or emotional abuse or neglect of any person under 18 years of age must report this information to county child protection services.

• A court order issued by a judge may require The Practice to release information contained in records and/or require a therapist to testify in a court hearing.

• A therapist may break confidentiality to the extent needed for treatment, payment, or health care operations.
Our guiding principle is to protect the best interest of our patients while delivering the highest quality services. We can do this most effectively if you help us by asking questions or raising concerns whenever such matters occur. Please talk about confidentiality with your child's mental health provider if you have any questions or concerns.

RELEASE INFORMATION FORM

Permission for The Practice to contact a particular person or agency on your behalf will be granted by signing an Authorization to Release Form. I understand that The Practice is not agreeing to be an expert witness or to testify on any parent's behalf or on behalf of any other individual other than the child at any deposition, court proceeding, or in any other way. I understand that The Practice may or may not meet with a parent, their attorney, or any other party or attorney in any custodial or divorce proceeding at our sole discretion. The Practice may also charge for the receipt of any correspondence or acceptance of any telephone calls, other than those directly from the court or counsel for my child.

REFERRALS AND AUTHORIZATIONS

I understand that it is my responsibility if I (we) have an insurance plan that requires any referrals, pre-certifications, or authorization to receive any additional therapeutic services, to obtain such approval from The Practice or insurance company prior to such non-emergency services being rendered. I further understand that I must notify The Practice prior to going, if possible, or within 48 hours, or in accordance with my insurance company's requirements, of any emergency room visit. Additionally, suppose any aforementioned procedures are not done. In that case, I understand that this may cause reduced or rejected coverage for which I will be held responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for my (our) child's claims. Any denial of claims is between the policyholder/subscriber and their insurance. I (we) agree to inform The Practice immediately of any change in insurance coverage and/or benefits and personal information change.

FINANCIAL AGREEMENT

I, the undersigned (jointly and separately if more than one), further agree that I am legally obligated and responsible and do hereby guarantee payment for all charges incurred by my child, stepchild, or any other extended family members; I (we) are financially accountable for; including but not limited to grandchild, niece, and nephew. I also understand that I (we) may be billed separately for services rendered by other professionals, including, but not limited to, other physicians, radiologists, and laboratory work, as appropriate and in accordance with the services rendered. The Practice will file for insurance benefits and accept payments per The Practice's contractual agreements with the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits are a matter between the insurance subscriber/policyholder and the insurance company. Any assistance in this matter granted by The Practice is given strictly as a courtesy and implies no responsibility on The Practice's part for filing, follow-through, or confirmation.

I understand that I am responsible for the entire balance in my child's account at the time of rendered services, including co-payments, co-insurance, deductibles, termination of coverage, not adding a dependent to insurance plan, non-payment at time of service, and/or any other reason. I understand and agree that I am expected to pay all balances within 30 days of rendered services. I understand and agree that if for any reason my personal check is returned for any reason, including insufficient funds on my account, I will be assessed and responsible for a $50.00 Returned Check Fee in addition to ALL original fees for services. Interest of one and one-half percent per month, eighteen percent per annum, will be charged on all accounts over 30 days. If the balance is not paid within the 30 days or if agreed upon payment arrangements on my (our) account are not made, I authorize the Practice to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify the credit bureaus of my (our) delinquencies. I understand that this will affect my (our) credit rating. If this account is placed for collection, I agree to pay one-third of the unpaid principal and interest as a collection fee, plus court costs and interest in the amount of one and one-half percent per month, beginning 30 days after the monies have become due or expenses have been incurred. Any costs incurred by such collection actions, including the maximum allowed interest, shall become an additional liability for which I (we) assume full responsibility. PAA is required to report all services rendered to your insurance carrier, even those that occur outside of regular business hours (M-F 8 am-4:50 pm). I understand that I am responsible for and agree to pay all balances rendered patient responsibility by my primary insurance carrier.

CONTACTING MENTAL HEALTH PROVIDERS

Your mental health provider often may not be immediately available by telephone. Additionally, he/she does not answer during business hours as they are with a patient or otherwise unavailable. At these times, you may leave a message on my confidential voice mail with our advise nurses and/or on-call service, and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear back from your child's mental health provider or they are unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep your child safe:

- Call 911 and explain your mental health emergency.

OR

- National Suicide Prevention Lifeline: 800-273-8255

The Practice will make every attempt to inform you in advance of planned absences and provide you with the name and phone number of the mental health professional covering scheduled sessions.

COPY OF SIGNATURE

I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic, or telephonic.

CERTIFICATION

I certify that I have read and discussed the above information with my child's mental health provider and, as the parent/guardian/guarantor, understand and fully accept this Therapy Agreement.

In cases of divorce or separation, unless otherwise specified in a court order, I understand that both parents will be permitted to schedule appointments, bring the child in for therapy sessions, and may be granted full access to the child's therapy records. If you have any concerns in this area, please contact The Practice for further questions.

I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a patient of the Pediatric Associates of Alexandria's Counseling Services. I acknowledge that I received HIPAA consent forms as a patient of Pediatric Associates of Alexandria, and these forms also apply to therapy services.

_____ _____

Signature of Parent/Guardian/Guarantor **Print Name**

_____ _____

Relationship to Patient **Date**

_____ _____

Signature of Therapist **Date**