Staple

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PRINCE WILLIAM *Counseling Center*

ADMISSION FACE SHEET

Patient Name: ______________________________ Admission Date: ______________
Last MI First
Clinical Record Number: ______________

Patient Address: ______________________________
______________________________ Zip + 4: __________ - ______

Home Phone Number: ______________ Work Phone Number: ______________

Date of Birth: ______________ Age: ________ Sex: M F Ethnicity: ______________

Social Security Number: ______________ Marital Status: S M Sep Div Wid Partnered

Occupation: ______________________________

Employer / School: ______________________________ Grade: ______________

Referral Source: ______________________________ Phone Number: ______________

Legal Next of Kin

Name: ______________________________ Relationship: ______________

Address: ______________________________

City: ______________________________ State: ________ Zip Code: ______________

Home Phone: ______________________________ Work Phone: ______________

Emergency Contact

Name: ______________________________ Relationship: ______________

Address: ______________________________

City: ______________________________ State: ________ Zip Code: ______________

Home Phone Number: ______________ Work Phone Number: ______________

Primary Care Physician

May we have the name and telephone number of your primary care physician? ______________

May we have the name and telephone number of your Pharmacy? ______________

Legal Custody of Patient

Legal Guardian: ______________________________

Address: ______________________________

City: ______________________________ State: ________ Zip Code: ______________

Employer: ______________________________ Occupation: ______________

Visitation Privileges, etc. of Non-Custodial Parent(s): ______________________________

____

Criminal Justice Status

Charges Pending ________ On Probation ________ Legally Detained ________ Other ______________

Explain: ______________________________

Contact Name: ______________________________ Relationship: ______________

Address: ______________________________

Phone Number: ______________________________

Special Conditions / Needs

____

____

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BILLING INFORMATION

Patient Name: ______________________________ Record #: ______________
Last MI First

Responsible Party Information

Responsible Party Name: ______________________________

Relationship to patient: ______________________________

Address: ______________________________

City: ______________________ State: VA ________ Zip Code: ____________

Home Phone Number: ______________________ Work Phone Number: ______________________

Employer: ______________________________

Primary Insurance Information

Subscriber's Name: ______________________ Birth Date: ______________

Subscriber's Address ______________________________

City: ______________________ State ________ Zip + 4: __________ - _____

Subscriber's Social Security Number: ______________ Patient's Relationship to Subscriber: ____________

Insurance Carrier Name: ______________________ Phone Number: ______________

Insurance Address: ______________________________

Policy Number: ______________ Group Number: ____________ Policy Effective Date: ____________

Secondary Insurance Information

Subscriber's Name: ______________________ Birth Date: ______________

Subscriber's Address: ______________________________

City: ______________________ State ________ Zip + 4: __________ - _____

Subscriber's Social Security Number: ______________ Patient's Relationship to Subscriber: ____________

Insurance Carrier Name: ______________________ Phone Number: ______________

Insurance Address: ______________________________

Policy Number: ______________ Group Number: ____________ Policy Effective Date: ____________

Subscriber's Employer: ______________________ Phone Number: ______________________

Employer's Address: ______________________________

City: ______________________ State: ________ Zip Code: ____________

I understand that billing my insurance company is an additional service being provided and that it is my responsibility to provide complete and accurate information to aid the billing process. It is my responsibility to keep Prince William Hospital Center for Psychiatric and Addictions Treatment Center aware of any changes or modifications to my insurance coverage. Use of this billing service does not remove my responsibility for any or all charges incurred in treatment.

______________________________ ______________________

Patient or Responsible Party Signature Date

______________________________ ______________________

Witness Signature Date

I have discussed the issues above with the client (and/or his or her parent/legal guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed or willing consent

______________________________ ______________________

Staff Signature Date

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Explanation of the Office Policies of *The Counseling Center at Prince William Hospital*

We welcome you to the Counseling Center and assure you that we will provide you the best care possible. This information is intended to provide clarification and prevent future misunderstanding. The demand for Counseling Center services is overwhelming. The appointment time you schedule is unavailable to many others seeking treatment.

Emergency Issues

Should you become suicidal or homicidal, go directly to the nearest emergency room for evaluation. Make sure to give the emergency room the name and number of your Psychiatrist or Therapist. For urgent issues requiring attention of your provider, call the office to leave a message and the office staff will have the provider call at their first opportunity. Please note the days your provider office is in the office.

Scheduled Appointments

Please note your appointment time carefully. This time is being reserved exclusively for you. If you miss an appointment or attempt to reschedule less than 48 hours before your original scheduled time, you will be charged for your appointment as follows: $50 per hour of scheduled treatment time with therapists, $100 per hour of scheduled treatment time for psychiatrists, $50 per medication check-up with a psychiatrist, and $50 per hour of scheduled group therapy. Keep in mind that insurance companies do not pay for missed appointments. All outstanding balances must be paid before you are seen for your next scheduled appointment.

Provider Time

In instances where provider time is spent outside an appointment, a charge in 15 minute increments can be applied which insurance does not cover. This could include letters, drafted, phone calls, etc...

Prescription Refills

If you miss your appointment and need a prescription refill, you must reschedule another appointment immediately and discuss the refill with the MD. The MD will give you the first available appointment which you would be required to attend to get further scripts. The follow up appointment would require the normal co-pay in addition to the missed appointment charge. In certain cases, a fee to replace a lost prescription may be charged to the patient which is not covered by insurance.

Insurance Coverage

We will be glad to help you obtain the appropriate benefit from your insurance carrier and bill your carrier as a courtesy to you. You are responsible for any co-payment at the time of service. Please remember that the insurance benefits are based on a contract between you and your insurance carrier, and you are ultimately responsible for your account balance should your insurance company deny payment.

Medical Records

There is a flat rate $15.00 charge for preparing / sending records. It is not covered by most insurance companies

Payment for Services

Payment is required for all services at the time of service. Non payment on your account can result in termination of services and referral to another provider. If your account is referred for collection you will be responsible for collection costs in the amount of 30% of your outstanding balance, together with court costs and attorney's fees.

Returned Checks

Checks that are returned to The Counseling Center are subject to a $25 bank processing charge.

Changes

When there are changes in your insurance coverage, personal information, or medical history please notify our office on your next visit, or you may call the office to provide such information.

By signing below, I certify that I consent to treatment at the Counseling Center and have read and understand the office policies. I agree to pay the fees established by this office or my managed care or insurance plan.

____ ____

Printed Name Date Signature

I have discussed the issues above with the client (and/or his or her parent/legal guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed or willing consent.

____ ____

Signature of Clinician Date

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The Counseling Center at Prince William Hospital

Conditions of Admission for Outpatient Service

1. Admission-Discharge

The undersigned agrees that the treatment of a patient by a The Counseling Center at Prince William Hospital clinician is a matter of clinical judgement and entirely within the discretion of the attending provider; that The Counseling Center admits the patient with the understanding that it reserves the right, at any time, to discharge the patient for any reason that may be satisfactory to The Counseling Center.

2. Assignment of Insurance Benefits

In the event that the undersigned is entitled to benefits of any type whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to The Counseling Center for application on the patient's bill. It is agreed that The Counseling Center may make receipt for any payment and such payment shall discharge the insurance company of any obligations under the policy to the extent of such payment, the undersigned and/or patient being responsible for such charges not covered by this agreement.

3. Financial Agreement

The undersigned agrees, whether he signs as agent or as a patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay all charges incurred by The Counseling Center for or in connection with treatment of the patient or cost related thereto in accordance with the regular rates and terms of The Counseling Center. Should the patient's account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate. The undersigned further agrees to pay the fair market value for all furniture, equipment and property that may be broken or damaged by the patient. It is understood and agreed that the undersigned are jointly and severally primarily liable hereunder and no demand or claim against the patient or the patient's estate for the amount due, and no attempt to collect therefrom, need to be made to render me/us liable hereunder.

4. 48 Hour Notice of Cancellation/Change of Appointment

The undersigned agrees, whether he signs as a agent or patient to give 48 hours advance notice of any change or cancellation of their scheduled appointment. Furthermore, the undersigned agrees to reimburse The Counseling Center for the specified amount of the changed or cancelled appointment, if 48 hours advance notice is not given.

5. Release of Information

So as to permit reimbursement, upon request, The Counseling Center may disclose treatment information pertaining to the treatment stay of a patient to any corporation, organization, or agent thereof that is or may be liable under a contract with The Counseling Center or to the patient or a family member of the patient, for payment of all or part of The Counseling Center's charges for services rendered. I understand that the purpose of any release of information is to facilitate reimbursement for services rendered. In addition, in the event that my health insurance program includes utilization review of services provided during this treatment, I authorize The Counseling Center to release only such information as is necessary to permit the review. I understand that this authorization to release treatment information is subject to revocation at any time except to the extent that action has been taken in reliance upon this authorization prior to its revocation. In any event, this authorization will expire once reimbursement for services rendered is complete.

The undersigned authorizes that they have read the above and is the patient, or is duly authorized by the patient to execute these conditions and to accept these terms.

Patient Signature	Date
Parent/Legal Guardian Signature	Date

I have discussed the issues above with the client (and/or his or her parent/legal guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed or willing consent.

Staff Signature	Date

PRINCE WILLIAM Counseling Center

As a client served at The Counseling Center, you have specific rights. The purpose of this form is to inform you of your rights as our client.

I. Right to Voluntary Services

You have the right to request voluntary services.

You have a right to

- have a staff person assigned specifically to work with you in resolving your problems and ensuring that your service is properly provided
- a personal, individualized assessment of your needs
- an individualized service plan, which will be reviewed regularly, developed with your input, and implemented with your consent
- services beginning within a reasonable time and ending when they are no longer needed or effective
- another opinion regarding services provided (However, seeing someone outside of this setting is done at your own expense.)
- referrals to other competent professionals and sources of help as indicated by your service plan
- terminate service if your circumstances require it or you feel it is in your best interest, unless doing so puts you or others in grave danger
- file a grievance if you feel your rights have been denied or violated. The Behavioral Medicine contact for filing a grievance is David Carlini at (703) 369-8883. The Regional Human Rights Advocate (703) 323-2098 is available as well to discuss Human Rights Violation Issues.

II. Right to Refuse Services

You have a right to

- refuse any form of service or treatment unless it has been ordered by the court or in emergency situations when necessary to prevent harm to yourself and others (If you must receive services not by your own choice, you have the right to a lawyer, a court hearing, and an appeal of the decision to a higher court. If you cannot afford a lawyer, the court will appoint one for you.)
- refuse service with your primary clinician and request another practitioner in this setting or a referral to another setting
- be informed that without services, your situation may get worse
- refuse to be filmed or audiotaped without your written permission
- refuse to take part in research studies without your written permission.

III. Right to Confidentiality / Privacy

All information about you is understood to be confidential to protect your privacy. This information includes the fact that you have or have not received services. All professionals and other staff associated with this setting are obligated to preserve your privacy to the extent permitted by law.

You have the right

- determine the amount of information to be released, whether to or from anyone outside this setting, by signing a consent form
- sign a consent form to release information that is specific to each situation when information is to be released (You will not be asked to sign a "blanket" consent for release of information.)
- determine the length of time that information may be released and cancel your permission at any time (However, information may be released without your permission in a medical emergency to save lives, to prevent injury to yourself or others, or when required by law or ordered by the court.)

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IV. Right to a Humane Mental and Physical Environment

You have a right to

- courtesy, respect, and professionalism from everyone involved in your service in this setting
- facilities that are comfortable and safe, promote dignity, ensure privacy, and contribute to positive outcomes of your service.

V. Right to Information

You have a right to verbal and written information about

- your rights, role, and responsibilities as a client in this setting
- your primary clinician's rights, role, and responsibilities in this setting
- what you can expect during your service process-appointment, cost, handling of emergencies, and other practices and procedures of this setting as they affect you
- your primary clinician's credentials and professional code of ethics
- means to contact your primary clinician in both emergency and nonemergency situations
- the name of and means to contact your primary clinician's supervisor
- procedure for reviewing your clinical records.

VI. Rights Pertaining to Medication

You have a right to

- the administration of medication only under the written order of a physician
- a complete explanation, in language you can understand, of the purpose of any medication, possible side effects, and possible results of long-term use
- full consideration of your opinions and reactions to the medications
- a regular review of your medication for the purpose of adjustment, as a check for possible side effects, and for possible reduction or elimination
- have accurate records kept noting your medication history, including any adverse reactions or drug allergies
- have medication prescribed for you only when necessary.

______________________________ ______________________

Patient Signature Date