



PRIVACY DISCLOSURE INFORMATION

The Counseling Center adheres to the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

We wish to provide you with a safe confidential setting where your Personal Health Information is only released with your written consent and the consent of your provider.

We would like to have you complete the following items to ensure your privacy and confidentiality.

I would like to be called at this number _____ for appointment reminders.

I want reminder calls for my Doctor appointments.

I want reminder calls for my Therapy appointments.

I do not want reminder calls.

I would like to be called at this number _____ for messages from my Doctor or Therapist.

I allow these persons to access my appointment times.

I would like any written correspondence or billing correspondence sent to this address.

This address is different from my home address.

When treatment has terminated (completion/non compliance), a discharge summary is completed. If you are not present to receive the discharge summary, you may call 703-369-8055 option 2 to have a copy made available to you. It will be necessary to complete a consent to release information and to show positive proof of identification to receive the discharge summary.

Please note your appointment times carefully. This time is being reserved exclusively for you. If you miss or reschedule an appointment without the 48 hour advanced notice, you will be subject to a missed appointment charge. The charges are as follows:

Missed first appointment for evaluation:	\$ 100.00
Missed medication management session (15-20 minute)	\$ 50.00
Missed medication management session (45 minute)	\$ 100.00
Missed therapy session	\$ 50.00

Keep in mind that insurance companies do not pay for missed appointments and they will be billed to you. It is expected that the missed appointment fee be paid before your next session unless you have made prior arrangement with the Billing Coordinator.

Patient/Responsible Party Signature _____ Date _____

Clinician Signature _____ Date _____