Outpatient Registration Information

•14900 Bogle Drive, Suite 200 • Chantilly, VA 20151-1652 • 703-817-9890 • FAX 703-817-9860 • www.fcsva.org•

Basic Information

Full Name: _____ Date _____

Address: _____
Street City State Zip

County of residence: _____ Male ☐ Female ☐ Client's DOB: _____ Age:_____

Ethnicity: _____

Please list all contact numbers and indicate if it's OK (Yes/No) to leave voice mail at any of the numbers.

Home: _____ ☐ Yes / ☐No Work: _____ ☐ Yes / ☐No

Cell: _____ ☐ Yes / ☐No Email: _____

Emergency Contact: _____
Name Number

How did you hear about us? _____

Briefly state presenting problem (be as specific as you can; when did it start, how it affects you): _____

_____

_____

Estimate the severity of above problem (circle): ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Insurance Information

Primary Ins.: _____ Policy Holder Name: _____

Policy #: _____ Group/Member ID #: _____

Policy Holder - DOB: _____ - SSN: _____ Relationship to client: _____

Policy Holder Employer: _____ Occupation: _____

Insurance Co. Phone #: _____ Authorization #: _____

Secondary Ins.: _____ Policy Holder Name: _____

Policy #: _____ Group/Member ID #: _____

Policy Holder - DOB: _____ - SSN: _____ Relationship to client: _____

Policy Holder Employer: _____ Occupation: _____

Insurance Co. Phone #: _____ Authorization #: _____

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Medical Information

Physician's Name: _____ Phone #: _____

Date of last exam: _____

Past/Present Medical Care (Specify major problems, accidents, hospitalizations): _____

_____

_____

_____

Psychiatrist's Name: _____ Phone #: _____

Date of last exam: _____

Current Medications (specify what for): _____

_____

_____

Past/Present Counseling/Psychotherapy/Mental Hospitalizations: _____

_____

_____

Past/Present Drug/Alcohol Use/Abuse (AA/NA, Treatment): _____

_____

_____

I, _____ authorize the above named provider to apply for benefits on my behalf for covered services rendered. I understand that services must be paid for at the time of my appointment. I certify that the information is true and correct and further authorize the release of any information for this or any related claim, to the above named provider. I permit a copy of this authorization to be used in place of the original. Either the above named provider or I may revoke this authorization at any time in writing.

_____ _____

Signature of Beneficiary or Subscriber Date

Office Use Only

FCS Therapist: _____ FCS Office: _____

Privacy Policy signed and on file: ☐ Yes ☐ No Date Signed: _____

Date of First Appointment: _____

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Outpatient Treatment Policies and Client Information

THE FOLLOWING INFORMATION IS A DESCRIPTION OF OUTPATIENT POLICIES AND CLIENT INFORMATION CONCERNING CONFIDENTIALITY, APPOINTMENTS, CANCELLATIONS, AVAILABILITY, AND INSURANCE. PLEASE FEEL FREE TO DISCUSS THESE POLICIES OR ANY OTHER MATTERS RELATED TO THE SERVICES YOU RECEIVE WITH YOUR THERAPIST.

Confidentiality: The services you receive are confidential, private and personal. Your written permission is required for the release of information except in situations of clear and imminent danger to yourself or others, court subpoena, or suspicion of child abuse or neglect.

Appointments: Unless special arrangements are made beforehand, all appointments are a maximum of 50 minutes in duration.

Cancellations: If for any reason you are not going to be able to keep an appointment, we request 24 hours notice, if this is not possible, we will have to charge you for the session. Insurance companies do not pay any portion of the fee for a missed appointment.

Availability: We can be reached through a voice mail system during business hours at 703-817-9890, which is checked frequently throughout the day. Your call will be returned as soon as possible. For after-hours emergencies, you may contact the FCS 24-hour On-Call Phone number, 540-454-3056. Your call will be answered by an FCS clinical on-call staff member, who will be able to reach your therapist directly in the case of an absolute emergency.

Insurance: Most insurance programs allow you to go outside the network for services and will reimburse you a percentage of the amount you paid for services. You are required to obtain an insurance company authorization number for services before your first appointment. We ask that when you contact your insurance company, please ask for your co-pay for behavioral health services. We can discuss who will complete insurance claim information and treatment plans on your behalf for covered services rendered. You are responsible for the full fee, payable at the end of each session unless other arrangements have been made. All insurance deductibles and co-payments are always payable in full at the end of each session.

I understand and agree to the above terms:

Signature: _____ Date: _____

Signature: _____ Date: _____

Outpatient Client's Rights/Code of Ethics

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- A client must be allowed to bring personal possessions to the agency. Tobacco (unless over 21), drugs/alcohol, illegal substances, and weapons are not allowed on any FCSVA premise. Legal substances and prescription medication are permitted in the proper container and are solely the responsibility of the legal guardian and the adult client.

- No input received will be used for research. Input will be used to assess service delivery including reporting and evaluation.

- Clients have the right to file a grievance if they are dissatisfied with the service. If a client wishes to file a grievance, they should notify any of the professional staff at FCSVA. Each FCSVA worker has the responsibility to respond within forty-eight hours. If the client is dissatisfied with the response, they may appeal to the Program Director of FCSVA, CEO of FCSVA or the Board of Directors of FCSVA. Any time a client feels they are not making progress in the appeal process they may contact their legally responsible party or state licensing representative.

- Clients have a right to participate in, provide input and be informed of their plans of service and to receive the services based solely on their needs. If there is a discrepancy among the services identified and the care, treatment, and/or payment of such services, FCSVA serves as an advocate to ensure resolution of such conflicts.

- Clients shall not be discriminated against due to sex, sexual orientation, gender, gender identity or gender expression.

- Clients have a right to the best effort of FCSVA to have any disability needs met. Clients with physical, mental, medical and/or emotional disabilities will be afforded all resources available to FOR CHILDREN'S SAKE OF VIRGINIA including but not limited to: assessments, support and clinical services provided by FCSVA staff and referral to other resources which may be better equipped to meet particular needs.

Client: _____ Date:_____

Legal Guardian: _____ Date:_____

FCSVA Staff:_____ Date:_____

For Children's Sake

FEE SCHEDULE

Evaluative Interview Procedures:

Diagnostic interview examination including history, mental status or disposition; may include communication with family or other sources. In certain circumstances other informants will be seen in lieu of the client. $150.00/Session

Psychotherapy Services

Individual Psychotherapy; which may include behavior management, play therapy or supportive psychotherapy. Approx. 45 – 50 minutes $125.00/Session

Family Psychotherapy; working within the context of marriage, couples, and family systems to treat a wide range of clinical issues, which may include depression, marital difficulties, anxiety, individual psychological concerns, as well as child-parent relationship issues. Approximately 45 – 50 minutes $125.00/Session

Group Psychotherapy; Group therapy is a collaborative effort in which the therapist assumes clinical responsibility for the group and its members in order to address feelings of isolation, depression or anxiety; develop, explore, and examine, interpersonal relationships within the group; as well as social/s skills, In a typical session, members work to express their current life issues, feelings, ideas and reactions as freely and honestly as possible. $125.00/Session

Routine Office Visit – Missed Appointment

We strive to be on time for your scheduled appointments and ask that you give us the courtesy of a call when you are unable to keep your appointment.
We require a minimum 24 hour notice for all routine office visits otherwise a missed appointment fee will be charged.

1. First missed follow-up appointment: We will call and offer to reschedule your appointment. You may be charged a missed appointment fee of $45. $45.00/Session

2. Second missed follow-up appointment: You will receive written notification of your missed appointment and you will be charged a fee of $45. $45.00/Session

3. Third missed follow-up appointment: You will be charged an additional missed appointment fee of $45. This will result in a discharge from the practice and a letter sent to the address on file for written notification. $45.00/Session

Please note that the full session fee will be charged until any required deductible or identified out-of-pocket expense is met and the client becomes eligible for co-payments if applicable.

Signature _____ Printed Name _____ Date _____

MISSED APPOINTMENT POLICY

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Thank you for choosing For Children's Sake to provide your therapeutic care. If you miss an appointment, you compromise your care. We want to remind you of our office policies regarding missed appointments.

A missed appointment is when you fail to show up for an appointment or when you cancel an appointment with less than 24 hours notification.

We strive to be on time for your scheduled appointments and ask that you give us the courtesy of a call when you are unable to keep your appointment. Please see below for the For Children's Sake missed appointment policies.

ROUTINE OFFICE VISITS

We require a minimum 24 hour notice for all Routine office visits otherwise a $45 missed appointment fee will be charged.

1. First missed follow up appointment: We will call and offer to reschedule your appointment. You may be charged a missed appointment fee of $45.

2. Second missed follow up appointment: You will receive written notification of your missed appointment and you will be charged a fee of $45.

3. Third missed follow up appointment: You will be charged an additional missed appointment fee of $45. This may also result in a discharge from the practice.

_____ _____

Signature Date

_____ _____

Signature Date

Receipt of Professional Disclosure Statement

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I have received a copy of my therapist's professional disclosure statement and had an opportunity to ask questions that I had in regard to the statement.

Signature _____ Date _____

Print Name _____

If a minor, please have guardian also sign below:

Signature _____ Date _____

Print Name _____

Authorization to Release Information

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I _____ (hereinafter "Patient") hereby authorize For Children's Sake therapist _____ (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including, but not limited to, therapist's diagnosis of Patient, to: _____

_____

- I understand that I have a right to receive a copy of this authorization.
- I understand that any cancellation or modification of this authorization must be in writing.
- I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it.
- I also understand that such revocation must be in writing and received by Provider at the address or via fax using the contact information listed above in order to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose(s): _____

_____

_____

The specific uses and limitations of the types of medical information to be discussed are as follows **(be as specific as you choose to be):** _____

_____

_____

Such disclosure shall be limited to the following specific types of information: _____

_____

_____

_____

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Virginia law may protect such information.

This authorization shall remain valid until: _____

_____ Date: _____

Patient's signature

_____ Date: _____

Parent/Guardian of Minor Patient:

EMAIL Confidentiality

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It is important to be aware that e-mail communication can be relatively easy to access by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mail in particular, is vulnerable to such unauthorized access as servers have unlimited and direct access to all e-mails that pass through them. Un-encrypted e-mails are even more vulnerable to unauthorized access.

- Please notify your therapist if you decide to avoid or limit in any way the use of e-mail.

- Please do not send e-mail for emergencies. While your therapist checks phone messages frequently during the day, he/she does not always check e-mail daily.

Name: _____

Address: _____

Phone: _____ _____

☐ Home ☐ Work ☐ Cell ☐ Home ☐ Work ☐ Cell

Fax: _____ ☐ Home ☐ Work

E-mail: _____

_____ _____

Signature Date

_____ _____

Signature Date

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INFORMED CONSENT

Treatment is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in treatment, you have certain rights that are important for you to know about because this is your treatment, whose goal is your well-being. There are also certain limitations to those rights that you should be aware of. As a counselor, I have corresponding responsibilities to you.

My Responsibilities to You as Your counselor

I. Confidentiality

With the exception of certain specific exceptions described below, you have the right to confidentiality of your treatment. I cannot and will not tell anyone else what you have told me, or even that you are in treatment with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act to protect your privacy even if you do release me in writing to share information about your treatment. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time.

You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law ensures confidentiality of all electronic transmission of information about your treatment. Whenever I transmit information about your treatment electronically (for example, sending bills or faxing information), it will be done with special safeguards to ensure confidentiality.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately. If you are between the ages of 16 and 18 and you tell me that you are having sex with someone more than five years older than you, or sex with a teacher or a coach, I must also report this to CPS, even though at age 16 you have the right to consent to sex with someone no more than five years older than you. I would inform you before I took this action.

3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or a crisis team. I am not obligated to do this, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the police and/or a crisis team.

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4. If you tell me of behaviors of another named health or mental health care provider that informs me that this person has either:

A. Engaged in sexual contact with a patient, including yourself or

B. Is impaired from practice in some manner by cognitive, emotional, behavioral, or health problems, then the law requires me to report this to their licensing board at the VA Dept. of Health. I would inform you before taking this step.

IV. Other Rights

You have the right to ask questions about anything that happens in treatment. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful or give input on your treatment. You can ask me about my training, and can request that I refer you to someone else if you decide I'm not the right counselor for you. A description of any benefits that may be expected from the service will be provided to you. A description of any alternative services that might be considered, along with their side effects, risks, and benefits will be discussed with you. You have the right to feel free to refuse or withdraw your consent and to discontinue participation in any services requiring your consent at any time without fear of reprisal against or prejudice to you. Prior to treatment goals being achieved, we will work together on your transition plan and procedures. Lastly, a description of the ways in which the individual or his/her authorized representative can raise concerns and ask questions about the services to which consent is given will be explained to you.

V. Managed Mental Health Care

If your treatment is being paid for in full or in part by a managed care firm, there are usually further limitations to your rights as a client imposed by the contract of the managed care firm. These may include their decision to limit the number of sessions available to you, to decide the time period within which you must complete your sessions with me, or to require you to use medication if their reviewing professional deems it appropriate. They may also decide that you must see another counselor in their network rather than me, if I am not on their list. Such firms also usually require some sort of detailed reports of your progress in treatment, and on occasion, copies of your case file. I do not have control over any aspect of their rules. However, I will do all that I can to maximize the benefits you receive by filing necessary forms and gaining required authorizations for treatment.

Client Consent to Treatment

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I understand my rights and responsibilities as a client, and my counselor's responsibilities to me. I agree to undertake treatment with For Children's Sake.

Signed:_____ Date:_____

Witness:_____Date:_____

HIPAA NOTICE OF PRIVACY PRACTICES

For Children's Sake

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.

IT IS THE LEGAL DUTY OF FOR CHILDREN'S SAKE TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).
By law FOR CHILDREN'S SAKE is required to insure that your PHI is kept private. The PHI constitutes information created or noted by FOR CHILDREN'S SAKE that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. FOR CHILDREN'S SAKE is required to provide you with this Notice about privacy procedures. This Notice must explain when, why, and how FOR CHILDREN'S SAKE would use and/or disclose your PHI. Use of PHI means when FOR CHILDREN'S SAKE shares, applies, utilizes, examines, or analyzes information within the practice; PHI is disclosed when FOR CHILDREN'S SAKE releases, transfers, gives, or otherwise reveals it to a third party outside the practice. With some exceptions, FOR CHILDREN'S SAKE may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, FOR CHILDREN'S SAKE is always legally required to follow the privacy practices described in this Notice.

Please note that FOR CHILDREN'S SAKE reserves the right to change the terms of this Notice and these privacy policies at any time. Any changes will apply to any PHI already on file with For Children's Sake. Before FOR CHILDREN'S SAKE makes any important changes to these policies, FOR CHILDREN'S SAKE will immediately change this Notice and post a new copy of it in each office. You may also request a copy of this Notice from For Children's Sake, or you can view a copy of it in any office.

I. HOW FOR CHILDREN'S SAKE WILL USE AND DISCLOSE YOUR PHI.
FOR CHILDREN'S SAKE will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

- **Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.**

  FOR CHILDREN'S SAKE may use and disclose your PHI without your consent for the following reasons:

- **For treatment.** FOR CHILDREN'S SAKE may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, FOR CHILDREN'S SAKE may disclose your PHI to her/him in order to coordinate your care.
- **For health care operations.** FOR CHILDREN'S SAKE may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - FOR CHILDREN'S SAKE might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. FOR CHILDREN'S SAKE may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that FOR CHILDREN'S SAKE is in compliance with applicable laws.
- **To obtain payment for treatment.** FOR CHILDREN'S SAKE may use and disclose your PHI to bill and collect payment for the treatment and services FOR CHILDREN'S SAKE provided you. Example: FOR CHILDREN'S SAKE might send your PHI to your insurance company or health

plan in order to get payment for the health care services that FOR CHILDREN'S SAKE has provided to you. FOR CHILDREN'S SAKE could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for the agency.

- **Other disclosures.** Examples: Your consent isn't required if you need emergency treatment provided that FOR CHILDREN'S SAKE attempts to get your consent after treatment is rendered. In the event that FOR CHILDREN'S SAKE tries to get your consent but you are unable to communicate with anyone in the agency (for example, if you are unconscious or in severe pain) but FOR CHILDREN'S SAKE thinks that you would consent to such treatment if you could, FOR CHILDREN'S SAKE may disclose your PHI.

II. Certain Other Uses and Disclosures Do Not Require Your Consent. FOR CHILDREN'S SAKE may use and/or disclose your PHI without your consent or authorization for the following reasons:

- **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.** Example: FOR CHILDREN'S SAKE may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
- **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**
- **If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**
- **If disclosure is compelled by the patient or the patient's representative pursuant to Virginia Health and Safety Codes or to corresponding federal statutes of regulations**, such as the Privacy Rule that requires this Notice.
- **To avoid harm.** FOR CHILDREN'S SAKE may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.
- **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if FOR CHILDREN'S SAKE determines that disclosure is necessary to prevent the threatened danger.**
- **If disclosure is mandated by the Virginia Child Abuse and Neglect Reporting law.** For example, if FOR CHILDREN'S SAKE has a reasonable suspicion of child abuse or neglect.
- **If disclosure is mandated by the Virginia Elder/Dependent Adult Abuse Reporting law.** For example, if FOR CHILDREN'S SAKE has a reasonable suspicion of elder abuse or dependent adult abuse.
- **If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.**
- **For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, FOR CHILDREN'S SAKE may need to give the county coroner information about you.
- **For health oversight activities.** Example: FOR CHILDREN'S SAKE may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
- **For specific government functions.** Examples: FOR CHILDREN'S SAKE may disclose PHI of military personnel and veterans under certain circumstances. Also, FOR CHILDREN'S SAKE may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
- **For Workers' Compensation purposes.** FOR CHILDREN'S SAKE may provide PHI in order to comply with Workers' Compensation laws.
- **Appointment reminders and health related benefits or services.** Examples: FOR CHILDREN'S SAKE may use PHI to provide appointment reminders. FOR CHILDREN'S SAKE may use PHI to give you information about alternative treatment options, or other health care services or benefits FOR CHILDREN'S SAKE offers**.**
- **If an arbitrator or arbitration panel compels disclosure,** when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.

- **FOR CHILDREN'S SAKE is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other heath-related benefits and services that may be of interest to you.**
- **If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.** Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
- **If disclosure is otherwise specifically required by law.**

III. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

- **Disclosures to family, friends, or others.** After giving you a prior opportunity to orally authorize (or refuse authorization), FOR CHILDREN'S SAKE may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.
- **D. Other Uses and Disclosures Require Your Prior Written Authorization.** In any other situation not described in Sections IIIA, IIIB, and IIIC above, FOR CHILDREN'S SAKE will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that FOR CHILDREN'S SAKE hasn't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

- **The Right to See and Get Copies of Your PHI.** In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If FOR CHILDREN'S SAKE does not have your PHI, but FOR CHILDREN'S SAKE knows who does, FOR CHILDREN'S SAKE will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, FOR CHILDREN'S SAKE may be compelled to deny your request, but if so, FOR CHILDREN'S SAKE will give you, in writing, the reasons for the denial. FOR CHILDREN'S SAKE will also explain your right to have my denial reviewed.If you ask for copies of your PHI, FOR CHILDREN'S SAKE will charge you not more than $.25 per page. FOR CHILDREN'S SAKE may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.
- **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that FOR CHILDREN'S SAKE limits the use and disclosure of your PHI. While FOR CHILDREN'S SAKE will consider your request, FOR CHILDREN'S SAKE is not legally bound to agree. If FOR CHILDREN'S SAKE does agree to your request, FOR CHILDREN'S SAKE will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that FOR CHILDREN'S SAKE is legally required or permitted to make.
- **The Right to Choose How FOR CHILDREN'S SAKE Sends Your PHI to You.** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). FOR CHILDREN'S SAKE is obliged to agree to your request providing that FOR CHILDREN'S SAKE can give you the PHI, in the format you requested, without undue inconvenience.
- **The Right to Get a List of the Disclosures FOR CHILDREN'S SAKE Has Made.** You are entitled to a list of disclosures of your PHI that FOR CHILDREN'S SAKE has made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years. FOR CHILDREN'S SAKE will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list FOR CHILDREN'S

SAKE gives you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. FOR CHILDREN'S SAKE will provide the list to you at no cost, unless you make more than one request in the same year, in which case FOR CHILDREN'S SAKE will charge you a reasonable sum based on a set fee for each additional request.

- **The Right to Amend Your PHI.** If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that FOR CHILDREN'S SAKE corrects the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. FOR CHILDREN'S SAKE may deny your request, in writing, if it is found that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If FOR CHILDREN'S SAKE approves your request, FOR CHILDREN'S SAKE will make the change(s) to your PHI. Additionally, FOR CHILDREN'S SAKE will tell you that the changes have been made, and FOR CHILDREN'S SAKE will advise all others who need to know about the change(s) to your PHI.
- **The Right to Get This Notice by Email** You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, FOR CHILDREN'S SAKE may have violated your privacy rights, or if you object to a decision FOR CHILDREN'S SAKE made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Office of Civil Rights, Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, FOR CHILDREN'S SAKE will take no retaliatory action against you**.**

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about For Children's Sakes privacy practices, or would like to know how to file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services: Human Rights Attorney General of Virginia - Office of Attorney General of Virginia: 202 N 9th St. Richmond VA, 23219 or can call 804-225-2292. The local representative is Ann Pascoe: ann.pascoe@dbhds.virginia.gov or call 804-297-1503 within 180 days of the suspected violation by me of your privacy rights or later, if you demonstrate good cause please contact me at 14900 Bogle Drive Suite 200, Chantilly, VA 20151 (703) 817-9890.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

I acknowledge receipt of this notice:

*Guardian's Name:*_____ *Date:* _____ *Signature:* _____

FCS Staff: _____ *Date:* _____ *Signature:* _____

BIOPSYCHOSOCIAL HISTORY

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Patient name _____ Patient SS# _____ Date _____

PRESENTING PROBLEMS

Presenting problems	**Duration** (months)	**Additional information**:

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

None = this symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning • **Severe** = Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
depressed mood	[ ]	[ ]	[ ]	[ ]	bingeing/purging	[ ]	[ ]	[ ]	[ ]	guilt	[ ]	[ ]	[ ]	[ ]
appetite disturbance	[ ]	[ ]	[ ]	[ ]	laxative/diuretic abuse	[ ]	[ ]	[ ]	[ ]	elevated mood	[ ]	[ ]	[ ]	[ ]
sleep disturbance	[ ]	[ ]	[ ]	[ ]	anorexia	[ ]	[ ]	[ ]	[ ]	hyperactivity	[ ]	[ ]	[ ]	[ ]
elimination disturbance	[ ]	[ ]	[ ]	[ ]	paranoid ideation	[ ]	[ ]	[ ]	[ ]	dissociative states	[ ]	[ ]	[ ]	[ ]
fatigue/low energy	[ ]	[ ]	[ ]	[ ]	circumstantial symptoms	[ ]	[ ]	[ ]	[ ]	somatic complaints	[ ]	[ ]	[ ]	[ ]
psychomotor retardation	[ ]	[ ]	[ ]	[ ]	loose associations	[ ]	[ ]	[ ]	[ ]	self-mutilation	[ ]	[ ]	[ ]	[ ]
poor concentration	[ ]	[ ]	[ ]	[ ]	delusions	[ ]	[ ]	[ ]	[ ]	significant weight gain/loss	[ ]	[ ]	[ ]	[ ]
poor grooming	[ ]	[ ]	[ ]	[ ]	hallucinations	[ ]	[ ]	[ ]	[ ]	concomitant medical condition	[ ]	[ ]	[ ]	[ ]
mood swings	[ ]	[ ]	[ ]	[ ]	aggressive behaviors	[ ]	[ ]	[ ]	[ ]	emotional trauma victim	[ ]	[ ]	[ ]	[ ]
agitation	[ ]	[ ]	[ ]	[ ]	conduct problems	[ ]	[ ]	[ ]	[ ]	physical trauma victim	[ ]	[ ]	[ ]	[ ]
emotionality	[ ]	[ ]	[ ]	[ ]	oppositional behavior	[ ]	[ ]	[ ]	[ ]	sexual trauma victim	[ ]	[ ]	[ ]	[ ]
irritability	[ ]	[ ]	[ ]	[ ]	sexual dysfunction	[ ]	[ ]	[ ]	[ ]	emotional trauma perpetrator	[ ]	[ ]	[ ]	[ ]
generalized anxiety	[ ]	[ ]	[ ]	[ ]	grief	[ ]	[ ]	[ ]	[ ]	physical trauma perpetrator	[ ]	[ ]	[ ]	[ ]
panic attacks	[ ]	[ ]	[ ]	[ ]	hopelessness	[ ]	[ ]	[ ]	[ ]	sexual trauma perpetrator	[ ]	[ ]	[ ]	[ ]
phobias	[ ]	[ ]	[ ]	[ ]	social isolation	[ ]	[ ]	[ ]	[ ]	substance abuse	[ ]	[ ]	[ ]	[ ]
obsessions/compulsions	[ ]	[ ]	[ ]	[ ]	worthlessness	[ ]	[ ]	[ ]	[ ]	other (specify) _____	[ ]	[ ]	[ ]	[ ]

How have these symptoms impacted your psychological and social adjustment daily?

_____

_____

EMOTIONAL/PSYCHIATRIC HISTORY

☐ **Yes** ☐ **No** **Prior outpatient psychotherapy?**

If yes, on occasions. Longest treatment by _____ for ____ sessions from ____/_____ to _____/_____
Provider Name Month/Year Month/Year

Prior provider name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?

☐ **Yes** ☐ **No** **Has any family member had outpatient psychotherapy?** If yes, who/why (list all):_____

_____

☐ **Yes** ☐ **No** **Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?**

If yes, on _____occasions. Longest treatment at _____ from ___/_____ to _____/_____
Name of facility Month/Year Month/Year

Inpatient facility name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?

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☐ Yes☐ No **Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder?** If yes, who/why (list all):

_____

☐ Yes ☐ **No Prior or current psychotropic medication usage?** If yes:

Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial?

☐ Yes ☐ No **Has any family member used psychotropic medications?** If yes, who/what/why (list all):_____

_____

FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]

_____

Parents' current marital status:

[ ] married to each other
[ ] separated for ___ years
[ ] divorced for ___ years
[ ] mother remarried ___ times
[ ] father remarried ___ times
[ ] mother involved with someone
[ ] father involved with someone
[ ] mother deceased for ___ years
age of patient at mother's death ___
[ ] father deceased for ___ years
age of patient at father's death ___

Describe parents:

	Father	**Mother**
full name	_____	_____
occupation	_____	_____
education	_____	_____
general health	_____	_____

Describe childhood family experience:

[ ] outstanding home environment
[ ] normal home environment
[ ] chaotic home environment
[ ] witnessed physical/verbal/sexual abuse toward others
[ ] experienced physical/verbal/sexual abuse from others

Age of emancipation from home: _____ **Circumstances:** _____

_____

_____

Special circumstances in childhood:_____

_____

_____

IMMEDIATE FAMILY

Marital status:

[ ] single, never married
[ ] engaged ____ months
[ ] married for ____ years
[ ] divorced for ___ years
[ ] separated for ___ years
[ ] divorce in process ____ months
[ ] live-in for ____ years
[ ] ___ prior marriages (self)
[ ] ___ prior marriages (partner)

Intimate relationship:

[ ] never been in a serious relationship
[ ] not currently in relationship
[ ] currently in a serious relationship

Relationship satisfaction:

[ ] very satisfied with relationship
[ ] satisfied with relationship
[ ] somewhat satisfied with relationship
[ ] dissatisfied with relationship
[ ] very dissatisfied with relationship

List all persons currently living in patient's household:

Name	Age	Sex	Relationship to patient

List children <u>not</u> living in same household as patient:

Frequency of visitation of above: _____

Describe any past or current significant issues in <u>intimate</u> relationships: _____

_____

_____

_____

Describe any past or current significant issues in other <u>immediate family</u> relationships: _____

_____

_____

_____

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MEDICAL HISTORY (check all that apply for patient)

Describe current physical health: [ ] Good [ ] Fair [ ] Poor

_____

List name of primary care physician:
Name _____ Phone _____

List name of psychiatrist: (if any):
Name _____ Phone _____

List any medications currently being taken (give dosage & reason):

_____

_____

_____

List any known allergies: _____

List any abnormal lab test results:
Date _____ Result _____
Date _____ Result _____

Is there a history of any of the following in the family:

[ ] tuberculosis [ ] heart disease
[ ] birth defects [ ] high blood pressure
[ ] emotional problems [ ] alcoholism
[ ] behavior problems [ ] drug abuse
[ ] thyroid problems [ ] diabetes
[ ] cancer [ ] Alzheimer's disease/dementia
[ ] mental retardation [ ] stroke
[ ] other chronic or serious health problems _____

_____

Describe any serious hospitalization or accidents:
Date _____ Age _____ Reason _____
Date _____ Age _____ Reason _____
Date: _____ Age _____ Reason _____

List any complementary health approaches that you are currently using: (For example: chiropractic, yoga, homeopathy, reiki or herbs/vitamins)_____

_____

SUBSTANCE USE HISTORY (check all that apply for patient)

Family alcohol/drug abuse history:

[ ] father [ ] stepparent/live-in
[ ] mother [ ] uncle(s)/aunt(s)
[ ] grandparent(s) [ ] spouse/significant other
[ ] sibling(s) [ ] children
[ ] other _____

Substance use status:

[ ] no history of abuse
[ ] active abuse
[ ] early full remission
[ ] early partial remission
[ ] sustained full remission
[ ] sustained partial remission

Substances used:

(complete all that apply)	First use age	Last use age	Current Use (Yes/No)	Frequency	Amount
[ ] alcohol					
[ ] amphetamines/speed					
[ ] barbiturates/owners					
[ ] caffeine					
[ ] cocaine					
[ ] crack cocaine					
[ ] hallucinogens (e.g., LSD)					
[ ] inhalants (e.g., glue, gas)					
[ ] marijuana or hashish					
[ ] nicotine/cigarettes					
[ ] PCP					
[ ] prescription_____					
[ ] other_____					

Treatment history:

[ ] outpatient (age[s]_____)
[ ] inpatient (age[s]_____)
[ ] 12-step program (age[s]_____)
[ ] stopped on own (age[s]_____)
[ ] other (age[s]_____
describe:_____

Consequences of substance abuse (check all that apply):

[ ] hangovers [ ] withdrawal symptoms [ ] sleep disturbance [ ] binges
[ ] seizures [ ] medical conditions [ ] assaults [ ] job loss
[ ] blackouts [ ] tolerance changes [ ] suicidal impulse [ ] arrests
[ ] overdose [ ] loss of control amount used [ ] relationship conflicts
[ ] other _____

DEVELOPMENTAL HISTORY (check all that apply for a child/adolescent patient)

Problems during mother's pregnancy:

Birth:
[ ] normal delivery

Childhood health:
[ ] chickenpox (age _____) [ ] lead poising (age _____)

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[ ] none
[ ] high blood pressure
[ ] kidney infection
[ ] German measles
[ ] emotional stress
[ ] bleeding
[ ] alcohol use
[ ] drug use
[ ] cigarette use
[ ] other

[ ] difficult delivery
[ ] cesarean delivery
[ ] complications _____
_____
birth weight ____lbs ___oz.

Infancy:
[ ] feeding problems
[ ] sleep problems
[ ] toilet training problems

[ ] German measles (age _____)
[ ] red measles (age _____)
[ ] rheumatic fever (age _____)
[ ] whooping cough (age _____)
[ ] scarlet fever (age _____)
[ ] autism
[ ] ear infections
[ ] allergies to _____
[ ] significant injuries _____
[ ] chronic, serious health problems _____
_____

[ ] mumps (age _____)
[ ] diphtheria (age _____)
[ ] poliomyelitis (age _____)
[ ] pneumonia (age _____)
[ ] tuberculosis (age _____)
[ ] mental retardation
[ ] asthma

Delayed developmental milestones (check only those milestones that did not occur at expected age):

[ ] sitting
[ ] rolling over
[ ] standing
[ ] walking
[ ] feeding self
[ ] speaking words
[ ] speaking sentences
[ ] controlling bladder
[ ] other _____

[ ] controlling bowels
[ ] sleeping alone
[ ] dressing self
[ ] engaging peers
[ ] tolerating separation
[ ] playing cooperatively
[ ] riding tricycle
[ ] riding bicycle

Emotional / behavior problems (check all that apply):

[ ] drug use
[ ] alcohol abuse
[ ] chronic lying
[ ] stealing
[ ] violent temper
[ ] fire-setting
[ ] hyperactive
[ ] animal cruelty
[ ] assaults others
[ ] disobedient

[ ] repeats words of others
[ ] not trustworthy
[ ] hostile/angry mood
[ ] indecisive
[ ] immature
[ ] bizarre behavior
[ ] self-injurious threats
[ ] frequently tearful
[ ] frequently daydreams
[ ] lack of attachment

[ ] distrustful
[ ] extreme worrier
[ ] self-injurious acts
[ ] impulsive
[ ] easily distracted
[ ] poor concentration
[ ] often sad
[ ] breaks things
[ ] other _____
_____

Social interaction (check all that apply):

[ ] normal social interaction
[ ] isolates self
[ ] very shy
[ ] alienates self
[ ] inappropriate sex play
[ ] dominates others
[ ] associates with acting-out peers
[ ] other _____

Intellectual / academic functioning (check all that apply):

[ ] normal intelligence
[ ] high intelligence
[ ] learning problems
[ ] authority conflicts
[ ] attention problems
[ ] underachieving
[ ] mild retardation
[ ] moderate retardation
[ ] severe retardation

Current or highest education level _____

Please list anyone who you feel could be a social support to you during this therapeutic process:

_____

Describe any other developmental problems or issues: _____

_____

Have you had any concerns with your:

Speech functioning: _____Yes _____No **Hearing functioning _____Yes _____No** **Visual functioning: ____Yes _____No**

Learning ability: ____Yes ____No

If yes, please explain: _____

Do you need assistive technology for your services? ____ Yes _____ No **If yes, please explain**_____

SOCIO-ECONOMIC HISTORY (check all that apply for patient)

Living situation:
[ ] housing adequate
[ ] homeless
[ ] housing overcrowded
[ ] dependent on others for housing
[ ] housing dangerous/deteriorating

Social support system:
[ ] supportive network
[ ] few friends
[ ] substance-use-based friends
[ ] no friends
[ ] distant from family of origin

Sexual history:
[ ] heterosexual orientation
[ ] homosexual orientation
[ ] bisexual orientation
[ ] currently sexually active
[ ] currently sexually satisfied
[ ] currently sexually dissatisfied
[ ] age first sex experience _____
[ ] age first pregnancy/fatherhood ___
[ ] history of promiscuity age ___ to ___
[ ] history of unsafe sex age __ to ____

BIOPSYCHOSOCIAL HISTORY

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[ ] living companions dysfunctional

Employment:
[ ] employed and satisfied
[ ] employed but dissatisfied
[ ] unemployed
[ ] coworker conflicts
[ ] supervisor conflicts
[ ] unstable work history
[ ] disabled: _____

Financial situation:
[ ] no current financial problems
[ ] large indebtedness
[ ] poverty or below-poverty income
[ ] impulsive spending
[ ] relationship conflicts over finances

Military history:
[ ] never in military
[ ] served in military - no incident
[ ] served in military - **with** incident
_____

Legal history:
[ ] no legal problems
[ ] now on parole/probation
[ ] arrest(s) not substance-related
[ ] arrest(s) substance-related
[ ] court ordered this treatment
[ ] jail/prison _____ time(s)
total time served: _____
describe last legal difficulty: _____
_____

Additional information: _____

Cultural/spiritual/recreational history:
cultural identity (e.g., ethnicity, religion): _____
_____
describe any cultural issues that contribute to current problem: _____
_____
currently active in community/recreational activities? Yes [ ] No [ ]
formerly active in community/recreational activities? Yes [ ] No [ ]
currently engage in hobbies? Yes [ ] No [ ]
currently participate in spiritual activities? Yes [ ] No [ ]
if answered "yes" to any of above, describe: _____
_____
_____

SOURCES OF DATA PROVIDED ABOVE: [ ] Patient self-report for all [ ] A variety of sources (if so, check appropriate sources below):

Presenting Problems/Symptoms
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Family History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Developmental History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Emotional/Psychiatric History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Medical/Substance Use History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Socioeconomic History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____