Mount Vernon Counseling Center

Name:_____
Last First Middle

Address:_____
Street

_____
City State Zip

Home Phone: (_____)_____Work Phone: (_____) _____

Cell Phone: (_____)_____Email: _____

Date of Birth:_____/_____/_____Sex: ❑ Male ❑ Female

Married: _____ Single: _____ Other: _____

Occupation:_____Employer: _____

Referred By: _____
Last First Profession

Other Source: _____

Person to Call in Emergency:

_____
Relationship to Patient Name Telephone

Is pre-certification required for coverage under your insurance plan? ❑ Yes ❑ No

Please note that we are out of network providers with all insurance plans. Our Administrative Staff can assist you with insurance submission. However, our office is not responsible for any steps of claim submission or reimbursement. If you want to be assured of the process, we suggest you submit the claims directly yourself.

Office Use Only
Recall

ICD codes _____ Initial Evaluation By: _____

Welcome to Mount Vernon Counseling Center

We are committed to providing you with top quality, up-to-date care and treatment. Our professional staff members are all licensed, highly trained, and have years of experience treating different conditions. Please read this document carefully and note any questions you might have so that we can discuss them in person. When you sign this document, it will represent an agreement between us but you may revoke this agreement in writing at any time. Please understand that our professionals spend from one to two sessions evaluating whether we are a good clinical match. Should we determine that this is not the case, we will provide you with some names of qualified practitioners.

Scheduling An Appointment: Most staff work both day and evening hours. They will make every effort to schedule a mutually convenient time. Generally, your therapist/doctor will schedule your next appointment with you at the end of each session.

Cancellation Policy: If you are unable to keep your appointment, we require at least **48 hours** notice; otherwise you will be billed in the **full amount of the session** for the cancelled or missed appointment. A late cancellation or no-show means that we were unable to serve another person.

Billing out of network: We are an out-of-network provider. If you have out-of-network benefits that you would like to use, we do monthly claim submissions for most insurance companies. If we are unable to submit for you, an itemized statement will be provided that you can submit to your insurance for reimbursement. Due to the different types of insurance policies, we cannot guarantee the claims submissions will be accepted. You can submit on your own to ensure that claim submissions have been done thoroughly.

Arrival: Please arrive promptly and expect your therapist/doctor to meet you in the waiting room. Our therapists/doctors use a signaling device so you can let them know you have arrived. Our administrative assistant will show you how to use this device at the beginning of your first session. If you arrive late, please check with the Administrative Office.

Administrative Office: Our Administrative Office hours are Monday through Friday from 9 AM to 5 PM. The administrative staff is available to answer general questions, relay messages to your therapist/doctor and assist with any billing/insurance concerns or questions.

Emails to administrative staff or therapist/doctors are returned within one business day. Please note this method of communication is not secure.

Confidentiality: Confidentiality is extremely important to us; and the privacy of all communications between a client and a therapist is protected by law. We can only release information about our work with your written permission.

Laws and standards of the profession necessitate that we keep clinical records of each client in a safe and secure manner. You are entitled to examine and/or receive a copy of your records if you request in writing. Considering the technical nature of these records however, they can be misinterpreted by individuals who are not mental health professionals. Thus, if you want to see your records, we recommend that we review them together so the contents are understood accurately.

If the release of confidential information becomes necessary, all reasonable steps will be taken to discuss it with you first. We will make every effort to disclose as little information as possible.

If the opinion of another clinician, for instance a primary physician or a psychiatrist, becomes necessary for your treatment, we will discuss the case with you and ask for your written permission before initiating contact.

Exceptions to Confidentiality:

1. There are indications that the client might seriously harm him/herself or someone else.
2. There is a possibility of neglect or abuse of a child, an elderly, or a disabled person.
3. If a court issues a formal order to view the information; or if a client files a complaint against us, in which case we may need to disclose relevant information in the hearing.

Confidentiality for Minors:

All policies in this document apply to minors in addition to the following:

For clients younger than 18, parental consent for treatment is required by law.

Between the ages of 14 to 18, parents have the right to review the treatment record but the consent of the minor is also necessary. In such cases, we will provide the parents only with general information about the progress of treatment and attendance to project the client's confidentiality.

Confidentiality for couples:

All policies in this document apply to couples in addition to the following:

Couples therapy is best conducted when both individuals in the relationship are present. If you must come alone to avoid a no-show fee, you may do so on a rare occasion. Frequent sessions attended by one person alone may result in termination of couples therapy.

If you are in the middle of a conflict prior to your session, that is not the time to cancel or send your partner to the appointment alone. Those times, in fact, can be the best for your therapist to observe your communication styles and intervene.

When a relationship is the focus of therapy, the couple is the "client", so the therapy concentrates on the relationship. However, if remaining together is significantly harmful to one or both partners, a change in focus will be discussed with both partners and there may be an agreed-upon shift to facilitating an amicable separation.

Please do not bring children with you either to be left in the waiting room unattended, or brought into the therapy room.

The information discussed in couples therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving the partners. "We agree not to subpoena providers at Mount Vernon Counseling Center to testify for or against either party or to provide records in a court action".

Confidentiality with electronic communications: Please note email is not a secure way of communication. Please limit the use of emails to scheduling or minor practical questions. Your use of email means that you understand the limits of confidentiality regarding email use.

Our professional pages are open to the public for work purposes. We do not accept personal friendship requests from clients or their family members on social media sites.

Prescription Refills: Call the Administrative Office to request a prescription refill during our business hours. If you are picking up the written prescription at the office, **please call 3 days in advance**.

Payment: Payment is expected at the day of your appointment. We accept personal checks, cash, Visa, MasterCard, and American Express. Your therapist/doctor will give you a billing statement after your session and you may either pay them directly or come to the administrative office.

In Case of Emergency: Before 8:00 AM, and after 5 PM and on weekends you may call and leave a message on your therapist's/doctor's voice mail. Your therapist/doctor will return your call as soon as possible. You also have an option of reaching to your provider directly through our phone system for very urgent matters. In crisis situations, call 911 or go to the nearest emergency room.

Informed Consent

I have read the above and fully understand the nature of the treatment and limits of confidentiality in the counseling/psychotherapy relationship.

I reviewed the HIPAA Notice Form and have been informed of Mount Vernon Counseling Center's practice policies. I have received Mount Vernon Counseling Center's Notice of Policy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

I understand that the information discussed in therapy is for therapeutic purposes and are not intended for use in any legal proceedings involving the client.

A copy of this document has been given to me for my records upon my request. My signature below indicates that I fully understood and agreed with Mount Vernon Counseling Center's policies and Notice of Policy Practices.

Name:_____ Signature:_____

Date:_____ Date of Birth: _____

Name:_____ Signature:_____

Date:_____

Notice of Privacy Practices

Patient Acknowledgement

Patient Name: _____

Date of Birth: _____

I have received this practice's Notice of Policy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request. I have reviewed the rights and responsibilities for services at Mount Vernon Counseling Center. This includes fees, no-show and late cancellations, and my rights as a client.

Signature:_____ Date: _____

Relationship to patient (if signed by a personal representative of patient):

_____

Mount Vernon Counseling Center
625 Slaters Lane, Suite 103
Alexandria, VA 22314

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(571) 800-9909

Mount Vernon Counseling Center now offers the **option** of paying by means of Visa, Mastercard, or Amex. Please fill in the areas below and return to our office. If there are any updates to this information, please call our administrative office at (571) 800-9909.

Thank you!

Patient Name:_____

Credit card number:_____

Expiration Date:_____CVV Code:_____

Please Circle: Visa Mastercard Amex

Name on card (please Print)

_____

Address:_____

Signature:_____

Standing Payment Agreement

I authorize Mount Vernon Counseling Center to charge my credit card, as indicated above, payment in the amount of $_____on the date of each session, starting on _____(date) with_____ (provider). This agreement shall remain in effect until otherwise cancelled by me in writing.

Please note, in the event of a cancellation less than 48 hours or a missed appointment, your credit card will be automatically charged the full session fee.