Thriving Families Counseling, LLC

1719 Grandin Rd.
Roanoke, VA 24015
(540) 988-3108

NEW CLIENT INFORMATION (Adult)

Date Completed: _____

Client Last Name:	First Name:	Middle Initial:
Date of Birth:	Gender:	
Address:		
City:	State:	Zip:
☐ Single ☐ Married (How long? _____) ☐ Divorced ☐ Widowed ☐ Separated		
Employer: Occupation:		

Contact Permission It may be necessary for our office to contact you with regard to counseling or billing matters. In giving permission for us to contact you, you are agreeing for us to leave a message or information.

		May we call this number?	**Message OK?**
Home Phone:		☐ Yes ☐ No	☐ Yes ☐ No
Work Phone:		☐ Yes ☐ No	☐ Yes ☐ No
Cell Phone*:		☐ Yes ☐ No	☐ Yes ☐ No

May we contact you by email? ☐ Yes ☐ No Email address_____
If you agree to communication via email by checking Yes above, you understand that email is not considered a secure means of communication and email can be compromised.
* Please note texting is used for scheduling purposes only. Please do not communicate through text except for scheduling.

Name of Emergency Contact Person:	
Relationship to you:	
Work Phone:	Home Phone:
Cell Phone:	Email:

NEW CLIENT INTAKE QUESTIONAIRE

A. <u>Reason For Seeking Counseling</u>

What is your Reason for Seeking Counseling at this time?

_____
_____
_____

Have you previously suffered from this complaint? ☐ Yes ☐ No
If yes, enter previous therapist(s) seen for complaint, describe treatment.

_____
_____
_____

B. <u>Current Symptoms</u>

Please indicate the severity by circling a number for each item on a scale of 0 (Not a problem) to 4 (A Severe Problem).

Anxiety Issues	
Frequent worry	0 1 2 3 4
Panic Attacks	0 1 2 3 4
Social Discomfort	0 1 2 3 4
Fear Away from home	0 1 2 3 4
Phobias	0 1 2 3 4
Obsessive thoughts	0 1 2 3 4
Compulsive behavior	0 1 2 3 4
Flashbacks	0 1 2 3 4
Nightmares	0 1 2 3 4
Mood Issues	
Crying spells	0 1 2 3 4
Sadness/depression	0 1 2 3 4
Fatigue	0 1 2 3 4
Lake of motivation	0 1 2 3 4
Hopelessness	0 1 2 3 4
Guilt	0 1 2 3 4
Inability to enjoy things	0 1 2 3 4
Low self worth	0 1 2 3 4
Thoughts of death/suicide	0 1 2 3 4
Feelings of Helplessness	0 1 2 3 4
Wide mood swings	0 1 2 3 4
Withdrawal from people	0 1 2 3 4

Attention Issues	
Distractibility	0 1 2 3 4
Hyperactivity	0 1 2 3 4
Impulsivity	0 1 2 3 4
Easily confused	0 1 2 3 4
Poor memory	0 1 2 3 4
Racing thoughts	0 1 2 3 4
General Issues	
Alcohol/drug use	0 1 2 3 4
Computer addiction	0 1 2 3 4
Binging/Compulsive Eating	0 1 2 3 4
Restricting Food	0 1 2 3 4
Purging/Bulimia	0 1 2 3 4
Parenting problems	0 1 2 3 4
Relationship problems	0 1 2 3 4
Sexual problems	0 1 2 3 4
Social Isolation	0 1 2 3 4
Sleep problems	0 1 2 3 4
Pornography problems	0 1 2 3 4
Somatic Complaints	0 1 2 3 4

Anger Issues	
Physical Aggression	0 1 2 3 4
Irritability/anger	0 1 2 3 4
Homicidal thoughts	0 1 2 3 4
Peer conflict	0 1 2 3 4
Property destruction	0 1 2 3 4
Other Issues	
Hearing voices	0 1 2 3 4
Visual hallucinations	0 1 2 3 4
Risky activity	0 1 2 3 4
Excessive Energy	0 1 2 3 4
Problems at Work	0 1 2 3 4
Self-harm behaviors	0 1 2 3 4
Suspicion/paranoia	0 1 2 3 4

Have you ever had any thoughts about suicide?	□ Yes □ No	When?
Do you have any thoughts about suicide now?	□ Yes □ No	When?
Have you ever attempted to commit suicide?	□ Yes □ No	When?
Do you have access to any guns or weapons?	□ Yes □ No	When?
Have you ever had any thoughts of hurting or killing someone?	□ Yes □ No	When?
Do you have any thoughts of hurting or killing someone now?	□ Yes □ No	When?
Have you ever attempted to hurt or kill someone?	□ Yes □ No	When?
Have you ever been physically hurt/threatened by someone?	□ Yes □ No	When?

Please check if you have experienced any of the following types of trauma or loss:

☐	Emotional Abuse	☐	Neglect	☐	Physical Abuse
☐	Sexual Abuse	☐	Violence in the home	☐	Crime Victim
☐	Parent Substance Abuse	☐	Parent Illness (during childhood)	☐	Teen Pregnancy
☐	Placed a child for adoption	☐	Multiple Family Moves	☐	Lived in a Foster Home
☐	Homelessness	☐	Loss of a Child	☐	Childhood Surgery
☐	Car Accident	☐	Traumatic Injury/Fall	☐	Other_____

C. Previous Mental Health Treatment

Have you had previous counseling? No ☒ Yes ☐ when? _____

With whom? _____

For what issue(s)? _____

_____

_____

Have you ever been hospitalized for a psychiatric reason?	☐ No	☐ Yes
Have you ever had substance abuse treatment?	☐ No	☐ Yes
Do you participate in any support groups?	☐ No	☐ Yes

D. Medical Information

Major (or chronic) Illnesses/Operations/Injuries: _____

_____

Please list all **CURRENT** medications (including psychotropic medicine):

Medication	Strength	Frequency	Start date	Prescribed by:

Please list all **PAST** psychotropic medications:

Medication	Strength	Frequency	Start date	Prescribed by:

When was your last physical? _____

Have you ever experienced any of the following medical conditions?

☐	Head injury	☐	Frequent stomach upset	☐	Miscarriage
☐	Fainting spells	☐	Diabetes	☐	Abortion
☐	Seizures	☐	Sexually transmitted disease	☐	Asthma
☐	Chronic pain	☐	Migraines	☐	Other:
☐	Arthritis	☐	Heart attack	☐	Lupus
☐	High blood pressure	☐	Migraines	☐	PMS

Did you have any extreme sensitivity to noise, texture, or taste as a young child?

☐ No ☐ Yes, what? _____

Please list any CURRENT health concerns: _____

Have you experienced any recent changes in:

☐ Sleep ☐ Nightmares ☐ Amount of Exercise ☐ Sexual Desire

☐ Eating/Appetite ☐ Weight ☐ Alcohol Intake ☐ Stamina ☐ Energy

How would you characterize your overall health? ☐ *Excellent* ☐ *Good* ☐ *Fair* ☐ *Poor*

E. Alcohol and/or Drug Use

Have you ever felt the need to cut down on your drinking?	□ Yes □ No
Have you ever felt annoyed by criticism of your drinking?	□ Yes □ No
Have you ever felt guilty about your drinking?	□ Yes □ No
Have you ever taken a morning "eye-opener"?	□ Yes □ No
How much beer, wine, or hard liquor do you consume each week, on the average?	□ Yes □ No
How much tobacco do you smoke or chew each week?	□ Yes □ No

Please list any drugs (not medications prescribed for you) have you used in the last 10 years:

Substance	When	Frequency

F. Family Information

☐ Parents legally married or living together ☐ Mother remarried: Number of times _____

☐ Parents temporarily separated ☐ Father remarried: Number of times _____

☐ Parents divorced or permanently separated ☐ Parent deceased: Which one? _____

Parents' ages: Mother _____ Father _____ Stepmother _____ Stepfather _____

Your place in birth order (oldest, youngest, etc): _____

Brothers and their ages:_____ Sisters and their ages: _____

Were you adopted? Yes ☐ No ☐

How is your relationship with your Mother? _____

_____

How is your relationship with your Father? _____

_____

Marital Status: Single ☐ Married (___ years) ☐ Living as married (___ years) ☐

Separated (___ years) ☐ Divorced (___ years) ☐ Widowed (___ years) ☐

Partner name and age (if applicable): _____

How is your relationship with your Partner? _____

_____

Children and their ages: _____

How is your relationship with your Children? _____

_____

Are there any custody issues with any of your Children? Yes ☐ No ☐ If yes, please explain:

_____

_____

Have any of your family members experienced any of the following:

Issue	Who?
Attention/Hyperactivity Problems	_____
Anxiety	_____
Panic Attacks	_____
Obsessive/Compulsive Behavior	_____
Depression	_____
Manic Depression (Bipolar)	_____
Schizophrenia	_____
Anger Management Problems	_____
Abusive Behavior	_____
Suicide Attempts	_____
Eating Disorder	_____
Sexual Abuse Survivor	_____
Emotional Abuse	_____
Drug/Alcohol Abuse	_____
Alcohol Abuse	_____

Were there any problems with your birth (i.e., fetal distress, emergency c-section, etc)?

☐ No ☐ Yes, what? _____

G. Social

Are you involved in any type of spiritual practice? ☐ No ☐ Yes, which? _____

Do you have a local support network (friends, family, church, etc)? ☐ No ☐ Yes

Race (optional) _____ Sexual Orientation (optional) _____

Hobbies_____

*****If there is any other information that you would like to provide, please feel free to attach it.*****

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Informed Consent for Treatment

General Information
Welcome to Thriving Families Counseling, LLC (TFC). Thank you for the opportunity to serve you. As a client seeking to engage in counseling with an TFC therapist, you have rights and responsibilities relating to your therapy treatment, which are summarized on this Informed Consent for Treatment ("Form"). Furthermore, the federal Health Insurance Privacy and Portability Act (HIPPA) entitles you to certain protections of confidentiality, which are explained in the Notice of Privacy Practices (attached). Also attached is our financial policy regarding payment for services. If you have any questions, please let us know.

About Thriving Families Counseling, LLC.
Thriving Families Counseling, LLC (TFC) is a private practice mental health counseling center serving clients in and around the Roanoke Valley area. The practice consists of licensed clinical social workers, licensed professional counselors, resident counselors, and supervisees in social work that are either employees or independent contractors of TFC. The Owner of TFC is Susan Owen, LCSW

Hours of Operation
Our hours of operation are from Monday to Friday, 8:00 a.m. to 5:00 p.m., although many of our therapists see clients in our office outside of these hours. We will answer our main telephone during office hours if possible. If we miss your telephone call, we will return your call within 24 hours. If you leave a message on your therapist's voicemail, they will make every effort to return your call the same day. Please note that therapists do not answer telephone calls while their appointments are in session.

Philosophy
We accept into our practice only clients whom we believe have the capacity to resolve their problems with the professional assistance of one of our counselors. The foundation of the healing process is the therapeutic relationship, which is based on trust, respect, honesty, confidentiality and effort. As people learn more about their personal strengths and weaknesses, they usually become more aware and accepting of themselves and others and feel more empowered to accomplish their goals.

As the client, you are responsible for setting the goals you want to accomplish and can terminate the counseling process at any time. Our responsibility is to help you accomplish these goals in the shortest time possible. We will discuss diagnoses and estimated length of treatment during the first or second session. If counseling is successful, you should feel better about yourself and be able to face life's challenges independently and effectively using the learned techniques and interventions. As with any program of counseling, results cannot be guaranteed.

We ask that you be as honest and as open as possible in discussing your concerns. If you are unclear about anything regarding your therapy, please ask questions. Psychotherapy can be very helpful for some individuals but it is not without some risks. These risks may include the experience of intense and unwanted feelings, such as sadness, anger, fear, guilt or anxiety. It is important to remember that these feelings may be natural and normal and are an important part of the therapy process. Other risks might include: recalling unpleasant life events, facing unpleasant thoughts and beliefs or possible alteration of an individual's relationships.

Our therapists will make every effort to minimize potential risks and hazards, which are not helpful to the therapeutic process. Often in therapy, major life decisions are made, including: decisions involving families or friends, changes in

relationships, or changes in your jobs or careers. These decisions are a legitimate outcome of therapy as a result of an individual's calling into question some of their beliefs and values, recognizing their strengths, increasing their self-acceptance, alleviating symptoms and problems or learning more helpful coping skills.

FEE AGREEMENT AND FINANCIAL POLICY

Please review this Fee Agreement and Financial Policy, which describes our schedule of fees for services, charges not covered by insurance, and additional fees. Please be sure you understand the policies regarding cancelations and missed appointments, methods of payment, insurance reimbursement, and past due accounts.

If you have any questions about anything, please ask your provider prior to signing this Agreement and Policy.

Our service rates and corresponding health insurance billing codes (numbers starting with '90' refer to mental health services) this is not a comprehensive list and reflects the most common services provided by our staff. Additional codes may be used by your provider as deemed appropriate.

In addition to individual therapy appointments, there are fees for other professional services you may need. Other services include report writing, telephone conversations lasting longer than 9 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing other services you may request.

- 90791 Initial Consultation – Individual (50-60 min.) $150.00
- 90837 Individual Therapy (53-60 min.) $130.00
- 90834 Brief Individual Therapy (38-45 min.) $100.00
- 90832 Brief Individual Therapy (25-30 min.) $80.00
- 90847 Couples Therapy (53-60 min.) $130.00
- Medical Records Requests $15.00 minimum request (see below)
- Case Management* $130.00 (pro-rated per 15 min.)

*Case Management includes indirect services we provide outside session times such as writing letters, consultations made at your request (for which a written authorization for disclosure of confidential information is required), and completing forms or reports.

- Phone Consultations (10-60 min.) $130.00 (pro-rated per 15 min.) ADDITIONAL FEES
- Late cancelations/Missed Appointment – fewer than 24 hrs. prior to appointment $65.00
- Non-sufficient funds (bounced) check $25.00
- Past-due accounts – over 30 days $25.00 per month
- Checks returned due to insufficient funds will incur a fee of $45.00 PAYMENT

Court Appearances & Legal Matters: If you become involved in legal proceedings that may require the participation of your therapist at TFC, please let your therapist know as soon as possible. Because of the difficult and time-consuming nature of legal involvement, TFC charges $175 per hour for preparation and attendance at any legal proceeding, with a minimum fee of 5 hours ($875) per legal proceeding. Please be aware that you will be expected to pay for all professional time involved in legal proceedings, including preparation and transportation costs, even if called to testify by another party. A 48 hour advanced notice is required for any cancelation or postponement of a legal proceeding. You will be responsible for all fees incurred if less than 48 hours' notice is provided. Insurance will not reimburse for these fees.

Requests for Letters: Therapists are sometimes asked to write letters on behalf of their patients. For letters pertaining to legal matters, TFC charges a base fee of $100, with the final amount varying based on the length and complexity of the letter. The charges for all other letters will be determined on a case-by-case basis, depending on the scope of the letter. Please be aware that insurance will not cover these charges, and TFC must receive payment before the letter can be delivered.

Requests for Forms: TFC charges $130 per hour to fill out forms at the request of a patient. If the form is long or complex, the therapist may request that you schedule an appointment and complete the form as part of your session. Please be aware that insurance will not cover these charges, and TFC must receive payment before the form can be delivered.

Record Requests: If you request a copy of your clinical record, you are responsible for the following cost-based fees associated with processing that request:

a. Handling and processing fee: $10 per request
b. Photocopy (pages 1-25): 50 cents per page
c. Photocopying (pages over 25): 25 cents per page

I agree to these charges (Signature) :_____

You will be expected to pay for either each session in full, or your insurance co-payment at the time of services. Accepted methods of payment are cash, check, or credit cards. Checks should be made payable to Thriving Families Counseling.

INSURANCE REIMBURSEMENT

Thriving Families Counseling, LLC accepts and processes insurance payments through a variety of insurance providers and Employee assistance plans. If you are using insurance or Employee assistance provider to pay for our services, then we will:
(1) Expect and accept payment of your copayment amount at the time of service;
(2) File your claim with the insurance provider
(3) Receive payment from your insurance provider
(4) Expect that you will pay your portion due of copay, co-insurance, deductible, or fee difference at the time of your appointment.

PLEASE NOTE: Thriving Families Counseling, LLC files insurance as a courtesy to you, and that you (not your insurance company) are ultimately responsible for your bill. If you insurance company denies a claim filed on your behalf, then you are responsible to pay Thriving Families Counseling, LLC for the difference between the standard rate and the amount previously paid as copay unless approved otherwise by owners of Thriving Families Counseling, LLC.

I agree to
(1) Allow Thriving Families Counseling, LLC to bill my insurance directly for services provided under the Outpatient Services Agreement;
(2) Give Thriving Families Counseling, LLC permission to release any information the insurance company may require in order to process payment; appoint Thriving Families Counseling, LLC as my authorized representative to act for me in obtaining payment;
(3) Assign all of my rights to claims and payment by my insurance to Thriving Families Counseling, LLC; and
(4) Agree to assist with the claims process as required by Thriving Families Counseling, LLC or my insurance provider.
I understand that if my insurance plan requires that I meet a deductible amount prior to coverage by insurance, I will be responsible for the full session fee until the required deductible amount has been met. I acknowledge that not all issues, conditions, and problems dealt with in psychotherapy are reimbursed by insurance companies.

CANCELATIONS & MISSED APPOINTMENTS

Insurance carriers will not pay for late cancelations or missed appointments. Once an appointment is scheduled, that time is reserved specifically for you. Cancelations must be made at least 24 hours in advance. Although 24 hours is the minimum,

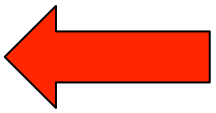
if you need to cancel or reschedule please give as much notice as possible. You may notify our office of cancelation by phone or email to your provider. Late cancelations (fewer than 24 hours before the appointment) will incur a fee of $65.00.

PAST DUE ACCOUNTS

Amounts past due by more than 30 days will incur a late fee each month of $25.00. If your account has not been paid for more than 45 days and arrangements for payment have not been agreed upon, Thriving Families Counseling, LLC may resort to legal means to secure payment. This may involve hiring a collection agency, an attorney or going through small claims court. If such legal action is necessary, you will be responsible for those costs.

I have read the Agreement and Policy above, and I have been offered a copy for my records. I understand the policy and by my signature below I agree to be bound by its terms in association with outpatient services provided to me by Thriving Families Counseling. Any and all negotiated exceptions or special arrangements are listed below and require approval and are not valid unless signed by a representative of Thriving Families Counseling, LLC.

I agree to the above financial policies of Thriving Families Counseling, LLC.



Patient name
(printed)_____

Patient /Guardian signature:_____

Patient Rights

1. **You have the right to be informed of the terms under which treatment will be provided.** You are, however, responsible for asking any questions regarding the policies contained in this form.
2. **You have a right to know the qualifications and training of your therapist.**
3. **You have the right to refuse or terminate treatment at any time and for any reason.**
4. **You have the right to know that sometimes you can feel worse at the beginning of treatment instead of better.** This is simply a result of opening up old wounds and discussing painful topics that you may have been avoiding, and it should ease over time, if it happens at all.
5. **You have the right to confidentiality as specified by state and federal law.** This means that anything that you tell your therapist and/or that your therapist writes down in your file will not be repeated or released to anyone else without your written permission, except as set forth in our Notice of Privacy Practices or otherwise required by state or federal law. You, of course, may discuss your treatment with anyone you choose, including another therapist.

If you choose to communicate with your therapist via email, you should understand that confidentiality cannot be guaranteed due to the nature of Internet security as well as the possibility that others in your household or place of employment could access your emails.

6. Should you wish to use your insurance benefits, it is necessary for you to sign a Consent to Bill Insurance form in order for TFC to bill your insurer or to request additional sessions as needed. While billing information is generally limited to your diagnosis, date of service, and type of session (individual, family, etc), insurance companies can request additional information when authorizing services. By signing this Form, you agree that TFC can provide your insurer with the necessary details regarding your treatment to obtain authorization and/or payment.

Patient Responsibilities

1. **Late Cancellations and No Show.**

If you are unable to make an appointment, please notify our office at least twenty four (24) hours in advance to cancel the appointment or reschedule it for another time. You will be charged $65 for appointments cancelled with less than 24

hours' notice if we are unable to fill your spot. If you fail to show up for an appointment without notice, you will be charged a fee of $65. Please be aware that insurance carriers do not reimburse for these charges.

_____Initials

2. You are responsible for keeping appointments, following the plan of care, and meeting the other obligations under this agreement. The therapist may cancel or terminate services for noncompliance with the plan of care or failing to keep appointments.

3. **You are responsible for paying your session fee or copay/deductible at the beginning of our sessions, along with any professional or administrative fees for legal proceedings, record requests or other matters**. A standard session is 45-60 minutes in length unless otherwise arranged in advance.

4. **You are responsible for knowing your insurance benefit limitations.** You should contact your insurer directly to determine whether your treatment requires preauthorization, if you have a deductible to meet, and the amount of your copay and/or co-insurance.

a. If your insurer requires preauthorization of the first session and you do not obtain it, you are responsible for the full cost of that session.

b. You are not responsible for the cost of sessions for which the therapist is required to obtain the preauthorization (this usually relates to ongoing treatment rather than the initial session).

c. You are responsible for notifying TFC of any changes in your insurance coverage. **Failure to immediately notify TFC of insurance changes could lead to denial of insurance claims. In this situation, you are fully responsible for payment of all claims denied by your insurance company.**

5. Our office is not set up to provide crisis intervention services. In case of an emergency, you may go to your local emergency room or call Connect at (540) 981-8181 or 911.

6. You are responsible for keeping TFC informed regarding changes in your contact information.

7. You are responsible for letting your therapist know if you are dissatisfied with your treatment in any way. Your therapist cannot address the problem he/she does not know that there is one.

8. You are responsible for working to address the concerns that brought you or your child to therapy. You will have to work on the things we talk about both during sessions and at home if you want to change.

I/We, _____have read the above rights and responsibilities, have had the opportunity to review the Notice of Privacy Practices, and the Financial Policy information and have had any questions answered. I understand I may withdraw from treatment at any time, but if I decide to do this, I will discuss my plan with my therapist before acting on it. I/We understand and agree to these policies. I consent to receive counseling/treatment for myself and/or my child.

_____ _____

Client Signature Date

_____ _____

Client Signature Date

Thriving Families Counseling, LLC

NOTICE OF PRIVACY PRACTICES
Effective Date: October 1, 2017

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is being provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). It describes how, when and why we may use and/or disclose protected health information ("PHI") about you. It also describes your rights to access and control of your PHI. "PHI" means any recorded or oral information about you, including demographic data, that may identify you or that can be used to identify you, that is created or received by the [insert company name] ("the Company") and that relates to your past, present or future physical or mental health or condition, the provision of health care to you, or the past, present or future payment for the provision of health care to you.

OUR PLEDGE REGARDING MEDICAL INFORMATION:
We understand that PHI about you is personal and confidential. We are committed to protecting the privacy of PHI. This Notice applies to the entire PHI generated or received by the Company. It also applies to all employees of the Company who may have access to or are required to use your PHI for any of the purposes described in this Notice, as well as persons having a business associate agreement with the Company.

WE ARE REQUIRED BY LAW TO:
- Make sure that your PHI is kept confidential;
- Give you this Notice of our privacy practices with respect to PHI about you;
- Abide by the terms of the Notice, as currently in effect; and
- Notify you in the event that there is a breach of your unsecured PHI.

I. Confidentiality
As a rule, we will disclose no information about you, or the fact that you are our patient, without your written consent. Our formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so We will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. "Limits of Confidentiality"
Possible Uses and Disclosures of Mental Health Records without Consent or Authorization. There are some important exceptions to this rule of confidentiality – some exceptions created voluntarily because of policies in this office/agency], and some required by law. If you wish to receive mental health services from TFC, you must sign the attached form indicating that you understand and accept our policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

We may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

1. Emergency: If you are involved in in a life-threatening emergency and we cannot ask your permission, We will share information if we believe you would have wanted us to do so, or if we believe it will be helpful to you.

*Client Name*_____

2. Child Abuse Reporting: If we have reason to suspect that a child is abused or neglected, we are required by Virginia law to report the matter immediately to the Virginia Department of Social Services.

3. Adult Abuse Reporting: If we have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, we are required by Virginia law to immediately make a report and provide relevant information to the Virginia Department of Welfare or Social Services.

4. Health Oversight: Virginia law requires that licensed social workers and counselors report misconduct by a health care provider of their own profession. By policy, we also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, we are required to explain to you how to make such a report. If you are yourself a health care provider, we are required by law to report to your licensing board that you are in treatment with me if we believe your condition places the public at risk. Virginia Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.

5. Court Proceedings: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information unless you provide written authorization or a judge issues a court order. If we receive a subpoena for records or testimony, we will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge's decision, we are required to place said records in a sealed envelope and provide them to the Clerk of Court. In Virginia civil court cases, therapy information is not protected by patient-therapist privilege in child abuse cases, in cases in which your mental health is an issue, or in any case in which the judge deems the information to be "necessary for the proper administration of justice." In criminal cases, Virginia has no statute granting therapist-patient privilege, although records can sometimes be protected on another basis. Protections of privilege may not apply if we do an evaluation for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

6. Serious Threat to Health or Safety: Under Virginia law, if we are engaged in our professional duties and you communicate to us a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and we believe you have the intent and ability to carry out that threat immediately or imminently, We are legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By our own policy, we may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, we can be required to provide your records to the magistrate, your attorney or guardian ad litem, a CSB evaluator, or a law enforcement officer, whether you are a minor or an adult.

7. Workers Compensation: If you file a worker's compensation claim, we are required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

8. Records of Minors: Virginia has a number of laws that limit the confidentiality of the records of minors. For example, parents, regardless of custody, may not be denied access to their child's records; and CSB evaluators in civil commitment cases have legal access to therapy records without notification or consent of parents or child. Other circumstances may also apply, and we will discuss these in detail if we provide services to minors.

9. Lawsuits and Administrative Proceedings. We may disclose PHI about you in response to a court or administrative order. We may also disclose PHI pursuant to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made by the party requesting the information to tell you about the

request or to obtain an order protecting the information requested. We may also use such information to defend ourselves or any personnel of the Company in any actual or threatened action.

10. Law Enforcement Purposes. We may disclose PHI if asked to do so by a law enforcement official: In response to a court order, subpoena, warrant, summons, grand jury subpoenas or similar process; To identify or locate a suspect, fugitive, material witness, or a missing person; About the victim of a crime if the individual agrees and, under certain limited circumstances, where we are unable obtain the person's agreement; About a death we believe may be the result of criminal conduct; About criminal conduct at the Company; In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime; or About certain types of wound or physical injuries as required by law.

Other uses and disclosures of information not covered by this notice or by the laws that apply to us will be made only with your written permission.

III. Patient's Rights and Provider's Duties:

1. Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care. If you ask TFC to disclose information to another party, you may request that we limit the information we disclose. However, we are not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell us: 1) what information you want to limit; 2) whether you want to limit our use, disclosure or both; and 3) to whom you want the limits to apply.

2. Right to Receive Confidential Communications by Alternative Means and at Alternative Locations — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we will send your bills to another address. You may also request that we contact you only at work, or that we do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

3. Right to an Accounting of Disclosures – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, We will discuss with you the details of the accounting process

4. Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, we may charge a fee for costs of copying and mailing. We may deny your request to inspect and copy in some circumstances. We may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

5. Right to Amend – If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing, and submitted to TFC. In addition, you must provide a reason that supports your request. We may deny your request if you ask us to amend information that: 1) was not created by us; We will add your request to the information record; 2) is not part of the medical information kept by us; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

*Client Name*_____

6. Right to a copy of this notice – You have the right to a paper copy of this notice. You may ask TFC to give you a copy of this notice at any time. Changes to this notice: TFC reserves the right to change our policies and/or to change this notice, and to make the changed notice effective for medical information we already have about you as well as any information we receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. We will have copies of the current notice available on request.

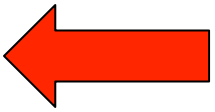
Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to our office. You may also send a written complaint to the U.S. Department of Health and Human Services. **You will not be retaliated against or penalized by us for filing a complaint.**

V. **PRIVACY OFFICER**

The Company's Privacy Officer for all issues regarding your rights under HIPAA is Susan Owen, LCSW. Information regarding matters covered by this Notice can be requested by contacting Susan Owen, LCSW, who may be reached at: Thriving Families Counseling, LLC, 1719 Grandin Rd. SW, Roanoke, VA 24015, (540) 988-3108.

Signature below is acknowledgement that you have received our Notice of Privacy Practices:

Print Name:_____ Signature:_____



Date:_____ Witness:_____

The client wanted a copy of this privacy practice (Circle one) YES NO

This signed HIPAA will remain in the patient's file; a copy may be given upon request.

Thriving Families Counseling, LLC

1719 Grandin Rd. SW
Roanoke, VA 24015

AUTHORIZATION TO BILL INSURANCE

Primary Insurance Company:	Phone Number:
Subscriber's Identification Number:	Group Number:
Subscriber's Name:	Relationship to Patient:
Subscriber's Social Security No:	Date of Birth:
Address:	
(Office Use) Diagnosis:	

I, _____ (client name), DOB_____, hereby authorize Thriving Families Counseling, LLC and it's providers to bill our insurance company/employee assistance program for treatment.

The primary subscriber (if not yourself) is _____, DOB _____, whose address (if different from mine) is _____and who is employed by _____.

I understand that our diagnosis will be provided to our insurer. I understand that the insurance company may request additional clinical information regarding our treatment progress in order to authorize sessions and/or payment, and I authorize Thriving Families Counseling, LLC and its providers to provide such information as necessary.

_____ _____
Client Signature Date

_____
Print Name

Thriving Families Counseling, LLC

Physicians Release

Physical and emotional issues often influence each other. To provide you with the most effective, coordinated care, physicians and therapists often need to communicate with one another and/or exchange records. To coordinate care with your physician/medical provider/clinic, we must have your written permission to do so

Decline to Release Information to Primary Care Physician:

If you do not want the Thriving Families Counseling, LLC to exchange information with your physician/medical provider, please check the appropriate line below and sign.

_____ I **do not** have a primary care physician/clinic or psychiatrist.

_____ I **do not** authorize the Thriving Families Counseling, LLC to communicate with our PCP/clinic or psychiatrist.

_____ _____

Signature of patient/parent/guardian Date

****(If you decline the release of information – then DO NOT fill out the information below)****

*Client's Name:*_____ *Date of Birth:*_____

Release of Information: I authorize Thriving Families Counseling, LLC, to obtain/release/exchange information with our Primary Care Physician (PCP), other healthcare practitioners, or as requested by our insurance company for the purpose of service coordination and continuity of care.

Primary Care Physician:	
Address:	
Phone Number:	Fax Number:

Psychiatrist or Other Healthcare Provider:	
Address:	
Phone Number:	Fax Number:

The undersigned authorizes the provider and primary physician to release/obtain the following medical records and information concerning client. The purpose of such release is to allow for coordination of care, which enhances quality and reduces the risk of duplication of tests and medication interactions. This consent to release information shall expire, unless otherwise provided by state law, 12 months from date of signature.

x_____ _____ _____

Signature of Client/Legal Guardian Relationship to Client (if applicable) Date

I understand that I have the right to inspect and copy the information to be disclosed. I understand that our records may be protected under the Federal Confidentiality Regulations (42CFR Part 2) and, if so, cannot be disclosed without our written consent unless otherwise provided for in the regulations. I understand that we may revoke this authorization at any time, except to the extent that action has already been taken upon it, by giving written notice to the parties above.

Thriving Families Counseling, LLC

1719 Grandin Rd. SW
Roanoke, VA 24015
FAX: (855) 515-5360

Confidential Communication Form for Primary Care Physician or Other Healthcare Provider

Reason For Communication: □ Initial Evaluation □ Routine Update □ Service Termination □ Safety Concern □ Non-Adherence with Treatment plan/Medication □ Other Coordination Need:_____	
Client Name: _____ DOB: _____ Client Address: _____	
PRIMARY PHYSICIAN INFORMATION	PROVIDER INFORMATION
Primary Physician Name and/or clinic _____ Office Address_____ _____ (City) (State) (Zip) Fax Number:_____	Therapist Name: _____ Therapist Number:

Date_____

Dear Colleague:
The above individual has sought mental health services at the Thriving Families Counseling, LLC. I have included information on this form to support coordinated care for our shared client. When authorized by our client, please consider sharing updates with me about significant medication changes or other concerns that may affect the area of service we provide.

The following is her/his diagnosis and treatment plan.

Date of Assessment: _____

Diagnosis _____

Current Symptoms: _____

Treatment Plan Includes: ___ Individual Therapy ___ Couples Therapy
___ Family Therapy ___ Psychiatric Consultation
___ Referral to Support Groups ___ Other _____

Additional
Information:_____
____

□ **Current, signed release of Information attached**