SOS Psychiatry, LLC
Jill K. Higgins, MSN, PMHNP-BC
119 The Plains Rd, Suite 300
Mailing Address: PO Box 618, Middleburg, VA 20118
Phone: 540-303-2432 Fax: 540-773-2774

Client Intake Forms

CLIENT INFORMATION

Last Name: ______________________________ First Name: ______________________________ MI: ____

Street Address: ___________________________ City:________________ State: ______ Zip: ____________

Home Phone: _________________ Mobile Phone: _________________ Work Phone: ________________

E-mail Address: ____

Date of Birth: __________________ Age:_________ Race: __________________ Gender: _____________

Social Security Number: ___________________________ Marital Status: ____________________________

MEDICAL INFORMATION

Physician Name: _____________________________ Physician Phone: ______________________________

Current Medications: ____

Allergies: ____

Referral: ____

EMERGENCY CONTACT

Last Name: ______________________________ First Name: ______________________________ MI: ____

Emergency Contact: ______________________________ Emergency Phone:________________________

Street Address: ___________________________ City:________________ State: ______ Zip: ____________

Relationship to Client:_____________________________

INSURANCE INFORMATION

Primary Insurance: _________________________ Secondary Insurance: ___________________________

____ ____

Policy Holder: _____________________________ Policy Holder: _________________________________

Policy Number: ____________________________ Policy Number: ________________________________

Group Number:____________________________ Group Number: ________________________________

____ ____________________

Client Signature Date

____ ____________________

Parent / Guardian's Signature *(If under 18 years old)* Date

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Client Rights

As a client seeking elective treatment, you are entitled to the following rights:

- To receive services regardless of race, sex, creed or color
- To considerate and respectful care.
- To know your records are protected which prohibits unauthorized disclosure of information.
- To receive privacy whenever it is indicated
- To individual treatment based upon your needs and goals.
- To know the rationale of all services provided to you.
- To know the identity and professional status of the individual providing services to you
- To know that the staff operates within a professional environment as Professional practitioners.
- To review your record upon request and to receive current information concerning your diagnosis treatment and prognosis. Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right
- To request amendments to your clinical file
- To receive a history of all disclosures of your protected health information. You will be required to pay $0.55/page.
- To restrict the use and disclosure of your protected health information for the purpose of treatment, payment and operations. If you choose to release any protected health information, you will be required to sign a Release of lnformation form detailing exactly what information you wish disclosed.
- To expect reasonable safety and comfort as far as the center's practices are concern.
- To be given information relative to transfer, discontinuing of services and continuity of care
- To refuse treatment at any time.
- To register a complaint with the Secretary of Health and Human Services if you believe your rights as stated above have been violated.

I have read and l understand the above Client Rights.

____   ____________________

Client Signature   Date

____   ____________________

Parent / Guardian's Signature *(If under 18 years old)*   Date

As noted above, psychotherapy notes are afforded special protection under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA is a federal law that required the creation of national standards to protect sensitive client health information from being disclosed without the client's consent or knowledge.

SOS Psychiatry, LLC does not release psychotherapy notes. We will be happy to provide you with a "designated recorded set" which will consist of: Results of Clinical Testing, Treatment Plans, Symptoms, Prognosis, Modalities and Frequencies of treatment, Functional status, Progress to date, Diagnoses and Medication prescription and monitoring.

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Professional Disclosure Statement and Consent to Treatment

Contact Information: Jill K. Higgins is located at the above stated address. This is also the mailing address. Hours of operation are arranged between the practitioner and the client Monday -Friday. Clients are seen by appointment and scheduled through Jill Higgins' website www.sos-psychiatry.com or by phone 540-303-2432. The website, email and voicemail are secure and confidential.

Personal Qualification: Jill K. Higgins, MSN, PMHNP-BC is a Psychiatric Mental Health Nurse Practitioner. She received her BSN from Shenandoah University in 2014, and her Masters in Nursing, MSN, from Shenandoah University in 2021. She has over 10 years of patient care experience with 7 years at Winchester Medical center and Winchester Rehabilitation center. Jill K. Higgins operates within a professional environment with Dr. Donna deVillier, DNP and Mark de Villier, MSW, LPC at Ashby Gap Psychiatric Center, LLC. Psychiatric services are offered to adults, children and adolescents for improving the emotional health in individuals, couples, families with treatment focused on cognitive behavioral therapy.

Dr. Donna de Villier, DNP, MSN, RN, RPTS is a Psychiatric Mental Health Advanced Practice Nurse with Ashby Gap Psychiatric Center, LLC. She is a Registered Nurse, received her BSN from the Medical University of South Carolina, 1980, her Masters in Nursing, MSN, University of South Carolina, 1989 and her Doctorate of Nursing Practice, DNP, Brandman University, 2014. She is a Registered Play Therapist, RPT, Association of Play Therapy and Registered Play Therapist Supervisor, RPT-S, Association of Play Therapy.

Mark P. de Villier, MSW, LPC is the primary counselor with Ashby Gap Psychiatric Center, LLC. His credentials are: VA Licensed Professional Counselor. Mr. de Villier received his Master's Degree in Social Work from the University of South Carolina with emphasis in micro and macro social work and his undergraduate degree in Psychology from the College of Charleston.

Consent: By signing this consent form, I expressly acknowledge that my child is/or I am being voluntarily admitted to SOS Psychiatry, LLC. I also express that l have custody of my child/children and may request services. I understand that the services of SOS Psychiatry, LLC are administered as an outpatient private practice and the services will be with a licensed professional. The services may consist of individual, family, and couples therapy approaches. I understand an Individual Treatment Plan will be developed through a collaborative process between the client and SOS Psychiatry, LLC which could include any or all of these modalities.

____ ____________________
Client Signature Date

____ ____________________
Parent / Guardian's Signature *(If under 18 years old)* Date

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Informed Consent

Your signature verifies you have been given copies of documents informing you of Patient Rights, Professional Disclosure, Consent to Treatment, Ethics, Informed Consent, Confidentiality, Fee Agreement and HIPAA and that you read and understand these forms. Your signature also grants consent for treatment to you or your child.

You need to know that:

- Treatment may open unexpected emotionally sensitive areas and isn't always successful.
- Jill K. Higgins is not a physician but a Psychiatric Mental Health Advanced Practice Nurse.
- Jill K. Higgins may need to consult with your physician, attorney, or other health care providers, and will ask for a signed Release of Information form before consultation is made.
- Jill K. Higgins is not available 24 hours a day or seven days a week.
- Jill K. Higgins is licensed through the State Board of Nursing for the Commonwealth of Virginia: Department of Health Professions located at 9960 Mayland Drive, Suite 300, Richmond, VA, 23233-1463. Phone number (804) 367- 4515 and the website is www.dhp.virginia.gov/nursing.

Confidentiality: The information you share in therapy with SOS Psychiatry, LLC staff is generally considered confidential by Virginia state law and federal regulations. Your clinical file can be subpoenaed in Virginia through court orders (signed by a judge) but is considered privileged in the federal court system. SOS Psychiatry, LLC staff are mandated by state and federal regulations - through duties to warn - to breach confidentiality if they are aware:

1) you being a harm to yourself or another
2) if a child has been abused or is being abused
3) if a vulnerable adult is being abused or neglected
4) if you intend to break or have broken a law against another

Any information other than the above will require a Release of Information form to be completed. I have read and understand the above.

____ ____________________
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Ethics

Jill K. Higgins follows the Code of Ethics of the following organizations:

- Virginia Board of Nursing

These ethics include but are not limited to:

- Beneficence or good health and welfare of the client.
- Nonmaleficence or No intentional actions that cause harm.
- Autonomy, freedom to decide right to refuse.
- Confidentiality, protecting private information.
- Social justice.
- Procedural justice.
- Veracity, truthfulness.
- Fidelity, faithful or loyal.

*Any type of sexual behavior between therapist and client is unethical. It is never appropriate and will not be condoned.

I have read and understand the above.

____ ________________

Client Signature   Date

____ ________________

Parent / Guardian's Signature *(If under 18 years old)*   Date

Additional family members involved with therapy after reading, reviewing and understanding the above, please sign.

____ ________________

Other Client Signature 2   Date

____ ________________

Other Client Signature 3   Date

____ ________________

Other Client Signature 4   Date

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Fee Agreement

SOS Psychiatry, LLC is a private outpatient practice providing services to children, adolescents, adults and families experiencing difficulties as an individual and/or system. The collection of fees for the psychiatric services to the clients is necessary for SOS Psychiatry to provide quality mental health services. It is customary to pay all co-pays and for services not covered by insurance at the time they are rendered. Jill Higgins is currently being credentialed with CareFirst Blue Cross Blue Shield, Aetna and Cigna Insurance Panels. If your insurance pays for out-of-network services, SOS Psychiatry, LLC is willing to bill your insurance carrier after verification of payment for services; however, any outstanding balance is expected to be paid upon the rendering of the service(s).

Responsibility for Payment: I agree to pay the following fee for service: Initial Assessments: $150; Individual Therapy, Family Therapy and Couples Sessions: $150 per 50min session; Med-Management and follow-up appointment: $75. Scheduled appointments missed/or not cancelled at least 24 hours prior to the scheduled appointment may be billed for the full amount of the session. Time related to Court Appearances, dealing with attorneys, dispositions and professional testimony is billed at $200 an hour. (see Policy on Court and Legal Proceedings) Checks may be made out to SOS Psychiatry, LLC. Cash, credit cards and ATM debit cards are accepted. Credit card payments can be paid online on the website: sos-psychiatry.com Returned checks are subject to a $25 charge. Accounts over 60 days may be turned over to a collection agency for collection.

My signature indicates that I have read and understand this fee agreement and agree to abide by the terms stated above. I accept full responsibility for charges for myself and/or my child.

____ ____________________
Client Signature Date

____ ____________________
Parent / Guardian's Signature *(If under 18 years old)* Date

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Assignment and Direction for Direct Payment

Last Name: ______________________________ First Name: ______________________________ MI: ____

Employer: ____

Claim/Group:____

SSN: ______________________________ ID#:____

I hereby instruct and direct that________________________ to pay by check made out and mailed to:
Insurance Company

SOS Psychiatry, LLC
PO Box 618
Middleburg VA, 20118

A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to my insurance company and/or adjuster involved in this case.

Dated this ___________ day of____________________ 20______

____ ____
Signature of Policyholder Signature of Witness

____
Signature of Claimant, if other than Policyholder

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Notice of Privacy Practice

On August 8, 1996, the US Congress passed Public Law 104-191, commonly known as the Health Insurance Portability and Accountability Act (HIPAA). The purpose of HlPAA is to 1) promote the use of standards in healthcare for administrative and financial transactions and 2) provide for the confidentiality and security of protected health information. SOS Psychiatry, LLC is considered a covered entity under HIPAA regulations and as a result, we will only distribute our clients' protected health information under the regulations set forth by HIPAA.

As a client you have the right to see your clinical file upon request. Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right.

As a client, you have the right to receive a copy of your clinical file as a "designated recorded set." Psychotherapy notes are afforded special privacy protection under the HTPAA regulations and are excluded from this right.

As a client, you have the right to request amendments to your clinical file.

As a client, you have the right to receive a history of all disclosures of your protected health information. As a client, you have the right to restrict the use and disclosure of your protected health information for the purpose of treatment, payment and operations. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly what information you wish to disclose.

As a client, you have the right to register a complaint with the Secretary of Health and Human Services if you believe your rights have been violated. In that Psychotherapy notes are afforded special protection, SOS Psychiatry will be happy to provide a designated record set which consist of: session start and stop time, results of clinical testing, treatment plans, symptoms, prognosis, modalities and frequencies of treatment, sessions, functional status, progress to date, diagnoses, medication prescription and monitoring.

I have read and understand the above.

____ ____________________
Client Signature Date

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Policy on Medication Management Follow Up Appointments

It is very important you follow your practitioner's treatment guidelines. At each appointment, your provider will indicate a time frame for your next visit. It is your responsibility to ensure you follow up with your appointment schedule within the time frame indicated and you keep these appointments. Please note your medication provider cannot refill medications without performing the appropriate follow up evaluation.

Some appointment times fill very quickly. We strongly recommend you schedule your next appointment before you leave the office. If this is not possible, please do your best to schedule follow up appointments shortly thereafter. This may assist in meeting your time need and ensure you do not run out of your medication as this may be dangerous to abruptly stop your medication. Delays in scheduling follow up appointments may result in significantly limiting your appointment time options.

I have read, understand, and will abide by the above policy.

____   ___________________
Client Signature   Date

____   ___________________
Parent / Guardian's Signature *(If under 18 years old)*   Date

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Authorization for the Use or Disclosure of Protected Health Information

Last Name: ____________________________ First Name: ____________________________ MI: ____

Date of Birth:____________________________ Date authorization initiated: ______________________

Authorization by: ☐ Client ☐ Provider ☐ Other

Authorization name ____

Information to be released to: ____

Authorization for Psychotherapy Notes ONLY (important if this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected heath information.)

Other (describe information in detail):____

Purpose of Disclosure: ____

The reason I am authorizing release is: ____

Person(s) Authorized to Make the Disclosure:____

Person(s) Authorized to Receive the Disclosure: ____

This Authorization will expire on/or upon the happening of the following event: ___________________

____

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

____ ___________________

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Authorization for the Use or Disclosure of Protected Health Information

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (HIPAA"). 1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you. 2. You have the right to revoke or cancel this authorization at any time, except (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable. 3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third-party, your provider has the right to decide not to treat you or accept you as a client in their practice. 4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. 5. If this office initiated this authorization, you must receive a copy of the signed authorization. 6. Special instructions for completing this authorization for the use and disclosure of Psychotherapy notes. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

____ _________________
Client Signature Date

____ _________________
Parent / Guardian's Signature *(If under 18 years old)* Date