New Patient Questionnaire and Consent

Complete each question. Please bring your insurance card and driver's license to your appointment.

Patient Name: ______________________________ Date of Birth: ____________

Street Address ______________________________ Sex: ☐ Male ☐ Female ☐ Other

City: ________________________ State: ____________ Zip Code: ____________

Home Phone#: ____________ Cell #: ________________ leave message ☐ Yes ☐ No

Circle One: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Occupation: ______________________ Employer: ______________________

Email: ____

Guardian or Spouse: ___________________________ Phone#: ____________

In case of Emergency ___________________________ Phone# ______________

Insurance Information

	Primary Carrier	Secondary Carrier
Insurance Company:		
Subscriber's Full Name:		
Subscriber's Birthday		
Policy ID Number:		
Group Number:		
Relationship to Patient:		
Address of Subscriber:		

- I authorize Beach Counseling to provide medical treatment, release medical information for insurance purposes, to bill claims to my insurance company, and to receive direct insurance payments. As a courtesy, this office will file your insurance claims for you. If your insurance company does not make a payment on your behalf, you **are responsible for the allowable amount**.
- I understand the risk of counseling, and that it may bring up events from the past.
- Copayments are due at the time of service. I understand that I am financially responsible for payments of all services. **Insurance does not guarantee payment**.
- If there is default of payment of any amount due, and the account is placed in the hands of an agency/attorney for collection or legal action, you will be charged an additional fee equal to the cost of collection, including agency and attorney fees, court cost incurred and permitted by law governing these transactions. You will be responsible for attorney fees related to collections.
- There will be a fee of $50.00 for missed/cancelled appointment without 24 hour/business day notification. There will be a fee of $30.00 for all returned checks.

By my signature, I acknowledge that I have read and understand the terms of this agreement, and give consent for evaluation and treatment.

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Signature of Patient/Guarantor Relationship Date

Beach Counseling Center LLC

1064 Laskin Road, Suite 14C
Virginia Beach, Virginia 23451
757-233-1500 (Voice) 757-222-3833 (Fax)

Consent to Participate in a Telehealth Consultation

Patient Name: ___________________________ Date of Birth:__________________

1. I understand that my health care provider wishes for me to engage in a telehealth consultation. I hereby consent to forward my patient-identifiable information to a third party for HIPAA compliant video conferencing. I understand that it is the role of the health care provider to determine whether or not the condition being diagnosed and/or treated is appropriate for a telehealth encounter. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
2. My health care provider has explained to me how the video conferencing technology will be used and that telehealth services can include, appointment scheduling, taking payment, patient education, or psychotherapy, despite not being in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I also understand that all audio, video, file sharing, and chat features will require password protection and use the latest encryption protocols to assure that data integrity and privacy is maintained. I will hold the health care provider harmless for information lost due to technical failures. I agree to use landline or cellular telephones as an alternate means of communication should teleconference service be interrupted.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes
5. I have had the alternatives to a telehealth consultation explained to me, and in choosing to participate in a telehealth consultation, I also understand that some parts of the consultation may require an in-person office visit.
6. In an emergent consultation, I understand that the responsibility of my health care provider to notify my local providers or emergency services and that my health care provider's responsibility will conclude upon the termination of the video conference connection. It is my responsibility to notify my provider of my physical location during each meeting.
7. I understand that billing will occur just the same as in-person visits and I am responsible for all charges not covered by my insurer as per the previously signed financial agreement.
8. I have had a direct conversation with my health care provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits have been discussed with me in a language in which I understand.

By signing this form, I certify: That I have read or had this form read and/or had this form explained to me. That I fully understand its contents including the risks and benefits of the procedure(s). That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

__________________________________ _________________ _______________

Patient/Parent/Guardian Signature Date

Patient Acknowledgement of Policies

- To schedule or **cancel your appointment**,
  - Please call (757) 233-1500 during office hours M-F 9-5pm. Notify us 24 business hours in advance.
  - A message after hours or weekend is not considered 24 hours, business day notice.
  - We do not monitor email after hours or weekends.
  - Two missed appointments and we may refer you out of the practice.
- I understand Beach Counseling Center staff must be treated with respect **AT ALL TIMES.** Abusive language, **rude behavior**, threats, and harassment will not be tolerated. Failure to observe common courtesy towards our staff may be cause for discharge from the practice.
- **Missed Appointment Fees** –
  - A $50.00 appointment fee will be charged for all appointments cancelled without giving 24 hours, Monday to Friday 9-5pm. Insurance will not pay for missed appointments, or late cancellations.
  - You agree to pay for any missed appointments, or less than 24 hours' business day cancellation.
- After hour's **emergencies**, please call, **(757) 651-3003**. **Please keep these calls to emergencies only.**
  - **Emergency** – a **crisis situation** that occurs after-hours and **cannot wait until the following business day** for a response.
  - If this is an emergency, please go to the nearest hospital emergency room or dial 911.
  - **Prescription refill** is not an emergency. Calls to the emergency number will not be taken.
- **Texting, emailing or calling your therapist**
  - Your therapist may call from their personal cell at times. Please **do not call, email, or text** your therapist directly. Please **do not give sensitive information in an email** for your therapist.
- **Medication** – to refill a prescription, 4 to 5 working days are needed.
- **Payment is** expected at the time of service.
- **Insurance**
  - We file insurance as a courtesy to you. Payment is not guaranteed by your insurer.
  - You are responsible for any amounts not covered by your insurance.
- **Fee Schedule** I agree and understand the fee schedule. I received a copy of the fee schedule.
- **Patient Copy for Office Policies**. I received a copy of the policies.
- There is a **return check charge** of $30.00.

HIPAA (Health Insurance Portability and Accountability Act)

- Your therapy session is held in the strictest confidence. No information will be released without your written permission. Exceptions are in the HIPAA statement.
- I understand and have the right to request a copy of my HIPAA (Privacy Policy.) I understand that I have the right to review the notice prior to signing this consent.
- I have the right to request restrictions as to how my health information may be disclosed to carry out treatment, payment, or healthcare operations. I understand that I may revoke this consent in writing for future disclosures.

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history symptoms, test results, diagnoses, treatment, and any plans for future or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who contribute to my care.

A means by which insurance companies verify that services billed were actually provided.
If you would like a copy of our HIPAA policy, please ask the receptionist and one will be provided.

________________________________ ________________________ _______________

Signature of Patient/ Guardian Relationship to patient Date

Patient Copy for Office Policy

Appointment Information

Because appointment hours are reserved for you, we ask for **24 hours' advance notice** **(NOT AFTER HOURS OR WEEKEND)** if you need to cancel or change your appointment. There is a late cancellation or no show **fee of $50** that is not covered by insurance.

- Office phone – 757-233-1500
- 24-hour business notice is: Monday to Friday, 9am to 5pm. Please call during office hours to cancel. We do not answer the phone after hours.
- Weekend or after hours' cancellations are not considered during office hours.
- An email sent at night or over the weekend will not be answered until the next business day.
- If you have a Monday appointment, please call the office to cancel or reschedule by Friday, 5pm.
- A last-minute cancelation prevents another patient from being seen.

Emergencies

An emergency is typically a **crisis situation** that occurs after-hours and **cannot wait until the following business day** for a response. Our on-call therapist is available to current clients and will answer calls during those times. For extreme emergencies, please go to the nearest hospital or call 911. If you are a current patient with an emergency, please call 757-651-3003.

- When the office is closed, do not hesitate to call us if an emergency arises.
- If your therapist is not on-call, another therapist will respond to your call if you cannot wait until the next business day.
- **PRESCRIPTION REFILLS IS NOT AN EMERGENCY AND WILL NOT BE FILLED**.

Business Hours/Telephone Calls

Our office will answer the phone between the hours of 9am to 5pm for all calls.

- **Please do not email, text, or call the personal phone for your therapist**. They may call you from time to time to communicate, but all communication should be done through the office.

Medication Refills

- If you require paperwork to be filled out by our office, please allow 7 business days for this to be completed.
- **CALL 4 TO 5 WORKING DAYS IN ADVANCE TO HAVE MEDICATIONS REFILLED.**
- Refills will be made during regular office hours, Monday through Friday. **REFILLS WILL NOT BE MADE AT NIGHT, ON HOLIDAYS OR WEEKENDS.**

Insurance

- It is your responsibility to let the office know of any change in your insurance prior to your appointment. Failure to do so, may result in you being fully responsible for your session.

If you are rude to any of the staff members, by phone or in person, you will be discharged from the practice.

Fee Schedule

The following is a list of services that would not be covered under your insurance policy. These charges are payable at the time that the services are requested.

Transfer of Medical Records:	
Search and handling:	$20 (Virginia State Statue 8..04-413)
Per page, first 50	$.50/per page
Per page, 51 and above	$.25/per page
Court Appearance:	
Minimum two (2) hours	$150/per hour/ therapist
	Dr. Tsao/Dr. Warren, Dr.K –contact directly
Disability Forms/FMLA:	$45
Standard Letters:	$45
Missed Appointments:	$50
Return Check Charge:	$30

Notice of Privacy (HIPAA)

We are committed to providing you with high quality care and to forming a relationship with you that is built on trust. We understand that information about you is private and we are committed to protecting this information.

This notice describes how your health information may be used and disclosed by our office, your rights with regards to your health information and psychotherapy notes, and our duty to protect such information. It applies to all records of your care that we maintain, stored in writing, on a computer, or other means, we will keep this information in a safe and secure way that protects your privacy and confidentiality.

Your health information may be used and disclosed by our office for the following purposes without your legal permission.

Treatment, Payment, and Business Purposes. We use and disclose your health information to enable our office to provide treatment to you, obtain payment for your care, and manage and administer my practice. For example, we may use and disclose your health information to your insurer, HMO, or other third party payer to obtain payment for the services that we provide you. Also, in consulting with a specialist regarding your health care treatment, we use and disclose your information.

Individuals Involved in Your Care or Payment or Notification. We may disclose your information to your family members or caregivers who are involved in your care or who assist you in paying for your care. This notification may also be for a disaster relief effort, such as the American Red Cross.

Appointment Reminders. Your health information may also be used and disclosed when my office contacts you to remind you of an upcoming appointment.

To You. We will provide you with your health information upon your request for copying inspections and accounting purposes as discussed further in this notice under "Individual Rights."

Required by Law. We will discuss your information when we are required to do so by federal, state, or local law.

Health Oversight Activities. We may disclose your information for health oversight activities, such as the disclosure of information in the investigation of a provider's conduct to a state licensing board official.

To Avert a Serious Threat to Health and/or Safety. We may use and disclose your information if it is necessary to avert a serious threat to health or safety of yourself or others; or to assist law enforcement authorities in identifying or apprehending an individual.

Abuse, Neglect, or Domestic Violence. We may report your health information to government authorities if we have a reasonable belief that a situation involves abuse, neglect or domestic violence.

Judicial and Administrative Proceedings. We may release your health information for judicial and administrative proceedings. Such proceedings would include responses to court orders or subpoenas.

Workers' Compensation. We may release your health information for the purpose of processing and adjudicating Workers' Compensation claims.

For Specialized Government Functions. We may disclose your information if you are a member of the military as required by military authorities, or to federal officials for national security reasons as authorized by law.

Law Enforcement Purposes. We may disclose your information for law enforcement purposes if requested by law enforcement officials.

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Quality and Cost of Services. We may provide your information to a nonprofit organization established by law for the purpose of ensuring quality services at reasonable prices. Such a disclosure may be to assist that nonprofit organization in determining the relative quality of services provided by one physician as compared to his peers.

Limited Treatment, Payment and Business Purposes. We may use or disclose your psychotherapy notes if it is for the purpose of defending the provider or practice against a legal action or other proceeding brought by you.

All other uses and disclosures require authorization. You may revoke an authorization in writing to prevent future use and disclosure of your health information.

Individual Rights

Restriction on Release. You may request that we not use or disclose your health information (1) for your treatment, payment, or the administration of my practice, (2) in notifying family members and friends of your condition or location, and (3) to family and caregivers involved in your care. We will consider your request but we are not legally required to accept it. If we do accept your request, we will not use or disclose your health information except as agreed, unless it is required in emergency situations.

Confidential Communications. You may request in writing that we communicate with you at a different location, or in an alternative manner. we will try to accommodate your request provided that you specify the alternative contact and pay any additional costs related to such requests.

Access and Amendment. In most cases, you have the right to inspect or receive a copy of health information that we use to make decisions about you. Additionally, if you believe that information in your record is incorrect or if important information is missing, you have the right to request that this information be corrected or amended.

Accounting. You may request a limited list of instances where WE have disclosed your health information. The list will not include disclosures: (1) for treatment, payment or related administrative/management purposes; (2) to you; (3) to family or caregivers involved in your care or payment for your care, or for notifying your family/caregiver in situations where you indicate that you agreed to the disclosure; (4) under certain circumstances for national security or intelligence purposes; and (5) to correctional institutions or law enforcement officials having lawful custody of an inmate or information about an inmate or individual, under certain conditions. Additionally, disclosures to health oversight agencies or law enforcement officials may be temporarily suspended if such disclosures delay the activities of the agency or official.

Notice. You may obtain a paper copy of this notice from us upon request, regardless of whether you have received this notice electronically.

Our Responsibilities

We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your health information. We must abide by the terms of the notice currently in effect. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all health information that we maintain; however, before we make a significant change in the privacy policies, we will change the notice and post the new notice for you. We will provide you with a revised notice upon request. You can also request a copy of the notice at any time by contacting our office.

Complaints

If you feel that your privacy rights have been violated, you may inform our office by written notice. If you have additional questions, please contact our office.