WILLIAM K STROBEL
703-342-8790

17 HORNER ST
WARRENTON VA. 20186

OFFICE POLICIES

Welcome, I look forward to working with you and providing you with helpful professional services. If you have any questions or concerns about the following, please feel free to discuss them with me.

APPOINTMENTS

Individual appointments are 50 minutes in duration. Couples and family appointments can be extended in certain circumstances

EMERGENCIES

I will return messages left on my answering machine as soon as possible. If you have an emergency which requires immediate attention, go to the nearest emergency room or call 911

CANCELLATIONS

When you schedule an appointment, I reserve the hour for you. If you need to cancel or reschedule an appointment, you need to give 24 hours' notice and no fee will be charged. Otherwise you are responsible for full fee payment. Insurance companies do not pay for missed appointments.

PAYMENTS

Full payment of $160 for 50 minutes is due at each session. Should you decide to use an out of network insurance I will give you the necessary information to submit your claim.

CONFIDENTIALITY

The content of all sessions is confidential and will not be released or discussed without your consent unless it is an issue that I am ethically and legally obliged to disclose. If you choose to use insurance, your insurer may require that information be provided to them that would otherwise remain confidential.

I HAVE READ AND UNDERSTAND THESE POLICIES AND AGREE TO TREATMENT AND TO ABIDE BY THE ABOVE

_____ SIGNATURE

_____ DATE

William K. Strobel II, LCSW
17 Horner Street, Office #1
Warrenton, Virginia 20186
(703) 342-8790

NOTICE OF PRIVACY PRACTICES
Effective April 14, 2003

This notice describes how medical/mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I have a duty to maintain privacy of your health information and to provide you with this notice. You will be asked to sign a Consent Form. Once you have signed the consent form, I may use or disclose your Protected Health Information for purposes of diagnosis, treatment, and obtaining payment or to conduct healthcare operations. For example, if you choose to use insurance, to receive payment I must provide information about you to your insurance company.

Other permitted and required uses and disclosures that may be made without your consent, authorization or opportunity to object:

- **Abuse or Neglect** – If I suspect abuse or neglect of a child or elder, I am mandated to make a report to the appropriate public authorities.
- **Danger** – If I suspect you are in imminent danger of harming yourself or someone else, I am mandated to make a report to the person at risk and to the appropriate public authorities.
- **Legal Proceedings** – I may disclose Protected Health Information in response to a court order or subpoena or in certain other legal proceedings.

You have the following rights regarding health information I maintain about you:

- **Right to Inspect and Copy** – You have the right to inspect and request copies of information that may be used to make decisions about your care. Usually this includes demographic and billing records, but does not include psychotherapy notes. To inspect and/or receive copies of your information, you must submit a request in writing. If you request a copy of information, I may charge a fee for the cost of copying, mailing or other supplies associated with your request. I must respond to your request within fifteen days of receipt.
- **Right to Amend** – If you feel that health information about you is incorrect or incomplete; you may ask me to amend the information. You have the right to request an amendment for as long as the information is kept by me. Your request for amendment must be in writing and must provide a reason supporting your request.
- **Right to Accounting of Disclosures** – You have the right to request an Accounting of Disclosures I have made of information about you. You must submit your request in writing to the above address. Your request must state a time period for the disclosures, which may not be longer than six years and may not include dates before April 14, 2003.
- **Right of Restriction on Uses and Disclosures** – You may request that disclosure of confidential information be limited. If I am able to agree to that restriction, we can discuss other options, such as referral to another counselor.
- **Right of Limit Reception of Confidential Information** – For example, you may request that I only contact you at a certain telephone number or address. You do not have to give a reason for your request.
- **Right to a paper copy of this Notice.**

Other uses and disclosures of Protected Health Information and any disclosure of therapy notes will be made only with your written authorization. After such authorization is given, you may revoke that authorization at any time. This Notice may be amended as needed to comply with federal, state, and professional requirements.

If you believe your privacy rights have been violated, please let me know either in writing or by talking to me. Such a complaint will not result in any retaliation by me. You may also file a complaint with the Secretary of the United States Department of Health and Human Services.

_____ _____
Signature of Client/Custodial Parent/Guardian Date

_____
Printed Name of Client

CLIENTS RIGHTS AND RESPONSIBILITIES

I understand that this counseling relationship is confidential and that any information given to outside sources, such as doctors or attorneys, may only be shared with my written permission. The only exception to this rule is suspected abuse or neglect of a minor (under age 18), or if my therapist believes I may pose a danger to either myself or to others. Further, I agree that should I feel danger to myself or others, I will immediately call my therapist or, if he is unavailable, access the nearest emergency room/hospital or call 911.

I understand that I must give at least 24 hours notice in canceling a session, or I will be financially responsible for that session at the full rate of $160.00. I understand that payment is due at the time of service and that I will receive a receipt at the end of each session, should I request it. A late fee of $25.00 per month will be applied to any unpaid balance.

Please note: *William K. Strobel II, LCSW will not appear in court for any of the cases he covers unless required by a court (not attorney's) order. Should it be the intention of the client to pursue legal action with the aid of a therapist, please request a referral to an appropriate clinician. If court ordered, the daily fee is $2,500.00, due and payable in advance of the court date.*

Person completing this form:_____Date:_____

To help me better understand your concerns, please review the following list of issues and check those which may apply to you and/or your situation. This information is confidential. We will discuss this list during our counseling session.

_____Employment/school problems
_____ Legal problems
_____ Living arrangements
_____ Financial Problems
_____ Anxious/Worried/Nervous
_____ Increase/Decrease in appetite or weight
_____ Confusion
_____ Tearful
_____ Extravagance with money
_____ Fatigue
_____ Forgetfulness
_____ Frequent lying
_____ Generalized dissatisfaction
_____ Guilt Feelings
_____ Difficulty being alone
_____ Anxiety that limits activities
_____ Mood swings
_____ Hyperactivity
_____ Panic Attacks
_____ Perfectionistic
_____Shy, uneasy with others
_____Suicidal thoughts, even if only fleeting
_____Trouble with memory/concentration
_____Trouble sleeping
_____Unassertive
_____Unwanted behavior/habits (compulsions)
_____Withdrawn
_____Worry about drug/alcohol use
_____Aggressive/violent behavior
_____Worry about eating habits
_____Physically/Sexually abused
_____Physical abuse of spouse or partner
_____Physical abuse of child
_____Excessive Fighting
_____Sexual problems
_____Sexual identity concerns
_____Sexual promiscuity
_____Physical/Medical symptoms
_____Relationship problems
_____Sadness/Depression

William K. Strobel II, LCSW

REQUEST AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

I hereby authorize *William K. Strobel II, LCSW*, to obtain or exchange information regarding

Client name: _____
for the purpose of treatment planning and evaluation. This information may include some or all of the following:

intake and discharge summaries	medical history and evaluation
mental health evaluations	developmental and/or social history

I hereby authorize the following person or facility to release the above records and to discuss the needs of the person named above:

Name of Person or Facility: _____
Address: _____
_____
Telephone Number: _____

Name of Person or Facility: _____
Address: _____
_____
Telephone Number: _____

I understand this request/authorization to release records and information. This request is entirely voluntary on my part. I understand that I may take back this consent at any time and is valid for 1 year.

Signature of client: _____
Printed Name: _____ Date: _____
Signature of parent/guardian: _____
Printed Name: _____ Date: _____

CLIENT INFORMATION FORM
William K. Strobel II, LCSW
17 Horner Street, Office #1
Warrenton, Virginia 20186
(703) 342-8790

CLIENT

Name_____ Date of Birth_____

Address_____ City_____State_____Zip_____

Home Telephone (____)_____Cell Telephone (____)_____

Employer_____ How Long? _____

Occupation_____Email address_____

SPOUSE/PARTNER

Name_____ Date of Birth_____

Address_____ City_____State_____Zip_____

Home Telephone (_____)_____Work Telephone (____)_____

Employer_____

Occupation_____Email address_____

MARITAL HISTORY

Current Marital Status: _____married _____ separated _____divorced
_____ single _____ widowed _____ living together
Please give names of persons and dates in any of the following which apply

Date of Marriage(s)_____

Date of Separation(s)_____

Date of Divorce(s) _____

Death(s) of Spouse(s)/Partner(s) _____

Significant Relationships(s) _____

NAME:_____ _____ DATE_____ DATE of BIRTH_____

Marital Status_____

Marriages_____

Seperations_____ _____

Divorce_____ _____

Parents
Mother _____ Deceased_____
Father _____ Deceased_____
Currently _____
Remarried? Mother_____ Father_____

Siblings:
_____one older brother_____

_____

REASON FOR SEEKING COUNSELING

_____

_____

When did you first notice the problem _____

Any major stressors that have recently occurred?, _____

_____

PREVIOUS MENTAL HEALTH TREATMENT _____ _____

_____

SIGNIFICANT FAMILY HISTORY _____ _____

_____

CURRENT MEDICATIONS_____ _____

_____

PARENTS

Mother _____Living? ____yes _____no Resides where? _____

Father _____Living? ____yes _____no Resides where? _____

Currently married to each other/living together? _____yes _____no

Remarried? Mother _____yes _____no Father _____yes _____no

BROTHERS/SISTERS

Name	Age	Lives Where?
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHILDREN

Name	Age	Living Where?
_____	_____	_____
_____	_____	_____
_____	_____	_____

EDUCATION

Highest educational degree completed _____ Date _____

Educational major or specialization _____

RELIGION

Religious preference _____

Member? _____yes _____no Active? _____yes _____no

REFERRAL SOURCE

How did you learn about my services?

Name of Person _____

Other (indicate) _____

PREVIOUS COUNSELING

Have you received previous counseling? _____yes _____no Dates_____

From whom? _____

Are you currently being seen by another therapist? If so, who_____ For_____

AGENDA FOR COUNSELING: GOALS

List goals for counseling in order of importance to you.

_____

_____

_____

FAMILY PHYSICIAN

Name _____

Are you on medication? _____yes _____no

If on medication, give name & dosage _____

OTHER INFORMATION

Please add any additional information which you believe may be important for me to know

_____

_____