Alicia's Place
1021 Eden Way N, Suite 109
Chesapeake, VA 23320
Phone: 757-785-5540
Email: Alicia@AliciasPlace.org

# Contact Sheet

Today's date: _____

## A. Identification

Client name: _____ Nicknames or aliases: _____

Date of birth: _____ Age: _____ Social Security #: _____

Marital Status: □ Single □ Married □ Separated/Divorced □ Other: _____

School/Employer: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

*Client's* Phone: _____ □ Cell □ Home □ Work □ Other: _____

If applicable…

Parent/guardian name: _____ Relationship to client: _____

Phone 1: _____ □ Cell □ Home □ Work □ Other: _____

Phone 2: _____ □ Cell □ Home □ Work □ Other: _____

*Calls will be discreet, but please indicate any restrictions:*

Best Email: _____

## B. Emergency contact information

If some kind of emergency arises and we cannot reach you or your parent/guardian directly, or we need to reach someone close to you, whom should we call?

Name: _____

Relationship: _____

Phone: _____

Address: _____

# Alicia's Place

**1021 Eden Way N, Suite 109**
**Chesapeake, VA 23320**
**Phone: 757-785-5540 Fax: 757-410-0223**
**Email: Alicia@AliciasPlace.org**

## Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me/us, When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: .

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your PHI.

**If you do not sign this form agreeing to our privacy practices, we cannot treat you.** In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy by calling us at 757-785-5540.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_____ _____
Signature of client or his or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client

_____ _____
Signature of authorized representative of this office Date

Date of NPP: March 15, 2020 ❑ Copy given to the client/parent/personal representative

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## CONSENT FOR ELECTRONIC COMMUNICATIONS

I, the undersigned, request that staff from Alicia's Place be allowed to communicate with me via electronic communication (Ex:, email, text, telehealth, video conferencing). The risks and benefits of this approach, versus other forms of communication such as fax and telephone, have been explained to me. They include that electronic communication may not be secure and that there is a risk that my (or my child's) personal health information may be hacked. I understand that it is possible that my (or my child's) personal health information may be mistakenly sent to a wrong contact or that unintended individuals may be copied on the email. This may result in third parties knowing private information about myself (or my child), including but not limited to detailed information about the reason for referral to Alicia's Place, subsequent mental health diagnoses, and recommendations for future action and/or treatment. It may also include client contact information such as address or telephone number as well as date of birth and/or social security number. I understand that email may not always be encrypted and that there is a risk of the email getting "lost" in cyberspace. Many times, once an email has been sent, it cannot be reclaimed and/or deleted, thus there is the possibility that my (or my child's) personal information would be available for others to access for a long period of time.

I have had the opportunity to discuss these risks with a staff member from Alicia's Place and all of my questions have been answered to my satisfaction. I request that electronic communication be initiated between myself and Alicia's Place in future correspondence.

Best email: _____

Best phone for texting: _____

_____ _____

Signature of client/legal guardian Date

_____

Printed name of client/legal guardian

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## Explanation of Fees and Copays

As a courtesy, Alicia's Place verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan. If your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.

It is the policy of Alicia's Place that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. At the conclusion of your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly.

If you are covered by health insurance with therapy/counseling benefits, we will be happy to bill your insurance. Please provide us your insurance information and we will verify your coverage as a courtesy. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are ultimately responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

We recommend you also contact your insurance carrier and check into your coverage for therapy/counseling. This is also true for individuals who are covered by multiple insurance plans.

**By signing below I understand my financial responsibilities in accepting services.**

Insurance information:

| | |
|---|---|
| Name on insurance card | |
| Insurance number | |
| Phone Number (Ins. Co.) | |

_____ _____

Signature of client (or guardian of client) Date

Alicia's Place
1021 Eden Way N
Suite 109
Chesapeake VA 23320-1534
7577855540

## 6. Credit/Debit Card Payment Consent

Client name:

(Card holder) Name on card if different than client:

Card Type:

Last 4 digits of card number:

Expiration Date :

I authorize Alicia's Place to charge my credit/debit/health account card for professional services rendered. Such charges include the collection of copays and/or the portions of services that my insurance company does not cover. No show policy. If I do not cancel my appointment before 24 hours, I recognize that Alicia's Place will charge my card as a late cancel or no show fee if I do not show up for the appointment. I will be billed in the amount of $25.00 per occurrence.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Client Initials:

Card holder Initials (If different than client):

Date:

Signature:

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## Request/Authorization to Disclose/Receive Confidential Records and Information

| Client Name: | DOB: |
|---|---|

I AUTHORIZE: Alicia's Place

**TO DISCLOSE TO AND RECEIVE FROM:** (description of information that is to be disclosed/received)

- ☐ The entire medical/psychological record (both orally and by writing), or
- ☐ The minimum amount of information necessary for coordination of care as required by my insurance company, or
- ☐ Specify documents and methods: _____

Check all that apply:

| | | |
|---|---|---|
| ☐ | Primary Care Physician: | |
| | Phone: | |
| | Fax: | |

| | | |
|---|---|---|
| ☐ | Other behavioral health specialists: | |
| | Phone: | |
| | Fax: | |

FOR THE FOLLOWING PURPOSE: (*NOTE: The purpose is not required if the disclosure is requested by the client.)*

- ☐ At the request of the client/guardian
- ☐ To fulfill requirements of the referral source
- ☐ **To fulfill requirements of the insurance company**
- ☐ Other (specify):

I understand that any disclosure of health information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. In consideration of this consent, I release the source of the records from any and all liability arising there from. I understand that I may refuse to sign this authorization.

I understand that I may void this request/ authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
If I fail to specify an expiration date, event, or condition, this authorization will **expire in one year.**

I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request. I affirm that I am the client or the client's parent/legal guardian with the authority to authorize disclosure of this client's health information.

_____ _____ _____
Signature of client/legal guardian Relationship to client Date

☐ Check here if client refuses to authorize PCP coordination of care