**Connect the Dots-PC**

***Psychotherapy: Children, Teens, Adults, Families***

**6477 College Park Square**

**The Atrium, Suite 216**

**Virginia Beach, VA 23464**

**Ph: (757) 962-9503 Fax: (757) 962-2700**

**PATIENT INFORMATION**

**Last name:**  **First:**  **Middle Initial:**  .

**Email:**  **Preferred Phone:**  [ ]  **Cell** [ ]  **Landline**

**Address:**  **City:**  **State:**  **Zip:**  .

**Gender:**  **.**  .

**Relationship Status:**  [ ]  **Single** [ ]  **Domestic Partnership**  [ ]  **Married** [ ]  **Divorced** [ ]  **Widowed**

**Social Security Number:**  **Date of Birth:**  .

**Employer:**  **Work Phone:**  .

**Emergency Contact:**  **Relationship to Patient:**  **Phone:**  .

**RESPONSIBLE PARTY *(If Patient is a Minor)***

**Last name:**  **First:**  **Middle Initial:**  .

**Email:**  **Preferred Phone:**  [ ]  **Cell** [ ]  **Landline**

**Address:**  **City:**  **State:**  **Zip:**  .

**Social Security Number:**  . **Driver's License#:**  .

**Address:**  **City:**  **State:**  **Zip:**  .

**Employer:**  **Work Phone:**  .

**INSURANCE INFORMATION**

**Primary Insurance:**  **ID#:**  **Group#:** .

**Subscriber Name:**   **Relationship to Patient:**  .

**Secondary Insurance:**  **ID#:**  **Group#:**  .

**Subscriber Name:**  **Relationship to Patient:**  .

*I hereby authorize treatments and/or consultation for the above patient by Connect the Dots-PC. I also authorize release of records to any agency involved in the payment for treatment of this patient and assign all benefits to Connect the Dots-PC. I, the undersigned, agree to pay the amount due and if not paid at the time of service rendered, I shall be responsible for all costs of collections, including attorney/legal fees.*

**SIGNATURE**: *(Please type in name)*   **DATE:**  .

**RELATIONSHIP TO PATIENT:**  .

**RELEASE FOR COORDINATION WITH PRIMARY CARE PHYSICIAN**

*For the purpose of coordination of care, my Connect the Dots-PC mental health provider may wish to release pertinent information about my current treatment to my Primary Care Physician. This release shall be valid until sixty (60) days after my last date of treatment—or until the time I revoke this release in writing, which can be done at any time.*

[ ]  **I DO**  [ ]  I **DO NOT** give permission to my Connect the Dots-PC mental health provider to release information about my current treatment

 to my Primary Care Physician.

**Primary Care Physician:**  **Phone:** .

**Address:**  **City:**  **State:**  **Zip:**  .

**SIGNATURE:** *(Please type in name)* **DATE:**  **RELATIONSHIP TO PATIENT:**  .

 .

***How were you referred to us?***  .

|  |
| --- |
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**FINANCIAL AGREEMENT and AUTHORIZATION TO TREAT**

**PATIENT INFORMATION:**

**Last name:**  **First:**  **Middle Initial:**  .

**Date of Birth:**  .

*I hereby authorize the treatment of the above named person, and agree to pay all fees and charges for such treatment—including, but not limited to—co-pays, deductibles, non-covered services, and broken/missed appointment fees. I request payment of all insurance benefits be made on my behalf to Connect the Dots-PC for any services furnished to me and/or my family by provider. I authorize release of medical information to any requesting insurance company and other doctors as necessary.*

**ADDITIONAL FEES:**

**Broken/Missed Appointments**

**Broken/missed appointments are not reimbursed by any insurance company. There will be a $40.00 fee charged for broken/missed appointments, unless a 24-hour notice is given prior to the appointment. Please discuss this policy directly with your therapist.** *(Please type in initials)*  .

**Returned Checks**

**A $40.00 fee will be charged for any returned check.** *(Please type in initials)*  .

**Medical Records Request**

**Medical records requested by/for the patient carry the following charges at patient/family expense: medical records with pages greater than ten (10) will carry a processing fee of $10.00; in addition, there will be a charge of $0.50 per page for the first twenty-five (25) pages, and a charge of $0.25 per page thereafter. Please allow sufficient time to process the request.** *(Please type in initials)*  .

**Letters/Paperwork Request**

**A $25 fee will be charged for any short letters/paperwork requested. Please discuss directly with your therapist regarding any fees for longer correspondence.** *(Please type in initials)*

 .

***It is the PATIENT/family responsibility to keep appointments, follow treatment plans, and pay for services rendered in a timely manner, as provided in this Financial Agreement/AUTHORIZATION TO TREAT.***

**SIGNATURE:** *(Please type in name)*   **DATE:**  .

**RELATIONSHIP TO PATIENT:**  .

**I have received a copy of this Financial Agreement/Authorization to Treat:** *(Please type in initials)*  .

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**ACKNOWLEDGEMENT OF RECEIPT: NOTICE OF PRIVACY PRACTICES**

***(PATIENT'S RIGHTS and RESPONSIBILITIES)***

**PATIENT INFORMATION:**

**Last name:**  **First:**  **Middle Initial:**  .

**Date of Birth:**  .

***I have reviewed/received Connect the Dots-PC Notice of Privacy Practices (attached). The Notice of Privacy Practices provides, in detail, the uses and disclosures of my protected health information that may be made by Connect the Dots-PC; my individual rights and how I may exercise these rights; and legal duties of Connect the Dots-PC with respect to my private medical information.***

***I understand that Connect the Dots-PC reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information located at—or controlled by—Connect the Dots-PC.***

**SIGNATURE:** *(Please type in name)*   **DATE:**  .

**RELATIONSHIP TO PATIENT:**  .

**I have received a copy of the Notice of Privacy Practices:** *(Please type in initials)*   **.**

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**NOTICE OF PRIVACY PRACTICES**

***(PATIENT'S RIGHTS and RESPONSIBILITIES)***

|  |  |
| --- | --- |
| **STATEMENT OF RIGHTS*** Patients have the right to be treated with dignity and respect.
* Patients have the right to fair treatment regardless of race, religion, gender, ethnicity, age, disability, or source of payment.
* Patients have the right to have their treatment and other information kept private.
* Only in life-threatening situations or, if required, can records be released without a signed consent from patients.
* Patients have the right to information from staff/providers in a language they can understand.
* Patients have the right to an easy-to-understand explanation of their condition and treatment.
* Patients have the right to know about all their treatment options, regardless of cost coverage.
* Patients have the right to information about services offered by their providers and the patient role in the treatment process.
* Patients have the right to know the clinical guidelines used in providing and/or managing their care.
* Patients have the right to provide suggestions on office policies and procedures.
* Patients have the right to complain and be informed of the complaint, grievance, and appeals processes.
* Patients have the right to know about State and Federal laws governing patient rights and responsibilities.
* Patients have the right to participate in the formation of their plan of care.
 | **STATEMENT OF RESPONSIBILITIES*** Patients are responsible for providing their medical provider with information needed to deliver quality care.
* Patients are responsible for informing their provider when/if their treatment plan is no longer effective.
* Patients are responsible to follow their treatment plans and to inform their provider of any changes to the treatment plan made by other providers, including any changes in their medications.
* Patients are responsible for reviewing their care and treatment plans continuously, and reporting effectiveness or ineffectiveness of the care plan to their provider.
* Patients are responsible for treating those giving them care with dignity and respect.
* Patients should not be involved in any conscious behavior that could harm the lives of their provider, office staff, or other patients.
* Patients are responsible for keeping their appointments, arriving on time, and notifying the office of any cancellations at least 24 hours prior to the appointment.
* Patients are responsible for addressing questions about their care to their provider, and ensuring the understanding of their care and their role in the treatment process.
* Patients are responsible for notifying their provider of any concerns regarding payment or insurance coverages.
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**CHILD CHECKLIST of CHARACTERISTICS**

**PATIENT INFORMATION:**

**Last name:**  **First:**  **Middle Initial:**  **Date:**   .

**Age:**  .

**Person completing this form:**  .

***Please review this checklist, which contains concerns— as well as positive traits. Click on the box for any items that describe your child. You may add a note or details in the space next to the concerns chosen. Feel free to add any others at the bottom under “Any other characteristics or concerns.”***

[ ]  Abuse: emotional / physical / sexual

[ ]  Affectionate

[ ]  Alcohol / drug / tobacco use

[ ]  Anger issues: aggression / tantrums / destructive to property / violent behavior

[ ]  Argues / disrespectful

[ ]  Autism

[ ]  Bullies / intimidates / teases / provokes

[ ]  Cheats (schoolwork, games, etc.)

[ ]  Complains

[ ]  Conflicts related to chores / school / choices in attire, friends, music, etc.

[ ]  Concerned for others

[ ]  Cries easily / feelings easily hurt

[ ]  Cruel to animals

[ ]  Difficulties with parent's partner / new marriage / new family

[ ]  Dependent (overly)

[ ]  Developmental delays

[ ]  Disrupts family activities

[ ]  Disobedient / defiant / uncooperative / stubborn / breaks rules consistently

[ ]  Daydreams / distractible / inattentive / slow to respond

[ ]  Domestic violence

[ ]  Eating: obesity / overeating / undereating / vomiting

[ ]  Exercise: lack of physical exercise

[ ]  Extracurricular activities interfere with academics

[ ]  Fearful / nervous / anxious / tense

[ ]  Fire setting

[ ]  Friendly / outgoing / sociable

[ ]  Frustrated easily

[ ]  Grief

[ ]  Hypochondriac, always complains of feeling sick

[ ]  Immature / has only younger playmates

 *(continued on next page)*

**Connect the Dots-PC**

**CHILD CHECKLIST of CHARACTERISTICS**, cont.

[ ]  Imaginary playmates

[ ]  Independent

[ ]  Job issues: dissatisfaction with responsiblities / dissatisfaction with income / future goals / inability to keep a job /

 lack of ambition / lack of career options / overworked / personnel conflicts / safety / unemployment / workaholism

[ ]  Interrupts / talks out of turn / "clowns around"

[ ]  Lacks organization / unprepared

[ ]  Learning disability

[ ]  Likes to be alone / withdraws

[ ]  Lies persistantly

[ ]  Mental retardation

[ ]  Moody

[ ]  Mute (refuses to speak)

[ ]  Nail biting / hair pulling / picking at skin

[ ]  Need for high degree of supervision at home with chores / free time / schedules

[ ]  Negative / pessimistic

[ ]  Obedient

[ ]  Overactive / restless / out-of-seat behaviors / fidgety / loud

[ ]  Prejudiced / bigoted / name calling / intolerant

[ ]  Procrastinates / wastes time

[ ]  Recent move / new school / loss of friends

[ ]  Relationships with siblings / peers are poor (fights, teasing, provoking)

[ ]  Responsible

[ ]  Rocking or other repetitive movements

[ ]  Runs away

[ ]  Sad / unhappy

[ ]  School issues: failing / dropping out / truancy / trying but overwhelmed

[ ]  Self-harming behaviors: biting / cutting / head banging / hitting / scratching / strangling

[ ]  Speech difficulties

[ ]  Sexual: inappropriate sexual behaviors / public masturbation / sexual preoccupation

[ ]  Shyness

[ ]  Sleep issues: too much / too little / insomnia / nightmares

[ ]  Suicide talk / suicide attempt

[ ]  Swearing / inappropriate language

[ ]  Thumb sucking / finger sucking / hair chewing

[ ]  Tics (involuntary rapid movements / noises / words)

[ ]  Underactive / slow-moving / lethargic

[ ]  Uncoordinated / accident prone

[ ]  Wetting or soiling the bed or clothes

**Any other characteristics or concerns:**  .

**Please read over the concerns you have checked off. Which concern is the one you most want your child to be helped with?**  .