**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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**ADULT CHECKLIST of CONCERNS**

**PATIENT INFORMATION:**

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

**Date of Birth:**  .

***Please click on the box for any items below that are concerns. 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 concerns or issues.”***

**I have no problem or concern bringing me here**

Abuse: emotional / physical / sexual

Anger issues: aggression / lack of self-control / destructive to property / violent behavior

Alcohol use

Arguing / hostility / irritability

Anxiety / nervousness / tension

Attention span / concentration / distractibility

Childhood issues

Codependency (over-involvement with problems of others)

Confusion / thought disorganization / memory problems

Custody of children

Decision-making: indecision / mixed feelings / putting off decisions

Delusions (false ideas)

Dependency: emotional / physical

Depression / crying / sadness / reduced pleasure in normal activities

Divorce / Separation

Domestic violence

Drug use: over-the-counter medications / prescription medications / street drugs

Eating: overeating / undereating / vomiting

Emptiness / emotional numbness / hopelessness / lack of purpose

Failure: feeling like a failure / actual failure in regard to an event, task, situation

Fatigue / low energy

Fears / phobias

Friendships: lack of friends / lack of support network

Frustrated easily

Gambling

Grief

Guilt

Health issues: illness / physical problems / other medical concerns, incl. obtaining proper care &/or medications

Home upkeep, chores: quality / quantity / sharing duties

Impulsiveness / loss of control / outbursts

*(continued on next page)*

**Connect the Dots-PC**

**ADULT CHECKLIST of CONCERNS**, cont.

Irresponsibility

Job issues: dissatisfaction with responsibilities / dissatisfaction with income / future goals / inability to keep a job /

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

Judgment issues, incl. risk-taking behavior

Legal: civil or criminal charges / lawsuits / other legal matters

Loneliness

Marital/Partnerships: conflicts / disappointments / different expectations / distance, coldness / infidelity / remarriage

Menstrual issues / PMS / menopause

Mental retardation

Money troubles: business failure / debt / impulsive spending / low income

Mood swings

Motivation / ambition lack

Negativity /pessimism

Obsessions / compulsions (repetitive thoughts or actions)

Oversensitivity to criticism / rejection

Pain: chronic pain / headaches / other kinds of pain

Panic / anxiety attacks

Parenting: child management / safe child care / single parenthood

Perfectionism

Procrastination / laziness / work inhibitions

Relationship issues: conflicts, problems with coworkers / friends / relatives

School issues

Self-centeredness

Self-esteem: feelings of inferiority / lack of self-confidence

Self-neglect / poor self-care

Sexual issues: conflicts / dysfunctions / partner differences in frequency or type of desire / other

Shyness

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

Smoking / tobacco use

Spiritual / religious / moral / ethical issues

Stress / inability to relax

Suspiciousness / lack of trust

Suicidal thoughts / attempts

Threats: nonviolent / violent threats given or received; incl. custody, job, neighborhood related

Weight / diet issues

Withdrawing / isolating

**Other concerns / issues:**  .

**Please read over the concerns you have checked off. Which concern is the one you most want help with?**  .