Old Towne Counseling & Wellness

Patient Record

Today's Date: _____/_____/_____	**Please Circle: Male or Female**
Patient Name (NO Nicknames):	**Date of Birth: _____/_____/_____**
Marital Status:	**Referred to our practice - by whom?**
***Guardian* Name (If Patient Under 18 Years Old):**	
Please Circle: Male or Female	
***Guardian's* Relationship to Patient:**	***Guardian* Marital Status:**
***Guardian* DOB: _____/_____/_____**	***Guardian* Phone:**
***Guardian's* Street Address:**	
City:	**State:** **Zip Code:**
Patient's Street Address:	
City:	**State:** **Zip Code:**
Home Phone: (____) _____ - _____	**Cell Phone: (____) _____ - _____**
Work Phone:	
Email Address:	
Preferred Method of Contact (Please Circle): **Home Work Cell**	**Is Voicemail OK?** **YES or NO**
Patient Employer (If Student, Please List School):	
PRIMARY HEALTH INSURANCE INFO	
Primary Insurance Company:	
ID#:	**Group#:**
Primary Policy Holder Name:	**Primary Policy Holder DOB: _____/_____/_____**
Primary Policy Holder Employer:	
Primary Policy Holder SS#: _____ - _____ - _____	
SECONDARY HEALTH INSURANCE INFO	
Secondary Insurance Company:	
ID#:	**Group#:**
Secondary Policy Holder Name:	**Secondary Policy Holder DOB: _____/_____/_____**
Secondary Policy Holder Employer:	
Secondary Policy Holder SS#: _____ - _____ - _____	

EAP INFO	
Have YOU called your insurance carrier for authorization for this visit: YES NO	
Is this visit authorized through your (EAP = Employee Assistance Program): YES NO	
EAP Provider:	**EAP Contact Number:**
EAP Authorization #:	**Number of Approved EAP Sessions: _____**

MEDICAL HISTORY
Please list relevant medical conditions (history, current condition, changes in condition):
Have you ever experienced a head injury of any kind? If so, please explain.
Current prescribed & over the counter medications (dosage, dates of initial prescription, name of prescribing doctor):
Primary Care Physician (*Required for Tricare):
Primary Care Physician's Phone Number: (____) _____ - _____
Primary Care Physician's Address:
Do you have any Allergies/Adverse Reactions to any Medications or Foods?
Please list who resides with you in your home (Family, Friends & Pets).

Please, provide the reason for seeking counseling today (including any prior history of counseling for mental health, alcohol or other drug problems).

Do you use alcohol, illegal drugs, over the counter drugs, nicotine or caffeine? If so, please describe how often and how much.

OFFICE POLICIES

Please read the following important information carefully and sign in agreement:

We offer an appointment reminder service. Please let us know which number or email address you would like to be notified with. **Please do not rely solely on this service.**

Please, make co-payments each time you arrive for an appointment.

(Initial) _____ **The cancellation policy is as follows: Please cancel your appointment by phone NO LATER than 24 hours BEFORE your scheduled appointment time. If your appointment is not cancelled or you do not attend your appointment, you will be charged *$50.00 (Therapist Appt.)* or *$100 (Psychiatric Nurse Practitioner Appt.)* "Late Cancellation/Missed Appointment Fee". It is mandatory that all fees are paid prior to your next scheduled appointment. This policy allows us an opportunity to offer your cancelled appointment to another patient in need. You are responsible for these fees, insurance companies will not cover missed or cancelled appointments. **You are still responsible for this fee even if the reminder service does not call/email to remind you of your appointment.**

(Initial) _____ **Please arrive 15-20 minutes early for all "New Patient" appointments and 10 minutes early for "Regular Scheduled" appointments. This allows the required time to check in with our front desk, issue payment for your co-pay, thus allowing your therapist to start your session on time.**

(Initial) _____ **Your presence is needed for us to effectively do our work. Please make every effort to attend your scheduled appointment. It is our policy that frequent cancellations and or missed appointments will result in a delay in your therapy services, until your schedule allows proper time.**

(Initial) _____ **Returned checks will result in a $35.00 fee; balances are required to be paid prior to next scheduled appointment. Delinquent accounts will be turned over to our attorneys at which time any and all civil penalties as provided in Section 8.01-27.1 of the Code of Virginia (1950) will be imposed. I also waive the benefit of Homestead Exemption or other exemption under insolvency laws.**

Should this account become delinquent and collection becomes necessary, the undersigned agrees to be responsible for attorney's fees of 33 1/3%, interest at 18% per annum from the last date of payment and any and all applicable court costs.

Consent to Services

Each client has the right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment. Providers shall ask the individual to express his preferences about decisions regarding all aspects of services that affect him and shall honor these preferences to the extent possible. If I have any questions regarding this consent form or about the services offered at Old Towne Counseling Services, LLC, I may discuss them with my therapist. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by Old Towne Counseling Services, LLC. I understand that I may stop treatment at any time.

Patient/Guardian (Print): _____
Relationship to Patient: _____
(If you are UNDER 18, Parent/Guardian MUST sign this form.)

Patient/Guardian (Sign): _____ **Date:** _____/_____/_____

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ACKNOWLEDGEMENT OF RECEIPT / NOTICE OF PRIVACY PRACTICES

I, _____, was offered and:

(Printed Name of Patient or Patient Parent/Guardian/Representative)

I have received a copy of the "Notice of Privacy Practices" for Old Towne Counseling Services, LLC
I declined a personal copy of the "Notice of Privacy Practices" for Old Towne Counseling Services, LLC

As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. This notice is posted on our website and copies are available any time. I understand that I may ask questions of Old Towne Counseling, LLC if I do not understand any of the information in the "Notice of Privacy Practices"

AUTHORIZATION FORM FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We have explained that disclosures may be made to family and friends related to the patient's health. It has also been explained that we will only disclose information relevant to current treatment. By signing below you authorized Old Towne Counseling Services, LLC to disclose health care information to the following individuals (list all that apply):

SPOUSE NAME: _____ **Number: ( ) _____ - _____**

IN PERSON **BY PHONE** **VOICEMAIL OK?** **EFFECTIVE DATE: _____/_____/_____**

PARENT(S) NAME: _____ **Number: ( ) _____ - _____**

IN PERSON **BY PHONE** **VOICEMAIL OK?** **EFFECTIVE DATE: _____/_____/_____**

SIBLING(S) NAME: _____ **Number: ( ) _____ - _____**

IN PERSON **BY PHONE** **VOICEMAIL OK?** **EFFECTIVE DATE: _____/_____/_____**

OTHER NAME: _____ **Relation:**_____ **Number: ( ) _____ - _____**

IN PERSON **BY PHONE** **VOICEMAIL OK?** **EFFECTIVE DATE: _____/_____/_____**

_____ _____
(Printed Name of Patient/Parent/Guardian/Representative) **(Relationship to Patient)**

_____ **DATE: _____/_____/_____**
(Signature of Patient/Parent/Guardian/Representative)

Thank you, for choosing Old Towne Counseling & Wellness as part of your care.