POTOMAC CENTER ADULT INTAKE FORM

Name:_____ Date:_____
Address:_____ Gender: M F Age:_____
City:_____ State:_____ Zip:_____ Date of Birth:_____
Social Security #:_____ - _____ - _____
E-mail Address:_____
Is It ok to contact you by e-mail? **YES** **NO**
Chief Complaint:_____
_____

CONTACT TELEPHONE NUMBERS

Please complete relevant information and indicate the number at which you wish to be contacted first.

Phone Numbers		Ok to leave messages?		Primary number?	
Home:	_____	Yes	No	Yes	No
Work:	_____	Yes	No	Yes	No
Cell:	_____	Yes	No	Yes	No

RELATIONSHIP STATUS

Single Divorced (_____years) Living w/significant other (_____ years)

Married (_____ years) Separated (_____ years) Widowed (_____ years)

Spouse's/Partner's Name:_____

If PCI is unable to reach you, is it OK to contact your spouse/partner? **YES** **NO**

If yes, spouse's/partner's phone number: (____)_____

Employment Status:

Are you employed? **YES** **NO** Employer Name:_____

Employer address:_____

EMERGENCY CONTACT INFORMATION

Name:_____

Address:_____
_____

Phone: (____)_____ Relationship to you:_____

PRIMARY CARE PHYSICIAN
Current Physician:_____
Physician Address:_____
Physician Phone Number: (____)_____
By Whom were you referred?_____

RACE (optional):

Caucasian Native American Hispanic African American Asian Other

HOUSEHOLD MEMBERS

Name	Age	Gender	Relationship

INSURANCE INFORMATION

Primary Insurance_____
Insured_____
DOB:_____ Employer:_____
SSN _____
Patient's Relationship to Insured:
Self Spouse Child Other
Authorization Number_____
# of Visits_____
Copay_____Deductible_____

Secondary Insurance_____
Insured _____
DOB:_____ Employer:_____
SSN _____
Patient's Relationship to Insured:
Self Spouse Child Other
Authorization Number_____
# of Visits_____
Copay_____Deductible_____

MEDICAL HISTORY

Allergies (adverse reactions to medications, food….):_____

Date of Last Physical Exam:_____ Findings from exam:_____

Current Medical Conditions and Medications: (diabetes, hypertension, heart problems, asthma, cancer …..)

MENTAL HEALTH AND CHEMICAL DEPENDENCY TREATMENT HISTORY:

Outpatient Therapy:

Therapist Name	Treatment Dates	Reason for treatment	Outcome

Inpatient Therapy:

Location	Treatment Dates	Reason	Outcome

Is there anything else we should know in order to provide you with the best treatment?_____

Signature: _____

AGREEMENT FOR PROFESSIONAL SERVICES DATE _____ Name_____

This form describes the policies of the Potomac Center, which we will both agree to follow. If you have any questions at any time about these procedures, please ask them so that your concerns may be addressed. After reading this form, please sign each paragraph as indicated and the bottom of the form.

Evaluation: After the necessary initial information has been obtained, you will be given a clinical assessment about your situation and the way in which professional services could be helpful. Individual or family therapy or psychological testing may be recommended, or some combination. Group therapy may be beneficial, additionally now or following individual therapy.

Fees:

Intake Evaluation or Psychological testing evaluation code 90791	$195.00
Individual, Family, or Marital Therapy, per 45 minute session	$130.00
Individual, Family or Marital Therapy, per 60 minute session	$174.00
E-mail/phone/text communications with therapist outside of session	$25/15 minutes
Phone consultations with other professionals by therapist regarding patient	$40/15 minutes
Preparations of reports or letters by therapist, including insurance reports	$45/15 minutes
Emergency session	$250/hour
Psychological testing administrative fee	$50
NeuroPsychological testing administrative fee	$100
Initial Testing Evaluation	$195.00
Psychological testing, incl. test administration, Scoring, & Report Writing	$150.00/hour
Neuropsychological testing, incl. Test administration, Scoring & Report Writing	$200.00/hour
Forensic Evaluation, incl. any test administration, Scoring & Report Writing	$200.00/hour
Court Testimony	$800.00/half-day

Court testimony are billed per half-day (4 hour), not including transportation and incidentals on the court date.

Fees are due on the date of service, except for Court Testimony, which are due upon scheduling.

I have read and understand the Fee policy and agree to the terms:

Signature _____

Cancellations:

When you schedule an appointment, that time is reserved for you. If you cannot attend the session, please notify us as soon as possible. There will be a charge of $100 per missed session regardless of the reason unless 48 hour notice is given. There will be no charge if the therapist must cancel a session or if your time can be filled by another patient.

I have read and understand the Cancellation policy and agree to the terms:
Signature _____

Emergencies:

Please call the office for your therapist. lf your therapist is unavailable, please call 911 or go to the nearest emergency room.
I have read and understand the Emergency policy and agree to the terms:
Signature _____

Insurance:

You are responsible for understanding your coverage, getting authorizations or necessary referrals for your visits and for tracking usage of your allowed visits. We will bill your insurance company promptly. However, should

your insurance company be non-responsive or not pay for visits within 45 days, you will be responsible for the full amount due on your account. All copays, deductible and coinsurance are due at the time of visit unless otherwise agreed upon with PCI in writing.
I have read and understand the Insurance policy and agree to the terms:
Signature: _____

Confidentiality:
The information revealed by you is private, and will not be released to anyone without your knowledge and/or written consent. You may wish to grant permission to have your situation discussed with someone else (e.g., a teacher or your physician). We may seek peer consultation about your treatment, where clinically advisable, and discuss your situation among Potomac Center staff.
There are some circumstances where information about you may be revealed:
-If you plan to use medical insurance for your treatment, insurance and managed care companies require specific clinical information in order to process your claim. By using these companies, you agree to allow such information to be released. You will be informed prior to the release as to what information about you will be revealed.
-If there is a clear and imminent danger to yourself or someone else, your therapist has a legal responsibility to try to prevent that occurrence. If you indicate that you have impending suicidal or homicidal plans, knowledge of child abuse, or if you are a health care worker whose job functioning is impaired, warnings about these situations must be given to proper authorities to protect against harm.
-The rules of confidentiality change somewhat when the information is revealed to your therapist when someone else is also present. For example, in marital therapy your spouse may be present for some of the sessions. In group therapy, other patients may be present. Another party to the therapy at some point may request that the information disclosed in their presence be revealed. In these circumstances, the therapist will still attempt to keep your privacy, but the information may not be protected.
-If you become involved in a legal action where your mental health status is at issue, and if a Court of Law deems it necessary, records concerning your treatment may be subpoenaed.

I have read and understand the Confidentiality policy and agree to the terms:
Signature: _____

Payment:
Payment for therapy is expected at the time of each session. If paying by check, please have your check made out to PCI. Payment for psychological evaluations is expected prior to release of the report. If you are using your medical insurance, we will submit a claim to your insurance company for you. Should your insurance company not resolve the account within a reasonable period of time, or should the claim be denied in part or in full, you will be asked to settle the balance on the account in full. Copays, deductibles, coinsurances and self-pay visits are expected to be paid at each session. You are responsible for your own account balance and for any unpaid balances.
I have read and understand the Payment policy and agree to the terms:
Signature: _____

Collection:
Should there be an unpaid balance on your account, we will bill you for the amount due and payment will be expected within 30 days of billing you, unless specific arrangements have been made in writing between your therapist or PCI and you. Should the account not be resolved within 30 days, your account may then be turned over to a collection agency. A $25 collection fee, as well as any interest, may then be added to the account. All collection costs and attorney fees incurred in connection with this action will be the responsibility of the patient. It is further understood that in such a situation, some personal information may no longer be confidential as this information may be revealed to the collection agents.
I have read and understand the Collection policy and agree to the terms:
Signature: _____Date: _____ Name of Patient:_____
Name & Signature of Person responsible for Payment: _____

Potomac Center, Inc

Appointment Reminders:

PCI offers automated text message reminders that are sent out 48 hours (2 Days) & 2 hours before your scheduled appointment. Please keep in mind that this is **not** a reliable way to keep track of your appointments. Text reminders are just as a courtesy service offered by PCI. **You are not required to confirm your appointment to keep your appointment.**

If you need to cancel or reschedule an appointment or if you have any questions pertaining to an appointment, please contact the office either by phone (703-379-7350) or by email (admin@potomaccenter-inc.com).

5500 Holmes Run Pkwy, Ste C4
Alexandria, VA 22304
www.mypotomaccenter.com
admin@potomaccenter-inc.com
703-379-7350 P.
703-379-7352 F.

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between Behavioral Health Providers and your Primary Care Physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share Protected Health Information(PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, and medication if necessary.

I, _____the undersigned, understand that I may revoke this consent at any time. I have read and understand the information and give my authorization:

Patient Authorization

☐ I agree to release any applicable mental health/substance abuse information to my PCP
My Primary Care Physician is_____
Address_____
Telephone Number:_____
☐ I agree to release only medication information to my PCP
☐ I WAIVE NOTIFICATION of my PCP that I am seeking or receiving mental health services, and I direct you NOT to so notify him/her.
☐ I do not have a PCP and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a PCP that I am seeking or receiving mental health services.

Patient Signature_____ Date of Birth:_____ Date_____

Patient Rights:

- You can end this authorization (permission to use or disclose information) any time by contacting PCI, in writing, by mail, or e-mail (5500 Holmes Run Pkwy Ste C4, Alexandria, VA 22304 or admin@potomaccenter-inc.com)
- If you make a request to end this authorization, it will include information that had already been used or disclosed based on your previous permission.
- You have a right to copy of this signed authorization. Please keep a copy for your records.
- You do not have to agree to this request to use of disclose information

Information to be completed by Behavioral Health Provider

I saw_____on_____for_____
(Patient Name) (Date) (Reason/Diagnosis)

Summary:_____
_____
_____
_____

Provider Signature:_____ **Date:**_____

Provider: Please send a copy of this signed form to the PCP and keep the original in the treatment record.

Notice To recipient of Information

The information has been disclosed to you from records of confidentiality of which may be protected by federal and/or state law. Of the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal restrict any use of the information to criminally investigate any alcohol or drug abuse patient.

Potomac Center, INC.
5500 Holmes Run PKWY Ste C4
Alexandria, Virginia 22304

Virginia Notice Form

"Notice of Psychotherapists" Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

1. Uses and Disclosures for Treatment, Payment, and Health Care

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
  Treatment, Payment and Health Care Operations
- *Treatment* is when I provide, coordinate or manage health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
- *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- *Health Care Operation* are activities that relate to the performance and operation of my practice. Examples of health care operations re quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *Use* applies only to activities within my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

2. Uses and Disclosures Requiring Authorization

I may us or disclose PHI for purposes outside treatment, payment and health care operation when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when I am asked for information for purposes outside of treatment, payment, and health care operations. I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy note: are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection then PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to consent the claim under policy.

3. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization the following circumstances:

- **Child Abuse:** If I have reason to suspect that a child is abused or neglected, I am required by law to report the matter immediately to the Virginia Department of Social Services.

- **Adult and Domestic Abuse**: If I have reason to suspect that an adult is abused, neglected or exploited, I am required by law to immediately make a report and provide relevant information to the Virginia Department of Welfare or Social Services.

- **Health Oversight:** The Virginia Board of Psychology has the power, when necessary, to subpoena relevant records should I be in the focus of an inquiry.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena (of which you have been served, along with the proper notice required by state law). However, if you move to quash (block) the subpoena, I am required to place said records in a sealed envelope and provide them to the clerk of court of the appropriate jurisdiction so that the court can determine whether the records should be released. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advanced if this is the case.

- **Serious Threat to Health or Safety:** if I am engaged in my professional duties and you communicate to me as specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently. I must take steps to protect third parties. These precautions may include (1) warning and potential victim(s), or the parent or guardian of the potential victim(s), if under 18: or (2) notifying a law enforcement office.

- **Worker's Compensation:** if you file a worker's compensation claim, I am required by law, upon request to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

4. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy noted in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On our request, I will discuss with you the details of the request and denial process.

- Right to Amend – You have the right to request an amendment of PHI is maintained in record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice)/ On your request, I will discuss with you the details of the account process.

- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive notice electronically.

Psychotherapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will let you know by mail.

V. Questions and Complaints:

If you have questions about this notice, disagree with a decision we made about access to your records, or have other concerns or complaints about your privacy rights, you may contact us at admin@potomaccenter-inc.com or call us at 703-379-7350.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on_____ {date patient signs this form}.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with the revised notice if I make changes.

I acknowledge that I have read Potomac Center's Notice of Privacy Practices

_____

Please print your name here

_____

Signature

_____

Date

PATIENT'S RIGHTS AND RESPONSIBILITIES STATEMENT

Statement of Patient's Rights

Patients have the right to be treated with dignity and respect.

Patients have the right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.

Patients have the right to have their treatment and other member information kept private only by law, may records be release without patient permission.

Patients have the right to easily access care in a timely fashion.

Patients have the right to know all about their treatment choices. This is regardless of cost or coverage by the patient's benefit plan.

Patients have the right to share in developing their plan of care.

Patients have the right to information in a language they can understand.

Patients have the right to have a clear explanation of their condition.

Patients have the right to get information about Potomac Center, Inc. services and role in the treatment process.

Patients have the right to know the clinical guidelines used in providing and managing their care.

Patients have the right to information about provider work history and training.

Patients have the right to provide input on Potomac Center, Inc. policies and services.

Patients have the right to know about advocacy and community groups and prevention services.

Patients have the right to freely file a complaint, grievance or appeal and to learn how to do so.

Patients have the right to know about laws that relate to their rights and responsibilities.

Patients have the right to know of their rights and responsibilities in the treatment process.

Statement of Patient's Responsibilities

Patients have the responsibility to treat those giving them care with dignity and respect.

Patients have the responsibility to give providers information they need. This is so providers can deliver the best possible care.

Patients have the responsibility to ask their providers questions about their care. This is so they can understand their care and their role in that care.

Patients have the responsibility to follow treatment plans for their care. The plan of care is to be agreed upon by the patient and the provider.

Patients have the responsibility to follow their agreed upon medication plan.

Patients have the responsibility to tell their provider about medication changes, including medications given to them by others.

Patients have the responsibility to keep their appointments. Patients should call their provider as soon as possible if they need to cancel visits.

Patients have the responsibility to let their provider know when the treatment no longer works for them.

Patients have the responsibility to let their provider know about problems with paying fees.

Patients have the responsibility to not take actions that could harm others.

Patients have the responsibility to report abuse.

Patients have the responsibility to report fraud.

Patients have the responsibility to openly report concerns about quality of care.

SIGNATURE DATE

Potomac Center, Inc.

www.potomaccenter-inc.com

I, _____, hereby authorize the Potomac Center, Inc. to file claims to my insurance(s) on my behalf for covered services rendered, and request that payments from my insurance carrier(s) be made directly to Potomac Center, Inc.

I certify that the information I have reported with regard to my insurance(s) coverage is correct and authorize the release of any necessary information to my insurance carrier in order to determine and receive benefits to which I may be entitled.

☐ I have secondary insurance

☐ I do **not** have secondary insurance

This authorization may be revoked by either me or my insurance carrier at any time in writing. I permit a copy of this authorization to be used in place of the original.

_____ _____

Signature of Subscriber/Beneficiary Date

5500 Holmes Run Pkwy, Ste C4
Alexandria, VA 22304
admin@potomaccenter-inc.com
703-379-7350 P.
703-379-7352 F.

REQUEST FOR NON-COVERED SERVICES

I am hereby requesting that the following services be provided to me by _____ .
(Provider Name)

Service(s) (List All)	Frequency Limitations	Proposed Date(s) of Service	Estimated Cost of Service(s)

In making this request, I acknowledge that these services are not a benefit of my health coverage under TRICARE and that I will not receive the benefit of the TRICARE Hold Harmless Policy (defined below), which otherwise might apply to me. In addition, I acknowledge that if I have obtained services more frequently than authorized by TRICARE policy, I may be responsible for that professional service.

I also understand that if authorization for this care has been denied by TRICARE, or if reimbursement is denied upon submittal of a claim form, I may appeal the written notification of the denial issued by Health Net Federal Services, Inc./MHN Services.

Unless the decision to deny is overturned as the result of an appeal or dispute, I agree that I will be personally responsible for the payment IN FULL of the billed charges for these services.

_____ _____
Sponsor Name **Patient Name (Print)**

_____ _____
Sponsor Social Security Number **Signature of Patient**

_____ _____
Sponsor Address **Date**

TRICARE Hold Harmless Policy: A network provider may not require payment from the beneficiary for any excluded or excludable services that the beneficiary received from the network provider (i.e., the beneficiary will be held harmless) unless the beneficiary has been properly informed that the services are excluded or excludable and has agreed in advance in writing to pay for the services.

Privacy Act Statement:

In view of the fact that personal information is being requested from you, notice is hereby given as required by the Privacy Act of 1974. The information is requested and maintained under the authority of Chapter 55, Title 10, United States Code, Section 3101, Title 44, United States Code, and 41 Code of Federal Regulations 101-1100 ***et seq.*** *The information is requested to establish or update information to control or process claims for payment. Routinely, the information will be used to determine eligibility for TRICARE benefits, review and approve medical care as TRICARE benefits, and to determine reasonable charges/costs of care to be cost-shared under TRICARE. Disclosure of the information is voluntary; however, failure to provide the information may result in denial of benefits.*

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