Dominion Center for Behavioral Health Services, PC

New Patient Paperwork for Minors

Patient

Legal Name*: Last	First	Preferred Name:
Date of Birth:	Social Security Number:	
Marital Status:	Legal Sex*:	Preferred Pronouns:
Address:		
City:	State:	Zip Code:
Home Phone:		
Cell Phone:		
Work Phone:		
Home e-mail:		
Work e-mail:		

*While DCBHS recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence, if your preferred name and pronouns are different from these, please let us know.

Emergency Contact

Name:
Primary Phone Number:
Relationship:

Parent / Guardian Information - Required if the patient is less than 18 years of age

Legal Last Name:		
Legal First Name:		
Date of Birth:	Social Security Number:	
Custody Status:	Legal:	Physical:
Address:		
City:	State:	Zip Code:

Other Custodial Information:

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Dominion Center for Behavioral Health Services, PC

Primary Insurance Information (DCBHS will need a copy of both sides of the insurance card)

Insurance Company:	Employer:
Group Number:	
Member ID Number:	
Effective Dates: From:	To:

Insured's Information (if not self)

Relationship to insured:		
Legal Last Name:	Legal First Name:	
Date of Birth:	Social Security Number:	
Marital Status:	Legal Sex:	
Address:		
City:	State:	Zip Code:

Secondary Insurance Information
(If Applicable, DCBHS will need a copy of both sides of the insurance card)
Dominion Center for Behavioral Health Services, LP does not bill secondary insurance except as required by law.

Insurance Company:	
Group Number:	
Member ID Number:	
Effective Dates: From:	To:

Insured's Secondary Information (if not self)

Relationship to insured:		
Legal Last Name:	Legal First Name:	
Date of Birth:	Social Security Number:	
Marital Status:	Legal Sex:	
Address:		
City:	State:	Zip Code:

I authorize Dominion Center for Behavioral Health Services to contact me and leave messages for me using any of the above listed contact information, except as individually excluded below.

_____ _____

Parent / Guardian Date

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DCBHS CANCELLATION POLICY AGREEMENT

Appointments scheduled at DCBHS are blocks of time set aside exclusively for the benefit of the scheduled patient. A patient's failure to attend a scheduled appointment without providing adequate notice affects both the patient's behavioral health provider and other patients. The provider is deprived of income, and other patients are deprived of the opportunity to see that provider, because of the difficulty of filling the vacated time slot when inadequate or no notification is given. In an effort to accommodate all DCBHS' patients and providers, DCBHS has implemented the following cancellation policy. **PLEASE NOTE: All DCBHS patients must read, sign, and agree to the DCBHS cancellation policy prior to their first scheduled appointment. Failure to do so may result in denial of treatment.**

As a DCBHS patient (or patient's legal representative) (hereinafter me, my, I, etc.), I agree to the following terms of DCBHS' cancellation policy:

I. I understand and agree that I must call DCBHS **24 hours prior to my scheduled appointment** to notify DCBHS of my intent to cancel my scheduled appointment.
   a. To cancel an appointment at DCBHS call: 703-348-0030.
   b. I understand that, due to high call volume, calls may be routed to an automated voicemail. I understand that DCBHS voicemails are logged with the time and date of receipt.

II. I understand and agree that should I arrive late past the time below, I will not be seen and be charged a missed appointment fee.

Therapy/Intake Appointments	**20 MINUTES LATE**
15 min. medication management sessions	**7 MINUTES LATE**
30 min. medication management sessions	**10 MINUTES LATE**
45 min. medication management sessions	**15 MINUTES LATE**

III. I understand and agree that I may cancel an appointment with less than the required notice (listed above) **ONLY** if all requirements of the following situations are satisfied:
   a. If the Loudoun County Government (**NOT** THE LOUDOUN COUNTY SCHOOL SYSTEM) is declared closed due to snow or inclement weather.
   b. In the event of an illness, i) I must provide DCBHS a note from the medical professional or hospital indicating the date and time I was examined, and ii) I must call to cancel my scheduled appointment with DCBHS prior to the appointment time.
   c. In both cases, if I am unable to reach a DCBHS representative, I understand I must leave a voicemail message.

IV. I understand and agree that I may appeal to DCBHS to waive a missed appointment fee under the following conditions:
   a. I submit an appeal, in writing, within 30 days of the missed appointment. Appeals will not be handled over the phone.
   b. I will accept DCBHS' appeal decision as final.

V. I understand and agree that I will be charged a missed appointment fee to correspond with the chart below if I miss an appointment without making a timely cancellation (as described in Sections I and II above). I understand and agree that failure to pay any balance of missed appointment fees may result in the denial of treatment by DCBHS.

Provider / Visit Type	Missed Appointment Fee
M.D., N.P. or Ph.D.	$100.00
Master's Level Clinician (LCSW or LPC)	$75.00
Psychological Testing	$100.00 per hour
Supervisee/Resident	$40.00

By signing this form, I acknowledge that I have read, fully understand, and will abide by the policies and fees indicated in this DCBHS Cancellation Policy Agreement.

Parent/Guardian's Name: _____ Signature: _____

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Dominion Center for Behavioral Health Services, PC

Financial Policies Agreement (p. 1 of 2)

Patient Name: _____ Date: _____

If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our payment policy:

- Your bill is based on the services you received. You are responsible for paying the bill if your insurance company does not cover all the costs.
- What your health insurance covers is based on an agreement between the company, or person who employs you, and the insurance company.
- **It is the patient's responsibility to contact their insurance company with any questions about what they will cover. This includes referrals, eligibility, and benefit information.**
- We know that temporary financial problems can sometimes prevent you from making a payment on your account on time. If this happens, you need to contact us at 703-348-0030 x 130 at once so we can help you with this problem. The billing department will help to arrange a payment plan.
- Any bill not paid by the date it is due will be sent to a collection agency.

_____ **(Initial) PLEASE NOTE: We do NOT participate with Medicare, Medicaid (and their HMO plans), and Beacon Health.**

a. **IF YOU DO NOT HAVE HEALTH INSURANCE**

Your Responsibility:

- You must pay your entire bill at the time of service or inform us of your inability to pay.

Our Responsibility:

- The DCBHS billing department is available to discuss financial options with you at 703-348-0030 x 130.

b. **IF YOU HAVE HEALTH INSURANCE**

We participate with many insurance companies. This means we have signed a contract with them to provide care for the people they cover. The contracts are not all the same, and certain services may not be covered depending upon your benefits.

If we DO participate with your insurance plan:

Your Responsibility:

- You must pay any co-payment at the time you receive the service.
- You must pay any deductible amount or any amount that you know is not covered at the time of service.
- You must pay the amount not paid by your insurance. Payment is due upon receipt of the statement. If you do not pay we will begin collection efforts.

Our Responsibility:

- We will send a claim to your insurance company for all services done in our office.
- After insurance processes the claim, we will mail you a statement for any remaining balance.

If we DO NOT participate with your insurance plan:

Your Responsibility:

- You must pay for the service at the time it is given. Our office accepts cash, checks, VISA, MasterCard, Discover, and American Express.

Our Responsibility:

- After you have paid us, we will provide you with a detailed receipt upon your request. You will then submit it to your insurance for reimbursement.

c. **Returned checks will result in a $25.00 fee that will be posted to your account.** DCBHS has a "One Bad Check" Policy. If your account has one returned check then you will not be allowed to write checks for future services. **DCBHS is a partner in the Loudoun County Commonwealth Attorney's check enforcement program and as such, clients with multiple offenses will be reported accordingly.**

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Dominion Center for Behavioral Health Services, PC

Financial Policies Agreement (p. 2 of 2)

STATEMENT OF FINANCIAL RESPONSIBILITY

In accordance with the DCBHS financial policies above, the patient (or patient's legal guardian) (hereinafter I, me, my, etc.) hereby understands and agrees to the following terms:

1. I accept financial responsibility for all clinical and administrative services provided by Dominion Center for Behavioral Health Services, LP.

2. I authorize payment to Dominion Center for Behavioral Health Services, LP for all services rendered. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

3. I understand and agree that all ancillary services that are provided will be billed at the provider-specific hourly rate as noted below. Ancillary Services are defined as **patient-initiated** services which are not part of an initial assessment nor provided as part of a scheduled appointment. These services are not covered by insurance and involve an exchange of information, performed by the physician, psychologist, social worker, nurse practitioner, or therapist at DCBHS. Examples of ancillary services include but are not limited to: All patient-related phone calls including phone consultations with patient or family members, physicians, therapists, psychologists, school officials (administrators, teachers, counselors, etc.), attorneys, etc., crisis counseling on the phone, email correspondence, time associated with preparing for non-appointment medication refills, completion of any forms during non-appointment times, etc. This does not include communication with the administrative staff. Legal and court-related matters are billed at a higher rate and require a prior contract and retainer.

ANCILLARY SERVICE RATES:

Provider Type	Billable Rate (Per Hour / Per Increment)	Legal Service Billable Rate (Per Hour)
Psychiatrists	$220/hour; $55/Fifteen Minutes	$350/hour
Nurse Practitioners	$165/hour; $40/Fifteen minutes	$350/hour
Psychologists	$180/hour; $45/Fifteen Minutes	$350/hour
Master's Level Clinicians	$120/hour; $30/Fifteen Minutes	$250/hour
Supervisees/Residents	$60/hour; $15/Fifteen Minutes	$150/hour

- Legal services are billed with a 4 hour minimum requirement (including travel and wait time), and billed in 15 minute increments.

6. I understand and agree that if my account goes to a third party for collections; I am responsible for all fees incurred.

7. I understand and agree that if I have a balance on my account that it needs to be paid before my appointment and that failure to pay the debt may result in me not being seen and a missed appointment fee being added to my account. *PLEASE NOTE:* If you are unsure of your balance you may call DCBHS.

By signing this form, I acknowledge that I have read, fully understand and agree to abide by the policies and fees in this agreement.

Parent / Guardian's Name: _____ Signature: _____

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Dominion Center for Behavioral Health Services, PC

Informed Consent for Treatment

I, _____ (name of patient), agree and consent to participate in behavioral health care services offered at and provided by Dominion Center for Behavioral Health, LP, providers.

I understand that I am consenting and agreeing only to those services that the provider is qualified to provide within: (1) the scope of the provider's license, certification, and training: or (2) the scope of the license, certification and training of the behavioral health care provider directly supervising the services received by the patient. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent to treatment, and I am legally authorized to initiate and consent to treatment on behalf of this individual.

I agree to notify the other parent/guardian of the minor that they are seeking treatment at DCBHS and invite them to participate in the process.

Length of Services

Initial Evaluation and Diagnosis: 45-50 minutes
Subsequent Counseling Sessions: 45 minutes
Medication Management Follow-Ups: 15-45 minutes
Marriage and Family Sessions: 45-50 minutes

Phone Consultations/Emails/Ancillary Charges

Phone Consultations and Ancillary Fees will be billed in 15 minute increments at the provider's hourly self-pay rate.

Time spent answering emails outside of an appointment time is considered an ancillary charge and is subject to the associated fees.

We will make every effort to ensure that you are seen in a timely manner; however, the doctor may be called for an emergency consult. Please arrive for your appointment on time, or we may need to reschedule your appointment. We appreciate your cooperation and understanding.

Parent / Guardian's Name: _____ Signature: _____

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Dominion Center for Behavioral Health Services, PC

Notice of Privacy Practices

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

This notice covers all information in our written or electronic records which concerns you, your care and payments for your care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing your care, or manage some of our administrative operations.

Dominion Center for Behavior Health Services (DCBHS) physicians, clinicians and staff may use and disclose medical information (protected health information or PHI) about an individual for:

a. Mental Health Treatment – i.e.; providing mental health care services, sending/coordinating care information with other health care providers caring for you, ordering and obtaining off site tests/results, writing prescriptions, etc.
b. Payment – i.e.; submitting insurance claims on your behalf for treatment rendered.
c. Health Care Operations – i.e.; internal business planning activities and quality of care evaluation.

Dominion Center for Behavioral Health Services is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization, including, but not limited to:

a. **Disclosures required by law**
b. **Disclosures to avert serious threats to health and safety**
c. **Disclosures with reference to Workers' Compensation or Food and Drug Administration**

Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization. (Please see below for identifying persons to whom you would allow disclosures of otherwise protected information).

Dominion Center for Behavioral Health Services (DCBHS) may contact the individual to provide appointment reminders or information about treatment or other health-related benefits and services that may be of interest to the individual or patient. DCBHS will routinely contact patients via telephone or secured e-mail at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments, test results, etc.

Our patients have the following rights regarding their protected health information:

a. The right to request restrictions on certain uses and disclosures of protected health information. DCBHS is not required to agree to a requested restriction, however.
b. The right to receive confidential communications of protected health information, as applicable.
c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
d. The right to amend protected health information, as provided in the Privacy Regulation.
e. The right to receive an accounting of disclosures of protected health information.
f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.

DCBHS is required by law to maintain the privacy of the protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information. DCBHS is required to abide by the terms of the Notice currently in effect. DCBHS reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains. DCBHS will provide individuals or patients with a revised Notice by posting new regulations in each office.

Individuals may complain to DCBHS and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. DCBHS's contact person for matters relating to complaints is:

Michael Neuman – DCBHS Practice Administrator
43130 Amberwood Plaza, Suite 140, South Riding, VA 20152 703-348-0030 x 140

Dominion Center for Behavioral Health Services, PC

Please provide the name(s) of person(s), if any, to whom you would permit Dominion Center for Behavioral Health Services (DCBHS) to disclose personal health information as necessary for your continued health care. Please also note if specific health care information cannot be disclosed (i.e.; test results, appointment information, etc.) Otherwise, we will disclose only what is necessary for your continued health care in accordance to the Privacy Policy.

List below those individuals (family, friends, interpreter services, etc.) you will allow disclosure of your personal health information from DCBHS as necessary during the course of your health care services:

Name and Relation (circle one) **Allowed Disclosure(s) Please circle ALL or specify**

Spouse: _____ All or Specify: _____

Family/Friend -Name _____ All or Specify: _____

Family/Friend -Name _____ All or Specify: _____

Family/Friend - Name _____ All or Specify: _____

Family/Friend – Name _____ All or Specify: _____

_____ (Initial) if you will allow interpreter services if necessary for communication with health care providers

_____ (Initial) I acknowledge and understand that Dominion Center for Behavioral Health Services' policy is to obtain an authorization from the patient before sending copies of test results and/or other medical information to other physicians. DCBHS's policy is to only disclose specific information necessary for coordination of your health care or mental health treatment.

_____ (Initial) I acknowledge and understand Dominion Center for Behavioral Health Services' policy to contact me by various means when necessary for my health care services which may include by home/work/cell phone, text, fax, and/or email. I also understand that private health information may be included in that communication to me.

I **DO NOT** want DCBHS to use the following methods of communication which may include my private health information: **Please list**:

I hereby acknowledge that I have read pages 1 and 2 of Dominion Center for Behavioral Health Services Notice of Privacy Practices and received a copy (if requested).

Signature _____ Date _____

Printed Name _____

Patient Name _____

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PATIENT RESPONSIBILITIES FOR FOLLOW-UP APPOINTMENTS AND MEDICATION REFILLS

It is very important that you follow the treatment guidelines ordered by your doctor. During each appointment, your doctor will indicate a time frame for your next visit. **Please be advised that if you see a psychiatrist or a nurse practitioner, your doctor cannot refill medications without performing the appropriate follow-up evaluation.** It is your responsibility to ensure that you have appropriate follow-up appointments scheduled. Some of the appointment times (early morning, late afternoon, and evening) fill up very quickly, thus it is strongly recommended that you schedule your next appointment before you leave the office. If that is not possible, follow-up appointments should be scheduled within the next one or two days thereafter. This will allow you to choose a time that is most convenient for you, and will ensure that you do not run out of medication, as it is sometimes dangerous to abruptly stop your medication if you do not follow these procedures, your appointment time options will be very limited.

It is your responsibility to make and keep your appointments within the time frame indicated by your doctor.

All medical refill requests should be requested via email. Once received, all medication refill requests will be sent to the pharmacy within **3 business days**. Medication refill requests will be monitored and addressed between 9AM - 5PM Monday through Friday. Requests made after hours or on the weekends will be addressed the following business day. Clients must be seen at least every 3 months to properly manage the medications. Medications may not be refilled if the appointments are not kept, and this will be at the discretion of the prescribing provider. **Medication refills are subject to a fee of $15 if requested outside of an appointment.** Please communicate any time sensitive medication concerns (side effects, rash, etc.) to the medical assistant at **703-348-0030 x 152** to schedule an appointment or phone consultation with the prescribing provider.

I acknowledge reading the above policy:

Parent / Guardian's Name: _____ Signature: _____

DCBHS SUPERVISION AND ASSISTANCE AGREEMENT

DCBHS employees, providers and staff do not provide direct supervision of patients, nor any adults or minors in the waiting room, and cannot assume responsibility for supervision prior to, during, or following a scheduled appointment. If the individual requires such supervision and/or assistance with toileting or medication management during their appointment, a parent or guardian must remain in the waiting room to assist the individual or to provide necessary supervision immediately prior to or following the completion of the patient's appointment. Because of this, it is highly recommended that no minor under the age of 11 be left unattended in the waiting room.

By signing this form, I, the patient or the patient's parent/guardian, acknowledge that I have read, fully understand, and will abide by the policies indicated in this DCBHS Supervision and Assistance Agreement (SAA).

Parent / Guardian's Name_____

Signature_____

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Dominion Center for Behavioral Health Services, PC

DCBHS Policy on Rights of Separated or Divorced Parents/Guardians to Consent to Mental Health Services for Minor Child

In the event of a divorce or separation, the Commonwealth of Virginiaa recognizes only two legal custodial rights for parents/guardians of minor children: **1) Sole Custody** or **2) Joint Custody**. No other physical custody arrangements are legally recognized within the State.
The right of a parent/guardian of a minor child to seek mental health services for the minor child varies by the parent/guardian's legal custodial designation as follows:

1) **SOLE LEGAL CUSTODY:**
   A parent/guardian with **sole legal custody** has the right to seek a mental health evaluation and/or treatment of a minor child unilaterally and without consent from the non-custodial parent.

2) **JOINT LEGAL CUSTODY:**
   A parent/guardian with **joint legal custody** will be required to produce appropriate documentation in order to determine:
   a. Whether the other parent/guardian must be notified in the event one parent seeks mental health services for the minor child; **AND/OR**
   b. Whether both parents/guardians must agree to obtain a mental health evaluation and/or treatment for the minor child.
   c. *PLEASE NOTE: In some cases, depending on the custody agreement, parents/guardians who disagree can have a judge determine whether mental health services are in the minor child's best interest.*

3) **NO LEGAL CUSTODY:**
   A parent/guardian **without** a recognized legal custodial right:
   a. Has the right to access the minor child's medical records;
   b. Can seek emergency medical treatment, which likely will not include mental health treatment; **AND**
   c. Can petition a court for an order prohibiting the evaluation and/or treatment of the minor child because it's not in the child's interests.

In accordance with these limitations, DCBHS has enacted the following policies for separated or divorced parents/guardians of minor children seeking mental health services for the minor child:

1) A parent/guardian with **sole legal custody** shall produce, prior to services:
   a. A letter from their attorney stating that there is nothing in the custody agreement that would prevent this individual from seeking evaluation and/or treatment of this child; **OR**
   b. Evidence in the form of a copy of the section of the court approved legal custody agreement verifying that parent/guardian is the sole legal custodian and has the unilateral right to make decisions with regard to the minor child's mental health.

2) A parent/guardian with **joint legal custody** shall produce prior to services:
   a. Evidence of the court-ordered joint legal custody agreement (see above); **AND**
   b. Written consent from both parents to pursue mental health services for the minor child.

As the parent/guardian of _____, I, _____, acknowledge the DCBHS Policy on consent for mental health services for a minor by separated or divorced parents, and agree to furnish the appropriate documents, as described herein, to prove my custodial right to seek said mental health services.

_____	_____	_____
Printed Name	Signature	Date

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CONSENT TO TREAT MINOR PATIENT WITHOUT PARENT PRESENT

The State of Virginia and the Virginia Medical Board require consent before medical care can be given. During a session with a minor, they are typically seen for a portion of or the entirety of the session without the parent/legal guardian present as a component of the therapeutic process. Parents and legal guardians reserve the right to be present during the sessions, however this form allows the minor to be seen individually and does not *require* the parent or legal guardian to be present in the session. The parent or legal guardian is always encouraged to inform the treating clinician if they would like to take part in a session or if they would like an update regarding the minor's treatment.

I, _____ (print name here), am the parent/legal guardian of _____ (print name of minor), currently a minor, whose date of birth is _____.

I authorize DCBHS to provide mental health care to my minor child, including, but not limited to, diagnostic and necessary medical treatment as deemed appropriate by their clinician.

I understand that, should my minor child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such care is initiated.

I further understand, once my child reaches the age of majority, my consent for treatment is no longer required. This consent will remain in effect until the patient reaches the age of eighteen unless revoked in writing to DCBHS.

By signing this, I acknowledge I have read and agree to this consent and that any questions I had prior to signing were answered by DCBHS.

Parent / Guardian's Name: _____ Signature: _____

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Dominion Center for Behavioral Health Services, PC

Primary Care Physician Notification Letter

This letter provides notification that the patient listed below has entered into outpatient treatment at Dominion Center for Behavioral Health Services. The consent below allows for you, the Primary Care Physician, to collaborate with the patient's provider at 703-348-0030 to discuss the care and treatment of our mutual patient.

Name of Patient: _____

Date: _____

Primary Care Physician: _____

Physician's Address: _____

_____

_____

Phone: _____ Fax: _____

_____ I consent for this letter to be sent to the above Primary Care Physician.

_____ _____

Parent/Guardian Signature Printed Name

_____ I decline to have my Primary Care Physician notified/involved in my treatment while at Dominion Center for Behavioral Health Services.

_____ _____

Parent/Guardian Signature Printed Name

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