Welcome to RVA Counseling

Turning Over a New Leaf

Our practice is one that brings together a team of unique, passionate and professional mental health clinicians. We are seasoned professionals, pre-licensed clinicians working through residencies and dedicated interns. Each of us is committed to providing you with support. We understand that every individual and family is unique, which is why we value continuous collaborative learning of ourselves, of each other and of our world.

Counseling is a real commitment of time and energy. At any time, should you decide to terminate counseling for any reason, you have the right to end the therapeutic relationship. As well, your clinician retains the right to end the professional relationship and make appropriate referrals.

Client Rights

As a client of this practice, you have the right to be treated with dignity and respect regardless of your race, gender, religion, age, sexual preference or ethnicity. You have the right to participate in the planning of your treatment.

Limitations of Confidentiality

If you should threaten to harm an identifiable third party, it is required that notifications be given to local law enforcement agencies and the person in potential danger. If you should threaten to harm yourself in a clear and planned manner, it is required by law to take necessary steps to protect your life. Please refer to the Notice of Privacy Practices to see more about Protected Health Information (PHI).

Contact Information & Hours

Email: riverside@rvacounseling.com

Phone: 804-716-0428

Office hours: M-F 8am-8pm, Sat: 8am-2pm

Informed Consent For Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. Although there are benefits to telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

Risks to confidentiality: Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On our end, we will take reasonable steps to ensure your privacy. But it is important for you to make sure that you find a private place for our session where you will not be interrupted. The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. We will maintain a record of our sessions in the same way we maintain records of in-person sessions in accordance with our policies.

Issues related to technology: There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies. There is a risk that our electronic communications may be compromised, unsecured, or accessed by others. Both client and clinician agree to take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device being used for telepsychology).

Efficacy: Some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely. The efficacy and productivity of telepsychotherapy sessions should be communicated openly between clinician and client. We will let you know if we feel that telepsychology is no longer the most appropriate form of treatment.

Fee's. There are instances in which the insurance or other managed care providers may not cover sessions that are conducted via telecommunication, or they may have different amounts of coverage for telehealth. If your insurance, HMO, third-party payer, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session.

Please sign below to acknowledge your receipt of our practice policies and practices and consent to receive services.

_____ _____

Signature of Client, Parent, Guardian, and/or Representative *Date*

Client Information

Legal Name: _____

Preferred Name/Nickname: _____ Pronouns: _____

Date of Birth: _____ / _____ / _____ Administrative Sex: ▫ Male ▫ Female

Address: _____

City/State/Zip: _____

Phone Number: (_____) _____ - _____ ▫ Mobile ▫ Work ▫ Home

Gender Identity: _____ Sexual Orientation: _____

Race: _____ Ethnicity: _____

Languages: _____

Marital Status: _____ Religious Affiliation: _____

Employment: _____

Client History

Why are you seeking help now? What is happening or is it different? What stressors do you have? What do you hope will be different by seeking help?

Please give more details about the issue you named above: When did it start? How often does it happen? How does it affect your life? How have you dealt with it so far?

Have you ever experienced similar or other mental health symptoms before? If so, what was your experience like? When did it happen? Did you get help?

Has anyone in your family ever experienced mental health or substance use issues? If so, who was it? Did they seek help or get a diagnosis? What was it like for them? What was it like for you?

Do you have any current or prior medical issues? If so, what was it? Have you seen a doctor or other healthcare professional for it? What recommendations or treatment did you have? Is there any family history of disease?

Are you currently prescribed any medications? If so, please list the name, dosage, how often you take it, and the prescriber for each medication.

Do you now, or have you ever, used alcohol, tobacco, recreational drugs, or prescription medication other than as prescribed? If so, which? When did you start ? How often did/do you use, and how long did this occur? Please list each substance separately.

Who is in your family? What is your relationship with them like? Please list all individuals you consider to be a part of your family. For those who are not part of your family of origin (such as significant others), please include the duration of your relationship.

What social activities and relationships do you engage in? What important social relationships do you have? Do you belong to any social clubs or organizations? How do you like to spend your leisure time?

What spiritual practices and cultural influences are important to you? Do you belong to a religious, faith, or spiritual community? What other cultural groups do you identify with? How do you celebrate culture and spirituality in your life?

What was life like as you were growing up, both at home and in school? Did you meet developmental milestones on time or experience any delays? What were your friends like when you were younger? What was school like for you?

What significant educational and work/volunteer experiences have you had? What is the highest level of education you have completed? Are you currently employed? If so, where and for how long? What other work and educational experiences have you had (such as a stay-at-home parent or semester abroad)? Are you satisfied with your current employment and education?

Do you have any current or prior legal issues? Were you ever arrested or charged with a crime or misdemeanor? Do you have any involvement with the civil courts, such as a lawsuit or family law matter? If so, please describe them.

What strengths and abilities are you bringing to sessions? What needs or preferences do you have that will help us be successful? What coping skills have been working for you so far? What is important to know that will help make our time more effective for you?

What else is important to know about you?

Client Contacts

Party Responsible for Billing:

▢ Me/The Client ▢ Guardian ▢ Contact #1 ▢ Contact #2 ▢ Contact #3

Contact #1

Contact Name: _____

Contact Type: ▢ Emergency Contact ▢ Guardian ▢ Primary Care Physician

Relationship: _____ Date of Birth: _____ / _____ / _____

Address: _____

City/State/Zip: _____

Phone Number: (_____) _____ - _____ ▢ Mobile ▢ Work ▢ Home

Phone Number: (_____) _____ - _____ ▢ Mobile ▢ Work ▢ Home

Fax Number: (_____) _____ - _____

Email Address: _____

Contact #2

Contact Name: _____

Contact Type: ▢ Emergency Contact ▢ Guardian ▢ Primary Care Physician

Relationship: _____ Date of Birth: _____ / _____ / _____

Address: _____

City/State/Zip: _____

Phone Number: (_____) _____ - _____ ▢ Mobile ▢ Work ▢ Home

Phone Number: (_____) _____ - _____ ▢ Mobile ▢ Work ▢ Home

Fax Number: (_____) _____ - _____

Email Address: _____

Insurance Information

☐ **I do not have or do not want to use insurance benefits. I will be responsible for all charges related to the services rendered.**

Insurance Company: _____

Member ID: _____

Policy Group *(leave blank if unsure)*: _____

Plan Name *(leave blank if unsure)*: _____

Acknowledgement

I authorize RVA Counseling to release information to the insurance companies provided on this form in order to submit insurance claims on my behalf. This authorization extends to the extent necessary to obtain payment for the services provided to me, and includes authorization to release information about mental health, substance use, or HIV diagnoses as required. In consideration of the services provided to me, I assign all benefits to RVA Counseling if accepted, and authorize my insurance companies, Medicare, or other third-party payers to make payments directly to RVA Counseling and its affiliates. I understand that I remain responsible for all amounts due by me, including (but not limited to) copays, coinsurance, deductible amounts, and all services not covered by my insurance plan (including those for which I fail to obtain prior authorization), and mutually agreed-upon services or fees that are deemed not medically necessary.

Signature: _____ Date: _____

Fee Agreement

Below please find information about the billing policies and fees that apply to all clinicians at RVA Counseling. Please take the time to read through the following information and let us know if you have any questions.

Client Portal

The easiest way to request appointment changes or update your information is on our client portal system. You can use the portal system to complete paperwork, make or change appointments, complete online payments and update your insurance or demographic information.

https://www.therapyportal.com/p/riversiderva/.

Please contact our office for any questions, to notify us of changes on your account or if you need a new link or password reset at: riverside@rvacounseling.com.

Initial here _____

Session costs

Licensed and pre-licensed clinicians-
$160 - intake
$140- follow up sessions

Session costs for Masters' level student interns-
$45

The session cost is the cost billed to your primary insurance carrier, the full session fee that will appear on your Superbill and for all self-pay clients. Student interns cannot bill any insurance.

Initial here _____

Billing for Primary Insurance

At our mental health practice, we provide billing to your primary insurance carrier for our services as a courtesy. We will make every effort to work with your primary insurance company to facilitate the claims process and ensure accurate billing. We can **never** guarantee payment or coverage until your claim for services has been processed from your insurance carrier. It is the responsibility of the client to keep our practice and your insurance carrier updated on any demographic changes, including changes, additions or termination of any insurance which can often lead to claim denial or delays in processing. If you have questions about a claim denial or any uncovered fees please contact your insurance carrier promptly.

Superbill

Clients always have the option to pay for services in full and submit their claims directly to their insurance carrier on their own. You may also use this process if our clinician is considered out-of-network with your insurance carrier. We are happy to provide a Superbill following your session upon your request.

Initial here _____

Missed/Canceled Appointments

Scheduled sessions require 24-hour notice to cancel or reschedule. Failure to cancel an appointment before the 24-hour cut off or simply not presenting to a session is considered a missed appointment and subject to fees. You are responsible for keeping your appointment within the 24-hour window.

Counseling requires the collaborative effort of both you and your clinician. When you miss your scheduled appointment or cancel without the required 24-hour notice, you miss an opportunity for treatment and prevent someone else from having the opportunity to receive counseling.

There are so many ways to let your clinician know you won't be able to make it to a session or are having difficulties with attending your appointment including- emailing your clinician (all clinicians at RVA Counseling have an email of firstname@rvacounseling.com), using the Google Voice number your clinician may have provided you to text or call regarding scheduling, or by contacting the front office via email or phone. For telehealth sessions, most clinicians will log off after 15-20 minutes of nonpresentation to a session.

If you fail to communicate with your clinician or our office at all, all future scheduled sessions will be canceled. Please contact your clinician or the office to request new appointment(s) once your account balance has been satisfied.

Fees

Late cancellations and no shows will be charged a **$50.00** fee for the first occurrence.

The second and any subsequent occurrences of no show or late-cancel appointments will be charged a full session fee of **$140**.

Initial here _____

Missed / Canceled Appointment Policy for Clients using Medicaid Plans

Scheduled sessions require 24-hour notice to cancel or reschedule. Failure to cancel an appointment before the 24-hour cut off or simply not presenting to a session is considered a missed appointment. You are responsible for keeping your appointment within the 24-hour window.

If you fail to communicate with your clinician or our office at all, all future scheduled sessions will be canceled. Please contact your clinician or the office to request new appointment(s).

After 2 or more late-cancels or no-shows, we place you on a "same-day call" list; Which means we will not schedule appointments for future dates and instead offer you the opportunity to contact the office or your clinician for same-day only openings.

Initial here _____

Subpoenas/Attorney's Fees

RVA Counseling charges a fee of $1500.00 per day if a clinician is required to be away from the practice for court related cases. Payment is due two weeks prior to the court date. This is non-refundable regardless if the case is settled and/or continued. For over the phone conference, face-to-face and or dispositions with attorney(s) the fee is $200.00 an hour (minimum 1 hour). This must be canceled 72 hours in advanced writing to receive a refund.

Initial here _____

Form/Letter Fee

If a client requests letter(s) and/or form(s) to be completed by their counselor, a fee of $50.00 will be charged.

Initial here _____

Non-Billing for Secondary Insurance

Our practice does not directly bill secondary insurance carriers. If you have secondary insurance coverage, we kindly ask you to understand and be responsible for submitting any claims related to our services directly to your secondary insurance carrier. Many times, if a

client has more than one active insurance policy the primary policy will deny all or some of the claim(s). Before starting our services, we recommend that you contact your insurance carrier(s) to verify your coverage, understand any potential out-of-pocket costs and how to submit claims directly.

Coverage of Out-of-Pocket Costs

Should there be any out-of-pocket expenses incurred from our services that are not covered by your primary insurance, you may submit these expenses to your secondary insurance company independently, following their specific guidelines and procedures.

Superbill Receipts

To assist you with the submission process to your secondary insurance carrier or if one of our providers or the group/ your clinician is out of network with your insurance plan, upon your request, our practice will provide you with a superbill receipt. The superbill will contain all the necessary information, including service details and payment received, to help you seek **reimbursement** from your insurance company.

Initial here _____

Direct Payment Responsibility

Please be aware that as our client, you are responsible for all amounts due, including but not limited to copays, coinsurance, deductible amounts, and all services not covered by an insurance plan for any reason (including denied claims for any reason) and including any billed late cancellation, no show, or overdue balances. All payments are due at the time of service. Any and all balances are considered outstanding.

Initial here _____

Accounts with a Balance

Fees are due at the time service is rendered or immediately upon our office's notification of denials from your insurance carrier. Fees may include copays, deductible amounts, coinsurance, denied claims or missed/ late-cancelation fees.

Pausing Sessions
In order to reduce the likelihood of financial burden or debt to you (the client), any account with a balance will result in pausing sessions or referring out to another provider until the billing issues have been settled. We do this to minimize the compounding impact of large balances.

Ways to Reduce the Likelihood of Insuring a Balance
Communicate with your clinician regarding billing at **every session**. Ensure that your account is up to date on the portal system. Notify your clinician as soon as possible

regarding any appointment changes. Contact our office right away if there are any changes in your insurance or demographic information. Contact your insurance company with questions about your policy.

Initial here _____

Collecting Payments and Outstanding Balances

RVA Counseling may utilize your payment methods on file for any balances, including late cancellation, and no-show fees or claims denied by insurance companies ***without additional authorization.***

Initial here _____

By signing below, you acknowledge and agree to the terms of the billing policy listed in this document. You understand and agree that you remain responsible for all amounts due, including (but not limited to) copays, coinsurance, deductible amounts, and all services not covered by an insurance plan for any reason.

If you have any questions or require further clarification, please do not hesitate to contact our office. We are here to assist you throughout the process and ensure your experience at RVA Counseling is as seamless as possible.

Printed name: _____ Date: _____

Signature: _____

Payment Authorization

RVA Counseling may utilize my payment methods on file for any balances, including late cancellation and no-show fees or claims denied by insurance companies without additional authorization.

Please select the payment method below that you will be using.

▢ Check ▢ Cash ▢ Credit/Debit Card

Name on Card: _____

Card Number: _____

Security Code: _____ Expiration Month/Year: _____ / _____

Billing Address: _____

City/State/Zip: _____

By signing below, you understand and agree that you remain responsible for all amounts due, including (but not limited to) copays, coinsurance, deductible amounts, and all services not covered by an insurance plan for any reason and including any billed late cancellation, no show or overdue balances.

Name of Responsible Billing Party: _____

Responsible Billing Party's Signature: _____

Date: _____

Notice of Privacy Practices

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

RVA Counseling (the "Practice") is committed to protecting your privacy. The Practice is required by federal law to maintain the privacy of Protected Health Information ("PHI"), which is information that identifies or could be used to identify you. The Practice is required to provide you with this Notice of Privacy Practices (this "Notice"), which explains the Practice's legal duties and privacy practices and your rights regarding PHI that we collect and maintain.

YOUR RIGHTS

Your rights regarding PHI are explained below. To exercise these rights, please submit a written request to the Practice at the address noted below.

To inspect and copy PHI.

• You can ask for an electronic or paper copy of PHI. The Practice may charge you a reasonable fee.

• The Practice may deny your request if it believes the disclosure will endanger your life or another person's life. You may have a right to have this decision reviewed.

To amend PHI.

• You can ask to correct PHI you believe is incorrect or incomplete. The Practice may require you to make your request in writing and provide a reason for the request.

• The Practice may deny your request. The Practice will send a written explanation for the denial and allow you to submit a written statement of disagreement.

To request confidential communications.

• You can ask the Practice to contact you in a specific way. The Practice will say "yes" to all reasonable requests.

To limit what is used or shared.

• You can ask the Practice not to use or share PHI for treatment, payment, or business operations. The Practice is not required to agree if it would affect your care.

• If you pay for a service or health care item out-of-pocket in full, you can ask the Practice not to share PHI with your health insurer.

• You can ask for the Practice not to share your PHI with family members or friends by stating the specific restriction requested and to whom you want the restriction to apply.

To obtain a list of those with whom your PHI has been shared.

• You can ask for a list, called an accounting, of the times your health information has been shared. You can receive one accounting every 12 months at no charge, but you may be charged a reasonable fee if you ask for one more frequently.

To receive a copy of this Notice.

• You can ask for a paper copy of this Notice, even if you agreed to receive the Notice electronically.

To choose someone to act for you.

• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights.

To file a complaint if you feel your rights are violated.

• You can file a complaint by contacting the Practice using the following information:

Riverside Counseling Richmond DBA RVA Counseling
8003 Franklin Farms Drive Suite 101 Richmond, VA 23229
804-716-0428

• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

• The Practice will not retaliate against you for filing a complaint.

To opt out of receiving fundraising communications.

• The Practice may contact you for fundraising efforts, but you can ask not to be contacted again.

OUR USES AND DISCLOSURES

1. Routine Uses and Disclosures of PHI

The Practice is permitted under federal law to use and disclose PHI, without your written authorization, for certain routine uses and disclosures, such as those made for treatment, payment, and the operation of our business. The Practice typically uses or shares your health information in the following ways:

To treat you.

• The Practice can use and share PHI with other professionals who are treating you.

• Example: Your primary care doctor asks about your mental health treatment.

To run the health care operations.

• The Practice can use and share PHI to run the business, improve your care, and contact you.

• Example: The Practice uses PHI to send you appointment reminders if you choose.

To bill for your services.

• The Practice can use and share PHI to bill and get payment from health plans or other entities.

• Example: The Practice gives PHI to your health insurance plan so it will pay for your services.

2. Uses and Disclosures of PHI That May Be Made Without Your Authorization or Opportunity to Object

The Practice may use or disclose PHI without your authorization or an opportunity for you to object, including:

To help with public health and safety issues

• Public health: To prevent the spread of disease, assist in product recalls, and report adverse reactions to medication.

• Required by the Secretary of Health and Human Services: We may be required to disclose your PHI to the Secretary of Health and Human Services to investigate or determine our compliance with the requirements of the final rule on Standards for Privacy of Individually Identifiable Health Information.

• Health oversight: For audits, investigations, and inspections by government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

• Serious threat to health or safety: To prevent a serious and imminent threat.

• Abuse or Neglect: To report abuse, neglect, or domestic violence.

To comply with law, law enforcement, or other government requests

• Required by law: If required by federal, state or local law.

• Judicial and administrative proceedings: To respond to a court order, subpoena, or discovery request.

• Law enforcement: For law locate and identify you or disclose information about a victim of a crime.

• Specialized Government Functions: For military or national security concerns, including intelligence, protective services for heads of state, or your security clearance.

• National security and intelligence activities: For intelligence, counterintelligence, protection of the President, other authorized persons or foreign heads of state, for purpose of determining your own security clearance and other national security activities authorized by law.

• Workers' Compensation: To comply with workers' compensation laws or support claims.

To comply with other requests

• Coroners and Funeral Directors: To perform their legally authorized duties.

• Organ Donation: For organ donation or transplantation.

• Research: For research that has been approved by an institutional review board.

• Inmates: The Practice created or received your PHI in the course of providing care.

• Business Associates: To organizations that perform functions, activities or services on our behalf.

3. Uses and Disclosures of PHI That May Be Made With Your Authorization or Opportunity to Object

Unless you object, the Practice may disclose PHI:

• To your family, friends, or others if PHI directly relates to that person's involvement in your care.

• If it is in your best interest because you are unable to state your preference.

4. Uses and Disclosures of PHI Based Upon Your Written Authorization

The Practice must obtain your written authorization to use and/or disclose PHI for the following purposes:

• Marketing, sale of PHI, and psychotherapy notes.

• You may revoke your authorization, at any time, by contacting the Practice in writing, using the information above. The Practice will not use or share PHI other than as described in Notice unless you give your permission in writing.

OUR RESPONSIBILITIES

• The Practice is required by law to maintain the privacy and security of PHI.

• The Practice is required to abide by the terms of this Notice currently in effect. Where more stringent state or federal law governs PHI, the Practice will abide by the more stringent law.

• The Practice reserves the right to amend Notice. All changes are applicable to PHI collected and maintained by the Practice. Should the Practice make changes, you may obtain a revised Notice by requesting a copy from the Practice, using the information above, or by viewing a copy on the website [www.rvacounseling.com].

• The Practice will inform you if PHI is compromised in a breach.

This Notice is effective on [10/01/2019].

Signature: _____ Date: _____