Restorer of Broken Walls

PATIENT INFORMATION

PATIENT NAME:_____DOB: _____
First M.I. Last

GENDER: [ ] Male [ ] Female MARITAL STATUS: [ ] M [ ] W [ ] S [ ] D

ADDRESS: _____

CITY:_____STATE:_____ZIP: _____

HOME #_____CELL #_____EMERGENCY # _____

May we contact you via email? Y_____N____Email address_____

May we leave messages for you on an answering machine/voicemail? Y_____N_____

May we text you appointment reminders? Y___N_____

PHYSICIAN NAME:_____PHONE # _____

CURRENT MEDICATIONS: _____

If Employed: Employer Name:_____

Address:_____State:_____Zip:_____Phone:_____

If Student: School_____Grade:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____PHONE #: _____

SUBSCRIBER NAME:_____DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT:_____

EMPLOYER: _____

POLICY/SPONSOR #:_____GROUP #: _____

AUTHORIZATION #: _____

I hereby authorize Restorer of Broken Walls to apply benefits on my behalf for covered services rendered. I request that payment from my insurance company be made payable directly to Restorer of Broken Walls. I authorize release of information pertaining to professional services that is necessary for payment of benefits by my insurance company. I authorize the reproductions of this form in lieu of the original. I certify that the information regarding my insurance is correct to the best of my knowledge. I understand that I am financially responsible for the payment for all services at the time they are rendered. I understand that it is policy that I will be charged a $50.00 fee for any appointment that I do not cancel at least 24 hours in advance. Additionally, I am aware that insurance companies will not cover the failed appointment charge, and I will be personally responsible to pay the entire fee before my next appointment.

CLIENT/GUARANTOR SIGNATURE:_____DATE: _____

Restorer of Broken Walls
INFORMED CONSENT FOR TREATMENT

I_____, understand I/my family/ my child have/has consented to Outpatient Counseling Services and understand the type, purpose and frequency of service that will be delivered to me/my child for a specified duration.

1. I understand that Outpatient Services are voluntary and that I may at any time revoke my consent to receive these services, at which time these services will be terminated.

2. The following services will be provided to me/my family member.

   _____ Individual Counseling Services

   _____Family Counseling Services

3. Co-pays, self-pay fees, and deductibles are due at the time of service.

4. As a courtesy, we will bill your insurance for services provided. We will make every attempt to collect from insurance, but any denial, nonpayment, etc. will be the responsibility of the client.

5. Cancellation policy: If you find that you will be unable to keep your appointment, you must call to notify the office at least 24 hours in advance of your appointment. Failure to give a 24-hour notice will result in a late cancel fee. The fee is $50.00 and must be paid prior to the next scheduled visit. Late cancel/Missed appointment fees are not insurance reimbursable.

6. NSF/Returned checks: Checks returned for insufficient funds will result in a charge of $30.00 per check.

7. Clients must remain safe, behavior posing a significant threat to persons or property will not be tolerated and may result in termination of services.

_____ _____ _____
Client Signature Date of Birth Date

_____ _____
Legal Guardian Date

Restorer of Broken Walls

644 Independence Parkway
Suite 200
Chesapeake, VA 23320
Phone: 757-547-1811
Fax: 757-547-1118

2697 International Pkwy
PKWY 2 Suite 107
Virginia Beach, VA 23452
Phone: 757-689-2680
Fax: 757-689-2681

Restorer of Broken Walls Counseling Telehealth Informed Consent Form

I_____(patient's name) hereby consent to engaging in telehealth as part of my psychotherapy. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

Because of recent advances in communication technology, the field of tele-therapy has evolved. It has allowed individuals who may not have local access to a mental health professional to use electronic means to receive services. Because it is relatively new, there is not a lot of research indicating that it is an effective means of receiving therapy. An important part of therapy is sitting face to face with an individual, where non-verbal communication (body signals) are readily available to both therapist and client. What is important here is that you are aware that tele-therapy may or may not be as effective as in-person therapy and therefore we must pay close attention to your progress and periodically evaluate the effectiveness of this form of therapy.

The counseling services you are receiving is from Restorer of Broken Walls Counseling office and therefore are bound by the laws of the State of Virginia. These laws are primarily related to confidentiality as outlined in this form and on the treatment consent form.

I understand that I have the following rights with respect to telehealth:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area or come in to a Restorer of Broken Walls office. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improve, and in some cases may even get worse.

(4) I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with Virginia law.

(6) This telehealth consent is an ADDITIONAL consent to your treatment consent (not a replacement). All Restorer of Broken Walls Counseling policies apply to telehealth services.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Signature of patient/parent/guardian. If signed by other than patient indicate relationship

_____ _____

Print Name Date of Birth

_____ _____

Signature Today's Date

Restorer of Broken Walls

HIPAA PRIVACY NOTICE

I. THE FOLLOWING NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

* Your confidential healthcare information may be released to other health care professionals for the purpose of providing you with good care. An example of this is the release of information to a laboratory for the purpose of obtaining the results of lab tests needed to treat you.

* Your confidential health care information may be released to your insurance provider for the purpose of paying Restorer of Broken Walls for the care you received. An example of this is sending the insurance company information about your diagnosis and the date you received services for this diagnosis.

* Your confidential healthcare information may be released for the purpose of continuing healthcare operations, which may include conducting quality assessment and improvement activities, reviewing the qualifications of healthcare professionals, and conducting and arranging for medical review, legal, and auditing services.

* Your confidential information may be released to public health officials whose job is to improve the health of the community. An example of this is mandatory communicable disease reporting.

* Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.

* Your confidential information may be released to other healthcare providers in case you need emergency care.

II. YOUR HEALTH RECORDS ARE THE PHYSICAL PROPERTY OF RESTORER OF BROKEN WALLS BUT YOU DO HAVE RIGHTS REGARDING THE INFORMATION. PLEASE READ CAREFULLY.

* You have the right to restrict the use of your confidential healthcare information unless it is being used or disclosed for a reason that does not require a consent or an authorization. However, we may choose to refuse your restriction if it conflicts with providing you with quality healthcare or in the event of an emergency.

* Your confidential health care information may be released only after receiving written authorization from you or your legal representative. You have the right to take away your permission to release confidential healthcare information at any time.

* You have the right to inspect and copy your healthcare information; however, in certain situations we may deny access.

* You have the right to make changes to your healthcare information.

* You have a right to know who has accessed your confidential healthcare information and for what purpose.

* You have a right to have a paper copy of the Privacy Notice if you ask for it.

Client Name:_____ **Date of Birth:**_____

III. RESTORER OF BROKEN WALLS IS REQUIRED BY LAW TO PROTECT THE PRIVACY OF ITS CLIENTS. THE PROGRAM WILL KEEP CONFIDENTIAL ANY AND ALL CLIENT HEALTHCARE INFORMATION AND WILL PROVIDE CLIENTS WITH A LIST OF DUTIES OR PRACTICES THAT PROTECT CONFIDENTIAL HEALTHCARE INFORMATION.

* Restorer of Broken Walls will abide by the terms of this notice. The Program reserves the right to make changes to this notice and continues to maintain the confidentiality of all healthcare information. Changes to this notice will be posted and copies may be obtained at the Restorer of Broken Walls office.

* Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice or otherwise required by law.

* You have the right to complain if you believe your rights to privacy have been violated and you will not be penalized or otherwise retaliated against for filing a complaint If you would like further information or feel your privacy rights have been violated, please call the matter to our attention by sending a letter describing the reasons you are concerned to:

Restorer of Broken Walls
ATTN: Privacy Officer

644 Independence Parkway Suite 200
Chesapeake, VA 23320
Phone: 757-547-1811
Fax: 757-547-1118

2697 International Pkwy
PKWY 2 Suite 107
Virginia Beach, VA 23452
Phone: 757-689-2680
Fax: 757-689-2681

I hereby acknowledge receipt of the Restorer of Broken Walls' HIPAA Privacy Notice.

_____	_____	_____
Client or Guardian Signature	DOB	Today's Date

Restorer of Broken Walls

EMERGENCY MEDICAL INFORMATION AND HEALTH HISTORY

Name:_____ Date of Birth: _____

Please check all that apply:

	Yes	No
Chronic Conditions		
Recent Physical Complaints		
Past Illnesses or Injuries		
Communicable Diseases		
Physical Restrictions/Disabilities		

If you checked yes to any of the above questions, please explain below:

_____

_____

Do you have any allergies [ ] Yes [ ] No

If yes, please list allergies: _____

Are you taking any prescribed medications [ ] Yes [ ] No

Please list all current medications below

Medication	Dose	Frequency

Primary Care Physician Name:_____Phone: _____

In the event of an emergency, please provide the name and phone number(s) of the person you want to have contacted:

Name of person:_____Relationship: _____

Home Phone:_____Cell Phone: _____

Work Phone: _____

Restorer of Broken Walls
SYMPTOM CHECKLIST

Name:_____ Date of Birth:_____ Today's Date: _____

Please check any of the following symptoms that you may be experiencing:

- _ Depressed mood
- _ Diminished interest in activities
- ___ Significant weight loss
- _ Significant weight gain
- _ Sleeping too much
- Sleeping too little
- _ Fatigue Low
- _ energy
- _ Feelings of restlessness
- Feelings of being slowed down
- Feelings of worthlessness
- Feelings of guilt
- _ Difficulty thinking
- _ Difficulty concentrating
- _ Difficulty making decisions
- Suicidal thoughts
- ___ Suicidal plan
- Suicide attempt

- _ Elevated mood
- _ Irritable mood
- _ Inflated self-esteem
- Decreased need for sleep
- More talkative than usual
- _ Racing thoughts
- _ Easily distracted
- _ Increased energy
- Sexual indiscretions
- Buying sprees

- _ Heart pounding
- _ Trembling/shaking
- ___ Sensations of smothering
- _ Feeling of choking
- _ Feeling dizzy/lightheaded
- _ Numbness or tingling
- _ Feeling detached from self
- _ Fear of losing control
- _ Anxious
- _ Restlessness/feeling on edge
- _ Muscle tension
- _ Sleep disturbance
- _ Excessive worry

- _ Feeling detached
- _ Angry
- ___ Feeling in a "daze"
- _ Exaggerated startle response
- _ Hypervigilance
- _ Irritability

- _ Difficulty paying attention
- _ Difficulty completing tasks
- _ Difficulty organizing tasks
- _ Difficulty paying attention to details

- _ Frequently forgetful in daily activities
- _ Frequently fidgets
- _ Frequently looses objects

- _ Addictions
- _ Abuse of drugs
- ___ Abuse of alcohol

- _ Physical abuse
- _ Sexual abuse
- _ Emotional abuse

- _ Self control problems
- _ Threaten others
- _ Abuse others
- _ Refuse to obey others
- _ Destroy property
- _ Frequently argue
- _ Illegal activities
- _ Dangerous activities

- _ Bully others
- _ Bullied by others

Have you been hospitalized within the past year? Yes_____No_____

If yes, where were you hospitalized: _____

Why were you hospitalized: _____

Dates of hospitalization(s):___/_____/___;____/___/___;____/___/___

Attending Physician name:_____Phone: _____