



CHILD INTAKE PACKET

Family Life Resource Center

273 Newman Ave

Harrisonburg, VA 22801

Please complete this form if you are seeking services concerning your child under the age of 18. It will help your therapist and the therapy process to be as detailed as possible, and it's okay to be brief if any section feels overwhelming or too uncomfortable to write about.

Information about Your Child

Name and relationship of person completing form: _____

Child's Full Name: _____

Home Address: _____

Home Phone: _____

Parent/Guardian's Work Phone: _____

Cell Phone (parent/guardian): _____

Cell Phone (child, if applicable): _____

Email (parent/guardian): _____

Email (child, if applicable): _____

Child's Social Security Number: _____

Child's Age: _____

School Currently Attending: _____

Grade: _____

Age: _____

Birth date: _____

Family Information

Parent/Guardian(1): _____ Age: _____ Living in the home: Yes _____ No _____

Parent/Guardian(2): _____ Age: _____ Living in the home: Yes _____ No _____

Siblings (Include age, gender, & sibling type -biological, adopted, step, etc.): _____

Others living in home and relationship: _____

Has your child, or any other family members, previously received counseling or psychotherapy? Yes _____ No _____

If so, who received services? _____

For what reason? _____

When and with whom? _____

Previous mental health diagnoses for your child? _____



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History About Your Child

Any complications or concerns during pregnancy, delivery, or birth? _____

Age child talked: _____

Age toilet training completed: _____

Any concerns or difficulty with toilet training: _____

Age child walked: _____

Significant illnesses, diseases, allergies, high fevers, head injuries or hospitalizations: _____

Any concerns with physical, psychological, social, or academic history: _____

Pediatrician and/or family doctor's name, address and phone number: _____

Do we have your permission to advise the physician that your child is receiving care?

(if information is needed from your physician we will ask for completion of a different release)

No _____ Yes _____ *(Coordination of Care will be sent to your Child's Physician)*

You may grant consent by signing here:

Parent/Guardian Signature

Significant life events (such as divorce of parents, deaths in family, moving, etc.) and child's reactions to these events:

Current teachers name & school: _____

Other schools attended and dates of attendance: _____

Religious affiliation or church attending: _____



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What is your main concern about your child at this time, and how long have you had this concern?

Who referred you to our services? _____

On a scale of 1 to 10, with 1 being the worst and 10 the best, how would you rate your child's behavior in comparison to other children his/her age? 1 2 3 4 5 6 7 8 9 10 (Please Circle)

Below you will find a number of statements about your child and his/her problems. Circle "yes" for those that are true of your child at the PRESENT time. Circle "no" for those that do not pertain to your child.

- | | | |
|---|-----|----|
| 1. My child explodes under stress. | Yes | No |
| 2. My child cries easily. | Yes | No |
| 3. My child is a worrier. | Yes | No |
| 4. My child has many unusual fears. | Yes | No |
| 5. My child is often angry. | Yes | No |
| 6. My child is moody or sensitive. | Yes | No |
| 7. My child has sleep problems. | Yes | No |
| 8. My child has trouble remembering things. | Yes | No |
| 9. My child says people don't like him/her. | Yes | No |
| 10. We frequently have family problems. | Yes | No |
| 11. One or more of my other children have problems too. | Yes | No |
| 12. My child has trouble making friends. | Yes | No |
| 13. My child does not get along with other people in household. | Yes | No |

Specify who in household if circled yes: _____

- | | | |
|--|-----|----|
| 14. My child speaks of death or dying. | Yes | No |
| 15. My child has been physically or sexually abused. | Yes | No |
| 16. My child tells lies or often exaggerates. | Yes | No |
| 17. My child has learning problems at school. | Yes | No |
| 18. Teachers complain about my child. | Yes | No |



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19. My child has a discipline problem at home or school. Yes No
If yes, specify which: _____
20. My child steals. Yes No
21. My child has bladder or bowel problems. Yes No
22. My child is currently taking medication. Yes No
If yes, what type of medication? _____
23. My child has a visual, hearing or speech problem? Yes No
If yes. Which? _____
24. My child often complains of illness. Yes No
25. My child eats too much or not enough. Yes No
If yes, which one? _____
26. My child has sensory sensitivities such as being easily over stimulated or overwhelmed with loud noises, crowded places, fit of clothing, temperature, food textures, physical touch, etc. Yes No
If yes, please describe _____

27. My child has trouble sitting still. Yes No
28. My child has trouble waiting their turn. Yes No
29. My child is easily distracted. Yes No
30. My child has problems with organization or trouble completing tasks. Yes No
31. My child avoids or dislikes sustained mental effort (such as schoolwork/homework). Yes No
32. List any concerns not listed above.

33. List any strengths of your child.

34. List your child's hobbies or interests.



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Adolescent Informed Consent Form

Privacy of Information Shared in Counseling/Therapy: Your Rights and My Policies

What to expect:

The purpose of meeting with a counselor or therapist is to get help with problems that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counselor or therapist about these problems. Or, you may be here because your parent, guardian, doctor, or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of counseling.

As a general rule, *I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information.* There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

Confidentiality **cannot be maintained** when:

- You tell me about any plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself. Safety is my highest priority.
- You tell me about a plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, and I must inform the person who you intend to harm. Safety is my highest priority.
- You are doing things that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed to help ensure safety for all.
- You tell me you are being abused-physically, sexually, or emotionally-or that you have been abused in the past and there is still an active risk of on-going abuse by this person. In this situation, I am required by law to report the abuse to the Virginia Department of Social Services.
- You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement *unless* the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.



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Communicating with your parent(s) or guardian(s):

- Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian may not approve of, or would be upset by, but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this with you and with your parent or guardian. Please let me know if you have any questions about this boundary or what factors I consider when using my professional judgment for safety assessments.
- Even if I have agreed to keep information confidential - to not tell your parent or guardian- I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to communicate with them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you. Please let me know if you have any questions or concerns about this.
- **You should also know that, by law in Virginia, your parent/guardian has the right to see any written records I keep about our sessions. It is extremely rare that a parent/guardian would ever request to look at these records, but it can happen.**

Communicating with other adults:

School: I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you first and ask for your written permission. A very unlikely situation might come up in which I do not have your permission but both I and your parent or guardian believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether it is in your best interest to share any information.

Doctors: Sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a counselor or therapist. I will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don't have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

Minor's Signature: _____ Date: _____



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Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature : _____ Date: _____

Parents/Guardians' Consent To Mental Health Treatment for a Minor Child

As an organization, we strive to serve children and adolescents who are experiencing mental health difficulties or adjustment issues due to various circumstances. We also believe it is important therapeutically to have the consent of ALL parents/guardians to treat a child. For us to best serve your child, we ask that you complete this form and provide the necessary information prior to your **child's first** appointment.

**** If there is any physical/legal custody agreement, complete the section below; otherwise continue to the next page. ****

In Virginia, regardless of the arrangements about physical custody, legal custody, is either "sole" or "joint". Please place your initials next to the correct statement to identify whether you (the parent or legal guardian who is bringing the minor to counseling) have sole or joint legal custody.

_____ I have ***sole*** legal custody of _____.
(Minor's Name)

_____ I have ***joint*** legal custody of _____.
(Minor's Name)

If you have sole legal custody, please do one of the following:

*Provide a letter from your attorney stating that there is nothing in the custody agreement that would prevent you from seeking counseling and/or treatment for your minor.

OR

*Provide a copy of the legal custody agreement verifying that you are the sole legal guardian who has the right to make decisions for your minor's mental health treatment.

If you have joint legal custody, please do one of the following:

*All parents/guardians need to sign on the next page and provide a copy of the legal custody agreement

OR

*Provide a copy of the legal custody agreement verifying that you have joint legal custody.

AND

*Provide the information for the child's other parent/guardian so that the person's written consent may be obtained by FLRC. (Provide below)

I share custody with _____ (Name and relationship of minor's



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other parent or legal guardian). You may contact the other parent/guardian at: _____ (phone)

or _____ (address).

Signature: _____ Date: _____

***If there is no custody agreement established or all parents/guardians are signing on behalf of minor, sign below indicating you are aware and support the mental health treatment that is being provided for the minor.**

_____ (Name of Minor).

Parent/guardian Signature: _____ Date: _____

Parent/guardian Signature: _____ Date: _____

Parent/guardian Signature: _____ Date: _____

Parent/guardian Signature: _____ Date: _____

_____ **For Office Use Only** _____

Additional parent/guardian's signature cannot be obtained due to the following:

_____ parent/guardian inaccessible _____ abuse or neglect suspected/reported _____ unwilling to participate

_____ involvement detrimental to child _____ other: explain _____



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Information for Parent or Guardian About Minor's Counseling

I am providing you with the information which I think will be helpful to you as you plan to bring your child for counseling with me.

ABOUT THE TIME AND DURATION OF THERAPY SESSIONS:

The first session is a clinical interview with the parent/guardian(s) and child, during which I will gather relevant clinical information, including your view of the child's problems, assets and strengths, and pertinent background information.

I usually will spend the next 4 to 5 sessions with your child in some form of play therapy (when age appropriate). I will be with your child 40 to 45 minutes in each session and will meet with you 10 minutes before or after to address any questions or concerns that you may have. I will meet with you about the 6th session to discuss the child's progress. At that point, we will decide whether or not further sessions are needed or if some other services are warranted.

HOW DOES PLAY THERAPY HELP CHILDREN?

I know that you are concerned about your child. Since you are bringing your child to therapy, I am certain you want to help your child with the difficult time he or she is having coping at school or home. In the process of growing up children can experience difficulty adjusting. Some children may need more help than others in some areas and less help in others. Children have a difficult time sitting in a counselor's chair and talking about what bothers them. They don't often have the vocabulary or developmental capacity to describe what they are feeling or thinking. Therefore, sometimes they act out to cope with what they are experiencing, as a way of representing their emotional world and showing how they're feeling.

In play therapy, toys are provided because children can use the toys to show what they have difficulty putting into words. When children can communicate or play out how they feel or what they are experiencing with a trained counselor, they begin to feel a sense of relief. In play therapy, children can use dolls, puppets, art materials, sand, or other toys to express what they think or feel. Therefore, how children play or what they do in the play room is very important, just like what the adult says in the counselor's room is important. In play therapy, children learn how to express their thoughts and feelings in constructive ways, to control their behavior, to make decisions, and to accept responsibility.

WHAT SHOULD YOU ASK YOUR CHILD AFTER EACH SESSION?

After the play therapy sessions, if you were to ask your child what he/she did, he/she would probably say, "I just played" in the same way you may say "I just talked" if someone asked you what you did while you were here. Children are sometimes unaware that something important is happening in the moment during play. Additionally, sometimes it is easier for children to explore feelings, especially their fears or anger, with someone who can be objective than it is with parents or teachers. Thus, your child may not be able to fully explain what he/she did, or what happened in the session. If you have any questions or concerns about what we're doing in the therapy process, please don't hesitate to reach out to me and let me know.



NOTICE OF PRIVACY PRACTICES

PLEASE REVIEW THIS INFORMATION CAREFULLY.

This notice of Privacy Practices describes how information about you, the client, may be used and disclosed and how you can access this information.

We understand that information about you is personal. We are committed to protecting your information. We create a record of care and services you receive at this office. We need this record to provide you with quality care and to comply with legal requirements. This notice tells you about the ways in which we use and disclose your records. We also describe your rights and the obligations we have regarding the use and disclosure of records.

Uses and Disclosures of Information: We use information about you for treatment, to obtain payment for treatment, and for the purposes of ensuring the quality of care you receive. We may contact you about appointments, treatment alternatives or other benefits that may be of interest to you. We will contact you according to permission granted on the Intake form. We will provide information when required by law, such as with law enforcement in specific circumstances. Confidentiality will be waived if there is concern of harm to yourself or to others, such as abuse of a child, elder, or individual with special needs. In all other situations, we will ask for your written authorization to disclose information. You can later revoke that authorization to stop any future uses and disclosures.

For the purpose of ensuring quality services, our staff is involved in ongoing training and supervision. As deemed necessary by your clinician, cases and review of case notes may be discussed confidentially in consultation with other FLRC staff members. If your clinician needs to consult other professionals in our community, a release of information is available for you to sign.

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice of Privacy Practices and post the new notice in the waiting area. You can also request a copy at any time. For more information, contact the FLRC Director or your counselor. Please remember that you may reopen the conversation about these issues at any time during our work together.

Individual Rights: In most cases, you have the right to look at or get a copy of the information about you that we use to make decisions about you. If you request copies, we will charge you \$0.50 for each page up to 50 pages and \$0.25 thereafter (fees charged are pursuant with Virginia State guidelines). You also have the right to receive a list of instances where we have disclosed information about you for reasons of treatment, payment, or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with a decision made about access to your records, you may contact the FLRC Executive Director, Jonathan

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Sutton. You also may send a written complaint to the U.S. Department of Health and Human Services. The office staff can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices described in this notice. If you have any questions or complaints, please contact: Family Life Resource Center Executive Director, Jonathan Sutton.

Family Life Resource Center - Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge that the Family Life Resource Center has given you a copy of its Notice of Privacy Practices. This notice explains how your counseling information will be handled, HIPAA, the Federal law concerning medical privacy, requires this notice.

I have received a copy of the Notice of Privacy Practices. FLRC has given me this opportunity to ask any questions about this notice and all my questions have been answered.

Client or Guardian Signature _____

Date Signed _____

Provider Use Only

If the client was not able to sign due to an emergency/health issue or refused signature, please document if the client was given the notice and the reason why the client did not sign below.

Client was given the notice: Yes () No ()

Reason _____ signature _____ was _____ not _____ obtained _____ (If _____ Applicable):

FLRC Staff Signature _____

Date Signed _____

**CLIENT-CLINICIAN SERVICE AGREEMENT & INFORMED CONSENT**

Thank you for choosing Family Life Resource Center (FLRC) as your mental health provider. This document contains important information about FLRC's professional services, business policies, and summary information regarding the Health Insurance Portability and Accountability Act (HIPAA). When you sign this document, it represents a formal agreement between us.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in therapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should know. Your clinician has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Therapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of therapy often requires discussing unpleasant aspects of your life. However, therapy has been shown to have benefits for many individuals who undertake it. Therapy can lead to a reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, and resolutions to specific problems. But there are no guarantees about what will happen. Therapy requires a very active effort on your part. In order to be most successful, you will have to work on things you and your clinician have discussed outside of sessions.

The first 1-2 sessions will involve a comprehensive evaluation of your needs. At the end of the evaluation, you and your clinician will discuss and create an initial treatment plan that will include goals. You should evaluate and make your own assessment about whether you feel comfortable working with your clinician. If you have questions about the clinician's or organization's procedures, you should discuss such things with the clinician or the FLRC Director as soon as possible. If your doubts persist, the clinician will be happy to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS & CANCELLATIONS

Appointments will ordinarily be 45-50 minutes in length (after the first session which is 60 minutes), typically once per week, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinicians at Family Life Resource Center and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our clients or use the appointment for a client in crisis.

If less than a 24-hour cancellation notice is given, this will be documented as a "Late Cancel" appointment. In addition, you are responsible for arriving on time to your session. If you are late, your appointment will still need to end on time. If you are more than 15 minutes late, you still may be charged as a late cancel. If you do not present to the office for your appointment, this will be



documented as a "No-Show" appointment. After the "No-Show/Late Cancel" appointment, you will be charged a \$50.00 fee per missed appointment if contractually applicable. Please be aware that insurance companies do not provide reimbursement for late cancel/No show sessions so you will be financially responsible for this fee. If you have three (3) "No-Show/Late Cancel" appointments within a one-year time, counseling services will be suspended for a minimum of six (6) months. If this occurs, the agency can provide you with a list of referrals from other mental health specialists in the community.

PROFESSIONAL FEES & INSURANCE

Our fees for the initial evaluation and 45-50 minutes sessions thereafter differ depending on the counselor you see. You may be responsible for the full fee at the time of your appointment, if we do not bill insurance which can occur if your clinician does not determine that a mental health diagnosis is warranted or if the type of therapy (i.e., couples therapy) is not covered by your health insurance provider. If insurance is billed you will need to pay your co-payment or pay toward the deductible, if it has not been met. If you do not use insurance, you may ask the office staff about possible alternatives. Our fees are the same for all clients. Please note the clinicians are ONLY paid once fees are collected for the services rendered.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy, after a certain number of sessions. While a lot can be accomplished in short-term therapy, some clients feel they need more services after insurance benefits end. Some managed-care plans will not allow a clinician to provide services to you once your benefits end. If this is the case, we will do our best to find another provider who will help you continue your therapy.

You should also be aware that most insurance companies require you to authorize a clinician to provide them with a clinical diagnosis. Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. Sometimes your clinician has to provide additional clinical information such as treatment plans or summaries, or, in rare cases, copies of the entire record. This information will become part of the insurance company files and will likely be stored digitally. Though all insurance companies are held to similar standards regarding keeping this information confidential, your clinician has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information database.

If you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. Many policies leave a percentage of the fee (which is called the co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the client. In addition, some insurance companies also have a deductible, which is an out-of-the-pocket amount that must be paid by the client before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions at FLRC until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year.

INDIVIDUAL ADULT INTAKE PACKET

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Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for FLRC services yourself to avoid problems described above, unless prohibited by a provider contract. If a provider does not participate in your insurance plan, FLRC can supply you with a receipt of payment for services that you can submit to your insurance for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. By signing this Agreement, you agree that FLRC can provide requested information to your insurance carrier if you plan to pay with insurance.

We request that you handle any payments with the office staff at the beginning of each session. If the office staff is not in, please leave your payment with your clinician. We expect your payment at the time of each appointment. In addition to scheduled appointments, it is our practice to charge this amount on a prorated basis (the hourly cost will be broken down) for other professional services that you may require such as telephone conversations beyond 10 minutes, report writing, attendance to meetings or other services that are being requested of your clinician since these things cannot be billed to insurance companies. Court appearances and legal issues are billed at the rate of \$100 per hour and are payable in advance.

FEE COMMITMENT

Remember that insurance was designed to defray the cost of treatment, not cover those costs completely. So while we accept payment from your insurance company, you are ultimately responsible to see that the total amount of each visit is paid.

In recognition of the service provided through Family Life Resource Center, I understand that I am responsible for the cost of services rendered.

I understand that if conditions of employment, health, or other factors should warrant, I need to contact FLRC to work out a payment plan or necessary arrangements.

I understand that my insurance company will not pay for "no show/late cancellation" fees and I am responsible for payment.

I further agree to pay in full for services not covered by my insurance and for my portion of covered services, including any legal or other costs incurred in the collection of this amount, if it becomes delinquent.

Please initial one of the following regarding your choice of billing:

___A. I authorize FLRC to submit my insurance claim for the service provided and I hereby assign all insurance payments directly to FLRC. I authorize FLRC to release my information necessary to process this claim. I understand that my insurance claim may be filed electronically and I accept the possible risks involved with electronic transmission.

___B. I choose to personally pay for my counseling services. I understand that FLRC will not bill insurance for my services nor will they bill retroactively for services rendered. I acknowledge I have been



given the opportunity to use my insurance for covered services and have declined.

PROFESSIONAL RECORDS

Your clinician is required to keep appropriate records of psychological services that he/she provides. Your records are maintained in a secure location in the office and/or in a secure electronic health record. Your clinician keeps records noting the date you were here, your reasons for seeking therapy, the goals and progress set for treatment, your diagnosis (if there is one), topics discussed, your medical, social, and treatment history, records received from other providers, copies of records sent to others (with your permission) and your billing records. FLRC may use electronic/telephone communications including but not limited to email, fax machines, phones, and computers. FLRC will do the very best to ensure security/privacy of your communication and records. If you do not wish FLRC to use a specific type of communication device, talk to your clinician directly.

Client records are the property of FLRC, but you may request a copy of these in writing. Access to these records will be given according to Virginia State guidelines consistent with your condition and sound therapeutic treatment. Because these are professional records, they may be misinterpreted and or upsetting to untrained readers. For this reason, we recommend that you initially review them with your clinician, or have them forwarded to another mental health professional to discuss the contents.

CONFIDENTIALITY

Our policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and given the opportunity to discuss any issues. Please remember that you may reopen the conversation at any time during your time at FLRC.

SOCIAL MEDIA POLICY

It is policy for FLRC staff to not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Instagram, etc.). We believe that adding clients as friends or contacts on these sites can compromise confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. FLRC does have a public Facebook page that is operated by the Executive Director and used for communication, marketing, and networking purposes. If you choose to connect with our public Facebook page, please know that you're accepting any risks involved regarding confidentiality and this page will not be used for individual communication purposes. If you have any questions or concerns about anything in this social media policy, please bring them up to your clinician to discuss further.

PARENTS & MINORS



While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is our policy not to provide treatment to a child under age 13 unless she/he agrees that the clinician can share whatever information he/she considers necessary with a parent. For children 14 or older, we request an agreement between the client and the parents allowing the clinician to share general information about treatment progress and attendance. All other communication will require the child's agreement, unless the clinician feels there is a safety concern, in which case the clinician will make every effort to notify the child of the intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING YOUR CLINICIAN & EMERGENCY SERVICES

FLRC is an outpatient counseling practice and your clinician is often NOT immediately available by telephone. Typically, clinicians do not answer the phone or email when they are meeting with clients or otherwise unavailable outside of business hours. If you need to leave a message via phone, you may do so by asking the office staff to transfer you to the clinician's confidential voicemail. Staff will do their best to respond to voicemails in a timely manner. If for any reason you're in crisis and a clinician cannot be contacted immediately during business hours, or if the office is closed, please go to your local emergency room or call 911 or 988 to receive care.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, we want you to talk with your clinician so your concerns can be handled. Such comments will be taken seriously and handled with care and respect. You may also request that your clinician refer you to another therapist and you are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about your clinician's specific training and experience. If for any reason you do not feel comfortable addressing your concerns with your clinician directly, you're always welcome to discuss any concerns with FLRC's Executive Director, Jonathan Sutton.

CONSENT TO THERAPY

Your signature below indicates that you have read this agreement which includes the Notice of Privacy Practices, Client-Clinician Service Agreement/Informed Consent and the Social Media Policy and agree to the terms.

Client or Guardian Signature _____

Date Signed _____