Insight Psychological Services, PLLC
2126 Jefferson Davis HWY
Suite 103
Stafford, VA 22554
Phone: (540)-658-0888

PERSONAL HISTORY: ADULT

Patient's name: _____ Today's date: _____

Gender (circle one): Male Female Date of birth: _____ Current age: _____

Form completed by (if someone other than patient): _____

Address: _____ City: _____

State: _____ Zip: _____ Phone (home) _____

Phone (cell)_____ Phone (work)_____ ext._____

Email address _____

Insurance carrier: _____ Insurance ID number: _____

Name of insured: _____ Date of birth of insured: _____

Group number, if applicable: _____ If different from above, address of insured:

_____

Primary reasons for seeking services: _____

_____

_____

Family Information

Relationship	*Name*	*Age*	*Living?*	*Living with you?*
Mother			[ ] yes [ ] no	[ ] yes [ ] no
Father			[ ] yes [ ] no	[ ] yes [ ] no
Spouse			[ ] yes [ ] no	[ ] yes [ ] no
Children			[ ] yes [ ] no	[ ] yes [ ] no
			[ ] yes [ ] no	[ ] yes [ ] no
			[ ] yes [ ] no	[ ] yes [ ] no
			[ ] yes [ ] no	[ ] yes [ ] no

Marital Status (more than one answer may apply):

[ ] Single
[ ]Legally married, length of time: _____
[ ] Widowed, length of time: _____
[ ] Divorce in progress, length of time: _____
[ ] Separated, length of time: _____
[ ] Annulment, length of time: _____
[ ] Unmarried, living together: length of time: _____
[ ] Divorced, length of time: _____

Assessment of current relationship (if applicable): [ ] Good [ ] Fair [ ] Poor

Development

Are there special, unusual, or traumatic circumstances that affected your development? [ ] Yes [ ] No

If yes, please describe: _____

Has there been history of child abuse? [ ] Yes [ ] No If yes, which types? [ ] Sexual [ ] Physical [ ] Emotional

If yes, please describe: _____

If yes, you were the: [ ] Victim [ ] Perpetrator

Other childhood issues: [ ] Neglect [ ] Inadequate nutrition [ ] Other (please specify): _____

Other information you feel would be helpful for your therapist to know: _____

_____

Social Relationships

Any social difficulties or strengths of note? How do you usually get along with others? _____

_____

_____

Sexual orientation: _____ Comments: _____

Any current or past domestic violence? [ ] Yes [ ] No If yes, describe: _____

_____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? [ ] Yes [ ] No

If yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious

How important to you are spiritual matters? [ ] Not [ ] Little [ ] Moderate [ ] Much

Are you affiliated with a spiritual or religious group? [ ] Yes [ ] No

If yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? [ ] Yes [ ] No

If yes, describe: _____

Legal

Are you involved in any active cases (traffic, civil, criminal)? [ ] Yes [ ] No

If yes, please describe and indicate the court hearing/trial dates and charges: _____

_____

Are you on presently on probation or parole? [ ] Yes [ ] No

If yes, describe: _____

Any relevant past legal issues? (Do NOT include minor traffic violations such as speeding tickets): _____

_____

_____

Education

Please fill in all that apply: Years of education: _____ Currently enrolled in school? [ ] Yes [ ] No

High school grad/GED? [ ] Yes [ ] No

Vocational: Number of years: _____ Graduated? [ ] Yes [ ] No Major: _____

College: Number of years: _____ Graduated? [ ] Yes [ ] No Major: _____

Graduate: Number of years: _____ Graduated? [ ] Yes [ ] No Major: _____

Other training: _____

Special circumstances (learning disabilities, gifted): _____

Employment

Current employer: _____

Currently: [ ] Full-time [ ] Part-time [ ] Temp [ ] Laid-off [ ] Disabled [ ] Retired

Social security? [ ] Yes [ ] No Student? [ ] Yes [ ] No

Other (please describe): _____

Military experience? [ ] Yes [ ] No Combat experience? [ ] Yes [ ] No

Where? _____

Branch: _____ Discharge date: _____

Date drafted: _____ Type of discharge: _____

Date enlisted: _____ Rank at discharge: _____

Leisure/Recreational

Please describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, exercise, diet/health, traveling, etc.)

Activity *How often now?* *How often in the past?*

_____

_____

Medical/Physical Health

Current or relevant past medical concerns: _____

_____

Medication

Current prescription medications	*Dose*	*Dates/ Frequency*	*Purpose*	*Side effects*

Current over-the-counter medicines	*Dose*	*Dates/ Frequency*	*Purpose*	*Side effects*

Is the patient allergic to any medications or drugs? [ ] Yes [ ] No If yes, describe: _____

_____

Most recent examinations

Date, reason for and result of most recent physical examination: _____

_____

Any relevant past or upcoming surgeries? _____

_____

_____

Family history of medical problems: _____

_____

Pease check if there have been any recent changes in the following:

[ ] Sleep patterns [ ] Behavior [ ] Weight
[ ] Physical activity level [ ] Energy level [ ] Nervousness/tension
[ ] Eating patterns [ ] General disposition

Please describe the changes in any areas checked above: _____

_____

Chemical Use History

If chemical use is a problem, please complete this section. If not relevant, proceed to the next section.

Describe when and where you typically use substances: _____

_____

Describe any changes in your use patterns: _____

_____

Substance of preference:

1. _____ 3. _____

2. _____ 4. _____

How do you believe your substance use affects your life? _____

_____

Who or what has helped you in stopping or limiting your use? _____

_____

Does/has someone in your family past/present had/have a problem with drugs or alcohol? [ ] Yes [ ] No

If yes, please describe: _____

Have you experienced withdrawal symptoms when trying to stop using drugs or alcohol? [ ] Yes [ ] No

If yes, please describe: _____

Have you experienced adverse reactions or overdose to drugs or alcohol? [ ] Yes [ ] No

If yes, please describe: _____

Have drugs or alcohol created issues for you at work? [ ] Yes [ ] No

If yes, please describe: _____

Counseling/Prior Treatment History

Information about patient (past and present)

	Yes	No	When	Where	Your reaction to overall experience
Counseling/psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Psychiatric hospitalizations					
Involvement with self-help groups (AA, Al-Anon, NA, Overeater's Anonymous)					

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

[ ] Aggression
[ ] Alcohol dependence
[ ] Anger
[ ] Antisocial behavior
[ ] Anxiety
[ ] Avoiding people
[ ] Chest pain
[ ] Cyber addiction
[ ] Depression
[ ] Disorientation
[ ] Distractibility
[ ] Dizziness
[ ] Drug dependence
[ ] Eating disorder
[ ] Elevated mood
[ ] Fatigue
[ ] Gambling
[ ] Hallucinations
[ ] Heart palpitations
[ ] High blood pressure
[ ] Hopelessness
[ ] Impulsivity
[ ] Irritability
[ ] Loneliness
[ ] Memory impairment
[ ] Mood shifts
[ ] Obsessive thoughts
[ ] Panic attacks
[ ] Phobias/fears
[ ] Sexual addiction
[ ] Sexual difficulties
[ ] Sick often
[ ] Sleeping problems
[ ] Speech problems
[ ] Suicidal thoughts
[ ] Thoughts disorganized
[ ] Trembling
[ ] Withdrawing
[ ] Worrying
[ ] Other (specify): _____
_____

Any additional information that would assist us in understanding your concerns or problems? _____

_____

_____

What are your goals for therapy? _____

_____

_____

Do you feel suicidal at this time? [ ] Yes [ ] No

For staff use

Clinician's signature & credentials: _____ Date: _____

Supervisor's signature & credentials, if applicable: _____ Date: _____

Insight Psychological Services
2126 Richmond Hwy Suite 103
Stafford, VA 22554

OFFICE POLICIES AND PROCEDURES

Welcome to Insight Psychological Services. This document contains important information about professional services and business policies. Please read it carefully and make note of any questions you may have so that you and your clinician can discuss them at your next meeting. When you sign the consent to treatment form at the back of this packet, it will represent an agreement between Insight Psychological Services, your clinician, and you.

Psychological Services

Psychotherapy and psychological assessment is offered as appropriate by licensed clinical psychologists (PsyD or PhD), licensed marriage and family counselors (LMFT), licensed professional counselors (LPC), licensed clinical social workers (LCSW), recent graduates in those fields (i.e. postdoctoral residents), or graduate students pursing advanced degrees in those fields (i.e. interns or externs). If a clinician is not yet licensed, they provide services under the supervision of an appropriately licensed clinician.

Appointments and Associated Fees

Clinicians at Insight Psychological Services provide outpatient mental health counseling and assessment. Initial intake and assessment appointments take approximately 45-60 minutes and primarily involve treatment formulation and paperwork completion. Therapy sessions are generally scheduled once a week or twice a month for 45-60 minutes. A late cancellation or failure to attend your appointment (also known as a no-show) results in an open hour, inconvenience, and a loss of revenue. Once an appointment hour is scheduled, you will be expected to pay for that hour unless you provide 24 hours advanced notice of cancellation. If you cancel less than 24 hours in advance or no-show for your appointment, you may be charged for an amount equal the fee that would have been collected by your insurance company or a fee agreed to by you and your clinician. No show and late cancellation fees will only be waived on a case by case basis and decided upon by your clinician. If it is possible, your clinician will try to find another time to reschedule the appointment. If you arrive late for a scheduled appointment, only the remainder of the session will be available. If your clinician is running late with a prior appointment, you will still receive the full session time.

- Late cancellation (less than 24 hours' notice) or missed therapy appointment (no-show): **$60**
- Late cancellation or missed assessment (testing) appointment: **$150**

Payment of any late cancellation or missed appointment fees is due before the next scheduled appointment.

Insight Psychological Services reserves the right to modify or cancel all scheduled/standing appointments and close the chart at any time, specifically if:

- Two (2) scheduled/standing therapy or assessment appointments are missed consecutively without proper notification.
- The patient does not present for a session with his or her primary clinician for 60 days.
- Attendance at scheduled/standing therapy appointments is inconsistent for any reason.
- The patient's account has a past due balance exceeding $100.

Additional Professional Fees

In addition to weekly appointments, you may find that you need other professional services, such as a letter, from your clinician. Below is a list of fees associated with some common patient or parent/legal guardian requests:

- Returned checks: **$50**

- Completion of a form requested by the patient or parent/legal guardian: **$25**
- Letter written at the request of the patient or parent/legal guardian: **$25**

Other services that may be subject to fees include report writing, telephone conversations lasting longer than a few minutes, consulting with other professionals (with your permission), preparation of records or treatment summaries, and time spent for any other services you may request of your clinician. Fees for these services will be discussed with you by your clinician at the time of the request. Fees may increase periodically.

Billing and Payments

You are expected to pay the costs associated with your appointment in full at the time that services are rendered unless otherwise agreed upon. As a courtesy to you, Insight Psychological Services will submit a claim on your behalf to your or your child's insurance company. Should you decide to use your or your child's health insurance plan you are responsible for the copayment, co-percentage payment, payment toward a deductible, and costs not covered by your or your child's health insurance plan at the time of services unless otherwise agreed upon. Any balances due to Insight Psychological Services after your or your child's insurance carrier has provided any applicable payment will be billed to you. **Please remember that you are responsible for full payment of all fees associated with you or your child's account, not the insurance company.** If benefits cannot be determined prior to or at the time of service, and/or when there is any doubt regarding financial responsibility, payment is expected by you in full. Please note, that some insurances charge different copays depending on the billing code that is submitted to them. If you have questions regarding this, please speak with your clinician. Cash, check, and credit cards are acceptable forms of payment. Payment schedules for other professional services will be agreed upon when and if they are requested. If your account has not been paid for more than 60 days and payment arrangements have not been made, Insight Psychological Services has the option of using legal means to secure the payment. This may involve the use of a collection agency, which may affect your credit. If legal action is necessary, the cost of the collection fees and interest will be included in the claim. If your clinician is a recent graduate or graduate student, services are billed under her/his supervisor.

Patients of Divorced Parents/Legal Guardians

If the patient is a minor and the parents are separated or divorced, or the child lives with a legal guardian, your child's clinician may request a copy of official court documents outlining who is and is not able to make decisions regarding the child patient's medical/mental health care and/or who is privy to information concerning that child's care.

Additionally, the parent or guardian who brings the child to a therapy or assessment appointment at Insight Psychological Services is responsible for payment of fees at the time service is rendered, or if any fees for other services are accrued, regardless of what a divorce decree may state. Any judgment regarding court ordered financial responsibility must be determined between the individuals involved, without the inclusion or Insight Psychological Services' personnel.

Litigation Policy

Active litigation, such as custody disputes, can be detrimental to the therapeutic relationship and can hinder a clinician's ability to treat the patient as litigation often involves full disclosure of confidential information. Therefore, it is agreed that should you (the patient or parent/legal guardian of the patient) or your child become involved in any legal proceedings, you, your attorneys, or anyone acting on your behalf **will not** subpoena Insight Psychological Services' records or any Insight Psychological Services clinician or employee to provide a deposition, testify in court, or engage in any other legal process or proceeding. If any Insight Psychological Services clinician or employee is subpoenaed to provide records or testimony in violation of this agreement,

you agree to pay any and all fees accrued for document preparation and professional time, even if said records or testimony is requested by another party. Should this occur, which is again in violation of this agreement, Insight Psychological Services reserves the right to terminate treatment immediately. Referrals to other mental health professionals will be provided.

Should this agreement be violated, the following fees apply and must be paid in full five (5) business days before preparation of requested documents or appearance at any legal proceeding:

- Availability of treating clinician from 8:00 am to 12:00 pm or 1:00 pm to 5:00 pm (half day) within 50 miles of the Insight Psychological Services office: **$2000.00**
- Availability of treating clinician from 8:00 am to 5:00 pm (full day) within 50 miles of the Insight Psychological Services office: **$3000.00**
- Availability of treating clinician from 8:00 am to 5:00 pm (full day) beyond 50 miles of the Insight Psychological Services Office: **$4000.00**
- If the treating clinician is a recent graduate or graduate student and the presence of her/his supervisor is required for half a day, the following fee applies in addition to that outline above: **$1000.00**
- If the treating clinician is a recent graduate or graduate student and the presence of her/his supervisor is required for a full day, the following fee applies in addition to that outline above: **$2000.00**

Confidentiality

In general, the law protects the privacy of all communication between a patient and a clinician. However, information about you may be used by the personnel associated with Insight Psychological Services for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, other mental health professionals, mental health students, or business associates affiliated with Insight Psychological Services such as insurance carriers, billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a patient cannot be shared with another party without the written consent of the patient or the patient's legal guardian or personal representative. It is the policy of Insight Psychological Services not to release any information about a patient without a signed release of information except in certain emergency situations or exceptions in which patient information can be disclosed to others without written consent. Some of these situations are noted below. There may be other provisions provided by legal requirements.

- Abuse of a minor, elder, or person with a disability.
- Evidence of imminent suicidal or homicidal intent or other harm to self or others.
- Involvement in any legal proceedings in which you or your child were referred for services by the court/agency or in which your or your child's records are subpoenaed by a court. You have the right to prevent your clinician from releasing information about your treatment. Please also see the litigation policy above.
- Your or your child's health insurance company (payor source) requires certain pertinent information as required by law (i.e. diagnosis, treatment summary, or treatment plan).
- You or your child is being treated by a clinician who is being supervised by a licensed clinician.
- Certain patient information is submitted to a collection agency in order to collect the balance of an overdue account.

Although patients and a minor patient's parent/guardian have a right to access their or their child's records, because the records maintained by your or your child's clinician contain information that may be misunderstood and/or misinterpreted by someone who is not a mental health professional, it is the policy of Insight Psychological Services that patients and/or their parent/guardian not review them. However, a treatment summary may be provided at your request, if appropriate it and doing so would not be emotionally damaging. Alternatively, Insight Psychological Services personnel can send the record or treatment summary to another qualified health professional who is working with you or your child, with proper authorization

Termination of Services

If the treating clinician and/or clinical supervisor determine appropriate services can no longer be provided to you or your child for any reason, treatment will be terminated and referrals to other professionals will be provided.

Contacting your clinician

Due to your clinician's work schedule, she/he may not be immediately available by telephone. While your clinician may be in the office during regular business hours, your clinician will not be available if she/he is in session with a patient. When your clinician is unavailable, please leave a message on her/his voicemail. She/he will make every effort to return your call the same day, with the exception of weekends and holidays. If you are unable to reach your clinician and feel that you cannot wait for a return call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If your clinician is unavailable for an extended period of time, she/he will provide you with the name of a colleague to contact, if necessary. The same information should also be available on your clinician's voicemail. Your clinician only uses email for setting up appointments or contacting a patient who has missed an appointment. Email is not to be used to discuss clinical issues. Email is not a secure, confidential form of communication and therefore should not be used for communication related to private information.

Weather

Please do not assume that your clinician follows Stafford County Public Schools or Federal Government closure schedules. Your clinician may call or email you to cancel your appointment in the case of inclement weather or they will leave a message on their voicemail indicating if she/he is in the office that day. However, to avoid any no show fees, contact your clinician in case of inclement weather in order to determine if your session will be kept or cancelled.

Emergencies

Sometimes, emergencies arise that cannot be planned for. In case of an emergency call 911 and notify your clinician. If your clinician leaves town, another clinician will be on call for her/him in case of an emergency. Your clinician will leave the name and phone number of the person on call on his or her voicemail.

Please complete the next 2 pages and give to front desk. Pages 1-4 are yours to keep for future reference. Refusal to sign the next 2 pages will result in services not being rendered.

Insight Psychological Services
2126 Richmond Hwy Suite 103
Stafford, VA 22554

ACKNOWLEDGMENT OF OFFICE POLICIES AND PROCEDURES AND CONSENT FOR TREATMENT

I, the undersigned, acknowledge that I have received and reviewed the following policies of Insight Psychological Services in its entirety and agree to abide by the terms set forth in them for the duration of my professional relationship with my or my child's clinician and/or Insight Psychological Services:

(Initial next to paragraph that you read the policy)

_____ Psychological Services

_____ Appointments and Associated Fees

_____ Additional Professional Fees

_____ Billing and Payments

_____ Patients of Divorced Parents/Legal Guardians

_____ Litigation Policy

_____ Confidentiality

_____ Termination of Services

_____ Contacting your clinician

_____ Weather

_____ Emergencies

If you or your child is ***using insurance benefits***, please review the statements below and **initial** here: _____

- I authorize Insight Psychological Services to submit claims to my insurance company.
- I authorize the use of this form for all my insurance submissions.
- I authorize release of information to all my insurance companies.
- I authorize the provider to act as my agent in helping me obtain payment from my insurance company.
- I authorize payment directly to Insight Psychological Services.
- I understand that I am ultimately responsible for my bill.

If you are ***not using insurance benefits***, please review the statement below and **initial** here: _____

- I am not using insurance benefits and understand I am, therefore, responsible for 100% of the applicable fee at the time services are rendered.

Consent to Services

I, _____ (patient or authorized representative), hereby give clinicians at Insight Psychological Services permission to provide appropriate psychological services to me or my child, as necessary. I have read the office's policies and procedures including limits of confidentiality and am aware of the Patient Privacy Notice (HIPPA). I understand I have the right to revoke this consent at any time in writing. I also understand any changes to Insight Psychological Services' policies and procedures occurring after the date indicated below will be discussed with me in a timely manner.

Signature of patient or parent/guardian: _____ Date: _____

Relationship to patient: _____

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Credit Card Authorization Form

I, _____ agree that Insight Psychological Services will automatically charge the last credit card used for my/my child's therapy or assessment session, copayment, deductible, missed appointments, late cancellations for scheduled session(s) or for non-payment due to lapse in your coverage. If your account has not been paid for more than 60 days and payment arrangements have not been made, Insight Psychological Services has the option of using legal means to secure the payment.

It is my understanding that the charge for any no-show fee/late cancellation (less then 24 hours) will be a $60.00 fee and can be charged to my credit card on file.

Please let us know ASAP if a late/missed appointment is due to illness or emergency.

_____
Name on card

Type of card: Visa Mastercard American Express Discover

_____
Credit card number

Expiration date: _____ **CCV code: _____**

Address, including zip code:

_____

_____

_____

_____

_____
Signature **Date**

By signing this form, I understand that my card will be charged AUTOMATICALLY for fees owed.

IT IS YOUR RESPONSIBILITY TO INFORM US IF YOU WOULD LIKE TO USE A DIFFERENT CARD THEN WHAT YOU HAVE ON FILE.