**Connect the Dots-PC**

***Psychotherapy: Children, Teens, Adults, Families***

**6477 College Park Square**

**The Atrium, Suite 216**

**Virginia Beach, VA 23464**

**Ph: (757) 962-9503 Fax: (757) 962-2700**

**PATIENT INFORMATION**

**COMPANY AUTHORIZATION #:**  .

**Last name:**  **First:**  **Middle Initial:**  .

**Email:**  **Preferred Phone:**   **Cell**  **Landline**

**Address:**  **City:**  **State:**  **Zip:**  .

**Gender:**  **.**

**Relationship Status:**   **Single**  **Domestic Partnership**   **Married**  **Divorced**  **Widowed**

**Social Security Number:**  **Date of Birth:**  .

**Employer:**  **Work Phone:**  .

**Emergency Contact:**  **Relationship to Patient:**  **Phone:**  .

**RESPONSIBLE PARTY *(If Patient is a Minor)***

**Last name:**  **First:**  **Middle Initial:**  .

**Email:**  **Preferred Phone:**   **Cell**  **Landline**

**Address:**  **City:**  **State:**  **Zip:**  .

**Social Security Number:**  . **Driver's License#:**  .

**Address:**  **City:**  **State:**  **Zip:**  .

**Employer:**  **Work Phone:**  .

**INSURANCE INFORMATION**

**Primary Insurance:**  **ID#:**  **Group#:** .

**Subscriber Name:**   **Relationship to Patient:**  .

**Secondary Insurance:**  **ID#:**  **Group#:**  .

**Subscriber Name:**  **Relationship to Patient:**  .

*I hereby authorize treatments and/or consultation for the above patient by Connect the Dots-PC. I also authorize release of records to any agency involved in the payment for treatment of this patient and assign all benefits to Connect the Dots-PC. I, the undersigned, agree to pay the amount due and if not paid at the time of service rendered, I shall be responsible for all costs of collections, including attorney/legal fees.*

**SIGNATURE**: *(Please type in name)*   **DATE:**  .

**RELATIONSHIP TO PATIENT:**  .

**RELEASE FOR COORDINATION WITH PRIMARY CARE PHYSICIAN**

*For the purpose of coordination of care, my Connect the Dots-PC mental health provider may wish to release pertinent information about my current treatment to my Primary Care Physician. This release shall be valid until sixty (60) days after my last date of treatment—or until the time I revoke this release in writing, which can be done at any time.*

**I DO**   I **DO NOT** give permission to my Connect the Dots-PC mental health provider to release information about my current treatment

to my Primary Care Physician.

**Primary Care Physician:**  **Phone:** .

**Address:**  **City:**  **State:**  **Zip:**  .

**SIGNATURE:** *(Please type in name)* **DATE:**  **RELATIONSHIP TO PATIENT:**  .

.

***How were you referred to us?***  .

|  |
| --- |
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**POLICY FOR CLIENTS WITH NO COPAY**

**PATIENT INFORMATION:**

**Last name:**  **First:**  **Middle Initial:**  .

**Date of Birth:**  .

**You are receiving counseling services under an employer agreement or insurance policy at no cost to you. Some people tend to undervalue services that they are not paying for directly, and believe it is acceptable to cancel an appointment with little or no notice, thinking it is merely an inconvenience.**

**It is important to realize that your therapist/counselor has set aside 45 minutes to an hour of professional time for you. It is also important to realize that your provider is a contractor, and will not be reimbursed for failed appointments, thereby directly impacting his or her income. While true emergencies are sometimes unavoidable, we expect at least 24 hours cancellation notice for a scheduled appointment.**

**If you forget your appointment, fail to cancel the appointment, or get called in to work unexpectedly, please contact your provider immediately upon learning there is a problem. Your provider may be able to work out an abbreviated session or work with your schedule, so that neither you nor our counselor is penalized.**

***Connect the Dots-PC reserves the right to place clients on a call back list at our convenience, or, terminate services to those who do not honor our professional time.***

**I have read and agree to the foregoing**:

**SIGNATURE:** *(Please type in name)*   **DATE:**  .

**RELATIONSHIP TO PATIENT:**  .

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**ACKNOWLEDGEMENT OF RECEIPT: NOTICE OF PRIVACY PRACTICES**

***(PATIENT'S RIGHTS and RESPONSIBILITIES)***

**PATIENT INFORMATION:**

**Last name:**  **First:**  **Middle Initial:**  .

**Date of Birth:**  .

***I have reviewed/received Connect the Dots-PC Notice of Privacy Practices (attached). The Notice of Privacy Practices provides, in detail, the uses and disclosures of my protected health information that may be made by Connect the Dots-PC; my individual rights and how I may exercise these rights; and legal duties of Connect the Dots-PC with respect to my private medical information.***

***I understand that Connect the Dots-PC reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information located at—or controlled by—Connect the Dots-PC.***

**SIGNATURE:** *(Please type in name)*   **DATE:**  .

**RELATIONSHIP TO PATIENT:**  .

**I have received a copy of the Notice of Privacy Practices:** *(Please type in initials)*   **.**

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**NOTICE OF PRIVACY PRACTICES**

***(PATIENT'S RIGHTS and RESPONSIBILITIES)***

|  |  |
| --- | --- |
| **STATEMENT OF RIGHTS**   * Patients have the right to be treated with dignity and respect. * Patients have the right to fair treatment regardless of race, religion, gender, ethnicity, age, disability, or source of payment. * Patients have the right to have their treatment and other information kept private. * Only in life-threatening situations or, if required, can records be released without a signed consent from patients. * Patients have the right to information from staff/providers in a language they can understand. * Patients have the right to an easy-to-understand explanation of their condition and treatment. * Patients have the right to know about all their treatment options, regardless of cost coverage. * Patients have the right to information about services offered by their providers and the patient role in the treatment process. * Patients have the right to know the clinical guidelines used in providing and/or managing their care. * Patients have the right to provide suggestions on office policies and procedures. * Patients have the right to complain and be informed of the complaint, grievance, and appeals processes. * Patients have the right to know about State and Federal laws governing patient rights and responsibilities. * Patients have the right to participate in the formation of their plan of care. | **STATEMENT OF RESPONSIBILITIES**   * Patients are responsible for providing their medical provider with information needed to deliver quality care. * Patients are responsible for informing their provider when/if their treatment plan is no longer effective. * Patients are responsible to follow their treatment plans and to inform their provider of any changes to the treatment plan made by other providers, including any changes in their medications. * Patients are responsible for reviewing their care and treatment plans continuously, and reporting effectiveness or ineffectiveness of the care plan to their provider. * Patients are responsible for treating those giving them care with dignity and respect. * Patients should not be involved in any conscious behavior that could harm the lives of their provider, office staff, or other patients. * Patients are responsible for keeping their appointments, arriving on time, and notifying the office of any cancellations at least 24 hours prior to the appointment. * Patients are responsible for addressing questions about their care to their provider, and ensuring the understanding of their care and their role in the treatment process. * Patients are responsible for notifying their provider of any concerns regarding payment or insurance coverages. |

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**CHILD CHECKLIST of CHARACTERISTICS**

**PATIENT INFORMATION:**

**Last name:**  **First:**  **Middle Initial:**  **Date:**   .

**Age:**  .

**Person completing this form:**  .

***Please review this checklist, which contains concerns— as well as positive traits. Click on the box for any items that describe your child. You may add a note or details in the space next to the concerns chosen. Feel free to add any others at the bottom under “Any other characteristics or concerns.”***

Abuse: emotional / physical / sexual

Affectionate

Alcohol / drug / tobacco use

Anger issues: aggression / tantrums / destructive to property / violent behavior

Argues / disrespectful

Autism

Bullies / intimidates / teases / provokes

Cheats (schoolwork, games, etc.)

Complains

Conflicts related to chores / school / choices in attire, friends, music, etc.

Concerned for others

Cries easily / feelings easily hurt

Cruel to animals

Difficulties with parent's partner / new marriage / new family

Dependent (overly)

Developmental delays

Disrupts family activities

Disobedient / defiant / uncooperative / stubborn / breaks rules consistently

Daydreams / distractible / inattentive / slow to respond

Domestic violence

Eating: obesity / overeating / undereating / vomiting

Exercise: lack of physical exercise

Extracurricular activities interfere with academics

Fearful / nervous / anxious / tense

Fire setting

Friendly / outgoing / sociable

Frustrated easily

Grief

Hypochondriac, always complains of feeling sick

Immature / has only younger playmates

*(continued on next page)*

**Connect the Dots-PC**

**CHILD CHECKLIST of CHARACTERISTICS**, cont.

Imaginary playmates

Independent

Job issues: dissatisfaction with responsibilities / dissatisfaction with income / future goals / inability to keep a job /

lack of ambition / lack of career options / overworked / personnel conflicts / safety / unemployment / workaholism

Interrupts / talks out of turn / "clowns around"

Lacks organization / unprepared

Learning disability

Likes to be alone / withdraws

Lies persistantly

Mental retardation

Moody

Mute (refuses to speak)

Nail biting / hair pulling / picking at skin

Need for high degree of supervision at home with chores / free time / schedules

Negative / pessimistic

Obedient

Overactive / restless / out-of-seat behaviors / fidgety / loud

Prejudiced / bigoted / name calling / intolerant

Procrastinates / wastes time

Recent move / new school / loss of friends

Relationships with siblings / peers are poor (fights, teasing, provoking)

Responsible

Rocking or other repetitive movements

Runs away

Sad / unhappy

School issues: failing / dropping out / truancy / trying but overwhelmed

Self-harming behaviors: biting / cutting / head banging / hitting / scratching / strangling

Speech difficulties

Sexual: inappropriate sexual behaviors / public masturbation / sexual preoccupation

Shyness

Sleep issues: too much / too little / insomnia / nightmares

Suicide talk / suicide attempt

Swearing / inappropriate language

Thumb sucking / finger sucking / hair chewing

Tics (involuntary rapid movements / noises / words)

Underactive / slow-moving / lethargic

Uncoordinated / accident prone

Wetting or soiling the bed or clothes

**Any other characteristics or concerns:**  .

**Please read over the concerns you have checked off. Which concern is the one you most want your child to be helped with?**  .