Main Business Office
Associates in Brief Therapy, Inc.
4346 Starkey Rd, Suite 1
Roanoke, VA 24018
Phone: (540)772-8043
Fax: (540)772-8242

ABT Counseling
Serving Southwest Virginia

New Patient Information Sheet
(PLEASE PRINT)

Satellite Offices
Blacksburg, Daleville, Salem

Affiliate Offices
Blue Ridge Telehealth, LLC
Floyd Counseling

PATIENT INFORMATION:

Patient's Name_____
Last Name **First Name** **Middle Initial**

Responsible Party (if a minor) _____

Mailing Address (Street and/or PO Box) _____ **Apt #**_____

City_____ **State**_____ **Zip Code**_____

Phone: Home _____ **Cell** _____ **Work** _____

Email Address: _____ ☐ Yes, I would like to receive periodic informative emails from ABT, Inc.

Sex: ☐ **Male** ☐ **Female** **Date of Birth**_____ **Age**_____ **Social Security Number**_____

☐ **Single** ☐ **Married (How long?** _____**)** ☐ **Divorced** ☐ **Widowed** ☐ **Separated**

Please list children and their ages: (if applicable)

Patient Employer_____

Address_____ **City**_____ **State**_____ **Zip**_____

Occupation_____

How or from whom did you hear of ABT? (Name:_____**)**

☐ **Doctor** ☐ **Church/Pastor** ☐ **Yellow Pages** ☐ **Current/Former Patient** ☐ **Internet** ☐ **Other** _____

In Case of Emergency, Please Contact: _____ **Phone** _____

PARENT/SPOUSE INFORMATION:

Spouse/Parent _____ **Date of Birth**_____

Employer_____ **Work Phone**_____

Occupation_____ **Social Security Number**_____

INSURANCE INFORMATION:

Primary Insurance Company_____ **Phone Number**_____

Subscriber's Identification Number_____ **Group Number**_____

Subscriber's Name_____ **Relationship to Patient**_____

Subscriber's Social Security Number _____ **Date of Birth**_____

RELEASE OF INFORMATION:

I authorize ABT, Inc. to obtain/release/exchange information with my Primary Care Physician (PCP), other healthcare practitioners, or as requested by my insurance company for the purpose of service coordination and continuity of care.

Primary Care Physician's/Other practitioner's name _____

Address _____

Phone _____ **Fax** _____

☐ **Check here if you do not authorize this release of information.**

For Office Use Only:

Chart# _____

❒ *ABT* ❒ *Medisoft*

Initials _____

_____
(Signature of Patient or Responsible Party) **(Date)**

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New Patient Communication Sheet

(PLEASE PRINT)

Occasionally it will be necessary for our office to contact you regarding matters about counseling. This permission form will help us know when and how to contact you in ways which are comfortable for you.

By giving permission for us to contact you in one or more of the ways listed below, you are agreeing for us to leave messages and information. We will always try to be discreet in any messages we leave, but we cannot guarantee confidentiality once the message is left.

Which is your **preferred contact phone number**? (select one) ○ Home ○ Work ○ Cell

Home

○ Yes ○ No May we contact you at your home telephone number? # _____

Work

○ Yes ○ No May we contact you at your work telephone number? # _____

Cell Phone

○ Yes ○ No May we contact you at your cell telephone number? # _____

Courtesy Appointment Reminders **IMPORTANT:** (*We are no longer making phone call reminders*)

E-Mail ○ Yes ○ No *If you choose this option, E-mail reminders are sent (2) two days before your scheduled appointment.*

E-Mail Address:_____

Text Messaging ○ Yes ○ No Cell Phone _____

Choose how often you would like a text message: **(You cannot respond back to a text message)**

○ 48 hours ○ 48 & 24 hours

○ 24 hours ○ 48 & 2 hours

○ 24 & 2 hours

NOTE: If you need to make/change/cancel an appointment, have patient account or insurance questions, please CALL our office at 540-772-8043.

Would you like to sign up for a Patient Portal account? ○ Yes ○ No

_____ _____

(Signature of Patient or Responsible Party) **(Date)**

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Child Personal Health Questionnaire (PHQ)

All information is kept confidential in adherence with current HIPAA regulations.

Child's Name: _____ **Date:** _____

Custody Status: ○ Parent(s) ○ Sole Parental Custody ○ Joint Legal Custody ○ DSS Custody ○ Shared Custody ○ Other: _____

Name of person accompanying patient to first visit: _____ **Relationship:** _____

Other persons who are authorized to bring this child to therapy sessions:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

BACKGROUND INFORMATION

Family & Living Situation

○ At home with parent(s)/guardian ○ With other family
○ Foster Care ○ Residential Placement
○ Other: _____

Names of those living in the same household and any siblings/stepsiblings or other significant family members *not* living with the child:

Living with the Child?	Name	Age	Relationship
○ Yes ○ No			
○ Yes ○ No			
○ Yes ○ No			
○ Yes ○ No			
○ Yes ○ No			
○ Yes ○ No			

Are the child's parents separated or divorced? ○ Yes ○ No

If Yes, When? _____

Has either remarried? ○ Yes ○ No

Name of stepparent: _____

What contact does child have with other biological parent(s)?

_____

Social History

Education: School Name: _____

Teacher Name(s): _____

Grade Level: ○ K ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 11 ○ 12

Academic Performance:
○ Excellent ○ Good ○ Fair ○ Poor ○ Failing

Behavior in School:
○ Excellent ○ Good ○ Fair ○ Poor ○ Failing

IEP in Place? ○ Yes ○ No

If Yes, Explain _____

Legal: Has the child had any legal problems or are there any ongoing problems with custody issues? ○ Yes ○ No

Please describe: _____

_____

Other Agency Services:
☐ Occupational Therapy ☐ Speech Therapy
☐ Disability/Social Security ☐ Child Protective Services (CPS)
☐ Other DSS Services ☐ Other: _____

Spiritual: Is the child religious or spiritual? ○ Yes ○ No

Does the child currently participate in religious or spiritual activities? ○ Yes ○ No

If Yes, where? _____

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All rights reserved. No part of this publication by be reproduced, stored in a retrieval system, or transmitted in any form or by any means – electronic, mechanical, photocopy, recording, or any other – without prior written permission of the publisher. It is to be used as intended for patients of ABT Counseling.

THE PROBLEM WHICH BRINGS YOU AND THE CHILD HERE:

What brings you and the child to our office?
(Briefly explain the problem that brings you here now and what stressful circumstances have contributed to it.)

I/we would like to address the following:

- ☐ Child's mood or emotional state
- ☐ Child's school performance
- ☐ Child's cognitive/mental functioning
- ☐ Parenting
- ☐ Divorce
- ☐ Abuse or neglect
- ☐ Child's behavior
- ☐ Child's sleep, eating, or physical concerns
- ☐ Child's relationships with family
- ☐ Child's relationships with peers
- ☐ Other:

Please indicate your observations of the child using the scale below for *EVERY* item.

Over the past month: Not at All ○ | A Few Days ① | About Half the Days ② | Nearly Every Day ③

Appears sad	○ ① ② ③
Depressed	○ ① ② ③
Lost interest in previously enjoyed activities	○ ① ② ③
Oversleeping or insomnia	○ ① ② ③
Aches, pains, stomach aches	○ ① ② ③
Socially withdrawn	○ ① ② ③
Feeling worthless	○ ① ② ③
Low self-esteem	○ ① ② ③
Overeating or appetite loss	○ ① ② ③
Feels hopeless	○ ① ② ③
Easily irritated	○ ① ② ③
Fatigue	○ ① ② ③
Low energy	○ ① ② ③
Self-injury	○ ① ② ③

I/We have observed the child experiencing these problems for:

○ < 1 month ○ 1-3 months
○ 4-6 months ○ > 6 months

Elevated mood	○ ① ② ③
Does things without thinking of consequences	○ ① ② ③
More talkative than usual	○ ① ② ③
Mood swings	○ ① ② ③
Racing thoughts	○ ① ② ③

I/We have observed the child experiencing these problems for:

○ < 1 month ○ 1-3 months
○ 4-6 months ○ > 6 months

Anxiety	○ ① ② ③
Feelings of panic	○ ① ② ③
Racing heart	○ ① ② ③
Fearful	○ ① ② ③
Obsessive behaviors	○ ① ② ③
Anxious when away from loved ones	○ ① ② ③
Difficulty breathing	○ ① ② ③
Anxious in social situations	○ ① ② ③
Excessive worry	○ ① ② ③
Phobia of _____	○ ① ② ③

I/We have observed the child experiencing these problems for:

○ < 1 month ○ 1-3 months
○ 4-6 months ○ > 6 months

Fails to pay attention to details	○ ① ② ③
Difficulty following through on tasks	○ ① ② ③
Overactive	○ ① ② ③
Unusual behavior	○ ① ② ③
Hair pulling	○ ① ② ③
Defiant	○ ① ② ③
Cruel to animals	○ ① ② ③
Lying	○ ① ② ③
Views pornography	○ ① ② ③
Repetitive body movements	○ ① ② ③

Lacks friends	○ ① ② ③
Doesn't seem to listen	○ ① ② ③
Disorganized	○ ① ② ③
Always "on the go"	○ ① ② ③
Toileting issues	○ ① ② ③
Poor body image	○ ① ② ③
Head banging	○ ① ② ③
Argues with adults	○ ① ② ③
Fire setting	○ ① ② ③
Refuses to attend school	○ ① ② ③
Difficulty reading social cues	○ ① ② ③
Bullying	○ ① ② ③
Easily distracted when spoken to	○ ① ② ③
Fidgety	○ ① ② ③
Impulsive	○ ① ② ③
Gender image issues	○ ① ② ③
Hears voices	○ ① ② ③
Destructive	○ ① ② ③
Stealing	○ ① ② ③
Running away	○ ① ② ③
Poor social skills	○ ① ② ③

I/We have observed the child experiencing these problems for:

○ < 1 month ○ 1-3 months
○ 4-6 months ○ > 6 months

DEVELOPMENTAL HISTORY

Was the child: ☐ Planned ☐ Unplanned ☐ Breast Fed ☐ Bottle Fed ☐ In Day Care ☐ Kept at Home

Was the child exposed to any alcohol, medications, cigarettes, or toxins before birth? ◯ Yes ◯ No

If yes, please describe: _____

Did the child have any problems during birth or any health problems as an infant? ◯ Yes ◯ No

If yes, please describe: _____

At what age did the child do the following: Start Talking _____ Start Walking _____ Was Potty Trained _____

Which best describes the child's current ability to complete age-appropriate self-care tasks (such as dressing, bathing, brushing teeth, fixing hair, etc.)?
◯ Does not complete age-appropriate self-care ◯ Needs a lot of help with self-care
◯ Needs many reminders to complete self-care ◯ Fairly independent in self-care

If the child is female, has she begun menstruation? ◯ Yes ◯ No Age of onset: _____

PERSONAL MEDICAL HISTORY

Please check below if the child has <u>ever had</u> any of the following medical conditions:

☐ Allergies
☐ Bladder / Bowel Problems
☐ Asthma
☐ Cancer – Type: _____
☐ Chronic Headaches
☐ Chronic Pain
☐ Vision Problems
☐ Hearing Problems
☐ Diabetes
☐ Sensory Issues
☐ Head Injury / Concussion
☐ Heart Problems
☐ Kidney Problems
☐ Liver Problems
☐ Migraines
☐ Other Respiratory Problems
☐ PMS / Menstrual Problems
☐ Seizures
☐ Stomach Problems
☐ Thyroid Problems
☐ Traumatic Brain Injury
☐ Other: _____

Surgeries		
Date	Reason	Hospital/Doctor

Previous Counseling/Psychiatric Treatment (including hospitalizations)		
Date	Reason	Counselor/Doctor

Current Medications (please list all or provide a list)				
Medication	Strength	Frequency	Date Started	Doctor

Previous Psychotropic Medications (please list all you have ever taken)				
Medication	Strength	Frequency	Date Started	Doctor

Medication Allergies		
Date	Medication	Reaction

FAMILY MEDICAL HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father				○M ○F	
Mother				○M ○F	
Sibling(s)	○M ○F			○M ○F	
	○M ○F			○M ○F	
	○M ○F		**Grandfather** *Maternal*		
	○M ○F		**Grandmother** *Maternal*		
	○M ○F		**Grandfather** *Paternal*		
	○M ○F		**Grandmother** *Paternal*		

FAMILY MENTAL HEALTH HISTORY

Please indicate whether any of your (blood) relatives have had any of these concerns:					
	Parents	**Brothers/Sisters**	**Children**	**Grandparents**	**Aunts/Uncles/Cousins**
ADHD/ADD	☐	☐	☐	☐	☐
Autism Spectrum Disorders	☐	☐	☐	☐	☐
Suicide (attempted/completed)	☐	☐	☐	☐	☐
Alcohol/Drug Problems	☐	☐	☐	☐	☐
Mental Hospital	☐	☐	☐	☐	☐
Depression Problems	☐	☐	☐	☐	☐
Manic or Bipolar	☐	☐	☐	☐	☐
Psychosis or Schizophrenia	☐	☐	☐	☐	☐
Anxiety and/or Panic	☐	☐	☐	☐	☐
OCD	☐	☐	☐	☐	☐

FAMILY RELATIONSHIPS

Please describe the child's relationship with their parents/guardians:

If the child has siblings, half- or stepsiblings, please describe the child's relationship with them:

Are there any pets in the home? ○Yes ○No If yes, please comment on how the child relates to the pet(s): _____

Does the child have chores? ◯ Yes ◯ No

If yes, please describe: _____

_____

Does the child get an allowance? ◯ Yes ◯ No

If yes, please describe: _____

Please describe the parenting style used and how parents/guardians work together (i.e. similarities, differences, degree of ease):

HEALTH HABITS & ACTIVITIES

PLEASE TRY TO ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY				
Exercise / Activities	Has the child's level of activity changed? ◯ Yes ◯ No		Explain:	
	Is the child involved in sports?	◯ Yes ◯ No	Is the child involved in other extra-curricular activities?	◯ Yes ◯ No
	What are the child's interests, hobbies, and/or preferred activities?			
Eating	Has the child's appetite changed?	◯ Yes ◯ No	Details:	
	No. of meals the child eats in an average day?			
	Does the child eat refined sugar?	◯ Yes ◯ No	If yes, what kind and how often?	
	Does the child eat fast food?	◯ Yes ◯ No	If yes, what kind and how often?	
	Do any of these apply?	☐ Expressing they're fat when they're skinny ☐ Binge eating ☐ Purging		
Caffeine	☐ None ☐ Coffee	☐ Tea	☐ Soda	☐ Energy Drink ☐ Other:
	No. of cups/cans per day?			
Sleep	Does the child generally feel rested when they wake up in the morning?		◯ Yes ◯ No	
	What time does the child typically go to bed?		How long does it generally take the child to fall asleep?	
	What time does the child typically wake up?			
	Including naps during the day, how many hours, on average, does the child sleep per 24-hour day?			
	If the child awakens frequently through the night, how many times do they awaken, and how long does it take them to go back to sleep?			
	No. of times awaken:		Time to sleep?	
	Does the child struggle to stay awake when they should be awake?		◯ Yes ◯ No	
	Is child's life negatively affected by sleepiness? (for example, school)		◯ Yes ◯ No	
	Does the child stop breathing briefly at times while they are sleeping at night?		◯ Yes ◯ No	
	Does the child have bad dreams or nightmares?		◯ Yes ◯ No	
	Does the child have issues with wetting the bed or walking in their sleep?		☐ Wetting Bed ☐ Sleep Walking	
Electronics	Do you find the child spending more and more time online or on their digital devices (computer, laptop, tablet or Smartphone) than they seem to realize?			◯ Yes ◯ No
	Does the child sleep with his/her Smartphone ON under their pillow or next to their bed regularly?			◯ Yes ◯ No
	Do you find the child viewing and answering texts, tweets, and emails at all hours of the day and night — even when it means interrupting other things they're doing, such and schoolwork, meals, sports, or other family activities?			◯ Yes ◯ No
	Do you limit, block, or filter Internet and digital screen-time access for the child?			◯ Yes ◯ No
	If you do limit it or take it away from them, do they have a strong emotional or physical reaction?			◯ Yes ◯ No
	Do you feel the child's use of technology decreases their academic productivity and real-time socialization, family participation, or physical activity?			◯ Yes ◯ No
	Do they seem to lose track of time when using any of these technology devices?			◯ Yes ◯ No
	Do you find the child feeling somewhat ill-at-ease or uncomfortable when they accidentally leave their phone or other Internet/digital device in the car or at home, or when they have no service, or their device is broken?			◯ Yes ◯ No
Sex	Sexual Orientation:			
	Is the child sexually active?	◯ Yes ◯ No		
Tobacco	Does the child use tobacco?	◯ Yes ◯ No *If answer is No, skip to Alcohol section*		
	☐ Cigarettes – pks/day	☐ Vape – #/day	☐ Cigars – #/day	
	☐ Pipe – #/day	☐ Chew – #/day	☐ Dip – #/day	
	How long:	When did they quit:	Have they tried quitting before?	◯ Yes ◯ No

Alcohol	Does the child drink alcohol?	◯Yes ◯No ◯Never *If answer is No or Never, skip to Substance Abuse section*			
	How many drinks does the child have in the average:	day?	week?	month?	year?
	Are you concerned about how much the child drinks, or do you feel their drinking is sometimes out of control?	◯Yes ◯No			
	Has the child ever neglected some of their usual responsibilities because of using alcohol?	◯Yes ◯No			
	Have you felt the child wanted or needed to ***cut down*** on their drinking in the last year?	◯Yes ◯No			
	Has anyone ever objected to the child's drinking?	◯Yes ◯No			
	Have you ever found the child preoccupied with wanting to use alcohol?	◯Yes ◯No			
	Has the child ever used alcohol to relieve emotional discomfort, such as sadness, anger, or boredom?	◯Yes ◯No			
	Has the child's drinking ever caused legal problems?	◯Yes ◯No			
Substance Abuse	Does the child have a history of using recreational drugs?	◯Yes ◯No *If answer is No, skip to Personal Safety section*			
	Have you sought treatment for the child's drug use?	◯Yes ◯No			
	Please mark any of the following the child has ever taken:				
	☐ Cocaine	☐ Heroin	☐ LSD	☐ PCP	☐ MDMA (Ecstasy/Molly)
	☐ Marijuana (Cannabis, Hashish)	☐ Inhalants (Poppers, Glue, Aerosols)			☐ Methamphetamine
	☐ Synthetic Cannabinoids (Fake Weed)		☐ Synthetic Cathinones (Bath Salts)		☐ Barbiturates
	☐ Benzodiazepines (Xanax, Valium, Ativan)		☐ Sleep Medications (Lunesta, Ambien)		
	☐ Opioids (Codeine, Fentanyl, Hydrocodone, Morphine, Oxycodone)			☐ Amphetamines	
	☐ Anabolic Steroids				
Personal Safety	Has the child ever been afraid to go to school?	◯Yes ◯No			
	Has the child ever been the victim of bullying?	◯Yes ◯No			
	Is there any history or current issues of violence or abuse (verbal, physical, emotional, or sexual) in your family?	◯Yes ◯No			
	Has the child ever been or are you now being physically abused?	◯Yes ◯No			
	Has the child ever been or are you now being emotionally abused?	◯Yes ◯No			
	Has the child ever been or are you now being sexually abused?	◯Yes ◯No			
	Has the child ever experienced or witnessed a traumatic event (accident, crime, major mental illness)?	◯Yes ◯No			
	If you answered Yes to any of the Personal Safety questions, please elaborate with your counselor.				

RISK ASSESSMENT

◯Yes ◯No The child is having thoughts about killing self.
◯Yes ◯No The child has been thinking about how they might do this.
◯Yes ◯No The child is thinking about acting on these thoughts.
◯Yes ◯No The child has started to work out or has worked out the details of how to kill self.
◯Yes ◯No The child has access to guns or other weapons.
◯Yes ◯No The child has thought about suicide in the past.
◯Yes ◯No The child has attempted suicide in the past. If Yes, how many times? _____ When? _____

◯Yes ◯No The child feels like cutting or self-harming now. (asphyxiation, burning, scratching, use of other sharp objects, etc.)
◯Yes ◯No The child has thought about cutting or self-harm in the past.
◯Yes ◯No The child has cut or purposefully self-harmed in the past. If Yes, how many times? _____ When? _____

◯Yes ◯No The child is thinking about hurting someone else now.
◯Yes ◯No The child has thought about hurting someone else in the past.
◯Yes ◯No The child has hurt someone else in the past.

I declare as the person completing this form on behalf of the child described in this document that all information is true and accurate to the best of my knowledge and that I have the legal authority to request and consent to the child's treatment.

_____ _____

Signature of Parent/Guardian/Custodian who completed form **Date**

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INFORMED CONSENT

Welcome to our practice. We are pleased to have the opportunity to serve you and hope that this handout will provide helpful information in making an informed decision concerning our services. **Please ask questions at any time.**

Organization Information: Associates in Brief Therapy, Inc. (ABT, Inc.) consists of counselors who are employees and counselors who are independent contractors. The President and Clinical Director of ABT, Inc. is David L. Mortellaro, LPC, LMFT.

Hours of Operation: Our office staff, located in our Roanoke office, answers telephone calls from 8:30 a.m. until 5:30 p.m. Monday through Thursday and from 8:30 a.m. until 12:30 p.m. on Friday. At all other times calls are forwarded to a voice mail system. Therapists do not answer phone calls while they are in session. Therapists are available for appointments Monday through Friday. Evening appointments are available Monday through Thursday. Satellite office hours vary; please call our main office in Roanoke for specific appointment times.

Background & Training: All of our clinicians have earned a graduate degree (Masters or Doctorate) from an accredited university. All ABT, Inc. counselors are licensed to practice in the state of Virginia. ABT, Inc. also employs resident counselors who have completed a graduate degree and are pursuing licensure under direct supervision of a licensed clinician. The clinical supervisor's name and credentials may be obtained upon request. Our clinicians only practice within their scope of training and experience. In the course of our training and previous employment, we have had experience in treating a wide variety of individuals including children, adolescents, and adults in individual, couples, family, and group counseling. **Your counselor will have his/her own primary specialty areas of expertise.**

Philosophy: We accept in our practice only patients whom we believe have the capacity to resolve their own problems with our assistance. The foundation of the healing process is the therapeutic relationship which is based on trust, respect, honesty, confidentiality and effort. As people learn more about their strengths and weaknesses, they usually become more accepting of themselves and others and feel more empowered to accomplish their goals. As the patient, you are responsible for setting the goals you want to accomplish and can terminate counseling at any time. Our responsibility is to help you accomplish these goals in the shortest time possible. If counseling is successful, you should feel better about yourself and be able to face life's challenges in the future without our support or intervention. We cannot guarantee results.

We ask that you be as honest and as open as possible in discussing your concerns. If you are unclear about anything regarding your therapy, please ask questions. Psychotherapy can be very helpful for some individuals, but it is not without some risks. These risks may include the experience of intense and unwanted feelings, such as sadness, anger, fear, guilt, or anxiety. It is important to remember that these feelings may be natural and normal and are an important part of the therapy process. Other risks might include recalling unpleasant life events, facing unpleasant thoughts, and beliefs or possible alteration of an individual's relationships. We will make every effort to minimize potential risks and hazards which are not helpful to the therapeutic process. Often in therapy, major life decisions are made, including decisions involving families or friends, changes in relationships, or changes in your jobs or careers. These decisions are a legitimate outcome of therapy as a result of an individual's calling into question some of their beliefs and values, recognizing their strengths, increasing their self-acceptance, alleviating symptoms and problems or learning more helpful coping skills.

We use research-based "best practices therapy methods" including, but not limited to, Cognitive-Behavioral Therapy (CBT), Solution-Focused Brief Therapy, faith-based counseling, Person Centered Therapy, Strategic or System based approaches, assessments, and bibliotherapy. These methods sometimes utilize psycho-education methods with homework assignments.

Confidentiality

I understand the confidentiality of the work I do together with my therapist is upheld at all times. However, there are certain exceptions to this rule: (1) if my counselor suspects child or elder abuse has occurred, the law requires it be reported to the authorities; (2) if my counselor believes I am a clear and imminent danger to myself or another person, the counselor must

notify appropriate authorities to prevent that occurrence; (3) if it becomes necessary to contact an attorney or collection agency, then my name, identifying information about how to reach me, and amount owed becomes available to these agents; and (4) in a legal proceeding, a court may order a release of information.

Email and Text Message (SMS) communication is inherently insecure. We offer appointment reminders via both email and text message (SMS) at the patient's request. By requesting these reminders, you are also giving us permission to contact you via these methods as stated on the form. We do not receive any text messages on our lines. Any emails sent to us, by either our request or by your choice, is outside of our control and as such you understand that we can not guarantee your confidentiality or privacy therefore you send that information at your own risk.

Fees, Payments and Insurance: We make every effort to keep down the cost of your medical care. Therefore, we require that you pay for your treatment at the time of your visit. The cost of therapy is $130.00 for the initial session and $120.00 for each follow up session. Payment may be made by cash, check or credit/debit card. If you have insurance coverage, we ask that you make your co-pay and unmet deductible fees at the time of your office visit. If at any time during your treatment you are having financial difficulties and cannot make the required payments on your account, you may contact the Office Manager to set up financial arrangements. Most plans include co-payments/co-insurance, a deductible and other expenses which must be paid by the patient. If you have insurance, please bring your insurance card with you. We will automatically file your insurance for you if you have provided us with the necessary information. **However, we cannot fully guarantee your coverage or your benefits. In the event that your insurance company does not pay for services rendered, you will ultimately be responsible for payment.** If you have a change in insurance coverage or benefits, please notify the business office immediately.

Returned Checks: If you pay for any service provided with a check and that transaction is returned to us from your bank as non-payable, there will be a charge of $35.00. After a non-payment incident, checks may no longer be accepted, and you will be required to pay all outstanding balances on a **cash only basis**.

Psychological Testing: Psychological testing is sometimes a critical component of evaluating problems and strengths and assisting patients in accomplishing their goals in the shortest time possible. After an initial interview your therapist may recommend such assessment. Costs for this service depend on the testing instruments used and the length of time required for administration and scoring. The exact charges will be discussed with you prior to any testing.

Cancellations: Since therapists see patients by appointment only, and each appointment constitutes a significant portion of the therapist's day, it is common practice to charge a fee for missed appointments. A charge of $25.00 will be made when less than 24-hour advance notice is given for a cancelled appointment. A charge of $45.00 will be made if you do not show up for an appointment or call-in response to your absence. These charges are not reimbursable by insurance carriers. We would appreciate you notifying us at (540) 772-8043 if you will not be attending a session with as much notice as possible-preferably 48 hours or more. If you do not reach us personally, please leave a voice mail for the receptionist of your cancellation.

Messages: As you work together with your therapist, you will notice that he/she does not accept phone calls while with you. During those times and at other times during the day or evening, his/her calls are answered electronically. Messages are checked frequently during the day, and he/she will attempt to call you back as soon as possible. Usually, we can get back with you within 24 hours. If you need to speak with him/her directly during regular office hours, please leave your name and phone number on his/her voice mail. On evenings, weekends, and holidays, the messages will be received and acted upon during the next working day.

Complaints: If at any time you are dissatisfied with our services, please let your therapist know or contact our Office Manager or Clinical Director. If he/she is not able to resolve your concerns, you may report your complaints to the Virginia Department of Health Professions at 1-800-533-1560. Your therapist is required to follow a Code of Ethics. If you would like to see a copy of the Code, it can be found on-line at the website for the American Counseling Association at www.counseling.org.

Counseling and Financial Records: Counseling and financial records are maintained on each patient for a period of seven years. Records are stored in boxed paper files in a secure central location and/or electronically on our HIPAA compliant secure server. The records are our property but may be reviewed by a patient with 30 days notice.

Noncompliance: A therapist may cancel or terminate services for noncompliance with the plan of care, failure to keep or cancel appointments, violent behavior, a threat of violence or involvement in criminal behavior.

Inactivity: Your case will be closed or considered inactive after twelve consecutive months (one year) of not utilizing services.

Consultation: In keeping with generally accepted standards of practice, we may confidentially consult with other mental health professionals regarding the management of treatment. The purpose of the consultation is to assure quality care. Every effort is made to protect the identity of the patients.

Emergencies: Our office is not set up to routinely provide crisis intervention services. In case of an emergency and/or our office is closed, you may go to your local Emergency Room, call Respond at (540) 776-1100 or call CONNECT at (540) 981-8181 to reach a crises counselor.

Affiliation Relationships: Employees and independent contractors of Associates in Brief Therapy, Inc. are each wholly responsible for his/her own acts and omissions.

Copying Fees for Medical Records: We attempt to honor your request of medical records as quickly as possible. We make every effort to respond within 30 days. The charge for copying and mailing medical records is as follows:

- Handling and processing fee $ 15.00 per request
- Photocopying $ 1.00 per page

This charge is billed to the organization/individual requesting the records as outlined in your authorization and **payment is due in advance of the records being released**. However, you will ultimately be responsible for any unpaid fees should that party not make payment.

Permission to Treat a Minor Child: Please note that we require written permission before we can treat any patient under the age of 18:

- When parents are married, the signature of one parent is sufficient to provide treatment.
- If the parents are divorced, we require the signature of the parent having legal custody of the child.
- If the parents have joint legal custody, we may require the signature of both parents
- If the parents are separated, we may also require the signature of both parents to provide treatment.

Phone authorizations are not accepted. Parents must sign the "Informed Consent/Permission to Treat Form" in person, via. Our secure web portal, or have it notarized with seal and signature if signed off premises. We will not provide treatment for any child who does not have the proper signed consent form(s) on file. The office staff is directed to reschedule your appointment if the form(s) is not completed.

Request for Forms: In most instances your therapists will complete health or treatment forms on your behalf. However, please be aware that there is a charge of $15.00 for forms to be completed by therapists at the request of the patient. In the event that the form is lengthy or complex, your therapist may request that you schedule an appointment and complete the form as part of your session. Insurance benefits will not cover this charge; therefore, you will be fully responsible for this cost. Payment must be received before a form can be delivered.

Telephone Consultations: There is usually no charge for a brief phone conversation with your provider. If you require a lengthier discussion, a receptionist will schedule a time with your therapist by phone. Please ask your therapist to explain his/her rate for phone consultations. Insurance benefits will not cover this charge; therefore, you will be fully responsible for this cost. **We ask that you pay by credit card prior to the consult.**

Court Appearances and Testimony: Therapists are occasionally needed to testify in court or provide a deposition as an expert witness for a patient regarding a legal matter. Because of the restrictions of state and federal confidentiality regarding medical records, ABT Counseling will go to court or release records ONLY in response to a properly executed subpoena or subpoena deuces tecum.

- If you or your attorney subpoenas any ABT therapist to appear in court, **you will be charged an initial fee of $750**. **Payment is expected to be paid PRIOR to the scheduled court date**. Since our therapists must rearrange their

scheduled patients to appear in court for you, pre-payment is required. If the time required in court is **more than three (3) hours** (including travel time) you will be charged an additional $125 per hour. You will be billed for the balance due. You will be charged for our therapist's presence in court, regardless of if they testify or not. **If court is cancelled,** our office needs **at least a 24-hours' notice** for you to receive reimbursement of your initial $750 fee. Insurance will not reimburse for these fees.

- If records are subpoenaed, you will be charged **$1 per page** for retrieval, copying, and delivery. If a legal letter is needed, a fee ranging from **$25 to $100** will be charged depending on the length and time needed to compose the document. These fees are due and **payable upon receipt of the requested records**.

Payment of Outstanding Balances: Each month we mail billing statements for each account with outstanding balances due. **You are responsible for paying the total amount due upon receipt of the statement.**

- If we do not receive payment in full for balances due within 30 days of billing, this may result in the suspension of services.
- Outstanding balances exceeding 90 days past due will result in collection procedure. In the event that your account is forwarded to an external collection agency, all collection fees will be added to your account. In addition, finance charges of 1.5% will be added each month to accounts which are 90 days past due or a $5.00 finance charge, whichever is greater. In order to service your account if sent to collections, you may be contacted via phone or any telephone number associated with your account including wireless phone numbers, text messages (which could result in charges to you) or email.

Damages to Facility: Our office is structured in order to provide a comfortable and professional setting for you. It is our policy to hold our patients or their parents financially responsible for any damages imposed upon our building or its contents. Patients or parents will be billed in full for any cost of repairing or replacing anything which is damaged. Children/adolescents must be accompanied by an adult at all times while in our office.

Emergencies at the Facility: In case of a medical emergency at our facility, we will contact the nearest and most appropriate medical facility to provide care.

Supervision of Children: All children 10 and under must be supervised by a parent, other adult, or responsible teenager at all times. **No child under the age of 10 should be left unsupervised in the building.**

We hope this brief introduction answers some of your questions. Please feel free to ask any additional questions you may have. Again, we welcome you to our work together and trust that it will be mutually beneficial.

INFORMED CONSENT Signature Page

Permission for treatment is hereby authorized to _____, to render treatment

to _____ whose relationship to me is (circle one) self, child, spouse, guardian or

other _____Self_____.

_____ _____

Signature of Patient, Parent or Guardian Date

_____ _____

Signature of Witness or Counselor Date

I have received a copy of this Consent Form.

_____ _____

Signature of Client, Parent or Guardian Date

Main Business Office
Associates in Brief Therapy, Inc.
4346 Starkey Rd, Suite 1
Roanoke, VA 24018
Phone: (540)772-8043
Fax: (540)772-8242

ABT Counseling
Serving Southwest Virginia

Satellite Offices
Blacksburg, Daleville, Salem

Affiliate Offices
Blue Ridge Telehealth, LLC
Floyd Counseling

TELEHEALTH CONSENT ADDENDUM

Telehealth is an optional service offered by Associates in Brief Therapy, Inc. (ABT Counseling) and its affiliates. We are pleased to have the opportunity to serve you and hope that this handout will provide helpful information in making an informed decision concerning our services. **Please ask questions at any time.**

I hereby consent to participating in online counseling services (i.e. telehealth) with my counselor as a part of my treatment I have selected through ABT Counseling and its affiliates.

I understand that telehealth includes, but is not limited to, the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

I understand that telehealth involves the communication of my medical/mental information, both orally and visually, to health care practitioners that may be located outside my local area or state.

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. Exceptions for this are the same as those outlined in the Informed Consent I signed when I became a patient.
   I also understand that the dissemination of any personally identifiable images or information from telehealth 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 counselor, 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 the counselor believes I would be better served by another form of counseling services (e.g. face-to-face services) I may be asked to come into the ABT Counseling or affiliate office for my appointments or be referred to a counselor who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of counseling services, and that despite my efforts and the efforts of my counselor, I may benefit from telehealth sessions, but that results cannot be guaranteed nor assured.
4. I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured.
5. I understand that I have the right to access my medical information as outline in the Informed Consent in accordance with the HIPAA Privacy rules and applicable state law.
6. I understand that this Telehealth Consent is an **additional** consent to the Informed Consent (not a replacement) which I signed when I became a patient. All ABT Counseling and/or affiliate policies apply to telehealth services.

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

Print Patient Name	**Signature of Patient, Parent or Guardian**
Date	Self **Relationship if Parent or Guardian**

The client requested and was provided a copy of this Consent Form **Yes** **No**

Main Business Office
Associates in Brief Therapy, Inc.
4346 Starkey Rd, Suite 1
Roanoke, VA 24018
Phone: (540)772-8043
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HIPAA Notice of Privacy Practices

This privacy notice is provided on behalf of: Associates in Brief Therapy, Inc.

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law. We are required by HIPAA to provide you with this notice. This notice describes our privacy practices, legal duties and your rights concerning your Protected Information. We must follow the privacy practices described in this notice while it is in effect. This notice takes effect April 14, 2003. It will remain in effect unless and until we publish and issued a new notice.

OUR PLEDGE TO YOUR PRIVACY

We are responsible for the information that we collect about you and your privacy is important to us. We are committed to protecting the confidential nature of your medical information to the fullest extent of the law. These are designed to protect your information. We understand how important it is to protect your privacy. We will continue to make this a priority.

OUR LEGAL DUTIES

We are required by law to make sure that your Protected Information that identifies you is kept private. We are to give you this notice of your legal duties and privacy practices with respect to medical information about you and follow the terms of this notice that is currently in effect.

The HIPAA Privacy Regulations generally do not preempt state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a state, or other federal laws, rather than the HIPAA Privacy Regulation, might impose a privacy standard that we are required to follow. Where such laws are in place, we will follow more stringent state privacy laws that relate to use and disclosure of Protected Information about mental health, substance abuse, chemical dependency, etc.

DISCLOSURE AND USES OF PROTECTED INFORMATION

The following categories describe different ways that we use and disclose your Protected Information for purposes of treatment, payment and health care operations:

- **For Treatment.** We may disclose your Protected Information to people outside this facility who may be involved in your treatment such as doctors, nurses, technicians, medical students or other personnel who are involved in taking care of you. We may also disclose your Protected Information to people who may be involved in your medical care such as family members, clergy or others we use to provide services that are part of your care.
- **For Payment.** We may use and disclosed your Protected Information so that the treatment and services you receive at this facility may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover treatment.
- **For Health Care Operations.** We may use and disclose your Protected Information for health care operations. These uses and disclosures are necessary to run this facility and make sure that all of our patients receive quality care. For example, we may use your Protected Information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of the facility's patients to decide what additional services the facility should offer, what services are not needed and whether certain treatments are effective. We may also disclose information to other health care personnel for review and learning purposes. We may also combine the medical information we have with medical information

from other health care providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care without learning who the specific patients are.

OTHER USES AND DISCLOSURES OF YOUR PROTECTED INFORMATION

We must disclose your Protected Information to you with some exceptions. This will be described in the Individual Rights sections of this notice. You may give us written authorization or release of information to use or disclose your Protected Information to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosure permitted by your authorization while it was in effect. Without your written authorization, we may not use or disclose your Protected Information for any reason except as described in this notice.

The following is a description of other possible ways we may (and are permitted by law) to use and/or discuss your Protected Information without your specific authorization:

- **Family and Friends.** If you are unavailable to agree, we may disclose your Protected Information to a family member, friend or other person when the situation indicates that disclosure would be in your best interest. This includes a medical emergency or disaster relief. If you are available and agree, we may disclose your Protected Information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.
- **Research, Death or Organ Donation.** We may use or disclose your Protected Information for research purposes in limited circumstances specified in the HIPAA privacy regulation. We may disclose the Protected Information of a deceased person to a coroner, medical examiner, funeral director or organ procurement organization for certain purposes.
- **Public Health and Safety.** We may disclose some of your Protected Information permitted by state law to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may disclose your Protected Information to a government agency that oversees the health care system or government programs or its contractors, and to public health authorities for public health purposes. We may disclose your Protected Information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.
- **Required by Law.** We may use or disclose your Protected Information when we are required to do so by law. For example, we must disclose your Protected Information to the U.S. Department of Health and Human Services upon request in order to determine if we are in compliance with federal privacy laws. We may disclose your protected information to comply with worker's compensation or similar laws.
- **Legal Process and Proceedings.** We may disclose your Protected Information in response to a court or administrative order, subpoena, discovery request, or other lawful process. These disclosures are subject to certain administrative requirements imposed by the HIPAA privacy regulation and permitted by state law.
- **Law Enforcement.** We may disclose limited information to a law enforcement official concerning the Protected Information of a suspect, fugitive, material witness, crime victim or missing person subject to certain administrative requirements approved by the HIPAA privacy regulation and permitted by state law. We may disclose the Protected Information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances specified by the HIPAA privacy regulation. We may also disclose Protected Information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

INDIVIDUAL RIGHTS

- **Right to Inspect and Copy.** You have the right to inspect and copy your Protected Information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, submit your request in writing to: ***Associates in Brief Therapy, Inc., 4346 Starkey Road, Suite 1, Roanoke, VA 24018.*** If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy. If you are denied access to medical information, you may request that the denial be reviewed.
- **Right to Amend.** If you feel that your Protected Information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information

is kept by our office. We are required by law to keep records for six (6) years. We may deny your request for an amendment if it is not made in writing or does not include a reason to support the request. In addition, we may deny the request to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for Associates in Brief Therapy, Inc.;
- Is not part of the information which you would be permitted to inspect or copy;
- Is accurate and complete

- **Accounting of Disclosures.** You have the right to request and receive an accounting of disclosures of your Protected Information made by us. We are not required under the HIPAA regulation to provide you with an accounting of certain types of disclosures. The most significant types include:
  - Any disclosures made prior to April 12, 2003
  - Disclosures for treatment, payment of health care operations activities
  - Disclosures to you or pursuant to your release of authorization
  - Disclosures to persons involved in your care
  - Disclosures for disaster relief, national security or intelligence purposes

  To request an accounting of disclosures, you must send a written request to our office. The first list your request within a 12-month period will be free. For additional lists, we may charge you for the costs involved and you may choose to withdraw or modify your request at that time.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Information we use **or** disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care, like a family member or a friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
- **Confidential Communications.** You may believe that you will be in danger if we communicate Protected Information to you or to your address of record. If so, you have the right to request that we communicate with you about your Protected Information at an alternative location or by alternative means. We will make reasonable efforts to accommodate your request if you specify an alternate address.

CONTACTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

You may also submit a written complaint to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be penalized for filing a complaint.

This authorization is valid for one year from the date it is signed.

Signature below is acknowledgement that you have received our Notice of Privacy Practices:

_____ _____

Print Name Signature

_____ _____

Date Witness

The client requested and was provided a copy of this privacy practice. YES NO

*** This signed HIPAA will remain in the patient's file; a copy may be given upon request. ***