RESOURCE GUIDANCE SERVICES, INC.

Therapist: ______________________ Office: ____________

Referring MD: ______________________

Effective Date: __________ Circle one.....>> *new, readmit, change, or update*

Client name: ______________________ Dx#: ____________

Client name: ______________________ Dx#: ____________

Intake •Change•Update form

*** Required Fields**

Insurance Card & Driver's License – Copies needed.

Referred by (Name of Physician, Friend, Pastor, etc): ______________________ Relationship to Client: ____________

Is Client's Condition related to Employment, Auto Accident, or Other Accident? ____________ If yes, Attach Details

IF A CHILD IS THE CLIENT, Name: (F) ____________ (M) ____________ (L) ____________

Child's Sex: ________ DOB: ____________ Age: ________ Child's SS#: ____________

Child's Address: ______________________
number street apt. city state zip

CLIENT NAME *(if client is a child, give info on father)*: ______________________
first middle last

Date of Birth: ____________ Age: ________ Address: ______________________
number street apt city state zip

SS#: ____________ Sex: ______ Marital Status: *S M W SEP D*; Is client a Student? ______; *full time or part time*

Phones: (H) ____________ (C) ____________ (W) ____________ Ext: ________

Email: ____________ Work: *full time or part time* Employer: ____________ Job title: ____________

SPOUSE NAME *(if client is a child, give info on mother)*: ______________________
first middle last

Date of Birth: ____________ Age: ________ Address: ______________________
number street apartment city state zip

SS#: ____________ Sex: ______ Marital Status: *S M W SEP D*; Is client a Student? ______; *full time or part time*

Phones: (H) ____________ (C) ____________ (W) ____________ Ext: ________

Email: ____________ Work: *full time or part time* Employer: ____________ Job title: ____________

NAMES OF OTHER FAMILY MEMBERS	Sex	Date of Birth	Relationship	Covered by Insur?
	M F			
	M F			
	M F			
	M F			

* EAP (FREE VISITS) EAP NAME: ____________ PHONE: ____________ EMPLOYEE SS#: ____________

No. of visits/yr: ________ No. of visits approved: ______ Begin date: ____________ End date: ____________

Authorization #: ____________ Authorizing Rep. Name: ____________ Date of call: ____________

* HLTH INSURANCE (PRIMARY): ____________ SUBSCRIBER/EMPLOYEE: ____________ SUBSCRIBER DOB: ____________

Member #: ____________ Phone: ____________ # Visits authorized: ______ Begin date: ________ End date: ____________

Authorization #: ____________ Authorizing Rep. Name: ____________ Date of call: ____________

* HLTH INSURANCE (SECONDARY): ____________ SUBSCRIBER/EMPLOYEE: ____________ SUBSCRIBER DOB: ____________

Member #: ____________ Phone: ____________ # Visits authorized: ______ Begin date: ________ End date: ____________

Authorization #: ____________ Authorizing Rep. Name: ____________ Date of call: ____________

* HEALTH INSURANCE (OTHER): ____________ OTHER THIRD PARTY PAYER: ____________ ATTACH DETAILS ____________

*** Required Fields**

Resource Guidance Services, Inc., 5352 Twin Hickory Road, Glen Allen, VA 23059 (804) 592-2793

Contract and Policy Statement

I. Patient Name (s) ____

Payment for office visits is due at the time the service is rendered. There is a service fee for returned checks. Any questions regarding your bill must be made within thirty days of the bill date.

___ **[Initial]**

☐ If you must reschedule or cancel an appointment, we require at least 24 business hours' notice. If your appointment is on a Monday, the cancellation must be made by the same hour on the preceding Friday. There will be a $75 late cancellation fee if notice is not given.

Your insurance may require that you get preauthorization or a referral prior to your first visit; it is your responsibility to get them prior to your first visit. Your co-payment and deductible are due from you at each session. Although we may verify your benefits with your health insurance company and file your claims, you are responsible for payment if your insurance fails to pay in a timely manner or pays only part of the bill. In spite of our best efforts, the benefit information given by your insurance company is sometimes incorrect.

Your phone calls are received 24 hours a day by the voicemail system. Always leave a message. Please know that we make every effort to return your calls as soon as possible; but we ask you to realize that we provide services to people in crisis on a daily basis and receive many phone calls each day. We try to return these in the order in which they were received. If your message is urgent we will give it priority. We do not charge for brief phone calls, but do charge for our time if very ongoing or lengthy phone communication is necessary.

II. Medicare Clients:

Beneficiary Name: ______________________________ Health Insurance #: ____________________

I request that payment of authorized Medicare benefits be made on my behalf to Resource Guidance Services, Inc. for any services furnished me by Resource Guidance Services, Inc. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Beneficiary Signature: ______________________________ Date: ____________

III. Third Party Payer (TPP)

If there is a third party payer (TPP) other than insurance, complete the following:

TPP Name: ______________________________ Attention of: ______________________________

Address: ____ Phone: ____________________

IV. All Clients:

Initial evaluation $________; 60 min. session $________; 45 min. session $________; 30 min. session $________

Ed Seminar session not billable to insurance $________

Other Service – ADHD Testing for 16+ age $75 we will **NOT** bill to insurance; Other______________________ $________

V. Health Insurance: Do you want us to file claims to your primary insurance? ____________ (YES or NO)

VI. All Clients:

You, hereby, agree to be charged a one-time fee of $75 that will be assessed payable to RGS, Inc. if your account is sent to a recovery agent. On all accounts referred to an attorney for collection, interest will accrue on all unpaid balances at the rate of 18% from the date of referral. I, also, hereby give my permission to release the necessary information for such a process. I authorize the release of any medical information necessary to process my insurance claims and request payment of benefits directly to Resource Guidance Services, Inc. or designated vendor. I, the undersigned, agree to accept full financial responsibility for services rendered by Resource Guidance Services, Inc. I agree to abide by the conditions outlined in this policy statement and by my signature acknowledge receipt of a copy of this policy.

Responsible Party Signature:

(1) Name Printed: ________________________ Signed: ________________________ Date: ________

(2) Name Printed: ________________________ Signed: ________________________ Date: ________

Signature of Therapist: ______________________________, T.A. RGS, Inc. Date: ____________

Resource Guidance Services, Inc.

5352 Twin Hickory Road
Glen Allen, Virginia 23059

Telephone (804) 592-2793
Fax (804) 592-2794

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name: ______________________ Date of Birth: ______________________

I understand that I am eligible to receive a range of services from my provider. The type and extent of services that I receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.

I understand that I have the right to ask questions throughout the course of treatment and may request an outside consultation. (I also understand that my provider may provide me with additional information about specific treatment issues and treatment methods on an as-needed basis during the course of treatment and that I have the right to consent to or refuse such treatment). I understand that I can expect regular review of treatment to determine whether treatment goals are being met. I agree to be actively involved in the treatment and in the review process. No promises have been made as to the results of this treatment or of any procedures utilized within it. I further understand that I may stop treatment at any time, but agree to discuss this decision first with my provider.

I am aware that I must authorize my provider, in writing, to release information about my treatment but that confidentiality can be broken under certain circumstances of danger to myself or others. I understand that once information is released to insurance companies or any other third party, that my provider cannot guarantee that it will remain confidential. When consent is provided for services, all information is kept confidential, except in the following circumstances:

- When there is risk of imminent danger to myself or to another person, my provider is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physically abused, or is at risk of such abuse, my provider is legally required to take steps to protect the child, and to inform the proper authorities.
- When a valid court order is issued for medical records, my provider is bound by law to comply with such requests.

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the Notice of Privacy Practices which was provided to you for more detailed explanations, and discuss with your provider any questions or concerns you may have.

By my signature below, I voluntarily request and consent to behavioral health assessment, care, treatment, or services and authorize my provider to provide such care, treatment or services as are considered necessary and advisable. I understand the practice of behavioral health treatment is not an exact science and acknowledge that no one has made guarantees or promises as to the results that I may receive. By signing this Informed Consent to Treatment Form, I acknowledge that I have both read and understood the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

______________________ ______________________
Client Signature: Date

______________________ ______________________
Parent/Guardian Signature: Date
(for minor)

Resource Guidance Services, Inc.

5352 Twin Hickory Road
Glen Allen, Virginia 23059

FAX (804) 592-2793
Business Office: (804 592-2794

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name

____

Signer's Relationship to Patient

____

Signature

____

Date

____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. If you have any questions about this Notice, please contact our Privacy Officer, the Business Office Manager.

1. Purpose

We understand that medical information about you and your health is personal and we are committed to protecting that information. We create a record of the care and services you receive at the Medical Practice in order to provide you with quality care and to comply with certain legal requirements.

This Notice of Privacy Practices describes how we may use and disclose medical information about you, including demographic information, that may identify you and your related health care services to carry out your treatment, obtain payment for our services, to perform the daily health care operations of this practice and for other purposes that are permitted or required by law. This notice also describes your rights to access and control your medical information.

We are required to abide by the terms of this Notice of Privacy Practices.

2. Written Acknowledgement

You will be asked to sign a written statement acknowledging that you have received a copy of this notice. The acknowledgement only serves to create a record that you have received a copy of the notice.

3. Changes to this Notice

We may change the terms of our Notice, at any time. The new Notice will be effective for all medical information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. To request a revised copy, you may call our office and request that a revised copy be sent to you in the mail or you may ask for one at the time of your next appointment. The current Notice of Privacy Practices will be also posted on our Web site, www.fpsrichmond.com.

4. How We May Use and Disclose Medical Information about You

The following categories describe the different ways that the Medical Practice may use and disclose your medical information and a few examples of what we mean. These examples are not meant to describe every circumstance, but to give you an idea of the types of uses and disclosures that may be made by our office. Other uses and disclosures of your medical information that are not listed or described below will be made only with your written authorization. You may revoke this authorization, at any time, in writing, but it will not apply to any actions we have already taken.

- ✓ **For your treatment:** Your medical information may be used and disclosed by us for the purpose of providing medical treatment to you or for another health care provider providing medical treatment to you. For example, a nurse obtains treatment information about you and documents it in your medical record and the physician has access to that information. If you require an x-ray to be taken, the x-ray technician also has access to your medical information. In addition, your medical information may be provided to a physician to whom you have been referred or are otherwise seeing to ensure that the physician has the necessary information to diagnose or treat you.
- ✓ **To obtain payment for our services:** Your medical information may be used and disclosed by us to obtain payment for your health care bills or to assist another health care provider in obtaining payment for their health care bills. For example, we may submit requests for payment to your health insurance company for the medical services that you received. We may also disclose your medical information as required by your health insurance plan before it approves or pays for the health care services we recommend for you.
- ✓ **For our health care operations:** Your medical information may be used and disclosed by us to support our daily operations. These health care operation activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your medical information to medical school students that see patients at our office. We may also use the medical information we have to determine where we can make improvements in the services and care we offer.
- ✓ **For the health care operations of other health care providers:** We may also use your medical information to assist another health care provider treating you with its quality improvement activities, evaluation of the health care professionals or for fraud and abuse detection or compliance. For example, we may disclose your medical information to another physician to assist in its efforts to make sure it is complying with all rules related to operating a medical practice.
- ✓ **For appointment reminders:** We may use or disclose your medical information to contact you to remind you of your appointment, by mail or by telephone. Our message will include the name of our practice or the name of our physician as well as the date and time for your appointment or a reminder that an appointment needs to be scheduled.
- ✓ **To provide you with treatment alternatives:** We may use or disclose your medical information to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, we may contact several home health agencies or physical therapy providers to discuss the services they provide when we have a patient who needs these services.
- ✓ **To our business associates:** We will share your medical information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your medical information, we will have a written agreement that contains terms that will protect the privacy of your medical information. For example, the Medical Practice may hire a billing company to submit claims to your health care insurer. Your medical information will be disclosed to this billing company, but a written agreement between our office and the billing company will prohibit the billing company from using your medical information in any way other than what we allow.
- ✓ **Others involved in your health care:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your medical information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose your medical information to notify a family member or any other person that is responsible for your care of your location and general health condition. Finally, we may use or disclose your medical information to an authorized public or private entity to assist in (1) disaster relief efforts and (2) to coordinate uses and disclosures to family or other individuals involved in your health care.
- ✓ **As required by law:** We may use or disclose your medical information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.
- ✓ **For public health activities:** We may disclose your medical information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your medical information, if directed by the public health authority, to any other government agency that is collaborating with the public health authority.
- ✓ **As required by the Food and Drug Administration:** We may disclose your medical information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, or to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.
- ✓ **For communicable disease exposure:** We may disclose your medical information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- ✓ **To your employer:** We may disclose your medical information concerning a work related injury or illness to your employer if you are covered under your employer's policy in order to conduct an evaluation relating to medical surveillance of the work place or to evaluate whether you have a work-related injury, in accordance with the law.

✓ **For abuse or neglect:** We may disclose your medical information to a public health authority that is authorized by law to receive reports of child or adult abuse or neglect. In addition, we may disclose your medical information if we believe that you have been a victim of abuse, neglect or domestic violence as may be required or permitted by Virginia and/or federal law.

✓ **For health oversight:** We may disclose your medical information to a health oversight agency for activities authorized by law. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs (such as Medicare or Medicaid), other government regulatory programs and civil rights laws.

✓ **In legal proceedings:** We may disclose your medical information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena or other lawful request.

✓ **For law enforcement:** We may also disclose your medical information, so long as all legal requirements are met, for law enforcement purposes. Examples of these law enforcement purposes include (1) information requests for identification and location purposes, (2) pertaining to victims of a crime, (3) suspicion that death has occurred as a result of criminal conduct, (4) in the event that a crime occurs on the premises of the Practice, and (5) in an medical emergency where it is likely that a crime has occurred.

✓ **To coroners, to funeral directors, and for organ donation:** We may disclose your medical information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose medical information to a funeral director in order to permit the funeral director to carry out its duties. We may disclose such information in reasonable anticipation of death. Your medical information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

✓ **For research:** We may disclose your medical information to researchers when their research has been established as required by federal and state law.

✓ **Due to criminal activity:** Consistent with applicable federal and state laws, we may disclose your medical information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose your medical information if it is necessary for law enforcement authorities to identify or apprehend an individual.

✓ **For military activity and national security:** When the appropriate conditions apply, we may use or disclose medical information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your medical information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

✓ **For workers' compensation:** Your medical information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.

✓ **Regarding inmates:** We may use or disclose your medical information if you are an inmate of a correctional facility and your physician created or received your medical information in the course of providing care to you.

✓ **For required uses and disclosures:** Under the law, we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of the Health Insurance Portability and Accountability Act and its regulations.

5. Your Rights

Following is a statement of your rights with respect to your medical information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your medical information. You may inspect and obtain a copy of your medical information that we maintain. The information may contain medical and billing records and any other records that we use for making decisions about you. However, under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled related to a civil, criminal, or administrative action; and medical information that is subject to law that prohibits access to medical information in certain circumstances. We may deny your request to inspect your medical information. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your medical information. This means you may ask us not to use or disclose any part of your medical information for the purposes of treatment, payment or health care operations. You may also request that any part of your medical information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree to your request. If we agree to the requested restriction, we may not use or disclose your medical information in violation of that restriction unless it is needed to provide emergency treatment or unless we otherwise notify you that we can no longer honor your request. With this in mind, please discuss any restriction you wish to request with your physician. Please request all restrictions in writing to our Privacy Officer.

You have the right to request that we accommodate you in communicating confidential medical information. We will accommodate reasonable requests, but we may condition this accommodation by asking you for information as to how payment will be handled or other information necessary to honor your request. Please make this request in writing to our Privacy Officer.

You may have the right to ask us to amend your medical information. You may request an amendment of your medical information as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a disagreement with us and we may respond in writing to you. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your medical information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made pursuant to your authorization (permission), made directly to you, to family members or friends involved in your care, or for appointment notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us. If you would like a paper copy of this notice, please request one from our Privacy Officer or request one when you are in our offices.

6. Complaints.

You may complain to us if you believe your privacy rights have been violated by us. To file a complaint, please contact our Privacy Officer who will be happy to assist you. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint. If you do not wish to file a complaint with us, you may contact the Secretary of Health and Human Services.

7. Privacy Contact.

If you have any questions about this Notice or require additional information, please contact our Office Manager at 5352 Twin Hickory Road, Glen Allen, VA 23059. Our Office Manager is available during normal business hours to discuss your privacy questions, concerns or complaints.

8. Effective Date. This notice was published and becomes effective on March 1, 2017.