Reviving Wellness Counseling
3630 S. Plaza Trail, Suite 150 A
Virginia Beach, VA 23452
Office (757) 373-5128 Fax (757) 431-0700

CLIENT DEMOGRAPHIC FORM

Entire form must be completed

DATE: _____

CLIENT NAME: _____ SOCIAL SECURITY: _____

DOB: _____ AGE: _____ MARITAL STATUS: S M D W

STREET: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (CELL):_____ (HM):_____ (WK):_____

EMAIL: _____

EMERGENCY CONTACT PERSON & PHONE #:

_____

RESPONSIBLE PARTY:_____ PHONE:_____

RESPONSIBLE PARTY ADDRESS:_____

INSURANCE INFORMATION

	Primary Carrier	Secondary Carrier
Insurance Company:		
Subscriber's Full Name:		
Subscriber's Birthday		
Subscriber's Social Security #:		
Policy ID Number:		
Group Number:		
Relationship to Patient:		

_____ _____

Client Name Printed Date

_____

Client Signature

Reviving Wellness Counseling
3630 S. Plaza Trail, Suite 150 A
Virginia Beach, VA 23452
Office (757) 373-5128 Fax (757) 431-0700

FINANCIAL POLICY

Please initial by each paragraph below indicating that you read and agree to each statement.

I authorize Reviving Wellness Counseling, LLC to provide\ any and all records pertaining to my treatment to my insurance company's representative if such a disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes.

Initial: _____

I understand that I am financially responsible for payments of all services and that any coinsurance/co-pays will be collected at the time of service.

Initial: _____

As a courtesy, our office will file your insurance claims for you. If your insurance company inadvertently mails the payment directly to you, it is your responsibility to see that your balance is paid.

Initial: _____

I understand that it is my responsibility to notify the office any changes to my insurance information changes (i.e. new card, new provider, new employer, etc).

Initial: _____

I understand that Reviving Wellness Counseling, LLC uses an electronic billing facility and electronic health records.
Initial: _____

There will be a $50.00 fee for missed or cancelled appointments without a 24-hour notification.

Initial: _____

There will be a $30.00 fee for any returned checks.

Initial: _____

I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

Initial: _____

By my signature, I acknowledge that I have read and understand the terms of this agreement.

_____ _____
Client Name Printed Date

_____
Client Signature

Reviving Wellness Counseling
3630 S. Plaza Trail, Suite 150 A
Virginia Beach, VA 23452
Office (757) 373-5128 Fax (757) 431-0700

OFFICE POLICIES

APPOINTMENTS:

Appointments can be made by calling or texting Tina Curran-Taylor, LPC at (757) 373-5128. You are strongly encouraged to schedule at the end of your appointment to decrease any delay in services due to availability.

APPOINTMENT CONFIRMATIONS:

Appointment reminders are provided as a courtesy. Please check the appropriate box below.

☐ I prefer text reminders, cell number:_____.
☐ I prefer email reminders, email address:_____.
☐ I prefer telephone reminder, home phone number: _____.
☐ I prefer NOT to receive an appointment reminder notification.

Please note:
By signing this agreement, you are acknowledging that Reviving Wellness Counseling, LLC will be free of liability when sending a reply to text and email correspondence.

CANCELLATIONS/MISSED APPOINTMENTS:

We understand that emergencies can arise that require you to cancel or change your appointment. However, we require a minimum of a 24-hour notice for any change in appointment or cancellation of an appointment. If the required 24-hour notice is not received, you will be charged a $50.00 fee. This fee must be paid in advance of rescheduling any additional appointments. Missed and/or cancelled appointments are not covered under health insurance plans.

CONFIDENTIALITY:

All aspects of services provided to you are held in the strictest confidence, in accordance with legal and ethical practice. Generally, no information will be released without your signed consent (or the consent of a legal guardian regarding a minor child in treatment).

However, there are some situations in which we are required to break confidentiality. These situations are:

1. Suspected abuse of a child or elderly individual,
2. Imminent threat of harm to yourself or identifiable others, or,
3. When a court of law orders disclosure of the clinical record.

OFFICE HOURS:

All services are provided are by appointment only. At this time, we only have part-time administrative support. Pam Jankoski will be available on Tuesdays and Thursdays from 3:30-7:30 pm and on Fridays from 1:00-5:00 pm. She can be reached at (757) 431-0600 during those scheduled times.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact Tina Curran-Taylor, LPC between sessions, please leave a message at the answering service (757) 373-5128 and your call will be returned as soon as possible. Mrs. Curran-Taylor checks her messages a few times during the daytime only, unless she is out of town. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone right away call Psychiatric Emergency Services of Virginia Beach (757) 385-0888, or the Police: 911. Please do not use email or faxes for emergencies as these are not always checked daily.

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of patient consent and rights, this document is required as part of your medical record. In addition, this office feels providing this information to you in advance of your receiving services **will clarify our office policies and alleviate any misunderstanding regarding what you should expect from us and what we expect from you.** If you have any questions, please do not hesitate to contact Pam Jankoski, Office Manager, (757) 431-0600.

Printed Client Name Client Signature Date

Reviving Wellness Counseling
3630 S. Plaza Trail, Suite 150 A
Virginia Beach, VA 23452
Office (757) 373-5128 Fax (757) 431-0700

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I _____, understand that as part of my health care, Reviving Wellness Counseling originates and maintains paper and/or electronic records describing my health history, symptoms, evaluation, diagnosis, treatment process and treatment plan. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communicating among any health professionals who contribute to my care.
- A means by which insurance companies verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing the quality of care for competence of healthcare professionals.

HIPAA

Your therapy session is held in the strictest confidence. No information will be released without your written permission. Exceptions are in the HIPAA statements.

I understand and have been provided with a copy of my HIPAA (Privacy Policy) which gives a complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent.

I have the right to request restrictions as to how my health information may be disclosed to carry out treatment, payment, or healthcare operations. I understand that I may revoke this consent in writing for future disclosures.

I wish to have the following restrictions about health disclosures:

_____

_____.

I fully understand and accept / decline the terms of this consent. (please circle one)

_____

Signature of Client/Guardian Relationship to Client Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign
Communications barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining acknowledgement
Other (Please Specify) _____.

Reviving Wellness Counseling
3630 S. Plaza Trail, Suite 150 A
Virginia Beach, VA 23452
Office (757) 373-5128 Fax (757) 431-0700

CREDIT CARD AUTHORIZATION FORM

Sign and complete this form to authorize Reviving Wellness Counseling, LLC to debit your credit card listed below for the purpose of reconciling your account. This card would be used to collect your coinsurance/copay and any fees associated with late cancellations or missed appointments. **You will be notified prior to any charges being applied to your card.**

By signing this form, you give us permission to debit your account for the amount indicated on or after the date of service.

Please complete the information below:

- I _____ authorize Reviving Wellness Counseling, LLC to charge my credit card account indicated below for _____. This payment is for **my co-insurance/copay**.

  INITIAL _____

- I _____ authorize Reviving Wellness Counseling, LLC to charge my credit card account indicated below for **$50.00**. This payment represents the fee for **a late cancellation/missed appointment**.

  INITIAL _____

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Reviving Wellness Counseling
3630 S. Plaza Trail, Suite 150 A
Virginia Beach, VA 23452
Office (757) 373-5128 Fax (757) 431-0700

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN (PCP)

Insurance companies require the patient to complete the PCP Release form

To authorize release of information to physicians, other than the PCP, please complete general release form: 'Authorization to Release Information'

Name of Patient (last, first, MI) _____ Patient's Social Security Number _____ Patient's Date of Birth _____

1. Please check one of the following:

○ NO, I DO NOT give consent to release information to my Primary Care Physician (Please skip to section 3)

○ YES, I DO give consent to release information to my Primary Care Physician (PCP) named below (If you check yes, the therapist will communicate with the named physician and/or send treatment plan and/or progress notes of therapy as agreed upon by the patient and the Therapist.)

2. If you checked YES, please complete the following:

I hereby give my informed consent for _____ to
Reviving Wellness Counseling

(check all that apply)

○ Talk with Physician

○ Release written documentation regarding my treatment to

Primary Care Physician _____
Address _____
Phone (_____) _____-_____ Fax (_____) _____-_____

3. Patient Authorization: I understand
   - This Authorization may be revoked at any time by submitting a written request. Disclosure(s) made prior to receipt of revocation are authorized under the prior authorization.
   - My refusal to release records will not affect my ability to obtain treatment.
   - If a person or facility receiving the above stated information is not a healthcare or insurance provider covered by HIPAA Privacy Regulations, this information could be re-disclosed.

_____ _____
Signature of Patient (Or responsible party if Patient is a Minor) Date

_____ _____
Printed Name (last, first, MI) Relationship to patient

Reviving Wellness Counseling
3630 S. Plaza Trail, Suite 150 A
Virginia Beach, VA 23452
Office (757) 373-5128 Fax (757) 431-0700

Informed Consent for Treatment Using an Energy Therapy Approach

I have been informed about the new group of therapeutic approaches that work with the human energy system and are understood to effect the body/mind interconnection. In addition, I have been informed that clinical experience and scientific studies are confirming that these approaches can assist in addressing psychological conditions such as anxiety, phobias, and traumatic responses as well as enhancing relaxation, increasing a sense of well-being, and reducing pain sensation. I have been advised that there are currently no known side-effects to energy-oriented treatments when properly administered by an experienced practitioner.

I further understand that, because these methods are relatively new, the extent and breadth of their effectiveness, including risks and benefits, are not yet fully known. I have been advised of the following:

- Previously vivid or traumatic memories may fade. This could adversely impact the ability to provide detailed legal testimony regarding a traumatic incident.
- Reactions may surface during a treatment that neither my therapist nor I can fully anticipate, including strong emotional or physical sensations, or additional, unresolved memories.
- Emotional material may continue to surface after a treatment session and give indication of other incidents that may need to be addressed.
- My therapist may refer me to practitioners who have specific skills to help with the problem areas that have been identified.
- Light touch may be involved in assessment with clinical kinesiology (muscle testing), for which I can choose to give permission or not.
- I will be learning how to perform personal self-care by working with my own energy system.

I have considered the above information before selecting to receive an energy therapy treatment and have obtained whatever additional information or professional advice I considered necessary to make an informed decision. I choose to participate in energy therapy of my own free will and know I have the responsibility for my self-care in the physical, emotional, mental and spiritual dimensions of my life.

My signature on this form acknowledges my choice to consent to the innovative approaches of energy therapy that my practitioner offers. My consent is free from pressure or influence from any person or group.

Client Signature_____ Date_____