Hampton Roads Counseling Inc.

6515 George Washington Mem Hwy. Ste. 100
PO Box 1329
Yorktown, Va. 23692

Telephone (757) 877-9140
Fax (757) 877-3925

Name______________________________Age__________Date______________

Address________________________City_______________State______Zip____________

DOB____________________________SS#______________________________

Email____________________________May we contact you?____________________

Home Phone________________Work phone__________________Cell phone________________

Employer____________________________Occupation___________________________

Marital Status___________________Spouse____________________________________

Spouse's employer____________________Spouse phone_________________Spouse DOB__________

If Patient is a child:

Mother______________________Phone #____________________DOB_____________________

SS#_____________________________Occupation____________________________________

Employer____Work phone___________________

Father_______________________Phone #___________________DOB_____________________

SS#_____________________________Occupation____________________________________

Employer____Work phone___________________

Insurance Information:

Name of Company_________________________Insured's name____________________________

Policy #_________________________Employer______________________Phone____________

Primary Care Physician_______________________________Phone_________________________

May we contact them?___________________Emergency Contact_____________________________

How did you hear about us?____

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Counseling Questionnaire

Client Name________________________________Age_________________Date_________________________

Primary Reason for Treatment____

____

____

Please check all the following symptoms/problems that you feel apply to you:

___Depression
___Anxiety
___Anger
___Fatigue/Low energy
___High energy
___Difficulty Concentrating
___Poor Memory
___Cloudy Thinking
___Changes in Appetite
___Sleep Disturbance
___Low Motivation
___Decreased interest
___Joylessness
___Bleak Outlook
___Negative Thinking

___Feeling hopeless
___Feeling Helpless
___Suicidal Thoughts
___Suicidal Actions
___Violent Thoughts
___ Violent Actions
___Over-excitement
___Medical Health Problems
___Financial Problems
___Job related problems
___School Problems
___Legal Problems
___Death/Greif/Loss Problems
___Sexual Problems

___Repetitive thoughts
___Repetitive Actions
___Panic Attacks
___ Phobias
___ History of abuse:
__verbal
__physical
__Emotional
__Sexual
___Relationship Problems
__parent-child
__brother-sister
_marital
__Family dysfunction

___Feeling Worthless
___Learning Disorder
___ Other
___School
___Eating Disorder
___Heart Palpitations
___Work Related
___Drug Problems
___Social Isolation
___Social
___Alcohol Problems
___Low Self-esteem
___Family Violence
___Gambling/Spending problems

Please let us know if you have. or have had, difficulty with drugs or alcohol.

Alcohol:

First Started______________________________

How Often________________________________

How Much________________________________

Drugs:

First Started____________________________________

Current drugs used and when____________________

Past drugs used and when_______________________

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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 operations such as quality assessments and physician certifications.

I acknowledge that I have received 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 us 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: ____

Relationship to Patient: ____

Signature: ____

Date: ____

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Welcome to Hampton Roads Counseling Inc.

We hope that your experience at this office is a pleasant one. We have put this reference together regarding our office practice and procedure. Should you have any questions regarding the information given here or experience any difficulties, please speak with your therapist or Adrienne Isham, our Office Manager.

Office Hours:

The office is open Monday through Thursday. **Our office is closed on Fridays and weekends.** If you need to contact the office or office manager, please leave a brief message on the voicemail and someone will return your call.

Office Billing:

Our office will file your insurance claims as a convenience to you. However, and deductibles or co-payments are expected at the time of service. You are responsible for checking with your insurance company for any required authorizations.

There will be a **$25.00** fee for non Social Security Disability Forms. Any forms over 3 pages will be charged an additional **$5.00** per page.

If you have a life threatening emergency, call 911 or go directly to the emergency room. For non-life threatening emergencies, we can be paged and the on-call therapist will return your call. **Do not call page us to change and or cancel appointments.**

Main office number: (757)877-9140

Emergency Voicemail: (757) 881-1561

I authorize my insurance company to reimburse this office for services rendered. I am responsible for deductibles and co-pays and collection fees necessary to collect on my account. I agree with the terms and conditions listed above.

Patient or Guardian:____Date____________________

Witness:____Date____________________

IF YOU NEED TO CHANGE YOUR SCHEDULED APPOINTMENT, A 24 HOUR NOTICE IS REQUIRED/EXPECTED. IF YOU DO NOT GIVE 24 HOUR NOTICE, A FEE OF *UP TO $65.00* WILL BE CHARGED BY DISCRETION OF YOUR THERAPIST. IF THERE IS A TRUE EMERGENCY AND YOU CANNOT KEEP YOUR APPOINTMENT, PLEASE CALL AS SOON AS POSSIBLE. IN THE CASE OF "NO SHOWS" FOR SCHEDULED APPOINTMENTS, A *$65.00* FEE WILL BE CHARGED TO YOUR ACCOUNT.

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Court/Custody Policy

Hampton Roads Counseling Therapists will not participate in any custody cases or any case that requires a court appearance. Should any lawyer, of our clients or otherwise, subpoena our therapists, our fee for appearing in court is $1,500, paid in advanced.

Should the fee not be paid in advanced, the therapist may seek legal action the recover the fee, plus any accrued court costs. If needed, please discuss this policy with your therapist before issuing a subpoena.

Thank you for understanding and abiding by our Court/Custody policy. Please sign and date this form attesting that you have read and understood the information in this document.

Full Name: ___________________________ Date:____________________

Signature: ____________________________