THERAPY AGREEMENT

In order to make our relationship a successful one, please review the following information and ask any questions that you may have at this time.

SESSION LENGTH

Initial sessions are 55-60 minutes in length. Subsequent sessions are 55 minutes in length. Groups are 1 hour in length. If you are late to your session, I will be glad to see you, but due to scheduling restrictions I can not extend the length of your session.

CANCELLATION , DENIAL, AND FINANCIAL POLICY

Milgrim and Associates, P.C. has agreements with a variety of insurance companies. Prior to your initial visit Milgrim and Associates, P.C. will verify benefits, co-pays, and preauthorization requirements. However, in the past insurance companies have given incorrect information. This has resulted in substantial bills for clients. **Please contact your insurance company immediately if you have not already done so to verify your benefits.** Milgrim and Associates, P.C. will gladly file insurance claims on your behalf. However, **if your insurance company denies any claims, you will be responsible for the full amount of the visit ($150 for initial visit, $120 for subsequent individual visits, $50 per group).** When an appointment is scheduled that time has been set aside solely for you, therefore canceled and/or missed appointments will result in a **Missed Appointment fee of $60 , except in cases of emergency.** After 2 missed appointments, regardless of reasons given, Milgrim & Associates, P.C., reserve the right to charge a missed appointment fee and/or recommend possible case closure for multiple cancellations. This will be handled on a case by case basis. Insurance companies will not pay for missed appointments. Insurance companies will not pay for any time spent writing letters, reports, or making phone calls. Milgrim and Associates, P.C. will be glad to provide these services at the rate of $30 per 15 minutes. There will be a $35 charge for returned checks.

I understand that reasonable efforts will be made by Milgrim and Associates, P.C. to collect these fees from me. In the event that it becomes necessary for Milgrim and Associates, P.C. to forward this account to a collection agency, I authorize my demographic and financial information to be released and agree to pay all collection agency fees, a 50% agency fee, court costs and attorney fees .

CERTIFICATION AND AUTHORIZATION

I certify that the above information is correct. I authorize the release of any medical information necessary to process insurance claims. I request that payments be made directly to Milgrim & Associates, P.C. on my behalf. Therefore my signature will be on file with my insurance company.

SIGNATURE:_____ DATE:_____

HIPAA Privacy Notification

I have been provided a Notice of Privacy Practices that fully explains the uses and disclosures that Milgrim and Associates, P.C. will make with respect to my individually identifiable health information. I understand that I have the right to review the Notice before signing this consent. Milgrim and Associates, P.C. has afforded me sufficient time to review this Notice and has answered any questions that I have to my satisfaction. I also understand that Milgrim and Associates, P.C. cannot use or disclose my individually identifiable health information other than as specified on the Notice. I also understand, however, that Milgrim and Associates, P.C. reserves the right to change its notice and the practices detailed therein prospectively (for uses and disclosures occurring after the revision) if it sends a copy of the revised notice to the address that I have provided.

Cellular Telephone Communication Notification

Milgrim and Associates, P.C. utilizes cellular telephone communication. Due to the nature of cellular telephone communication, telephone calls on cellular telephones are subject to the possibility of unintended disclosure. Therefore, calls made on cellular telephones can not be considered secure. Milgrim and Associates, P.C. will not disclose Protected Health Information on cellular telephones unless specifically requested to do so by patients.

The following telephone numbers are cellular telephone numbers:

1. (571) 278-0118

I understand that telephone calls made to this telephone number are not secure. I may request at any time that telephone calls with Milgrim and Associates, P.C. be made from a secure land line. Milgrim and Associates, P.C. will comply with these requests at the earliest possible time.

Contact by Telephone and Messages

I authorize Milgrim and Associates, P.C. to leave messages on my home or cellular telephone regarding presence in treatment and appointments. I authorize Milgrim and Associates, P.C. to leave messages on my work telephone with the name of the provider and a request to return the call.

_____

Patient Signature Printed Name Date

INTAKE BIOGRAPHICAL DATA

DEMOGRAPHIC INFORMATION

Name:_____ Date:_____

Address: _____

_____

Phone (Home)_____ (Work)_____

(Cell)_____ (Pager)_____

Date of Birth:_____ Age:_____ Gender:____

Social Security #_____ Marital Status:_____

Email:_____

Guardianship (Where applicable)_____

Family Members:

Name Age Sex Relationship

_____

_____

_____

_____

Employer or School:_____ Occupation or Grade_____
Referral Source:_____
Primary Care Physician:_____ Phone:_____
Emergency Contact:_____ Phone:_____
Relationship to Client:_____
Allergies:_____
Current or Chronic Medical Problems:_____
Current or Past Mental Health Treatment (Please Include Name of Providers, Approximate Dates of Treatment, and Diagnoses): _____

_____

Current Medications (Including name, dosage, name of prescribing physician)

_____

Developmental History ***Adults complete about self if information is known***

Was pregnancy normal? YES NO Explain_____
Was birth premature? YES NO Explain_____
Birth weight normal? YES NO Explain_____
Any use of alcohol, tobacco, or other drugs during pregnancy?
YES NO Explain_____
Born addicted? YES NO Explain_____

Require care in neonatal intensive care unit ?
YES NO Explain_____
Routinely followed by a pediatrician for first five years?
YES NO
Any congenital defects, speech, vision or hearing difficulties?
YES NO Explain_____
Growth and development occur within normal time frames?
YES NO Explain_____
Begin school as scheduled? YES NO Explain_____
Ever held back? YES NO Explain_____
Learning disabilities (IEP)? YES NO Explain_____
Diagnosed with ADHD? YES NO Age_____
Tendency towards violence towards self/others/animals?
YES NO Explain_____

_____
Client/Guardian Signature

_____
Clinician Signature

Milgrim & Associates, P.C.

12584 Darby Brooke Court
Woodbridge, VA 22192
Telephone and Fax (703) 499-9889

Informed Consent for Treatment

I, _____ (name of client or guardian), agree and consent to participate in behavioral health care services offered and provided by Steven Milgrim, Licensed Professional Counselor and Licensed Substance Abuse Treatment Practitioner. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

I understand that behavioral health care is a cooperative process, and I agree that I will attend sessions regularly, share openly and honestly with the provider, and make my wishes regarding treatment known. I am aware that behavioral health treatment may temporarily intensify my symptoms, and I agree to inform the provider of any changes that may occur. I further understand that I have the right to decline any services offered or suggested to me by the provider, and I may terminate treatment at any time. I agree to discuss termination of treatment with the provider prior to discontinuing treatment, as premature termination of treatment may have adverse effects.

I am aware that if at any time the behavioral health care provider, in his professional opinion, deems me a threat to myself or others, the provider will take appropriate steps to insure the health and safety of myself and others.

Signature_____ Date_____

Printed Name_____

Relationship to Client_____