The Mind Health Center, LLC
5700 W. Grace St., Suite 105-A or 108
Richmond, VA 23226
804-442-3116
www.mindhealthcenter.net

TREATMENT CONSENT FORM

I, _____ (*for* _____)
(myself or guardian's name) (minor's name if applicable)

do voluntarily consent to care and treatment by licensed clinicians (including contracted licensed clinicians) assistants, or designees at The Mind Health Center, LLC. I am aware that the practice of clinical therapy is not an exact science and I acknowledge that no guarantees have been made as to the results of evaluation or treatment. I am aware that I am an active participant in establishing my treatment goals, treatment process, and termination of services. By signing this form, I agree that I have read it and understand its content. I am also aware that should I display aggressive behavior during a session I may be asked to leave the office immediately and/or any further services may be terminated. Regarding social media – Clinicians will not engage Clients in social media requests or interactions. Clinicians will respond to text messages and/or emails having to do with scheduling ONLY. If you are having an emergency or are in a crisis, please call 911 or go to your nearest emergency center.

_____ _____
Signature of Person agreeing to treatment (Client) Date

_____ _____
Signature of Guardian if Client is a minor Date

Cancellation Policy

Clients will be charged the full session fee (not just the copay) for sessions that are missed and not canceled 24-hours in advance of the session.

_____ _____
Signature of Person agreeing to treatment (Client) or Guardian Date

_____ _____
Signature of Witness Date

Updated as of 10/24/2023

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Credit Card Authorization Form

I am providing my debit or credit card information below for the purpose of paying for my sessions at the Mind Health Center under the following conditions:

- My card will be charged after each appointment missed that I did not cancel with 24-hour notice.
- My card will be charged if a balance accrues due to an unpaid balance from the insurance company, or if a check is returned unpaid. I understand I will be charged an additional $25 if a check is returned.
- I am also responsible for any charge back fees if, for some reason, my credit card is declined. They must be paid within 7 days of being notified of such charges and paid by check or cash.
- I may opt at any appointment to pay by cash or check in lieu of debit or credit card.
- This authorization becomes a permanent part of my records and will be treated with privacy, confidentiality, and the utmost financial safeguards for the length of time my records are required by law to be retained (up to 7 years).

I, _____ (client or guardian of minor) am authorizing the Mind Health Center, LLC, to use my credit card information to charge my credit card in the event that I do not notify my clinician of my inability to attend a scheduled therapy appointment, and do not cancel my appointment at least 24 hours in advance, if a check is returned for any reason, or there is any outstanding balance.

Type of Card: VISA ☐ MasterCard ☐ Discover ☐

Card Number: _____

Verification/Security Code:_____ Exp. Date: _____/_____ Zip Code:_____

By signing below I am authorizing the Mind Health Center, to charge for scheduled appointments or outstanding balances.

Client or Guardian's Signature:_____ Date:_____

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PERSONAL INFORMATION/MEDICAL HISTORY

Today's Date: _____ Referred By:_____

Client's Name:_____

Date of Birth: _____ Sex: _____ Race: _____ Spiritual Preference:_____

Veteran? _____ Branch of Service: _____ Dates Served:_____

Address: _____

City: _____ State: _____ Zip: _____

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

Voicemail: Yes ☐ No ☐ on which phone #(s):_____

Text messages: Yes ☐ No ☐ on which phone #(s):_____

Email Address: _____

Would you like appointment reminders by: ☐ text (#_____) and/or ☐ email

Employer: _____

Marital Status (Single, Separated, Divorced, Widowed, Partnered):_____

Occupation: _____ Education: _____

Number of Children: _____ Ages: _____

Primary Care Physician (PCP): _____ Phone #_____

Do you consent to disclose your records to your PCP?: Yes _____ No _____ **(initials)**

Psychiatrist Name: _____ Phone # _____

Are you currently being treated for any medical conditions? Yes ☐ No ☐

If yes, please explain: _____

Please list all current medication, both prescribed and over-the-counter, and dosage:

_____

_____

Have you ever been diagnosed or treated for a mental illness? Yes ☐ No ☐

If yes, please explain: _____

Have you ever been hospitalized for any medical or mental illness or received inpatient treatment for substance abuse? Yes ☐ No ☐

If yes, please explain: _____

Have you ever experienced a head injury or lost consciousness? Yes ☐ No ☐

If yes, please explain: _____

Please list any losses you've experienced in the past five years:_____

_____

Do you drink caffeine? ☐ Never ☐ Daily ☐ Weekly

Do you smoke or use tobacco in any form? ☐ Never ☐ Daily ☐ Weekly

If yes, what form and how much do you use daily?_____

Do you Drink Alcohol? ☐ Never ☐ Daily ☐ Weekly

Do you use marijuana? ☐ Never ☐ Daily ☐ Weekly

Do you use opiates? ☐ Never ☐ Daily ☐ Weekly

Do you use cocaine? ☐ Never ☐ Daily ☐ Weekly

Please list any other substance(s) you use and the frequency:_____

What are your hobbies? _____

_____

What do you consider are your greatest strengths?

_____

_____

What are your goals/expectations for counseling?

_____

_____

Please include any additional information you would like your counselor to know about you?

_____

_____

_____

Insurance Provider: _____ ID #: _____

Group #: _____ Phone #: _____ Co-Pay: _____

Deductible: _____ Authorization # (if required): _____

Date of Birth for Policy Holder: _____

I authorize the MHC to bill insurance our company directly:

_____

(Client/Guardian's signature)

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HIPAA PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Your health record contains personal information about you and your health that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. It is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how Mind Health Center, LLC, may use and disclose your PHI in accordance with applicable law and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How Mind Health Center, LLC, may use and disclose health information about you:

For Treatment - Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization. We may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Payment - We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations - We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we

may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law - Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization - Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the NASW Code of Ethics and HIPAA.

Child and Adult Abuse or Neglect - We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child or adult abuse or neglect.

Judicial and Administrative Proceedings - We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients - We may disclose PHI regarding deceased patients as mandated by state law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.

Medical Emergencies - We may use or disclose your protected health information in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will strive to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care - We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight - If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement - We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in

connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions - We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health - If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety - We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious

threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission - We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization - Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI.

- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

COMPLAINTS - If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our office or with the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

The effective date of this Notice is January 2022.

I _____ acknowledge that I have received a copy of the Privacy

Practices for Mind Health Center, LLC.

_____ _____

Client or Guardian's Signature Date

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Adult Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability, temper, violence
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career/School concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Compulsions
- ❑ Custody of children
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Domestic violence
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ❑ Emptiness, hopelessness, loneliness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce

❑ Headaches, other kinds of pains

❑ Health, illness, medical concerns, physical problems

❑ Impulsiveness, loss of control, outbursts

❑ Judgment problems, risk taking

❑ Legal matters, charges, suits

❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments

❑ Memory problems

❑ Mood swings

❑ Obsessions, compulsions (thoughts or actions that repeat themselves)

❑ Panic or anxiety attacks

❑ Parenting, child management, single parenthood

❑ Perfectionism

❑ Procrastination, work inhibitions

❑ Relationship problems (with friends, with relatives, or at work)

❑ Self-esteem

❑ Sexual Assault

❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also “Abuse”)

❑ Sleep problems—too much, too little, insomnia, nightmares

❑ Suicidal thoughts

❑ Thought disorganization and confusion

❑ Weight and diet issues

❑ Other concerns or issues:

_____

_____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

_____

_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I,_____, hereby authorize The Mind Health Center, LLC, to discuss information relevant to my case/coordination of care with the below named person(s). I understand that this release of information is valid from the date of this authorization to the time I terminate treatment with The Mind Health Center, LLC. Termination is deemed to occur when I discontinue contact with The Mind Health Center, LLC, either formally or informally, no longer wish to seek treatment, or when terminated by a licensed clinician employed by The Mind Health Center, LLC.

Name: _____

Address:_____

Telephone: _____Fax: _____

Information to be Released or Discussed:

- ❑ Intake/Treatment Plan
- ❑ Treatment Progress
- ❑ Diagnosis
- ❑ Discharge Summary
- ❑ Verbal Consultation
- ❑ Billing & Payment Information
- ❑ Other (specify)_____

_____ _____

Client's Signature Date

_____ _____

Guardian's Signature if Client is a minor Date

Checklist of Intake Paperwork

(Must be completed and in paper file)

- ☐ MHC Treatment Consent form completed and signed
- ☐ MHC Client Demographic form completed
- ☐ MHC Credit Card Authorization form completed and signed
- ☐ MHC Personal Information – Medical History form completed with insurance information
- ☐ MHC – HIPAA Privacy signature page completed and signed with copy given to Client
- ☐ MHC Adult Checklist of concerns completed
- ☐ MHC Initial Assessment Guide
- ☐ MHC Release of Information form completed and signed
- ☐ LEGIBLE Copy of photo ID
- ☐ LEGIBLE Copy of FRONT and BACK of insurance card
- ☐ Self-pay Rate: $_____

If client does not wish to allow sharing of personal information or declines any other part of the paperwork, please notate that on the applicable paperwork as well as this page with your signature, and give to Luke Giannini for review.

_____

Clinician **Printed** Name

_____

Clinician Signature