Information

Office: 703-552-2722
Fax: 703-564-8567
E-mail: info@washnutrition.com

Name *

Middle Name

Preferred Name

Sex ☐ Male ☐ Female ☐ Trans ☐ Prefer Not to Disclose

Age

Birth Date

Address/Apt #

City/State/Zip

Primary Phone/Email

Marital Status ☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Legally Separated

Social Security #

Primary Phone/Email Address

Have you ever been a patient of our practice Yes No

Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Full Time Student ☐ Part Time Student

Reason for Visit

Referred By ☐ Website ☐ Google ☐ Social Media ☐ Walk In ☐ Friend ☐ Family

Referral

Insurance

Who is responsible? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other ☐ Family

Name

Age

Birth Date

Sex ☐ Male ☐ Female ☐ Trans ☐ Prefer Not to Disclose

Address/Apt #

City/State/ZIP Code

Social Security #

Primary Phone/Email Address

Primary Insurance

Do you have Insurance? Yes No

Insurance Company Name

Insurance ID #

Insured First and Last Name

Insurance Phone

Group Name/Number

Relation to Patient

Birth Date

Sex ☐ Male ☐ Female ☐ Trans ☐ Prefer Not to Disclose

SSN/Contact Phone

Address/Apt #

City/State/ZIP Code

Secondary Insurance

Do you have Secondary Insurance? Yes No

Secondary Insurance Company Name

Insurance ID #

Insured First and Last Name

Insurance Phone

Group Name/Number

Relation to Patient

Birth Date

Sex ☐ Male ☐ Female ☐ Trans ☐ Prefer Not to Disclose

SSN/Contact Phone

Address/Apt #

City/State/ZIP Code

Health History

Name of Current Physician

Phone

Date of Last Visit

Have You Had:

ADD/ADHD	Yes No	Chronic Fatigue Syndrome	Yes No	Gout	Yes No
Radiation Treatment	Yes No	Headaches	Yes No	Circulatory Problems	Yes No

AIDS/HIV Positive	Yes No	Rapid Weight Gain/loss	Yes No	Alcoholism	Yes No
Heart Attack	Yes No	Heart Disease	Yes No	Allergies/Hayfever	Yes No
Convulsions/ Seizures	Yes No	Anemia	Yes No	Heart Surgery	Yes No
Herpes	Yes No	Sleep Apnea	Yes No	Smoking	Yes No
High Blood Pressure	Yes No	Crohn's Disease	Yes No	Depression	Yes No
Snoring	Yes No	Anxiety	Yes No	Stroke	Yes No
High Cholesterol	Yes No	Irritable Bowel Syndrome	Yes No	Diabetes	Yes No
Dizziness/fainting	Yes No	Drug Addiction	Yes No	Kidney Disease	Yes No
Thyroid Disease	Yes No	Liver Disease	Yes No	Bipolar Disorder	Yes No
Fen-Fen Use	Yes No	Bruises Easily	Yes No	Cancer	Yes No
Fever Blisters	Yes No	Cerebral Palsy	Yes No	Chemotherapy	Yes No
Gall Bladder Problems	Yes No	Ulcerative Colitis	Yes No	Osteoporosis	Yes No

Psychiatric Care Yes No

Any Drug Or Food Allergies? Yes No

Any Other Medical Conditions Not Listed Above?

Are You Currently Under A Physician's Care? Yes No

If Yes, Describe

Are You Being Treated For Cancer Of Any Kind? Yes No

May I Have Your Permission To Speak Directly With Your Physician(s) Regarding Your Treatment? Yes No

Have You Ever Been Hospitalized? Yes No

If Yes, Describe

Women: Are You Pregnant?	Yes No	Nursing?	Yes No	Taking Birth Control Pills?	Yes No

If Yes, Please Indicate The Condition Being Treated.

Have You Ever Experienced An Adverse Reaction During Medical Treatment? Yes No

List All Medications You Are Now Taking (Please Include Over-the-counter Vitamins, Herbs, Pain Relievers And Illegal Drugs)

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Washington Nutrition & Counseling Group to help determine appropriate and healthful treatment. If there is any change in my medical status, I will inform Washington Nutrition & Counseling Group. I authorize the insurance company indicated on this form to pay Washington Nutrition & Counseling Group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Washington Nutrition & Counseling Group to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether, or not, paid by insurance. Payment is due in full at time of treatment, unless prior arrangements have been approved.

Signature Of Responsible Party _____

Date _____

WASHINGTON NUTRITION & COUNSELING GROUP™

I hereby authorize: **Washington Nutrition & Counseling Group**

Address: _____

Phone: 703-552-2722 to exchange information from records about _____

born on _____, with: Person or facility: _____

_____

Address: _____

_____

Phone: _____ for the following purpose(s):

□ Further mental health evaluation, treatment, or care

□ Treatment planning

□ Other:

These records concern the time between _____ and _____. The information to be disclosed is marked by an X in the boxes below:

□ Medical history and evaluation(s)

□ Mental health evaluations

□ Developmental and/or social history

□ Educational records

□ Progress notes, and treatment or closing summary

□ Other:

I fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____
Signature of client or parent

_____
Printed name

_____
Date

WASHINGTON NUTRITION & COUNSELING GROUP™

Informed Consent Client-Patient Service Agreement

Welcome to Washington Nutrition & Counseling Group. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES AND NUTRITION COUNSELING

Therapy and nutrition counseling is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a patient in psychotherapy and/or nutrition counseling, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. Washington Nutrition & Counseling Group has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy and/or nutrition counseling has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 1-2 sessions of psychotherapy and/or nutrition counseling will involve a comprehensive evaluation of your needs. By the end of the evaluation, the therapist and/or dietitian nutritionist will be able to offer you some initial impressions of what the work might include. At that point, the therapist and/ or dietitian nutritionist and patient will discuss treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with the therapist and/or dietitian nutritionist. If you have questions about the procedures, you should discuss them with therapist and/or dietitian nutritionist whenever they arise. If your doubts persist, the therapist will be happy to help you set up a meeting with another mental health professional or dietitian nutritionist for a second opinion.

APPOINTMENTS

Appointments will ordinarily be 50-60 minutes in duration for therapy, once per week at a time agreed on by your therapist and once a week to once a month for nutrition counseling for 30 minutes to 2 hours or as agreed on by yourdietitian./ nutritionist. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, we ask that you provide us with 24 hours notice. If you miss a session without canceling, or cancel with less than 24-hour notice, you may be required to pay full fee for the session [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the cancellation fee. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES

The standard fee for therapy is $200 for an initial intake and future therapy sessions is $150. The standard fee for nutrition counseling is $200 for an initial intake and future nutrition sessions is $100.

In addition to weekly appointments, it is our practice to charge this amount, on a prorated basis (the therapist and/or dietitian nutritionist will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request. If you anticipate becoming involved in a court case, we recommend that you discuss this fully with your therapist before you waive your right to confidentiality. If your case requires the therapist's participation, you will be expected to pay for the professional time required even if another party compels them to testify.

INSURANCE

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some some coverage for mental health treatment and/or nutrition counseling. With your permission, our billing service will assist you to the extent in filing claims but you are responsible for knowing your coverage and for letting us know if/when your coverage changes.

You should also be aware that most insurance companies require you to authorize the practice to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems.) Sometimes the therapist and/or dietitian nutritionist has to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier if you plan to pay with insurance.

PROFESSIONAL RECORDS

Washington Nutrition & Counseling Group is required to keep appropriate records of the psychological services and/or nutrition couseling services that are provided. We keep brief records noting that you were here, your reasons for seeking therapy or nutrition counseling, the goals and progress set for treatment, your diagnosis, topics discussed between you and your therapist and/or dietitian nutritionist, your medical, social, and treatment history, records we receive from other providers, copies of records we send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, we recommend that you initially review them with your therapist and/or dietitian nutritionist, or have them forwarded to another another mental health professional and/or dietitian nutritionist to discuss the contents. If we refuse your request for access to your records, you have the right to have the therapists and/or dietitian nutritionist decision reviewed by other mental health professional and/or dietitian nutritionist, which the therapist and/or dietitian nutritionist will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY

Washington Nutrition & Counseling Group policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and have discussed those issues with your therapist and/or dietitian nutritionist. Please remember that you may reopen the conversation at any time.

PARENTS & MINORS

While privacy in therapy and nutrition couseling is crucial to successful progress, parental involvement can also be essential. It is the practices policy not to provide treatment to a child under age 13 unless s/he agrees that the therapist and/or dietitian can share whatever information they consider necessary with a parent. For children 14 and older, we request an agreement between the client and the parents allowing the therapist and/or dietitian to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy and/or nutrition counseling. All other communication will require the child's agreement, unless the therapist and/or dietitian feels there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING

A therapist and/or dietitian nutritionist is often not immediately available by telephone. They do not answer their phones when they are with clients or otherwise unavailable. At these times, you may leave a message on their confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If you feel you cannot wait for a return call or it is an emergency, go to your local hospital or call 911.

CONSENT TO PSYCHOTHERAPY AND/OR NUTRITION COUNSELING

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

_____

Date

Description of Personal Representative's Authority: _____

_____

“Notice of Privacy Practices”

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. “Limits of Confidentiality”

Possible Uses and Disclosures of Health Records without Consent or Authorization
There are some important exceptions to this rule of confidentiality – some exceptions created voluntarily by my own choice, [some because of policies in this office/agency], and some required by law. If you wish to receive health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

- Emergency If you are involved in in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.
- Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required byVirginia law to report the matter immediately to the Virginia Department of Social Services.
- Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Virginia law to immediately make a report and provide relevant information to the Virginia Department of Welfare or SocialServices.
- Health Oversight: Virginia law requires that licensed psychologists report misconduct by a health care provider of their own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession,I am required to explain to you how to make such a report. If you are yourself a health care provider, I am required by law to report to your licensing board that you are in treatment with me if I believe your condition places the public at risk. Virginia Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence ormisconduct.
- Court Proceedings: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge’s decision, I am required to place said records in a sealed envelope and provide them to the Clerk of Court. In civil court cases, therapy information is not protected by patient-therapist privilege in child abuse cases, in cases in which your mental health is an issue, or in any case in which the judge deems the information to be “necessary for the proper administration of justice.” In criminal cases, Virginia has no statute granting therapist-patient privilege, although records can sometimes be protected on another basis. Protections of privilege may not apply if I do an evaluation for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety: Under Virginia law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death,to an identified or toan identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, I can be required to provide your records to the magistrate, your attorney or guardian ad litem, a CSB evaluator, or law enforcement officer, whether you are a minor or an adult.
- Workers Compensation: If you file a worker’s compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.
- Records of Minors: Virginia has a number of laws that limit the confidentiality of the records of minors. For example, parents, regardless of custody, may not be denied access to their child’s records; and CSB evaluators in civil commitment cases have legal access to therapy records without notification or consent of parents or child. Other circumstances may also apply, and we will discuss these in detail if I provide services tominors.

- Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.
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III. Patient's Rights and Provider'sDuties:

- Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.
- Right to an Accounting of Disclosures – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process
- Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiledin reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.
- Right to Amend – If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted dot me. In addition, you must provide a reason that supports s your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.
- Right to a copy of this notice – You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as wellas any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

EFFECTIVE DATE: _____

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Patient's Acknowledgement of Receipt of Notice of Privacy Practices

Please sign, print your name, and date this acknowledgement form. I have been provided a copy of the Notice of Privacy Practices. We have discussed these policies, and I understand that I may ask questions about them at any time in the future. I consent to accept these policies as a condition of receiving mental health services.

_____
Signature

_____
Printed Name

_____
Date

WASHINGTON NUTRITION & COUNSELING GROUP™

Insurance and Payment Policies

Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. As a courtesy, we will file your initial claim for you at no charge. If you have a co-pay or deductible, we require your estimated portions be paid at the time of service. We will then gladly file insurance claims as a courtesy to you, but any and all account balances are ultimately your responsibility. Please note that not all services are a covered benefit in all contracts.

At the time of scheduling your visit we require you give us your credit card information. We store your credit card number in a secure reputable payment processor called STRIPE.

We will charge your credit card OR health flex spending card for any outstanding balances including deductibles, co-pays and co-insurance or for uncovered services when we receive the explanation of benefits summary from your visit and send you a receipt by email. If you would rather us charge your health flex spending card please make sure your provider has this card on file in addition to your credit card. If we do not have this card on file your credit card will be charged. Please keep in mind that we are a small business and failing to call and cancel your appointment without a 24-hour advance notice can have severe effects on our practice. If you must change or miss an appointment, we require a 24-hour advance notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $50 per nutrition appointment and $100 per therapy appointment. Your credit card will be charged for these no-show fees on the same day of the missed appointment. This policy is strictly enforced.

Should your insurance coverage change, we do require this change at your appointment in order to utilize your new benefits for the scheduled appointment. If we do not receive this change within 48 hours of your appointment you will be responsible for all charges.

If your credit card does not go through, we will send you a bill with a collections letter. If the balance is not paid within 1 month of receipt of the collection notification letter, your information and amount due will be turned over to collections.

Should you have a credit on your account after your insurance company pays their portion, it is your responsibility to call and request the credit be refunded to you. The parent who requests treatment for a child is responsible to us for all fees incurred.

CONSENT I have read and understand all the above information. The undersigned hereby give authorization to perform those diagnostic and treatment procedures deemed necessary. If I ever have any change in my health or change in my medication, I will inform the doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the doctor and authorizes the release of medical records to my insurance company.

If you would like your health flex spending card on file to be charge for all deductibles, co-insurance and co-pays please check here. Please note we must have this card on file ___.

_____
Signature

_____
Printed Name

_____
Date