Adult Questionnaire

MeridianHelp.com

10109 Krause Rd., Suite 100
Chesterfield, VA 23832-6501

Office: (804) 751-8644
Fax: (804) 751-0648

_______________________________________ Clinician: ___ John Dwyer, PhD ___ David Epstein, Psy
Time and Date of First Appointment ___ Melissa Findlay, LCSW ___ Jill Sexton-Newton, LCSW
___ Elizabeth Novak, LCSW

Name: ____
first middle initial last

Age:______ Date of Birth:_______________ Gender: M F Education Level: ____________________

Street Address ______________________________City:________________ State:_____ Zip:__________

Primary Phone: _________________________ cell home work Second Phone Contact: _____________________ cell home work
Please list only phone numbers your clinician may call

Place of Employment: _______________________________Occupation:_____________________________

Who Referred You to our Office?:______________________Your Email:______________________________
Please list only if your clinician may use

Primary Care Physician (PCP):________________________ Practice Name:___________________________

Who Will Be Responsible for Payment of This Account?

Name:____________________________ Phone:____________________ SSN#:______________________

Street Address (if different from above):____
street city state zip

Signature:____ Date:_____________________________
Cannot sign for someone else.

Agreement to Allow Direct Insurance Payment

I authorize medical payments from:____
Insurance Company(s)

____
Name of Individual Holding Insurance Their Date of Birth Insurance ID Their SSN

to The Meridian Group and/or specific clinician seen for services rendered.

Employer of Insured:_________________________ Your Co-pay for each session (if known): __________

Do you have a deductible?: ___No ___ Unsure ___Yes If yes, amount and start date: _____________

Does your insurance require pre-authorization?: ___Yes ___ No ___ Unsure

If yes, have you called your insurance company to have services approved?: ___No ___ Yes ___ Auth #

Signature: ____ Date: ________________________

Marital Status: S M Partnered W Div Sep Presently Living With:_____________________________

Spouse's Name:__________________________ Date of Marriage:_________________________________

Spouse's Occupation::_____________________ Dates of Previous Marriages (You):_____ (Spouse):_____

Is Your Father ___ Living ___Deceased Age (or year he died):______________

Is Your Mother ___ Living ___Deceased Age (or year she died):_____________

Number of Brothers & Sisters: __________ Ages & Gender of Your Children:_______________________

Names of Emergency Contact:__________________________________ Phone: ______________________

Please Briefly Describe Why You Are Seeking Services At This Time:

____

____

Current Medications:____

Describe Current Health Status: ____________________Approximate Date of Last Physical Exam:________

Major Illnesses, Accidents, or Surgeries (include year): ____

Current & Previous Mental Health and or Substance Abuse Treatment, Including Medication: ____________

____

Family History of Problems with Mental Health, Substance Abuse, Trauma, Etc. (including parents, spouse, children)

____

Personal Symptoms History

Check any that apply to you now. Place a "P" by those that have been problems in the past but are not problems now.

____Depression
____Insomnia/Sleep Problems
____No Appetite
____Fatigue
____Irritable
____Can't Make Decisions
____Low Self Esteem
____Mood Swings
____Inferiority Feelings
____Anger Problems
____Attention & Focus
____Concentration
____Violent Behavior
____Obsessive Compulsive
____Overeating
____Weight Problems
____Sexual Problems
____Sexual Preoccupation
____Suicidal Thoughts
____Past Suicidal Attempts

____Anxiety
____Feel Tense
____Constant Worrying
____Panic Attacks
____Excessive Fears
____Withdrawn
____Excessive Guilt
____Over Ambitious
____Overly Suspicious
____Headaches
____Stomach Problems
___ Dizziness
____Fainting Spells
____Seizures
____Disorientation
____Memory Problems
____Chronic Pain
____Nightmares
____Medical Problems
____Significant Childhood Illness

____School Problems
____Work Problems
____Financial Problems
____Legal Problems
____Marital / Partner Problems
____Relationship Problems
____Physical Abuse
____Emotional Abuse
____Dislike Weekend/Holidays
____Family Conflict
____Loneliness
____Recent Loss
____Childhood Trauma
____History of Sexual Abuse
____History of Sexual Assault
____Flashbacks
____Excessive Alcohol Use
____Drug Abuse
____Hallucinations

Other:

Patient-Clinician Agreement

Thank you very much for choosing the Meridian Group for mental health services. We understand that the decision to seek treatment is not always an easy one. Please be assured that we will provide individualized, quality services that will actively involve you in your treatment. Should you have any questions or concerns about any aspect of your treatment or office procedures, please do not hesitate to talk to your clinician.

Your clinician is associated with the Meridian Group of Chesterfield, which was formed to more fully serve the community by offering a full range of mental health and substance abuse services. However, each individual clinician maintains their own independent practice. Record keeping and confidential clinical information is maintained separately by each clinician, and therefore your individual clinician is solely responsible for your treatment. Your clinician may occasionally find it helpful to consult other health and mental health professionals about you. During a consultation, HIPAA regulations are always observed to insure that all information remains confidential. The other professionals are also legally bound to keep the information confidential. If your clinician is out of town or otherwise not available, another clinician of the Meridian Group of Chesterfield may be asked to cover for emergencies. Any information given to them about you will be kept confidential.

In Case of Emergency: If you believe there is an emergency that could result in injury to yourself or another, call 911. For other emergencies, during office hours, call our main number, 751-8644 and press "0" and the office manager will contact your clinician. Outside of office hours, call our main number and follow the prompts for emergency contact after hours. You will be given instructions on how to contact the answering service, who will contact the on-call clinician, who will return your call promptly. In the unlikely event that you cannot reach the clinician on call, contact your local Community Mental Health Crisis Line. For any medical emergencies, including problems with medication, your prescribing physician should be contacted.

Psychotherapy: Psychotherapy is not easily described in general statements. It varies depending on the personalities of the clinician and patient, and the particular problems you are experiencing. It is a collaborative process between you and your clinician. There are many different methods to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor's visit, in that it requires an active effort on your part. In order for the therapy to be most successful, you will have to work toward treatment goals both during your sessions and at home. Please inform your clinician of any problems you anticipate in following recommendations.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience. If you have questions about procedures, please feel free to discuss them whenever they arise.

Psychological Testing: Psychological testing involves standardized measures that may include measures of attention, intelligence, achievement, emotions, personality, or other psychological factors. You will be provided with an explanation of the purpose of testing and testing procedures and will have access to the results. If the testing referral was made by an outside referral source, please be sure you understand how the results will be used and how they will affect you.

HIPAA and Patient Rights and Responsibilities: Clinicians of the Meridian Group believe that intervention is most effective when you are aware of your rights and responsibilities. We are also committed to protecting your confidentiality and privacy. The HIPAA Notice of Privacy Practices and Policies given to you (blue form) tells you about the ways your clinician may use and disclose the protected health information about you. It explains the limits of confidentiality and describes the clinician's obligations and your rights regarding the use and disclosure of information.

Your signature below indicates that you have read this Client-Clinician Agreement and agree to its terms. It also serves to acknowledge that you have received the HIPAA Notice described above. Concerning all of these forms and notices, please feel free to bring up any questions or points of clarification with your clinician at any time.

List of Charges

Initial Diagnostic Evaluation Psychologist……………$150
Initial Diagnostic Evaluation Clinical Social Worker…$140
Initial Diagnostic Evaluation Professional Counselor…$140
Co-parenting: (per hour):……..…………..………..…..$150
Group Therapy: 1 to 2 hours…..…................... .....Variable
Psychotherapy Psychologist: 45 Minutes...................$130
Psychotherapy Clinical Social Worker: 45 Minutes...$120
Psychotherapy Professional Counselor: 45 Minutes...$120
Court Appearance…………..…...…See Payment Policy
Consultations (per hour):……..…………..….……..$150
Letters, treatment summaries, and report to third parties (e.g., courts, attorneys, schools)……….……….....$50 and up
Psychological Evaluations:……………..…………...$150 hr (billed hourly, including interpretation and report)

Payment Policies

1. Insurance companies will generally reimburse for services at the same level as other medical visits. We will file your insurance claims as a courtesy to you. Please be aware, however, that you, not the insurance company, are ultimately responsible for payment of all charges. By agreeing to these Payment Policies, you agree to be responsible for paying for all services provided. Please have your insurance card available on your first visit to verify coverage. You should also determine if there is an annual deductible before your first visit. Deductibles usually apply at the beginning of your benefit year. **Your co-pays and deductible payments must be made at the time of each visit.**

2. If your account is unpaid for more than 45 days and arrangements for payment have not been agreed upon, then the option of using legal means may be used to secure payment. This may involve hiring a collection agency, attorney, or going through small claims court which will require the disclosure of otherwise confidential information. The cost of that service, up to 33.33% of the amount owed, will be added to your balance. In most collection situations the only information released regarding a patient's treatment is his/her name (and parents' names for children), address, phone numbers, the nature of services provided, payment history, and the amount due.

3. In some cases another party may be legally responsible for payment of medical bills. However, responsibility for payment of fees falls to the individual, parent or guardian who arranged for services.

4. Insurance companies do not reimburse for missed appointments. Therefore, there will be a $50.00 charge for missed appointments unless the clinician or the receptionist is notified at least 24 hours prior to the appointment. This charge may be waived in the event of emergency or illness. There is also a $50.00 returned check fee for checks written with insufficient funds If records are requested, there is a copying fee of $.50 per page plus mailing costs.

5. If consultation with the legal system is requested or required as a result of services provided to you or your child, you will be expected to assume the expenses associated with the time involved. Court appearance cost includes travel, preparation, and total time spent at the courthouse. It also includes time lost at the office if the court hearing is canceled on short notice. Court related activities are charged at a minimum of $750 which includes the first 3 hours of time. There is an additional charge of $250 per hour when more than three hours is required. Court appearance for one-half day, four hours or less, is $750. A full day court appearance, more than four hours, is $1500. An initial fee of $750 is due fourteen (14) days in advance of the court date. Payment is due by you regardless of who initiates a court appearance. For contact with others involved in legal proceedings (e.g.: attorneys, CASA workers, guardians ad litem, social services, court evaluators, judges) the cost is $250 per hour, billed by the quarter hour. Payments for letters, reports, treatment summaries, or other information provided to third parties will also be assessed at $250 that will be due prior to the release of the information. Brief contact with those involved in legal proceedings will not result in a charge. If records are requested, there is a copying fee of $.50 per page plus mailing costs.

6. If you wish to seek third-party reimbursement for services, your contract with them gives them the right to request information for determination of medical necessity and payment. Typical information supplied includes dates of treatment, type of treatment, and nature of your problem or illness (diagnosis). Some insurance companies may also require more detailed information such as treatment plans and periodic chart reviews. Information provided to them will become part of the insurance company file and your clinician will not have control over their use of the information. They are, however, bound by HIPAA, state and federal law to handle the information with your confidentiality in mind. Your signature below provides authorization for me to disclose this information. Please refer to your insurance contract for their specific information requirements.

I have read the patient-clinician agreement and office policies and agree to abide by conditions specified.

SIGNATURE:____ DATE:______________________

Authorization for the release of confidential information
Primary Care Physician

It is often helpful to inform your primary care physician (PCP) that you are involved in psychological treatment. Your PCP is typically your family physician or pediatrician. While most insurance does not require an authorization from the PCP for you or your child to receive counseling, you may want your PCP informed that you are receiving services. However, you are under no obligation to have any information released. You or your child's treatment will not be affected in any way if you decide not to authorize the release of information.

If you authorize information released to your PCP, a brief letter or phone call may be made to your PCP informing him or her that you or your child have started receiving services and the reasons you have come for treatment. Ongoing contact may occur as needed.

Patient's Name: ____

Primary Care Physician (PCP): ____

Please sign A or B below, but not both:

A: I hereby **give** my authorization to inform my primary care physician that I or my child is receiving treatment and the reasons for treatment. This release is valid for one year unless noted otherwise.

I have the right to revoke this authorization at any time by informing the above-named therapist in writing. However my revocation will not be effective to the extent that my clinician has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Please understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient: ____________________________________ Date: _______________

Signature of Parent/Legal Representative*: ______________________ Date: _______________

B: I hereby **decline** authorization to inform my primary care physician that I or my child is receiving services (no information will be released to your primary care physician):

Signature of Patient: ____________________________________ Date: _______________

Signature of Parent/Legal Representative*: ______________________ Date: _______________

* If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided. This information is confidential and is protected by Federal law. A photocopy of this completed form is considered as valid as the original.