Laurie Wilson, LMFT, LPC, LSATP
Marriage & Family Therapy Solutions, LLC
17521 Tripoli Blvd, Dumfries, VA 22026

ADULT CLIENT INFORMATION AND INTAKE FORM

DEMOGRAPHIC INFORMATION

Name: (First, middle initial, last)	Home phone:
Address:	Cell phone:
City/State	Work phone:
Zip Code:	Email Address:
DOB & Age:	Referral Source:
Contact and relationship to client:	Emergency Contact phone:

INSURANCE & BENEFIT INFORMATION (if applicable)

Insurance Co:	Provider services phone:
Insurance ID	Group #:
Subscriber name:	Client relationship to subscriber:
Subscriber DOB:	Subscriber employer:
Co-pay/ Co-Insurance:	Policy effective date:
# Visits allowed:	Deductible (amount met?):

CANCELLATION POLICY & OUTSTANDING BALANCES

A 24-hour notice is required for your scheduled appointment. If you do not give a 24-hour cancellation notice, you will be charged a **$150 fee**.

CERTIFICATION AND AUTHORIZATION (if applicable)

I certify that the above information is correct. I authorize the release of any medical information necessary to process this claim. I request that payments be made directly to Laurie Wilson, LMFT, LPC, LSATP on my behalf. Therefore, my signature will be on file to file with my insurance company.

TEXT AND EMAIL AUTHORIZTION

I give permission to receive Text messages from Laurie Wilson, LMFT _____ Yes _____ No

I give permission to receive Email messages from Laurie Wilson, LMFT _____Yes _____ No

Signature of Patient: _____ **Date**: _____

Current Symptoms (check all that apply)

- I have no problems or concerns
- Aggression, violence
- Anger
- Anxiety
- Difficulty concentrating
- Career concerns
- Parenting concerns (your own child)
- Custody of children
- Delusions (false ideas/ hallucinations)
- Drug or alcohol dependence
- Depression
- Divorce/ separation
- Eating problems
- Fatigue/ low energy
- Fears, phobias
- Financial problems Grief
- Health, medical concerns
- Interpersonal conflicts
- Irritability
- Legal matter problems
- Loneliness
- Marital/ relationship problems
- Memory problems
- Mood swings
- Nervousness/ tension
- Obsessions & compulsions
- Chronic pain
- Panic or anxiety attacks
- Perfectionism
- School problems
- Self- esteem
- Sexual problems
- Shyness, oversensitive to criticism
- Sleep problems
- Smoking and tobacco use
- Spiritual, moral, religious, ethical issues
- Stress
- Suicidal thoughts
- Through disorganization and confusion
- Withdrawal or isolation
- Work problems
- Other_____

How long have these difficulties been present?
What are your goals for treatment?
What significant life changes or stressful events have you experienced recently?
What do you consider to be some of your strengths?
What do you consider to be some of your weaknesses?

Marital Status:

____ Never Married ____ Married ____Separate ____Divorced ____Widowed

Family Members (Spouse, children or others living with you)

Name	DOB/Age	Sex	Relationship

MENTAL HEALTH HISTORY

Have you received **mental health treatment** in the past?				
Date(s)	Therapist/ Facility	Reason for seeking treatment	Length of treatment	Was treatment helpful?

	YES	NO	If yes, please describe:
Have you ever been hospitalized for mental health reasons?			
Have you ever had thoughts about death or wanting to de? Have you ever threatened to hurt yourself?			
History of suicidal gestures and/ or attempts:			
Any legal history:			

ALCOHOL/ SUBSTANCE USE

Please describe your current use of drug, alcohol, and/ or tobacco.			
	YES	NO	If yes, please describe:
Has using drugs or alcohol ever caused problems for you?			
Have you ever been treated for drug or alcohol abuse?			

MEDICAL HISTORY

Please list all medical concerns here:

List any **CURRENT** or **PREVIOUSLY** prescribed **PSYCHIATRIC** medications below

Date(s) prescribed	**Medication**	**Dosage & Frequency**	**Reason for prescription**	**Is/ was the medication helpful?**

FAMILY AND SOCIAL HISTORY	**YES**	**NO**	If yes, please describe:
Is there a history of **psychiatric/ psychological disorders** in family? (for example, depression, anxiety, learning disorders, bipolar disorder, schizophrenia, etc.)			
Is there a history of **drug or alcohol abuse** in the family?			
Is there a history of **suicide** in the family?			
What was your birth order: _____ out of _____			

My signature below indicates that I have voluntarily and accurately completed the form. A photocopy pf this agreement will be considered as valid as an original.

Client Name *Client Signature* *Date*

Laurie Wilson, LMFT, LPC, CSAC
Marriage & Family Therapy Solutions, LLC
17521 Tripoli Blvd, Dumfries, VA 22026

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____

I hereby authorize the communication of clinical information between Laurie Wilson, LMFT, LPC, CSAC and the following individuals: (Please initial, date, and mark all that apply)

_____ **Primary Care Physician** _____
(Initial and date) Address _____
Phone/ Email (P) _____ (E)_____

_____ **Psychiatrist** _____
(Initial and date) Address _____
Phone/ Email (P) _____ (E)_____

_____ **School/Teacher** _____
(Initial and date) Address _____
Phone/ Email (P) _____ (E)_____

_____ **Other** _____
(Initial and date) Address _____
Phone/ Email (P) _____ (E)_____

Communication may include direct verbal communication, clinical documentation including inpatient and outpatient treatment notes, discharge summaries, testing and laboratory results, and similar clinically relevant materials. I understand that I may withdraw this consent at any time by submitting a request in writing. Please note that once the requested information is disclosed pursuant to this Authorization, Laurie Wilson, LMFT, LPC, CSAC will no longer have control over the information and there is a potential that it may be re-disclosed by the recipient and will no longer be protected by the privacy rules under the Health Insurance Portability and Accountability Act.

_____ _____

Signature of Client **Date**

**This authorization for release of information is good for one year after date signed, until client revokes authorization, or until client is discharged from treatment (whichever precedes).

Marriage & Family Therapy Solutions, LLC
Laurie Wilson, LMFT, LPC, LSATP
17521 Tripoli Blvd, Dumfries, VA 22026

INFORMED CONSENT TO TREATMENT

Welcome to Marriage and Family Therapy Solutions, LLC. This document contains important information about my professional services and business policies. Please read it carefully and let me know if you have any questions, as I am happy to discuss further. When you sign this document, it will represent an agreement between us.

24-HOUR CANCELLATION POLICY

I reserve a limited number of sessions each week so I can devote a certain amount of time and attention to each of you that is required to provide excellent service and outcomes. Therapy is most successful when sessions are regular and consistent. If you need to cancel an appointment, please contact me as soon as possible so we may reschedule. It is extremely difficult to schedule another client on short notice, which is why I charge the full out-of-pocket fee for a missed appointment or an appointment cancelled in less than 24 hours. If you know you will not be able to make your appointment the following week during your session, please let me know and I am happy to reschedule for you. Insurance companies will not reimburse for missed appointments.

PSYCHOTHERAPY: THE INTAKE CONSULTATION

The initial consultation will last 60 minutes, but can extend to additional sessions. During the first session, we will discuss your reasons for seeking treatment and basic background information about you. Policies, fees, and scheduling will also be discussed in this meeting. To the extent possible, I will offer you some first impressions of what our work will include. You should evaluate this information along with your own opinions to determine whether you feel comfortable working with me. Therapy involves a noteworthy commitment of time, money, and energy. You should be very thoughtful about the therapist you select. If you have questions or doubts about participating in therapy at the present time or specifically with me as your therapist, please talk to me about your concerns.

BENEFITS & RISKS

Engaging in therapy often involves discussing unpleasant aspects of your life. Therefore, you may experience uncomfortable feelings like frustration, sadness, guilt, anger, loneliness, and helplessness. On the other hand, psychotherapy may help you change your unhealthy or maladaptive thoughts and behaviors. Consequently, you may benefit by minimizing your overall distress, learning more effective problem-solving strategies, and experiencing more rewarding interpersonal relationships.

COUNSELING SESSIONS

Frequency of counseling sessions will be determined by the severity of your presenting symptoms, your treatment goals, and agreed upon treatment plan. Frequency of counseling sessions a week are based on the needs of the client, however, they are generally scheduled once a week, and may be reduced in frequency as you progress in treatment. A given hour is considered blocked for a particular client; this

hour is comprised of 50 minutes of psychotherapy and 10 minutes of administrative procedures (i.e., note-taking, phone calls, insurance claim submissions).

LATENESS

If you arrive late for a scheduled appointment, only the remainder of the 50-minute session will be available. If I run late with a prior appointment for some reason, you will still receive the full 50 minutes. If you arrive more than 15 minutes late to your scheduled appointment, without notice, it will be considered a no-show and you will be responsible for the missed appointment fee.

INCLEMENT WEATHER AND CLOSURES

If there is inclement weather and/or if local schools are closed due to weather conditions, I will do my best to contact you via phone or email if I will not be in the office and may need to reschedule the appointment. The same protocol will apply for any personal emergencies that may arise causing me to reschedule or cancel scheduled appointments.

PSYCHOTHERAPY FEES

My rate for the 60-minute intake session is $185. Fees for weekly services are $150 per 50 minute session.

OTHER PROFESSIONAL SERVICES & FEES

In addition to weekly appointments, I charge the same hourly rate for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals (with your permission), preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

FORENSIC AND LITIGATIVE SERVICES

It is the stated philosophy of this practice that I do not participate in lawsuits of any type on a plaintiff's behalf, unless compelled to do so by subpoena or court order. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation, deposition, telephone time, transportation costs, court appearance, report writing, consultation and supervision, even if I am called to testify by another party. Because of the complexity of legal involvement, any court appearance or telephone contact with the court during a court case regarding the client or the client's family members in a civil or criminal matter will be charged at $2500.00 per day, paid two weeks in advance and non-refundable. Travel time will be billed at an hourly rate of $185.00 per hour, plus mileage portal to portal. Depositions will be charged at $185.00 per hour plus travel time, wait time, and transportation costs portal to portal.

INSURANCE

I participate and am in-network for certain insurance providers. For other insurance companies, I am considered "out-of-network" and you may receive full or partial reimbursement according to guidelines they have been established for out-of-network providers. The client (not the insurance company) is responsible for full payment of our fees. It is very important that you find out exactly what mental

health services your insurance policy covers. If you have questions about the coverage, call your plan administration.

BILLING AND PAYMENTS

Payment is due at the time of service. Cash, check, or credit cards are acceptable forms of payment. A credit card is required to be kept on file to hold all scheduled appointment times. Missed sessions (including sessions cancelled within 24 hours) will be charged to the credit card on file.

CREDIT CARD AUTHORIZATION. Your signature authorizes Laurie Wilson, LMFT, LPC, LSATP to charge your credit card for late cancellations, missed appointments, and outstanding balances (over 60 days): Payment method MASTERCARD VISA AMERICAN EXPRESS DISCOVER Credit card number_____ Print name as it appears on credit card _____ Zip code_____ Security code_____ Expiration date _____/_____ Email address for receipts _____ Authorization signature _____ Date_____

By signing this agreement, you are confirming that you understand that it is your responsibility for full payment of my fees. Further you understand that I (or a third-party billing company on my behalf) may submit your claims to your insurance company (ies), if applicable, for direct payment to Laurie Wilson, LMFT, LPC, LSATP/Marriage and Family Therapy Solutions, LLC and that if your insurance company does not cover 100% of your bills for services provided that it is your responsibility for full payment of my fees, not your insurance company's. Further, you confirm that you understand that it is your responsibility to:

• Pay, at the time services are rendered, the agreed upon session fee, co-pay, co-insurance, deductible, or any other fees relating to services rendered that are denied or not fully covered by your insurance company (ies);

• Provide current mailing address and phone numbers, as well as notification when there are any changes to this information.

• Confirm with your insurance company that the therapist is a participating provider under your specific insurance plan;

• Provide appropriate and current insurance information and updates to ensure efficient billing and payment;

• Obtain all necessary referrals or authorizations required prior to treatment

ASSIGNMENT OF BENEFITS

By signing this agreement, you authorize payment of all medical insurance benefits, which are payable under the terms of your insurance policy to be paid directly to Laurie Wilson, LMFT, LPC, LSATP/Marriage and Family Therapy Solutions, LLC for services rendered. You further authorize the release of any information needed for the purposes of treatment, payment and health care operations, including, but not limited to the processing of these insurance claims. A copy of this authorization may be used in place of the original. You understand that you are financially responsible for charges not paid by your insurance company.

_____	_____	_____
Signature of Patient	Relationship to Patient	Date

DELINQUENT ACCOUNTS AND COLLECTIONS

You are responsible for payment of your therapy fees, regardless of whether or not they are covered by your insurance carrier. Outstanding balances of more than 60 days will be charged to the credit card on file. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency, and this could affect credit. You agree to the costs of any action necessary to collect your portion of the fee due, including court and attorney fees that might accrue. You will receive appropriate notice of efforts to obtain this debt. There will be a $30 charge for the return of a check from the bank.

CONTACTING ME

Because this is a limited private practice, I am often not immediately available by telephone. When I am unavailable, please leave a message on my voicemail. I monitor my voicemail frequently during the day on weekdays, and at least daily on weekends and holidays. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If I will be unavailable for an extended time, such as for a scheduled vacation, I will provide you with the name of a colleague to contact if necessary. Email is usually best for the quickest response. Please do not leave emergent or personal information in an email, as they are not secure.

EMERGENCIES

In the event of a psychiatric emergency, and you are unable to reach me, please call a local Mental Health Hotline or CALL 911 or go to the nearest Emergency Room of your nearest hospital and ask to be evaluated by the psychologist or psychiatrist on call. Mental Health Hotline numbers include 703.792-4900 (Prince William County), 540.373-3223 (Fredericksburg), and 703-573-5679 (Fairfax County). For less urgent matters or for scheduling issues, please leave a message on my voicemail, by email or on the practice management portal. Email is not a secure, confidential form of communication and should not be used for discussion of clinical issues or for urgent communications.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records unless I believe that you seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Alternatively, I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted by and/or upsetting to untrained readers. If you wish to see your records, I recommend you review them in my presence so that we can discuss the contents. Clients will be charged a fee for any professional time spent in responding to information requests.

MINORS

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request that I will provide parents only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concerns. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have about it.

CONFIDENTIALITY

In general, the law protects the privacy of all communications between a client and a therapist and I can release information about our work to others only with your written permission. All aspects of your treatment are confidential, and I will need your written permission if you wish me to discuss your treatment with anyone else, including your insurance company. Even the fact that you are a client in my practice is protected by confidentiality. However, there are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly, or disabled person is being abused, I am required to file a report with the appropriate state agency. If I believe that a client is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself or herself, I may be obligated to seek hospitalization for him or her or to contact family members or others who can help provide protection. I will make every effort to fully discuss it with you before taking any action.

In legal proceedings, you may have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he or she determines that the issues demand it. I may occasionally find it helpful to engage in professional consultation with another professional regarding some aspect of a client's treatment. During a consultation, I make every effort to avoid revealing any identifying information about my client. The consultant is also legally bound to keep the information confidential. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential issues, it is important that we discuss any questions or concerns you have. I will be happy to discuss these issues with you, but if you need formal legal advice please consult an attorney.

ENDING THERAPY

My goal is to provide a quality service in the shortest period of time that is necessary for you to derive benefit from the therapy. You have the right to withdraw from treatment for any reason at any time. I ask that you agree to have a final session after you notify me of your voluntary termination of treatment, so that I may responsibly review and evaluate your reasons, and make recommendations related to the termination of treatment.

SEVERABILITY

If any of the provisions of the Agreement shall be held to be invalid or unenforceable, all other provisions shall nevertheless continue in full force and effect. The Agreement shall be interpreted in accordance with and controlled by the laws of the State of Virginia in effect at the time of the execution of this Agreement.

_____ _____

Signature of Client **Date**

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT:

_____ (Initial) I HAVE REVIEWED AND BEEN PROVIDED A COPY OF THE HIPAA NOTICE OF PRIVACY PRACTICES. I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS ABOUT 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.

INFORMED CONSENT TO TREATMENT: I HAVE READ, UNDERSTOOD, AND HAD OPPORTUNITY TO QUESTION, AND I AGREE TO THE ABOVE CONDITIONS AND POLICIES. I AGREE AND CONSENT TO PARTICIPATE IN BEHAVIORAL HEALTH CARE SERVICES OFFERED AND PROVIDED AT MARRIAGE & FAMILY THERAPY SOLUTIONS, LAURIE WILSON, LMFT, LPC, CSAC 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 ALSO PERMIT THE USE OF A COPY OF THIS SIGNED AUTHORIZATION IN PLACE OF THE ORIGINAL.

_____

Signature of Client / Legal Representative **Print Name of Client / Legal Representative** **Date Signed**

_____ _____

Client Date of Birth **Relationship to Client**

_____

Signature of Therapist **Print Name of Therapist** **Date Signed**