**Perspectives Counseling Center of Vienna, PC**

360 Maple Ave. W, Suite D, Vienna, VA 22180

lgrossmanlpc@gmail.com

(703) 405-6361

Intake Form

Client Information:

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_

Highest Level of Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY INSURANCE:

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance ID No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Group No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender M or F (circle one) Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cell / work / home)

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we send a thank you note to the person or agency that referred you?

Please circle: YES or NO

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**Fee and Policies Amendment Agreement**

Perspectives Counseling Center of Vienna, PC fees are $200 for the initial assessment and $175 for an individual therapy session. Sessions are 45-55 minutes in length. Longer sessions are billed at $87.50 per half hour. Returned checks are subject to a $75 fee. This agreement supersedes all previously agreed to financial agreements and is effective as of the date signed. You are responsible for any fees at the beginning of each session. You are responsible for fees not covered by insurance. I accept credit cards, flexible spending cards, checks, transfers via Zelle and cash.

**Cancellation policy:** The scheduling of an appointment involves the reservation of time specifically for you. In the event of a “No Show” or failure to give a **full 24-hour notice** of a cancellation, **you will be charged the full session fee for all late cancellations and missed appointments.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Legal Representative Signature Date

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**Credit Card Authorization:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am authorizing Perspectives Counseling Center of Vienna, PC to charge the full session fee and/or copayment to the credit card indicated below. I further authorize Lisa Grossman to charge my credit card for any unpaid balances for services rendered that remain on the account.

Card Type (circle one): Visa MasterCard

Card Number: \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ Exp. Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Name as printed on card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CVV \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (code on the back or front of card) Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read the above fee agreement document carefully, and I understand it and agree to all of its terms and conditions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized cardholder Signature Date

**Perspectives Counseling Center of Vienna, PC**

**Informed Consent for Treatment**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name of Client or guardian as applicable), agree and consent to participate in behavioral health care services (assessment, treatment, and/or diagnostic procedures) offered and provided by Perspectives Counseling Center of Vienna, PC, a psychotherapy health care provider. I understand that I am consenting and agreeing only to those services that the above named provide is qualified to provide as a licensed provider of mental health services. This may consist of various modalities including individual or couples counseling, group therapy and/or family therapy with the goal of stabilizing current stressors and associated symptoms.  As treatment progresses and difficult issues are discussed levels of stress and tension may also rise.  Likewise, the benefits of treatment may include improved levels of functioning, self-confidence and self-esteem, etc.  It is important for Client and therapist to work together in managing these ups and downs.  In addition, continued treatment is Client’s decision.  However, therapist may make recommendations for ongoing treatment based upon Client’s progress.

If the Client 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.

Signature of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Witnessing Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_

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**RELEASE OF INFORMATION**

CLIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of release: \_\_\_\_\_\_\_\_\_\_\_\_

I hereby give my written permission forPerspectives Counseling Center of Vienna, PC to exchange the following information as indicated below with, (List name, address and telephone)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the purpose of:

\_\_\_\_\_\_ Collaboration with other health professionals regarding my treatment

\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date and/or condition when release will expire

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not specified the release will expire one year from the date signed or 30 days from discharge, if this occurs before one year.

Signature of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_

**Perspectives Counseling Center of Vienna, PC**

**Office Policies**

**Confidentiality**

All information disclosed within sessions or consultations is held strictly confidential and may not be revealed to anyone without a written release of information, except where disclosure is permitted or required by law. Disclosure is required in the following circumstances:

1. When there is a reasonable suspicion of child abuse or neglect, or abuse to a dependent or elder adult,

2. When the patient presents an imminent danger to self,

3. When the patient presents an imminent danger to others,

4. If a judge determines that our discussions are not confidential, a judge may request specific information.

**If the patient is a minor, you acknowledge that your child’s records are confidential except in the above stated exceptions. I require a copy of all custody agreements in the case of divorce.** Please be aware that submitting mental health claims to your insurance company carries a certain amount of risk to confidentiality, privacy, and to future capacity to obtain health or life insurance, or even a job. I receive regular professional consultation. In such cases, no identifying information about you is revealed.

**Phone & Emergency Contact**

Please do not hesitate to call my office number, 703-405-6361. The number is also my mobile phone. If I am not available, you can leave a message on my voicemail and I will usually return the call that day. In the event of an emergency, you may be able to reach me on the same number. If you cannot reach me in an emergency, please call 911 or go to the nearest emergency room and ask for the mental health professional on staff.

**Telephone calls**

Phone calls lasting more than 10 minutes will be billed at the rate of $175.00 per hour.

**Recording Therapy**

All recordings must be by mutual agreement. Perspectives Counseling Center of Vienna, PC and Lisa Grossman, LPC do not give permission to record therapy sessions. A separate agreement must be signed by both therapist and client in order for a recording to occur.

**Therapy Process & Termination**

Psychotherapy can result in a number of benefits to you, including improved relationships and a reduction in psychological symptoms. The process of talking about painful memories, thoughts, and feelings, however, can be difficult and can make patients feel worse for a time. If you are feeling worse, please discuss this with me. There is no guarantee that therapy will yield positive or intended results. Most problems require at least 12-20 sessions which last 45-50 minutes each. Many issues take much longer than this, up to a few years. You are free to terminate therapy at any time. I can provide you with referrals to other therapists at your request. I do not prescribe medication or make recommendations about medication I will refer you to your physician or to a psychiatrist if I believe you need a medication evaluation. If calls and emails have not been returned in 14 days therapy will be considered terminated.

**Cancellation of Appointments**

The scheduling of an appointment involves the reservation of time specifically for you. In the event of a “No Show” or failure to give a **full 24-hour notice** of a cancellation, **you will be charged the full session fee for all late cancellations and missed appointments.** Please be aware that insurance companies will not cover cancellation charges.

**Perspectives Counseling Center of Vienna, PC**

**NOTICE OF PRIVACY PRACTICES**

**This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information.  Please review it carefully.**

**HIPAA**
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by Perspectives Counseling Center of Vienna, PC known herein as PCCV, I or Agency, in any form are kept properly confidential.  This act gives you certain rights and control regarding how your health information is used.

**Honoring your privacy**

Your health record contains personal information about you and your health.  Except in the specific instances mentioned below, PCCV does not release identifying health information (called protected health information or PHI) about you without your specific written authorization.

**Use and disclosure of health information**

1. Treatment: If PCCV needs to communicate with others about your treatment, your prior written permission will be obtained.  In most instances, the purpose of this communication is to enable me to provide or coordinate your treatment.  This can include consultation with physicians, other clinicians or consultants.  There are some very circumscribed situations as explained in the “Required or Permitted by Law” section of this document in which your written permission for PCCV to communicate with other parties is not required.
2. Payment: PCCV may use and disclose PHI so that I can receive payment for the treatment provided to you.  This will only be done with your authorization.  Examples of payment related activities include determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, or reviewing services provided to you to determine medical necessity.  The type of information usually requested by insurance companies pertains to your diagnosis, symptoms, current functioning, treatment plan, response to treatment, etc.  I will, at your request, discuss what information I am sharing with your insurer and allow you to review this information prior to it being submitted.  If you request that this information not be shared with your insurer, treatment may be arranged on a self-pay basis.
3. Health Care Operations: At times, I will have to contact you regarding your treatment, scheduling of appointments, billing and other matters.  It is your responsibility to inform me which methods you prefer to maintain your privacy.  For example, if you do not want to be contacted at work please inform me of this fact.  Or, if you do not want me to leave my name on a family voice mail message system.  I attempt to conduct these communications with a respect for your privacy, but you will need to inform me of special concerns you have regarding such matters.

Also, I share information about my clients with professional colleagues for the purpose of facilitating your treatment, fostering my own professional development or helping to train other colleagues.  In doing so, I am careful to conceal the identity of the client.  Such non-identifying disclosures are not formally considered “protected” information.

**Revocation of Authorization**

You may revoke an authorization you have given for release of your personal health information at any time provided it is done in writing.  You may not revoke authorizations to the extent that (1) I have already taken actions relying on your original authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

**Required or permitted by law: Uses & disclosures of PHI from mental health records not requiring consent**

1. Right to Access, Inspect and Copy: You may request access to your protected health information and billing records.  Requests for access must be made in writing.  I charge a fee for summaries of treatment progress provided. The fee is based on my current rates.
2. Right to Amend: If you feel that the PHI, I have about you is incorrect or incomplete, you may ask me to amend the information.  Please note that I am not required to make such amendments.
3. Right to Accounting Disclosures: You generally have the right to receive an accounting of the disclosures of your PHI made by me after April 14 of the current calendar year.
4. Right to Request Restrictions: You have the right to reasonable requests to receive confidential communications of protected health information from me by alternative means or at alternative locations.  For example, you may wish to receive phone calls from me at home rather than at work or you may prefer to have bills sent to a particular location.
5. Right to a Copy of this Notice: A copy of this document will be provided upon request.

**Perspectives Counseling Center of Vienna, PC**

**Consumer Notice of Rights and Responsibilities**

Each individual who receives services with Perspectives Counseling Center of Vienna, PC shall be assured protection to exercise his/her legal, civil and human rights related to the receipt of services; shall be shown respect for her/his basic dignity; and shall be provided services consistent with sound therapeutic practices.

Every client receiving services will be treated with dignity and be protected, respected and supported in exercising all of her/his legal, civil and human rights. All staff are prohibited from limiting or taking away these rights for any reason, including a client’s disabilities or barriers that may be created due to a disability.

**IT IS YOUR RIGHT**

* To be treated with dignity and respect
* To be told about your treatment
* To have a say in your treatment
* To speak to others in private
* To have complaints resolved
* To say what you prefer
* To ask questions and be told about your rights
* To get help with your rights

As a partner in your own health care, you have the right to refuse treatment, providing you accept responsibility for the consequences of such a decision. You have a responsibility to participate, to the degree possible, in understanding your behavioral health problems and in developing mutually agreed upon treatment goals. You also have the responsibility to identify yourself and insurance coverage or changes in coverage when receiving behavioral health services. You have the responsibility to provide your current provider with previous treatment records, if requested, as well as to provide accurate and complete medical information to any other health care professionals involved in the course of your treatment. You have the responsibility to be on time for your appointments and to notify your provider as far in advance as possible if you need to cancel or reschedule an appointment. And, you have the responsibility to pay all required co-payments and deductibles.

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