Fairfield Psychological Associates
5265 Providence Road, Suite 500 Virginia Beach, Virginia 23464
Phone (757) 467-9500
Fax (757) 467-9560
www.FairfieldPsych.com

PATIENT INFORMATION:
PLEASE WRITE YOUR NAME EXACTLY AS IT APPEARS ON YOUR INSURANCE CARD

Last Name: _____ First Name: _____ Middle Initial:_____
Sex: male __ female __ Date of Birth: _____ SSN: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Cell #: _____ Home #: _____ Work #: _____ Email Address: _____

RESPONSIBLE PARTY:
If you are over the age of 18, you are your own responsible party or parent/ guardian information for all patients under 18 (responsible party MUST sign paperwork)

Relationship to Patient: _____
Last Name: _____ First Name: _____ Middle Initial: _____
Sex: male __ female __ Date of Birth: _____ SSN: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Cell #: _____ Home #: _____ Work #: _____
Employer: _____

PATIENT INSURANCE INFORMATION:
Primary Insurance Carrier:

_____
Identification #:

_____

Secondary Insurance Carrier:

_____
Identification #:

_____ I hereby assign insurance benefits to Fairfield Psychological Associates (FPA). I acknowledge that I am voluntarily seeking services and understand that insurance may be filed as a service on my behalf. I also acknowledge that I am personally responsible for collection fees if &/or when the account becomes delinquent & collection proceedings are required.

_____
Patient Name (PLEASE PRINT)

_____ _____
Patient or Responsible Party Signature Date

Why are you currently seeking treatment?

Please list any & all medical conditions:

Have you had any psychiatric hospitalizations? Yes __ No__ If yes, how many times, where, & when?

Please list your previous mental health, therapy, &/or medication providers:

Please list all current medications:

Please list previous mental health medications that have been tried:

Please list the name, location, & phone number of your pharmacy:

Please give a brief mental health history:

The information below is utilized to establish a clear understanding regarding the details of your financial account with this practice. Your signature is an acknowledgement of your understanding & agreement with the provisions of these statements.

I agree to be responsible for payment in full of the charges for professional services rendered by Fairfield Psychological Associates (FPA) to the patient mentioned below. INITIAL HERE___

Fairfield Psychological Associates will file insurance claims on behalf of the patient for rendered services. Insurance payment shall be made to the practice. Should payment be made to the patient or responsible party by the insurance carrier, the responsible party agrees to promptly forward the payment to the practice or pay the balance due themselves. INITIAL HERE___

The patient or responsible party must pay the co-payment at the time services are rendered. This is the amount which is estimated as not being covered by the patients' insurance. I also acknowledge that it is my responsibility to inform the office immediately if there is any change with my insurance. INITIAL HERE___

The responsible party shall pay any outstanding balance which is not covered by insurance which includes but is not limited to deductible, co-payment, denied claims, no shows, &/or medication refill fees. The patient or responsible party may receive a statement when there is an outstanding balance. The responsible party, not the insurance company, is ultimately responsible for the payment of the rendered services. INITIAL HERE___

It is understood that the usual & customary collection procedures will be initiated should the account become 90 or more days delinquent. It is also understood that any collection fees, including court costs, will be payable by the responsible party. INITIAL HERE___

If this account is referred to an attorney for collection, then the undersigned person promises & agrees to pay all collection costs including attorney fees of 33 1/3% of the principal amount due & owing when turned over for collection & further agree to pay interest at a rate of 1 1/2% per month (18% per Annum) on the unpaid balance from the date the services were last rendered. I authorize photocopies of this form to be as valid as the original. In the event this matter is turned over for collection, I hereby expressly give permission for my current employer to provide verification of my said employment to this office, our attorney or collection agency. INITIAL HERE ___

I understand that as a patient of Fairfield Psychological Associates I MUST give at least 24 business hour notice to cancel &/or reschedule any appointment. I acknowledge 24 business hours does not include weekends &/or after office hours. INITIAL HERE___

It is understood that after two missed appointments (EX: No show, late cancel, same day cancel, etc.) we will no longer be able to provide you with the care you need. This will result in a dismissal from Fairfield Psychological Associates. INITIAL HERE____

_____ _____

Patient or Responsible Party Signature Date

The following policies are in place to provide timely & efficient care for all clients. Please read this page in its entirety. Your signature is an acknowledgment of your understanding & agreement with the provisions of the following policies of Fairfield Psychological Associates (FPA).

- By signing this document, I am acknowledging that I am aware if I need any paperwork completed by my FPA provider is subject to a paperwork fee of $25- $150 that must be paid in full before the completed paperwork is released. I understand my FPA provider is not obligated to complete any paperwork.
- By signing this document, I am acknowledging that I will always treat the staff of FPA respectfully. I understand that if I am disrespectful to staff &/or disrupt the care of other patients I will be dismissed from the practice effective immediately & I will lose the ability to return.
- By signing this document, I am acknowledging that I understand FPA is strictly an outpatient facility. We do not provide emergency or after business hours services. While the office staff will do their best to accommodate last minute appointments during business hours, if I am to need immediate emergency care, I must call 911, admit the person(s) in need to The Virginia Beach Psychiatric Center or go to the nearest hospital emergency room without hesitation.
- By signing this document, I am acknowledging that it is my sole responsibility as a patient of FPA to schedule follow-up appointments with the front desk staff. I understand I am also solely responsible for keeping track of my own appointments I schedule with my FPA provider. Reminders from the office are generated by an automated system as a courtesy.
- By signing this document, I am acknowledging that I understand that I may lose my right to treatment in this office if I break any of the policies of FPA.

_____ _____

Patient or Responsible Party Signature Date

Calls re: Scheduling

We ask that you please be considerate when cancelling &/or rescheduling appointments with your provider here at Fairfield Psychological Associates. While unfortunate events happen that are unavoidable, your scheduled appointment is very important to both your provider & you, therefore, please consider the following:

- Phone business hours are Monday through Friday from 9AM to 4:30PM.
- Twenty-four (24) business hour notice is required to cancel &/or reschedule your appointment.
- Messages after hours or on the weekends are NOT considered twenty-four (24) business hour notice.
- We do not monitor emails &/or voicemails on the weekends or after office hours.
- We ask that you do not text, email or call the personal cell phone of your provider for any reason whatsoever.
- When you contact the front office at (757) 467-9500, if your call goes to voicemail, we ask that you please leave one (1) voicemail with your name, the patients name (if applicable), the patients date of birth, the reason you are calling, & the best phone number to reach you. The office staff will return your voicemail within twenty-four (24) to forty-eight (48) business hours. If you need emergency care, or are in crisis, you should immediately utilize 911, The Virginia Beach Psychiatric Center or the nearest hospital emergency room.
- All phone calls will be handled by the front office & forwarded to the appropriate provider if necessary.

_____ _____

Patient or Responsible Party Signature Date

FPA offers automated text messages & emails sent by our electronic health record system.
The reminders are a courtesy & maintaining all scheduled appointments are still the responsibility of the patient and/or guarantor. All appointments must still be cancelled &/or rescheduled twenty-four (24) business hours in advance. Any appointments that are not cancelled within twenty-four (24) business hours prior to the appointment are subject to the $75 fee. Insurance does not pay for missed &/or cancelled appointments.
Note: reminder emails may go to your spam folder. Some systems such as work or school emails have a filter & prohibit reminder emails. Our system DOES NOT let us know of this & it is the SOLE responsibility of the patient &/or guarantor to keep track of scheduled &/or rescheduling appointments.

Patient Name (PLEASE PRINT): _____

Parent name/ Guardian name (if patient is a minor): _____
____ YES, I would like to receive phone calls & text messages for appointment reminders (2 days prior to appointment).
____ YES, I would like to receive email messages for appointment reminders (1 week prior to appointment & 1 day prior to appointment).
____ NO, I would NOT like to receive phone calls & text messages for appointment reminders.
____ NO, I would NOT like to receive email messages for appointment reminders.
Telephone Number to Receive Text Message and/or Phone Call Reminders: (_____) _____ Email Address for Email Reminders: _____

_____ _____
Patient or Responsible Party Signature Date

HIPAA RELEASE OF INFORMATION AUTHORIZATION FORM

Name of Patient (Please PRINT): _____Patients Date of Birth: _____

I hereby authorize Fairfield Psychological Associates, P.C. to release &/or discuss protected health information about the patient named above to the entities listed below:

_____
Please list name(s) of all parties authorized to receive specified information

I authorize the parties listed above to receive the following information (Please check all that apply):
All Medical ___ All Financial ___ Appointments Only ___ All Information ___ This authorization shall expire on:

_____
(If I fail to provide an expiration date, this authorization will expire six months from the date signed)

I understand that I have the right to revoke or amend this authorization at any time & that I have the right to inspect or copy the protected health information I wish to be disclosed to the parties listed in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed because of this authorization may be subject to redisclosure by the recipient & may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization & that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____
Patient or Responsible Party Signature Date

Fairfield Psychological Associates

Statement of Confidentiality and Informed Consent to Treatment

The concerns you bring to explore and/or resolve in counseling are important and personal. This is a statement to acknowledge that the information you share in counseling will be managed within the legal and ethical conditions of confidentiality. Information you disclose may not be shared with a third party outside of the practice without your written consent, except under the following conditions, as outlined by HIPAA and applicable statutes of the Commonwealth of Virginia:

1. If a client communicates that he or she poses an urgent life-threatening risk to him/herself or someone else, appropriate parties may need to be notified to prevent harm.

2. If information is disclosed which indicates the abuse of a minor or an elder, there is a legal mandate that abuse must be reported to Child or Adult Protective Services or other state divisions.

3. If any legal action involves a patient, wherein a court or judge legally compels the counselor via subpoena to release information from practice records, then the counselor would need to disclose the clinical file or content from the file to the court.

4. In the event of any malpractice action taken against the counselor, the counselor can provide relevant and necessary client information to legal authorities, as evidence necessary to the provider's legal defense.

5. If a couple enters counseling treatment together, a couple's clinical provider may not be compelled to testify in court on behalf of one partner against the other, due to conflict of interest.

6. Mental health practice providers may seek clinical consultative support with colleagues, as necessary, for maintaining standards of best practice toward supporting optimal patient care.

7. All case files are property of FPA or clinical provider and are maintained within mandatory security guidelines, as outlined by HIPAA and applicable statutes of the Commonwealth of Virginia.

Please ask your mental health provider any questions regarding the stated items above. Sign below to indicate that you understand the conditions of confidentiality and that you consent to clinical treatment by your assigned or scheduled mental health counselor, who may be an employee of FPA or an independently contracted mental health therapist. Talk therapists are licensed or clinically supervised by Board-approved supervisors.

_____ _____

SIGNATURE (Patient over age 18 or Parent/Guardian) PRINT NAME

_____

Date

Consent for Telehealth Consultation

If I am being seen via telehealth:

1. I understand that telehealth treatment has potential benefits including, but not limited to, easier access to care.
2. I understand that it is my obligation to notify my provider of my location at the beginning of each treatment session. If for some reason, I change locations during the session, it is my obligation to notify my provider of the change in location.
3. I understand that it is my obligation to notify my provider of any other persons at the location, either on or off camera and who can hear or see the session. I understand that I am responsible to ensure privacy at my location. I will notify my provider at the outset of each session and am aware that confidential information may be discussed.
4. I agree that I will not record either through audio or video any of the session, unless I notify my provider, and this is agreed upon.
5. I understand there are potential risks to using telehealth technology, including but not limited to, interruptions, unauthorized access, and technical difficulties.
6. I understand that my provider is not responsible for any technological problems of which my provider has no control over. I further understand that my provider does not guarantee that technology will be available or work as expected.
7. I understand that I am responsible for information security on my device, including but not limited to, computer, tablet, or phone, and in my own location.
8. I understand that my provider or I (or, if applicable, my guardian or conservator), can discontinue the telehealth consult/visit if it is determined by either me or my provider that the videoconferencing connections or protections are not adequate for the situation.

By signing this document, I acknowledge:

1. Telehealth is NOT an emergency service. In the event of an emergency, I will use a phone to call 9-1-1 or another appropriate emergency contact.
2. I recognize my provider may need to notify emergency personnel in the event he/she feels there is a safety concern, including but not limited to, a risk to self/others or my provider is concerned that immediate medical attention is needed.
3. The telehealth platform facilitates videoconferencing, and this technology platform is not, itself, a source of healthcare, medical advice, or care.
4. I understand that the same fee rates apply for telehealth as apply for in-person treatment. It is my obligation to contact my insurer before engaging in telehealth to determine if there are applicable copays or fees which I am responsible for.
5. To maintain confidentiality, I will not share my telehealth appointment link or information with anyone not authorized to attend the session.
6. I understand that either I or my provider can discontinue the telehealth services if those services do not appear to benefit me therapeutically or for other reasons which will be explained to me. I understand there may be no other treatment alternative available.

I have read and understand the information provided above regarding telehealth, have discussed it with the practice, and I hereby give informed consent to the use of telehealth.

_____	_____	_____
Signature of patient or guardian	Print name	Date

Medication Management Guidelines:

I understand that if I am 7 minutes or more late for any medication appointment, I will be declared a "no show" which will incur a fee of $75 and my appointment will be rescheduled for another date/time. The "no show" fee MUST BE PAID IN FULL before re-scheduling. INITIAL HERE ____

I agree that if I need a refill of any medication outside of my scheduled appointment, a refill fee of $25 per medication must be paid in order to receive refills. Please allow 24-48 business hours for your provider to process your refill request. I also understand that refills of CONTROLLED MEDICATIONS outside of an appointment are PROHIBITED. Therefore, it is my responsibility to keep my prescriptions in a safe place & to take them as prescribed. PLEASE NOTE: Insurance companies DO NOT pay for missed appointment fees, cancelled appointment fees and/or medication refill fees. INITIAL HERE ____

By signing this document, I am acknowledging that I will take my medication as prescribed & I will not change the way I take it without first consulting with my FPA provider or other member of the treatment team. INITIAL HERE ____

I understand that I must keep my medication in a safe place. I will not accept any controlled substances from another doctor without first consulting with my FPA provider. INITIAL HERE ____

I understand that my medication provider will not supply or replace any prescriptions if they are lost, misplaced or stolen. INITIAL HERE ____

I understand that if my medication is stolen, my medication prescriber may provide me with a refill one (1) time only if a police report is made & a copy of the police report is submitted to the front office staff. NOTE: replacement prescriptions are at the complete discretion of my medication provider & if given will require a $25 refill fee paid before I am able to receive new prescriptions. INITIAL HERE ____

I will never give my prescription to anyone else. I will keep all my regularly scheduled appointments with my medication provider. I agree to refrain from any & all addiction drugs and/or alcohol while taking my medications. INITIAL HERE ____

I agree t random urine drug screens. I agree to take medications exactly as prescribed to me unless first consulting with my medication provider to make a documented change. I agree that any infractions of any of the statements listed above, misuse of prescriptions, etc. will result in immediate dismissal from Fairfield Psychological Associates. INITIAL HERE ____

_____	_____
Signature of patient (or parent/guardian)	Date

Services Needed

Therapy _____ Medication Management _____ Couples/Family Counseling _____

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

CreditCard Information

Card Type: MasterCard ___ VISA ___ Discover __ AMEX__ Other _____

Cardholder Name (as shown on card): _____

Card Number: _____

CVV/CVC Code: _____

Expiration Date (mm/yy): _____

Billingaddress: _____ Zip Code _____

I, _____, authorize **FAIRFIELD PSYCHOLOGICALASSOCIATES** to charge my credit card above for agreed upon fees/purchases. I understand that my information will be saved to a secure file for future transactions on my account.

This card on file will be utilized to charge fees on the day of service. Agreed upon purchases include:
-Any copay amount set forth by your insurance.
-Any deductible amount imposed by your insurance.
-Any services not covered by your insurance.
-If no insurance is on file or if you choose to pay “out of pocket”.

_____ _____

Signature Date