Office Directions to **ACA Counseling** 3247 Electric Rd., SW Suite 1A (Building F)

From Salem, go up Electric Rd (Rt 419) towards Tanglewood Mall. Go thru the light at Rt 419 and Brambleton Ave. (Cave Spring Corners) and take the FIRST RIGHT into the Cave Spring Professional Center. (If you go to the stoplight at Ruby Tuesday, you have gone too far) We are the first building on the left (Across from Wheelock and Johnson Orthodontist).

From Roanoke, go up Electric Rd (Rt 419) from Tanglewood mall TOWARDS Salem. Go thru 7 lights. At the 7th stoplight (approximately 2 miles) there will be a Ruby Tuesday on your right. Go THROUGH that light and the next immediate LEFT into Cave Spring Professional Center. (If you get to Rt 221/Bambleton Ave. at the corner with a Sun Trust Bank on your left and a Goodwill on your right, you have gone too far). Once you turn into Cave Spring Professional Center, we are the first building on the left.

ACA COUNSELING SERVICES
3247 ELECTRIC ROAD, SUITE 1-A
ROANOKE, VA. 24018
(540) 772-0690

PATIENT INFORMATION SHEET AND CONSENT FOR TREATMENT

Patient's Name _____ Home Phone: ( ) _____
First Middle Last

Patient's Address: _____
Street City State Zip Code

Patient's Social Security Number: _____ Patient's Birthdate: _____
Patient's Relation to Responsible Party: ____ Self ____ Spouse ____ Child ____ Other
Patient's Marital Status: ____ Single ____ Married ____ Widowed ____ Divorced ____
Patient's Gender: ____ Female ____ Male

Referral Source: _____ Phone: _____
First Last Address
Patient's School/Employer: _____ Phone: _____
Employer's Address: _____ Work Phone: _____
Spouse's Name: _____ Social Security Number: _____
Spouse's Employer: _____ Work Phone Number: _____
Person to Notify in Case of Emergency: _____ Phone Number: _____
Number you Prefer to be Notified of Scheduling Issues/Appointments: _____
Do you wish to be contacted by this office by phone? YES NO

IF PATIENT IS A MINOR, PLEASE GIVE THE FOLLOWING INFORMATION:

Father's Name: _____ Social Security Number: _____

Father's Employer: _____ Phone: _____

Mother's Name: _____ Social Security Number: _____

Mother's Employer: _____ Phone: _____
Parent's Marital Status: ____ Single ____ Married ____ Widowed ____ Divorced
Guardian's Name: _____ Social Security Number: _____
Guardian's Employer: _____ Phone Number: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Policy Number: _____
Insured's Name (if other than patient): _____ Group Number: _____
Secondary Insurance: _____ Policy Number: _____
Insured's Name (if other than patient): _____ Group Number: _____

PLEASE SIGN AND READ THE BACK.

CONSENT FOR TREATMENT

I understand that my insurance policy is a contract between the insurance company and myself. I acknowledge and agree that I am personally responsible for the immediate payment for services rendered in this office. I authorize the release of any information that is necessary to process claims that have been filed with my insurance company, or to obtain further information if required. I also endorse any payments from government benefits (if applicable to me) for services provided to the Clinician. I authorize payment of medical or therapy benefits directly to the Clinician for services rendered.

If a referral is required by my insurance company to pay for services provided, it is my responsibility to obtain the document. Otherwise, I will be financially liable should my insurance company deny these services. Should provided services extend beyond the services authorized by my carrier, I will be responsible for the balance due.

APPOINTMENTS CANCELLED WITHIN LESS THAN 2 BUSINESS DAYS OF MY SCHEDULED TIME WILL BE BILLED DIRECTLY TO ME FOR THE FULL FEE OF THE SCHEDULED APPOINTMENT.
There are certain circumstances that if mutually agreed upon, may result in waiving of the missed appointment fee. This can be discussed with my Clinician in my next scheduled appointment.

We accept payments in cash, personal check, money order, and major credit cards. Unfortunately, we cannot accept post-dated checks. Returned checks are assessed a $35.00 processing fee to cover related accounting and banking expenses incurred to us.

_____ _____

Patient's Signature (or Parent, if minor) Date

If I am a Medicare participant, I request that payment under the Medicare Insurance Program is made on my behalf to the Clinician for any services rendered by the Clinicians therein. I authorize any holder of medical information about me to release Medicare and its agents any information needed to determine those benefits of the benefits payable for related services.

_____ _____

Beneficiary's Signature (For Medicare clients only) Date

PAYMENT IS EXPECTED AT THE TIME OF SERVICE. If you choose to use an insurance company for partial reimbursement, please be aware that your contract is between you and your insurance company. We cannot guarantee your insurance coverage or benefits. You remain financially responsible for these charges. We do require completed insurance information and a copy of your insurance card to verify benefits. We ask that you preauthorize any treatment with your insurance carrier and/or physician, and we will also contact your insurance company to verify authorization. We will file primary insurance claims for you. We do require payment in full at the time of service for co-payments, deductibles, and any charges not reimbursed by your insurance carrier. OUTSTANDING CHARGES OVER 60 DAYS WILL BE ASSESSED WITH A FINANCE CHARGE OF 1.5%. Failure to make payments in a timely manner may result in the use of a collection agency with your account. Be aware that this situation will affect your credit report and your ability to receive these services in the future. If you are having difficulty with payment and would like to discuss a payment plan, please contact our office manager. Some therapists do accept credit cards for your convenience. We ask that you make out your check in the name of the provider with whom you are working. Please discuss any questions about these policies with our staff.

RELEASE OF INFORMATION:

Information regarding our clients is treated as strictly confidential. We will not release any information without specific written authorization as mandated by HIPPA requirements, except for the following reasons:

1. In case of suspected child abuse or abuse/neglect of a disabled adult, we are legally mandated to report it to the proper authorities.
2. When a client is judged to be a serious threat to himself/herself or others, the clinician has the legal responsibility to report the threat to the appropriate person.
3. We must comply with a court order for the release of records.
4. In the event of a crisis during the absence of your therapist, it may be necessary for other clinicians to have access to your records in order to assist you in the best possible manner.
5. In some instances, your insurance carrier may require diagnostic and/or treatment information before authorizing services and providing reimbursement. We will release that information to them with your written permission. Be aware that we no longer have control of the confidentiality of that information, once it has been released from our office. If you prefer to not have that information released, you must inform us of your wishes in writing. Should your insurance carrier fail to authorize or reimburse services, you remain responsible for the fee for services. Verbal/telephone requests for release of confidential information will not be filled.

DEPENDENT CLIENTS:

Please be aware that we require written permission from the legal guardian of a minor to provide services to this minor. If there is joint legal custody, we must have the signature of both guardians. We cannot provide treatment without theses signatures. The parent bringing the child for treatment will be required to sign all forms and will be held responsible for ALL financial charges, regardless of any financial arrangements made between the parties. Parents must also be aware of our policy regarding confidentiality. As the therapist of a child it is most important that we create a trustworthy atmosphere and provide this child with complete confidentiality. Parents, however, do have the right to information concerning the treatment activities and progress of treatment with the child. In addition, the courts of Virginia have judged that non-custodial parents have the right to receive information concerning the child's psychological status. Because this is a delicate issue, please discuss any of your concerns about confidentiality prior to treatment.

EMERGENCY SITUATIONS:

In the event of an emergency, please contact our office immediately to speak with the secretary or leave a voice-mail message for your therapist. Be aware that our phone system is not a 24-hour crisis line, and your message may not be received until the next working day. If this is a life-threatening emergency, you will need to proceed to the emergency room of your local hospital. You may also contact a 24-hour crisis line

(RESPOND: (540 776-1100 or CONNECT: (540) 981-8181). Please be as specific as possible when leaving a message with our office, including where and when you may be available for a return call.

LETTERS:

Letters and reports to be written at the request of the client will be charged to the client. This includes family leave forms, Homebound Instruction forms, and disability forms. This payment must be received prior to the mailing/faxing of this document.

TELEPHONE CONSULTATIONS:

We understand that important issues may arise between sessions. If at all possible, we request that you bring these issues directly into the therapy session, where we might address them with sufficient time. Please reserve your calls between sessions to emergencies or urgent situations. Due to the volume of phone calls, please understand that we must return them on a priority basis throughout the week. Phone consultations over 15 minutes in length will be charged to the client (see fee schedule).

COPYING POLICY:

If you, or someone on your behalf, request the copying of your records or a specific document, we require your WRITTEN authorization for the release of these records. Please check the fee schedule for the charges for this service. The client is responsible for these charges and must pay prior to the release of these records.

COURT APPEARANCE POLICY:

While our priority is to treat your psychological needs within the therapy session, occasionally your records or your therapist may be requested or subpoenaed to court on your behalf. Be aware that the charges for court appearances or legal consultations will be billed directly to the client. Insurance companies will not reimburse these charges. Charges will include the time preparing and spent in court, time away from the office, as well as mileage and parking fees.

PAYMENT FOR DAMAGES TO THE FACILITY:

Clients and parents are financially responsible for any damages to our facility or its contents. Please help us in maintaining a clean and orderly environment for your comfort.

QUESTIONS OR CONCERNS:

If you have any questions or concerns about these policies, please speak with your therapist or our secretary as soon as possible. We welcome all feedback and suggestions for improvement with our services.

Please sign below that you have read, understood, and accept the above policies.

_____	_____
Client's Printed Name	Date
_____	_____
Client's Signature	Parent/Legal Guardian Signature

2. REVOKING AUTHORIZATION

You may revoke this authorization at any time, in writing, except to the extent that your provider or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

3. YOUR RIGHTS

Following is a state of your rights with respect to your protected health information:

Inspect and Copy: Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Right to Request Restriction of your PHI: This means that you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If the provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Health Care Professional.

You have the right to request to receive confidential communication from us by an alternative means or at an alternative location. You have a right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e., electronically).

You have the right to have your provider amend your PHI. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, of your PHI. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and became effective on/before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please speak with our HIPAA Compliance Officer in person or by phone at our office phone number.

Signature below is only acknowledgment that you have received this Notice.

_____ _____

Client Printed Name Client/Parent or Legal Guardian Signature

_____

Date

ACA COUNSELING SERVICES

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ROANOKE, VA. 24018

(540) 772-0690

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by the law. It also describes your rights to access and control your own protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services, to you, to pay your health care bills, to support the operation of the physician's practice, and other uses required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or treatment services may require that your relevant protected health information be disclosed to the health plan to obtain approval for the services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review actions, training of students, licensing and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician/provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use your protected health information, as necessary, to contact you to remind you of your appointment.

We may use your protected health information in the following situations without your authorization. These situations include: Public Health Issues as required by the law; Communicable Diseases; Health Oversight; Abuse or Neglect; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; Inmates. Required Uses and Disclosures: Under the law, we must make disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted Uses and Disclosures: Will be made only with your Consent, Authorization, or Opportunity to Object unless required by law.

ACA COUNSELING SERVICES

3247 ELECTRIC RD., SUITE 1-A

ROANOKE, VA 24018

NAME OF PATIENT:_____

DATE OF BIRTH:_____

APPOINTMENT NOTIFICATIONS

We welcome you to ACA Counseling Services. As part of your involvement in professional services with us, we provide "courtesy reminders" of your scheduled appointments. This form indicates the means by which our office will provide you the "courtesy reminder." We will provide such reminders by electronic communication via our EHR. If you do not wish to receive such reminders in this format, you will be responsible for attendance at the scheduled appointments and will accept responsibility for any fees incurred due to late cancellations and/or not showing for appointments.

I agree to email reminders via EHR _____ (initials)

Email to be used: _____

Any changes in the manner of contact or email address are **your** responsibility and must be presented in writing and signed by you to our Office in a timely manner. We will continue with the designated approach and email if changes are not communicated to us in this manner. Your signature on this form indicates your permission for ACA Counseling to communicate with you in this manner.

_____

Signature

_____

Date

New Client Intake Form - Nutrition Counseling

Tina Renick, RD, CSP
Nutrition Counseling
ACA Counseling
3247 Electric Road, Suite 1-A
Roanoke, VA 24018
(540) 772-0690

Today's Date: _____/_____/_____

Name: _____ Age: _____ DOB: _____/____/_____

Phone: (H) _____ (W) _____ (Cell) _____

Address: _____

City: _____ State: _____ ZIP: _____

Email: _____ May I email you? ____ Yes ____ No
*Please note email correspondence is not considered a confidential medium of communication.

Marital status: _____ Who lives in your household? _____

Highest level of education: _____

Employer: _____ Occupation: _____ # Hours/week: _____

Are you a student? _____ If so, name of school: _____

Name of primary care physician: _____

What issue(s) have led you to seek nutrition counseling at this time? _____

_____

_____

What goals do you have for nutritional counseling? _____

_____

List any chronic medical problems: (examples include diabetes, heart disease, hypertension, gastrointestinal disorders, etc)

_____

_____

Do you have any food allergies or intolerances? _____ If yes, please list: _____

_____

Do you have any religious food restrictions? _____ If yes, please list: _____

Are you a vegetarian? _____

List any current medications you take regularly, including over-the-counter:

_____

_____

List all vitamins, herbal or other dietary supplements: _____

_____

Are you following a special diet at this time? ____Yes ____ No

If yes, please indicate the diet and why: _____

Current Weight: _____ Height: _____
Highest adult weight: _____ Age? _____ Lowest adult weight: _____ Age?: _____

How do you presently think of yourself:
_____ underweight _____at your normal weight ____ moderately overweight ____ very overweight

Do you have an eating disorder/disordered eating? _____

If yes, please describe eating disorder history: _____

_____

Do you:
Diet: _____ How often? _____
Binge: _____ How often? _____
Vomit: _____ How often? _____
Restrict: _____ How often? _____
Avoid certain foods: _____ Which foods? _____
Use laxatives: _____ How often? _____
Use diet pills: _____ How often? _____
Smoke: _____ How many cigarettes each day? _____
Drink alcohol: _____ How often/amount? _____
Use recreational drugs: _____ How often? _____

Do you currently exercise? _____ How often? _____
Type of exercise you enjoy: _____

Describe your meal pattern each day:

____ 3 meals/day _____ sometimes skip meals ____ snack/graze throughout the day
____ night-time eater _____ eat in private/when no one else is around
Who does the grocery shopping? _____ Cooking? _____
How often do you eat away from home each week? _____
Check all that apply: I am an emotional eater._____ Which emotions? _____
I mindlessly snack.____ I am always hungry.____ I forget to eat.____ I eat when I am bored.____ I eat to the point of being stuffed.____ I limit my food quantities.____ I rely on convenience foods.____ I travel often. ____
Sleep Habits:
How many hours per night do you sleep? _____ What time do you go to bed? _____ What time do you wake up? _____ Do you have sleep apnea? ____ Do you awaken at night? _____ If yes, how many times? _____

Physical and Psychological Complications
Please check all that apply:

Physical:
_____changes to hair, skin, or nails
_____menstrual irregularities
_____fatigue, lethargy
_____headaches
_____osteoporosis
_____electrolyte imbalance
_____tingling/numbness
_____heart irregularities
_____delayed stomach emptying
_____bloating, gas, stomach pain
_____reflux
_____dental problems
_____dehydration
_____constipation
_____diarrhea
_____edema (fluid retention)
_____muscle cramps
other: _____

Psychological:
_____depression
_____suicidal thoughts
_____social anxiety
_____anxiety, panic or panic attacks
_____obsessive compulsive symptoms
_____mood swings
_____impaired concentration & memory
_____difficulties with decision-making
_____social isolation
_____sleep disturbance
_____decreased self-esteem
_____self harm behaviors
_____drug use/abuse
_____poor impulse control
_____anger/irritability
_____family conflict/relationship struggles
other: _____