



Christian Psychological Services, PLLC

55 Meridian Parkway, Suite 103

Martinsburg, WV 25404

(304)260-8808

Welcome to your initial appointment. We are committed to excellence in mental health treatment and counseling and to helping you accomplish the goals for which you sought assistance. Please read the policies below so you clearly understand important facts about your relationship with us. Your signature will be your way of expressing your understanding and agreement with these policies. These documents will become part of your permanent record.

Professionals affiliated with Christian Psychological Services, PLLC are committed to providing quality counseling services, while encouraging clients to freely integrate their faith in the therapeutic process. All professionals affiliated with this counseling service are independent sole proprietors (self-employed) and are not employees or consultants of Christian Psychological Services PLLC.

Treatment: In order to provide quality professional treatment, we depend on you to be a partner in the therapeutic process. We expect change to happen. But change does not come without work. We will work our hardest for you. We expect you to work your hardest for the change you are seeking. To that end, please welcome and expect the following: 1) your willingness to actively work on the treatment issues and goals; 2) attend all scheduled appointments; 3) complete written homework assignments as given.

Confidentiality: Clients are provided confidential treatment as protected by the legal code of the State of West Virginia. Exclusions are listed of a separate page for you to review.

Fees: *You will be expected to pay for each session at the time it is held*, unless you provide 24 hour advanced notice of your cancellation. If a payment is not made on your account within 30 days, you will receive a past-due invoice notification. If payment is not made within 30 days of the notice, *it will be turned over to a collections agency*.

The charges for service is based on the usual, customary, and reasonable fees for the area. This fee includes the cost of our time, expertise, billing for services, and record keeping.

90 Minute Initial Session	\$300
50 Minute Follow-up Sessions.....	\$200

Missed Appointments: When an appointment is scheduled, we make arrangements to meet with you a high priority. The appointment time is reserved for you *only*. It is expected that you will attend the appointment. You will be responsible to pay for the session unless arrangements are made *48 hours in advance* of your scheduled appointment. Insurance companies will not pay for missed appointments. Payment for the missed session is due at the next regular session. Extenuating circumstances may be discussed with us. If two or more sessions are missed without giving us 48 hours' notice, we reserve the right to terminate treatment with you either by letter or phone call.

If your therapist must cancel an appointment due to extenuating circumstances, he/she will extend the same courtesy to you, with a 48-hour notice.

Telephone Contact: Cancellation calls can be received by the office voicemail system at any time of the day or night by calling (304)260-8808. Telephone calls will be returned as promptly as possible, although depending on the time of your message, it may not be the same day. Telephone coverage during our vacation/holidays may be limited, but will be discussed as needed.

Emergencies: If an emergency occurs and we are not able to be reached, please contact your local 911 and/or proceed to the nearest emergency room. You may also call: **City Hospital's 24 Hour Mental Health Service at (304) 263-1230 or East Ridge Health Systems at 304-263-8954.**

Insurance Reimbursement: If you are using health insurance, we will make every effort to contact your insurance carrier in advance to verify your eligibility, number of sessions authorized, deductible amount, and co-pay amount. *However, verification of eligibility is not a guarantee of payment. Benefits cannot be determined until a claim is received by your insurance company.* As a result, there may be times when there is a balance owed after your carrier reimburses for services at an amount lower than what was initially quoted. In that case, **you are responsible for the remaining balance owed.**

Within this packet, is an “Authorization for Release of Confidential Information.” This form will give Christian Psychological Services, PLLC, your written permission to send information, such as your dates of service, to your insurance carrier for submission and billing processes.

I have read the above pages and understand its contents. I hereby consent to treatment. I understand the financial responsibilities for treatment. I will be given a copy of these policies and procedures upon request.

Your signature

Date



General Information

Name: _____

Address: _____

Street

City

State

Zip

Referred By: _____ **May I Thank The Person Who Referred You? Yes/ No Initials:** _____

Home Phone: (____) _____ **Work Phone:** (____) _____ **May We Contact You at Work?** __Yes or __ No

Cell Phone (____) _____ **Email:** _____

Preferred Contact Method? _Home _Cell _Work _Email

Special Instructions For Leaving a Message: _____

Birth Date: _____ **Social Security Number:** _____

Primary Physician: _____

Emergency Contact: _____ **Phone:** _____

Household Members:

Name Date of Birth Relationship

Name Date of Birth Relationship

Name Date of Birth Relationship

***List Additional Household Members on Reverse Side**

Please List All Medications You Are Currently Taking:

Signature

Date



Initial Appointment Questionnaire

Reason For Your Visit:

-In 2-3 sentences, please describe the primary reason for your visit:

-In 2-3 sentences, what are you hoping to get through counseling?

Medical/Mental Health History:

-Please list any active medical or mental health conditions you are being treated for:

-Please list any medications you are currently taking:

-Who is prescribing them?

-When was your last visit with a physician?

-Please list the approximate dates of previous counseling:

-Have you ever attempted suicide? Yes No

Social History

-How many brothers and sisters did you have growing up?

-How many step or half siblings did you grow up with?

Please circle the answers to the below questions. (Circle all that apply):

-You grew up in a:	Stable Home	Two Parent	Single Parent
	Chaotic Home	Abusive Home	Loving Home
	Home with a Widow/er Parent		

Initial Appointment Questionnaire

(2)

-How would you describe the relationship with your father?

-How would you describe the relationship with your mother?

-Describe your progression in school (circle all that apply):

Progressed normally through all grades

Graduated High School

Quit School

Repeated a grade

-Soon after High School you (circle all that apply):

Entered the workforce

Attended college/trade school

Married and Settled down

Mix work and trade school/college

-Are you in a committed relationship? If yes, how long?

-On a scale of 0-10 with 10 being "great", how would you rate your relationship?

-How many times have you been married before?

-Please list your current employment:

-How many places (approximately) have you worked in the last 10 years?

Alcohol and Drug Use

-Do you drink alcohol? Yes No

-Do you or have you used any kind of illicit drugs? Yes No

(If no to the 2 questions above, please skip to the next section.)

-How much do you drink on each occasion?

-How many times per month do you drink?

-Has anyone ever suggested you cut back on your drinking or drug use? Yes No

-Have you ever become angry with someone suggesting you drink or drug too much? Yes No

-Have you felt guilty over how much you drank or used? Yes No

-Have you found yourself wishing for a drink or drug at the beginning of your day? Yes No

Emotional History

-What words would describe your mood, for the most part, over the past 2 weeks?

-Do you find yourself being fairly stable in your mood, or does your mood often jump around?

Spiritual Life

-Describe briefly your faith and if or how it plays a role in your life.



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Jonathan M. Hartiens, Ph.D.

Hannah Stewart, LGSW

Marlena Pique, LCSW-C

Gregory Finch, MSW, GSW

Timothy Teague, Ph.D.

Licensed Psychologist

Licensed Graduate Social Worker

Licensed Clinical Social Worker

Clinical Social Worker

Licensed Professional Counselor

Authorization for Release of Confidential Information

I, _____ (print your name), give permission to have information shared TO and FROM Christian Psychological Services with my insurance company for the sake of billing and receipt of reimbursement of services.

My insurance carrier is : _____ (Name of Insurance Company)
and my Member ID is:

Information released to, or provided from, include the following:

- Dates of prior treatments
- Diagnoses
- Type of service (initial evaluation, individual therapy, family therapy, etc.),
- Course and Response to Treatment.

I understand that my records are protected under state and federal confidentiality regulations and cannot be released without my expressed written consent unless otherwise provided for in HIPPA regulations. I also understand that I may revoke this consent at any time, in writing.

I understand that this consent will remain open as for one year post termination of treatment to allow for all claims and billing processes to be closed out.

Client Signature

Date



Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may request includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client Signature (Client's Parent/Guardian if under 18)

Today's Date



Policies

Revised October 2022

_____ Initial **No Show/Late Cancellation Policy**

If for any reason, you are not able to keep your appointment, please give at least **48 hours notice**. This will enable another person who is waiting for an appointment to be scheduled at that time. Anything less than a 48 hour notice does not allow us to offer the appointment to someone else. **All no show and late cancellations will be charged a \$200 fee that is the sole responsibility of the patient and must be paid before your next appointment.**

_____ Initial **Form and Letter Fees Policy**

Forms and letters that are needed to be filled out by our providers will be charged based on the amount of time that is required to complete the paperwork. The base fee will be **\$50 for every 15 minutes**. *We are able to file these claims to your insurance; however, if they are denied, this will become your responsibility.*

_____ Initial **Phone Consult/Emergency Call Fee Policy**

Phone calls that our clinicians are asked to make on your behalf or for any call that interrupts another client's session will be charged based on time, as well. This fee will also be **\$50 for every 15 minutes** he/she spends on the phone call. *This fee, unfortunately, cannot be submitted to your insurance; therefore, this will be the client's responsibility.*

_____ Initial **Social Media**

To support and sustain our objectivity in treatment, all staff are prohibited from becoming "friends" with or "followers" of clients on any social media site including, but not limited to Facebook, Twitter, Instagram, SnapChat, etc.

_____ Initial **Texts and Emails**

Should your treatment warrant follow up with you via texts or emails, please know all messages are considered part of your clinical record and subject to review equally as your medical records.

Client Signature

Date