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. There are some exceptions that pre-empt confidentiality. These exceptions include:

a. I am required to notify relevant others if I determine that a client has an intention to harm his or her own self, or another individual(s).
b. I am obligated by law to report any incident of suspected abuse, neglect, or molestation to any child, elderly, or disabled person.
c. In legal action, I or my records may be ordered by the court.
d. If you authorize in writing to waive your right to confidentiality (i.e., when you authorize me in writing to release information to specific agencies or people).

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 …….$250

50 Minute Follow-up Sessions…….$180

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 *24 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 me. If two or more sessions are missed without giving me 24 hours' notice, I reserve the right to terminate treatment with you either by letter of phone call.

If your therapist must cancel an appointment due to extenuating circumstances, he/she will extend the same courtesy to you, with a 24-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 that 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 and 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: _____

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

-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. *Licensed Psychologist*
Rachel Weiman, Psy.D. *Licensed Psychologist*
Marlena Pique, LCSW-C *Licensed Clinical Social Worker*

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)

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

CHRISTIAN PSYCHOLOGICAL SERVICES
55 Meridian Pkwy, Ste 103 ● Martinsburg, WV 25404 ● 304-260-8808

Policies

Revised March 2016

_____ No Show/Late Cancellation Policy

Initial

If for any reason, you are not able to keep your appointment, please give at least **24 hours notice.** This will enable another person who is waiting for an appointment to be scheduled at that time. Anything less than a 24 hour notice does not allow us to offer the appointment to someone else. ***All no show and late cancellations will be charged a $180 fee that is the sole responsibility of the patient and must be paid before your next appointment.***

_____ Form and Letter Fees Policy

Initial

Forms and letters that are needed to be filled out by our clinicians will be charged based on the amount of time that is required to complete the paperwork. The base fee will be **$45 for every 15 minutes**. *We are able to file these claims to your insurance; however, if they are denied, this will become your responsibility.*

_____ Phone Consult/Emergency Call Fee Policy

Initial

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 **$45 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.*

_____ _____

Client Signature Date