



Adult Background Information

Thank you for taking the time to complete this form and bringing it with you to your initial appointment. The information you provide will enable your therapist to have a better understanding of your concerns and will help your evaluation and/or treatment.

Today's Date: _____

Name: _____ Age: _____
Last First Middle

Date of Birth: _____ Sex: _____ Gender: _____

Religion: _____ Race/Ethnicity: _____

Home Address: _____

College Address: _____
If applicable

Home Phone: _____ Cell Phone: _____

Email address: _____

We have an automated reminder system regarding your appointments. Do we have permission to:

Text reminder to cell phone: Yes No Leave voice mail on home #: Yes No

Email a reminder: Yes No

Emergency Contact: _____ Phone: _____

Spouse/Partner's Name: _____ Age: _____

What is your highest level of education completed? _____

Occupation: _____

Employer: _____ Work Phone: _____

Name of Primary Care Physician: _____ Phone: _____

Date of your last medical evaluation: _____

Referred by: _____ Phone: _____

REASON FOR REFERRAL:

Please list your presenting concerns. If you are requesting a psychological evaluation, please let us know what questions you hope to have answered by this evaluation.

Attempted Solutions:

Please list the members of your family and others living at home:

<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Occupation</u>	<u>Highest Grade Completed</u>
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Please list any other significant family members who are not living with you:

<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Occupation</u>	<u>Highest Grade Completed</u>
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Please note if there have been previous marriages, divorces, or if there have been any deaths in your immediate family.

Please list schools you attended:

School name: City/Location: Dates Attended: Graduated/GED?

When you were in school, were you ever retained, or did you skip a grade? Yes No

If yes, please explain. _____

Did you ever received Special Education services or have an IEP through school? Yes No

If yes, what services? _____

Please list your current and past 5 years job history:

Place of employment: Type of work: Dates:

Other medical or mental health professionals currently or previously consulted:

Name Date: Phone # and Fax #

If you have reports, treatment summaries, or other documents from these professionals, please bring copies with you.

Please describe your medication history:

Medication Dosage Start/Stop Date Prescribed by Whom

Please note any previous psychological evaluations:

Date Tests Given/Type of Evaluation Reason for Referral Examiner

Please bring copies of any previous psychological evaluations.

Please list your greatest strengths:

Please list your greatest sources of stress:

Please tell us anything you think might be important for us to know about you, your family, or any exceptional circumstances that might directly or indirectly affect you:

What do you hope to accomplish by participating in treatment and/or an evaluation at this time?

Is there anything else you would like for us to know about you?

PERMISSION FOR TREATMENT

This form was completed by: _____

I have reviewed the above information. I agree to undertake therapy/evaluation with Partners in Parenting, PC. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me, and agree to the terms specified. I understand the limits to confidentiality required by law. A copy of the informed policies and procedures is available at www.piprva.com, through paper copy in lobby or directly available upon request.

Client's signature: _____ Date: _____

Client's printed name: _____

Permission for Email and/or Text Message Communication

Email and text messaging allow Partners in Parenting therapists to exchange information efficiently for the benefit of our clients. At the same time, we must recognize that email and text messaging are not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or during transmission.

If you give signed permission for us to send you email and/or text messages about appointments and scheduling, please complete and sign this Consent below. You are not required to authorize the use of email and/or text messaging and a decision not to sign this authorization will not affect your health care in any way. If you prefer not to authorize the use of email and/or text messaging, we will continue to use U.S. Mail or telephone to communicate with you.

Signature: _____ Yes, Cell Phone Yes, Email No, Decline All



PARTNERS
IN PARENTING

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Payment Policy

We are happy that you have chosen Partners in Parenting, PC (PIP). The following Payment Policy is written in order to clarify in advance our policies regarding payment for services and provide us with an opportunity to answer any questions you may have. Payment is required at the time services are rendered, unless other arrangements have been made in advance. This includes applicable coinsurance, co-payments and outstanding account balances. Partners in Parenting (PIP) accepts cash, personal checks and credit cards. Please bring your insurance card to your first appointment. There is a \$35 service charge for returned checks and no additional appointments will be scheduled until your balance is paid in full.

Your insurance policy is a contract between you and your insurance carrier. PIP is not a party to that contract. We are happy to bill participating insurance companies as a courtesy to you. Nevertheless, you are responsible for payment regardless of your insurance company's decision to deny coverage or reimburse less than the allowable charge. It is your responsibility to contact your insurance company prior to the first appointment to verify coverage.

Your insurance company contract determines the amount of your co-pay and other patient responsibilities. Co-payment/co-insurance amounts are not always clearly indicated on your insurance card. It is your responsibility to know whether or not you have a co-pay/co-insurance and to pay it at the time of service. If our staff does not "ask" you for your co-pay/co-insurance amount or if your co-pay/co-insurance is not clearly indicated on your insurance card, this is not considered a waiver of your contractual requirement with your insurance company to pay this fee nor is it to be construed as our waiver of acceptance of your co-payment at the time of service. If you are unsure, please check with your employer or call your insurance. Additionally, you are responsible for notifying your therapist of any changes in your insurance coverage.

If you do not have health care benefits or have insurance by which your PIP clinician is not an in-network provider, you are required, and you agree to pay at the time of service all charges as well as any outstanding balances and delinquent accounts.

If we have not received the payment from your insurance company within 60 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges. Questions regarding nonpayment by your insurance company should be directed to your insurance company.

You will be billed monthly for all unpaid balances deemed by PIP or your insurance company to be your responsibility. You are responsible for paying the bill in full unless special arrangements have been made in advance. Delinquent accounts may be turned over to a collection agency at which time you agree to be responsible for collection charges and all associated legal fees in addition to the amount owed.

I have read the Partners in Parenting Payment Policy, had sufficient time to be sure that I considered it carefully, asked any questions I needed to, and understand it. I understand I am ultimately responsible for my bill even if I am using insurance or another third-party payor. I understand that PIP may refuse treatment if I do not remain current in payments for therapy services.

Patient Name (print)

Signature

Date

Credit Card Payment

It is necessary that a credit card number is kept on file with Partners in Parenting through our HIPAA-compliant and secure KASA billing program to cover any fees incurred that you are not able to cover at the time of your visit such as co-pays, items not covered by your insurance, or if you do not show for a scheduled session. This credit card will be charged at the end of each month for any outstanding bills that are not in process with the insurance company or that have exceeded the 60-day time period with the insurance company. A receipt for any transaction is available upon request.

Credit card type: _____ Number: _____ Exp Date: _____ CVV #: _____

Billing address (if different from above): _____

Acknowledgement

I have read the above statement, had sufficient time to be sure that I considered it carefully, asked any questions I needed to, and understand it. I understand I am ultimately responsible for my bill even if I am using insurance or another third-party payor. I authorize use of my credit card for any balances to my account with Partners in Parenting, PC such as no shows for appointments, non-payment of any session fees, or any other fees not covered by insurance if I am using insurance for my bill.

Patient Name (print)

Signature

Date

Financial Arrangements

Our fees are listed below and vary according to the type and length of service provided. PIP will file claims only with those insurance companies for which we are participants. Fees for therapy and testing not covered by insurance will need to be paid in full at the time of service. Our specialized services and evaluations will require agency or community funding. If you need a claim form to file with your insurance company, please let us know. Partners in Parenting accepts VISA, Mastercard, American Express, Discover, personal checks, and cash at the time of service.

Standard fees:

Initial Clinical Appointment	\$175
Initial Clinical Appointment - Couple	\$200
45 Minute Therapy Session	\$125
60-70 Minute Therapy Session	\$150
Family Therapy Session	\$175
90 Minute Couple Therapy Session	\$180
Psychological Testing	\$150/hour
Court/Legal Testimony	\$300/hour
Extended Case Management	\$75/hour

Note: \$75.00 will be charged for a missed 45-60 minute session and per hour for missed psychological testing sessions and \$150 for a couples therapy sessions.