# Sophrosyne Counseling Services, LLC

North Chesterfield, VA 23234 Office # (631) 745-3778

| **Referral Source:** |
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*"Finding True Happiness Through Self-Awareness"*

## Screening Form

| Client Name: | Date of Contact: |
|---|---|
| Address: | Phone Number: |
| Social Security #: | Date of Birth: Age: |

| Insurance/Payment Information | Commercial: | Medicaid: | Self-Pay: | Co-Pay: | Sliding Scale: |
|---|---|---|---|---|---|

| Name of Insurance: | Person Responsible: |
|---|---|
| Insurance #: | Member #: |
| Child- Grade level: | Adult- Employer: |

| Parent/Emergency Contact Information Name: | Phone Number: |
|---|---|
| Address: | City, State, Zip Code: |

| Reason for Treatment | Session Type: Group: Individual: |
|---|---|
| Substance Use/Addiction: | Bipolar/Depression: |
| Anxiety: | Family/Relational: |
| Defiant Behavior: | Crisis/Suicidal: |
| Court/EAP/Mandate: | Grief/Trauma: |
| Co-occurring (Physical, Mental): | Other: |

| Coordination of Care Providers | Recent Hospitalization: |
|---|---|
| Physicians Name: | Physicians Number: |
| Psychiatrist Name: | Psychiatrist Number: |

| Working DSM 5 Diagnosis: | Notes: |
|---|---|
| Assessment Date: | |
| Assessment Time: | |

Please send all referrals to Arpinkney294@gmail.com. Thank you so much for all you do!

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## INFORMED CONSENT AND AGREEMENT FOR PSYCHOTHERAPY SERVICES

**Introduction.** This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask any questions that you may have regarding its contents before signing it. You may have questions about your provider, his/her qualifications, nature of the services provided, or anything not addressed here. It is your right to have a complete explanation for any questions you may have now or in the future. Please feel free to ask questions or share any concerns that may arise to allow your provider to better serve you.

**Disclosure of Ownership:** Sophrosyne Counseling Services, LLC is owned by Alayshia R. Pinkney, LPC, CAADC, CSAC, a Certified Substance Abuse Counselor, Certified Advanced Alcohol & Drug Counselor, & Licensed Professional Counselor.

**Sessions:** All sessions are conducted via HIPAA compliant telehealth through a third provider. Psychotherapy sessions may be provided within the home, in accordance with applicable laws and safety.

**Fees:** Self-pay rates for a Licensed Professional Counselor are as follows:
Initial Diagnostic Evaluation – $150.00 per 60-minute therapy session.
Subsequent psychotherapy sessions – $100.00 per 60-minute therapy session.

Sophrosyne Counseling Services reserves the right to periodically adjust service rates. You will be notified of any fee adjustment in advance. Fees are payable at the time that services are rendered. Please ask us if you wish to discuss a written agreement that specifies an alternative payment procedure. Sliding scale and reduced rates are available to those who qualify.

**Appointment Scheduling and Cancellation Policies.** Psychotherapy sessions vary based on the level of intervention needed. On average, sessions are conducted once a week. Consistency is key in successfully addressing difficulties. Please notify us via telephone or email 24 hours in advance if you must cancel a session. Missed appointment or appointments canceled with less than 24 hours' notice will incur a charge of $50.00 for the full fee for that missed session. **Exceptions may be made if you are sick or have an unavoidable emergency.**

**Insurance**. Deductibles, co-insurance and co-payments are your responsibility. They are calculated based on the stipulations of your specific insurance plan.

Please note insurance plans generally limit coverage to certain diagnosable mental conditions, which then become part of your medical record. Also note that you are responsible for verifying and understanding the limits of your insurance coverage.

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**Delinquent Accounts.** You understand that you are responsible for all charges incurred and that services must be paid in full at the time of each visit, unless other arrangements have been made in advance.

**Discussion of Treatment Plan.** Next to your diagnosis, your treatment plan is essential to your success in psychotherapy. Treatment plans are a collaborative effort with you. Your provider will discuss the details of your treatment plan with you early on in treatment. Our primary goal as an agency is to enhance our patients' wellbeing by helping you gain mastery over your thoughts, emotions, and behaviors.

**Confidentiality.** Any information that you disclose is considered confidential and will not be released to any third party without written authorization from you, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to, situations where you pose a threat of serious harm to yourself or someone else; cases involving suspected child, elder or dependent adult abuse; cases in which your provider is court-ordered to testify or produce records; or as outlined in the *HIPAA Notice of Privacy Practices* available on our website and in the waiting room.

**Psychotherapist-Patient Privilege**. Any information that you disclose as well as records created are subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between a therapist and patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If your provider receives a subpoena for records, deposition testimony, or testimony in a court of law, he/she will assert the psychotherapist-patient privilege on your behalf until instructed, in writing, to do otherwise by you or your representative. **You should be aware that you might be waiving the psychotherapist-patient privilege regarding your entire treatment if you make your mental or emotional state an issue in a legal proceeding.** You should address any concerns you might have regarding the psychotherapist-patient privilege with your attorney.

**Patient Litigation**. Your provider will generally not provide records or testimony unless compelled to do so. Should your provider be subpoenaed or ordered by a court of law to appear as a witness in an action involving you, you will be billed a fee of $200 per hour. Billable services include [document] preparation for court, travel time, time spent in court. A written document will be signed by both parties, evidencing your agreement to reimburse Sophrosyne Counseling Services, LLC for total amount.

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**E-mail and Phone Communication.**
Please be aware that phone messages are stored on a password-protected server for up to 30 days, similar to a cellphone server. Please ask if you have questions about this. Please initial the options below that meet your needs. You can change this at any time by informing us in writing:

__ I understand the risks of unencrypted e-mail, and do hereby give permission for Sophrosyne Counseling Solutions to contact me or to reply to me via unencrypted e-mail.
__ I do not wish to receive any treatment-related information via e-mail.

Occasionally, we e-mail newsletters or similar information material. We do not share our lists with anyone. Would you like to receive these? ______ Yes ______ No

**Therapist Availability / Emergencies.** You may leave a message for your provider at any time on the general confidential voicemail at (631) 745-3778. If you wish for your provider to return your phone call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are generally returned within 24 hours during normal workdays (Monday through Friday). **Please understand that Sophrosyne Counseling Services, LLC does not provide continuous 24-hour crisis services. In the event of a mental health or medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance, go to the nearest emergency room, and/or call RBHA CSB at 804-819-4100**.

**Acknowledgement**
By signing below, I acknowledge that I have reviewed and fully understand the terms and conditions of this Agreement. I have discussed such terms and conditions with the provider, and have had any questions regarding its terms and conditions answered to my satisfaction. I agree to engage in tele-health sessions. I agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with my provider. Moreover, I agree to hold my provider free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

______________________________ ______________________________ ____________
Patient Name (please print) Signature of Patient (or authorized representative) Date

______________________________ ______________________________ ____________
Patient Name (please print) Signature of Patient (or authorized representative) Date

I understand that I am financially responsible for payment for all services rendered and that I am obligated to pay all charges denied by my insurance carrier. Any assignment and authorization in no way releases me from said responsibility and imposes no obligation on my therapist to collect money on my behalf.

Name of Responsible Party (Please print) Date

Signature of Responsible Party Date

Consent to Treatment of Minors

This section must be completed by the parent or legal guardian of each child who attends sessions. Some custody agreements require the signatures of both parents for treatment. It is thus our policy to require all documentation to custody, separation, divorce, and foster cases. We may also require the signatures of **both** parents in divorce and custody cases **before** providing services.

**Confidentiality with Minors**

The State of Virginia provides significant confidentiality to minors seeking mental health treatment. One of our aims as a mental health agency is to help minors learn how to communicate openly and directly with their parents. We thus typically involve parents in the treatment process, especially when children are making poor and dangerous decisions and/or are a danger to themselves or other.

I hereby consent to treatment of my child per the terms outlined in this document:

Parent / Guardian Name (please print) Parent / Guardian Signature Date

Parent / Guardian Name (please print) Parent / Guardian Signature Date

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## HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) NOTICE OF PRIVACY PRACTICES

**Effective Date: 11/1/2019**

**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.**

Sophrosyne Counseling Services, LLC is required by law to maintain the privacy and security of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice"). We must abide by the terms of this Notice, and must notify you if a breach of your unsecured PHI occurs. We may change the terms of this notice, and such changes will apply to all information that we have about you. The new notice will be available upon request, at our office, and on our website. The website will always have the most recent version.

Except for the specific purposes set forth below, we will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving us written notice of your revocation.

This information is available on our website in the "HIPAA and Other Forms" section. Please note that this notice is required by Federal law, and the information it contains is mandated by that law. If you have any questions about this notice or how your Protected Health Information (PHI) is used, please contact Sophrosyne Counseling Services, LLC by-telephone at 631-745-3778.

**USES (INSIDE PRACTICE) AND DISCLOSURES (OUTSIDE PRACTICE) RELATING TO TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS DO NOT REQUIRE YOUR WRITTEN CONSENT.** We may use and disclose your PHI without your Authorization for the following reasons:

**For your treatment**. We may use and disclose your PHI for treatment purposes, which may include disclosing your PHI to another health care professional. For example, if you are being transferred to another therapist or additional resources are sought to assist in your treatment, relevant details of your case would be disclosed with the involved providers in the agency.

**To obtain payment for your treatment**. If you use insurance service, we would use and disclose some information from your PHI to bill and collect payment for the treatment and services provided to you.

**For health care operations**. We may use and disclose your PHI for purposes of conducting health care operations pertaining to our practice, including contacting you when necessary. For example, we may need to disclose your PHI to our attorney to obtain advice about complying with applicable laws.

**When disclosure is required by state or federal law**, and the use or disclosure complies with and is limited to the relevant requirements of such law.

**For public health activities**, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

**For health oversight activities**, including audits and investigations.

**For judicial and administrative proceedings**, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

**For law enforcement purposes**, including reporting crimes occurring on my premises.

**To coroners or medical examiners**, when such individuals are performing duties authorized by law.

**For research purposes**, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

**Specialized government functions**, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

**For workers' compensation purposes**, in which we may provide your PHI in order to comply with workers' compensation laws. However, our standard practice is to obtain an Authorization from you in such instances.

**Appointment reminders and health related benefits or services:** We may use and disclose your PHI to contact you to remind you that you have an appointment with Sophrosyne Counseling Services . We may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that we offer.

**CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION AND/OR GRANT YOU THE OPPORTUNITY TO OBJECT TO DISCLOSING YOUR PHI.** Your consent is required for the following:

**Disclosures to Other Providers/Professionals:** Information provided or exchanged with other providers or professionals would require your authorization. However, we may still disclose your PHI if you are a danger to yourself or others.

**Disclosures to family, friends, or others.** Your PHI is not provided to family, friends, employers, or others you have not authorized to obtain your PHI. We will provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

**YOUR PRIVACY RIGHTS:** You have the following rights regarding your PHI:

**The Right to Request Limits on Uses and Disclosures of Your PHI**. You have the right to ask Sophrosyne Counseling Services, LLC not to use or disclose certain PHI for treatment, payment, or health care operations purposes.

**The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full**. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

**The Right to Choose How We Transmit Your PHI to You**. You have the right to ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and we would agree to all reasonable requests.

**The Right to See and Get Copies of Your PHI**. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that we keep about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, **within 30 days** of receiving your written request, and we may charge a reasonable, cost-based fee for doing so.

**The Right to Get a List of the Disclosures We Have Made**. You have the right to request a list of instances in which Sophrosyne Counseling Services, LLC may have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided us with an authorization. We will respond to your request for an accounting of disclosures **within 60 days** of receiving your request. The list we provide you will include disclosures made in the last six years unless you request a shorter time. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable cost-based fee for each additional request.

**The Right to Correct or Update Your PHI**. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that Sophrosyne Counseling Services, LLC correct the existing information or add the missing information.

**The Right to Get a Paper or Electronic Copy of this Notice**. You have the right to obtain a copy of this notice by paper and/or by e-mail.

**Psychotherapy Notes**. We do not keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501. However, we keep a record of your treatment and you may request a copy of such records at any time, or you may request that we prepare a summary of your treatment. There may be reasonable, cost-based fees involved with copying the record or preparing the summary.

**Marketing Purposes**. We will not use or disclose your PHI for marketing purposes. Marketing is defined as receiving financial remuneration for communicating about other businesses' health-related services or products to patients.

**Sale of PHI**. We will not sell your PHI in the regular course of operating our business.

## HOW TO FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you think Sophrosyne Counseling Services, LLC may have violated your privacy rights, you may file a complaint in the following ways:

1. With us. Our address and telephone number are at the beginning of this document.

2. With the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-877-696-6775; or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

We will not retaliate against you if you file a complaint about our privacy practices.

**EFFECTIVE DATE OF THIS NOTICE:** This notice went into effect on November 1,

2019.

# Sophrosyne Counseling Services, LLC

**North Chesterfield, VA 23234**
**Phone# 631-745-3778 Fax# 804-800-9156**

## CONSENT TO RELEASE INFORMATION

I, ___________________________________________________________ authorize:
[Print Full Name of Person(s) consenting to Disclosure or authorizing release of protected health information]

___________________________________________________ of Sophrosyne Counseling Services, LLC

To disclose to: _______________________ Exchange with: _____________________ Obtain from: _______________________

Name of person or agency: ___________________________________________________________________________________

Address: ______________________________________________________________________________________________

The information specified below concerning the treatment of:

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(Print Client's full Name, Date of Birth, and Social Security Number)

Information to be disclosed [check all that apply]:

☐ Treatment Plan
☐ Summary of Services received
☐ Summary of Participation/attendance
☐ Medication(s) Prescribed
☐ Diagnosis
☐ Psychological Evaluation
☐ Progress Notes
☐ Social History
☐ Substance Abuse/Use History
☐ Family/Social History
☐ Legal Status/History
☐ Employment
☐ History/Performance
☐ Urine Drug Screen Results
☐ School Results
☐ Case Closing Summary
☐ Other:

Disclosure may include (check all that apply): ☐ Alcohol and/or Drug Abuse Information ☐ AIDS or HIV related information
☐ Other Infectious Disease (such as TB, Hepatitis, etc.)

Purpose of Disclosure: ☐ Assessment ☐ Follow-up care ☐ Ongoing Treatment ☐ Other[specify]:
_____________________________________________________________________________________________________

As the person signing this consent to Disclosure and Authorization for the Release of Protected Health Information, I understand that I am giving permission for Sophrosyne Counseling Services, LLC to release or obtain and use confidential health information. I understand that treatment, payment, enrollment or eligibility for benefits is not affected by signing this form. I understand that I may refuse to sign this authorization. I also understand that the information disclosed may be subject to redisclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations and may no longer be protected by state law. A copy of this authorization will be included in the client's services (medical) record.

I understand that I may revoke this Consent/Authorization at any time, except to the extent that action has already been taken in reliance on it. I will notify Sophrosyne Counseling Services, LLC in writing of my desire to revoke this Consent/Authorization; my revocation is not effective until delivered in writing to the person in possession of the client's medical records. Unless otherwise revoked, this Consent/Authorization will expire in one year.

_X_______________________________________________________ ____________________________
_ [Client or Representative's Signature] [Date]
****Authorization must be signed by the client.** If the signature is not that of the client, check one of the following:

☐ Client is a minor ☐ Client is unable to sign for the following reasons: _______________________________________________
_____________________________________________________________________________________________________
Basis of Representative's authority to sign Authorization on behalf of the client: __________________________________________

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[Staff Witness to Signature] [Date]

*Note: This information may be protected by federal regulations concerning alcohol and drug abuse patient records (42 CFR, Subchapter A, Part 2), which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or as otherwise permitted by such regulations. These regulations also restrict any use of the information to criminally investigate or prosecute.*