

Client Information Form



Fairfax Office
3921 Old Lee Hwy
Suite 73B
Fairfax, VA 22030

Loudoun Office
44081 Pipeline Plaza
Suite 320
Ashburn, VA 20147

Client Name:	Referral Source:
DOB: Age: Sex:	Marital Status:
Street Address:	Occupation:
City: State: Zip:	Years of Education:
Preferred Phone:	Alternate Phone:
Email:	
<p>*** Please note that general messages may be left at the provided phone number unless you otherwise specify. Email is only used for scheduling appointment unless you otherwise specify. Messages will not include personal healthcare information.***</p>	

Psychiatric Medications: _____

Reason for Seeking Services: _____

Responsible Party/Parent/Guardian (if applicable)

Name:	Relationship to Client:
Street Address:	Preferred Phone:
City: State: Zip:	
Email:	



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Welcome to Finding Solutions Counseling Centers (FSCC). We appreciate your trust and confidence in us. Please take a few minutes to review the following information regarding our policies and procedures. If you have any questions or concerns, please ask your clinician for clarification.

Appointments: Scheduling is done directly with your clinician. Sessions are billed on an hourly basis. A clinical hour is 50-55 minutes. There is 24-hour cancellation policy. Appointments cancelled with less than 24 hours notice are billed at the rate of the session. The receipt will reflect a missed appointment and not a clinical session.

Initial: X _____

Fees and Payment: Fees vary by provider for different types of services and will be discussed with you prior to your session. Additional services such as completing forms, writing treatment summaries, and engaging in phone consultations lasting more than 15 minutes may be billed on a prorated basis based on your clinician's hourly rate.

FSCC does not submit directly to insurance companies, but you will receive a receipt that you can submit to your insurance company for direct reimbursement should you choose to do so. Please be aware that insurance companies vary in the amount of reimbursement that you will receive based on your out of network benefits. We are not a Medicare or Medicaid participating practice. We are not Tricare providers. If you have Tricare insurance, please notify your clinician because there is an additional form that needs to be reviewed and signed.

Payment by cash, check, or credit card is expected at the time of service. Checks should be made out to Finding Solutions Counseling Centers. If paying by credit card, please present your card to your clinician. Once the account information is entered into our billing system, it will be encrypted to protect your personal information.

Initial: X _____

Notice of Privacy: According to the HIPAA Omnibus Final Rule all health care providers and practitioners must maintain the privacy of Protected Health Information (PHI), provide notice of legal responsibilities and privacy practices, and conduct business in accordance with the privacy notice. A copy of our privacy policies is available online and a paper copy is available at both office locations. Please take a moment to review your rights.

Initial: X _____

Confidentiality: All session material is considered confidential with the following exceptions: you authorize release of information by signing a release form; child or elder neglect and/or abuse is suspected; there is foreseeable and imminent danger to yourself or others; or there is a court order for information. FSCC clinicians work collaboratively with one another. Your clinician may consult with professional colleagues at FSCC, who have expertise relevant to your needs. Please note that your receipts will contain the following confidential information: name, procedure codes, diagnosis codes, and dates of service.

Initial: X _____

Social Media: Clinicians at FSCC cannot accept friend or contact requests on Facebook, Linked In, or other social media sites from past or current clients. You and your clinician may use e-mail for administrative purposes, such as scheduling appointments and sending invoices, but please do not send personal or private information to your clinician via e-mail. Written correspondence does get included in client files. Email correspondence and connecting on social media can compromise confidentiality and privacy. It may also blur the boundaries of the therapeutic relationship.

Initial: X _____

Emergency Situations: There is no guarantee that your clinician will be immediately available in the case of a crisis or emergency situation. It is safest to go directly to your nearest medical center or dial 911. If you are able to leave a message for your clinician, he or she will follow up with you within 1-2 business days.

Initial: X _____

Court Involvement: In the event that you request your FSCC clinician to become involved in a forensic matter, there is a fee of \$5000 to cover the costs of preparation time, clearing schedule for court appearances, and travel expenses. The fee is due 2 weeks prior to the court date and is non-refundable even if circumstances change and the clinician no longer needs to appear in court. Your clinician is not a member of any legal team and his or her role is to provide requested information in an unbiased manner. FSCC clinicians do not provide custody evaluations or go to court regarding custody disputes.

Initial: X _____

Psychological Testing (if applicable): Pre-authorization for psychological testing (CPT 96101) is sometimes required. It is your responsibility to check with your insurance company. If pre-authorization is required, please provide your clinician necessary information to complete the form on your behalf. The following psychological testing evaluations are available at FSCC: Psycho-Educational Evaluation (\$2,400), Psychological Evaluations (\$1,800), and Screening Assessments (\$200/hour). Follow-up services such as additional consultations and preparation of additional summaries or reports are billed at the hourly rate of \$200/hour. If you are interested in scheduling psychological testing, please speak to your clinician for further information.

Initial: X _____

Our mission at FSCC is to provide the highest quality care and personal growth opportunities for our clients in a safe, trusting, and compassionate environment. Thank you again for placing your trust and confidence in us. We look forward to developing and maintaining a positive therapeutic relationship with you.

Signature of Client

Date

Signature of Parent or Guardian (if applicable)

Date

Signature of FSCC Clinician

Date

Credit Card Authorization



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By signing below you are granting your permission for FSCC to charge your account(s) for services provided, missed appointments, and appointments not cancelled within 24 hours. If any charges are disputed FSCC is authorized to discuss the matter and submit a copy of this document and a copy of invoices to the responsible party, credit card company, bank, and/or merchant service.

Name of Client: _____

Date Information Provided to FSCC	Name on Card	Type of Card	Last 4 Digits	Expiration Date

Signature: _____

Date: _____