EVALUATION/TREATMENT AGREEMENT

Name: _____ DOB: _____

Spouse Name: _____ Spouse DOB:_____

Probation Officer: _____

Offense Conviction: _____

Address:_____ SSN:_____

_____

Phone: _____

☐ I agree to allow Counseling and Forensic Services to contact me using the above information.
☐ I do not want Counseling and Forensic to contact me using the above information. Please use the following information instead:
Address_____ Phone_____
_____

Who lives in the house with you **(give age of anyone under 18)**

Employer: _____ Work Phone:_____

Position: _____

Job Responsibilities: _____

Who at your job knows about your offense?
_____

List **drugs/alcohol** used in the last five years with frequency and date of last use:

Emergency Contact: _____ Phone: _____

I have been told the limits of confidentiality and that information will be obtained from the Court, Police, Probation Officer, Department of Social Services, Attorney(s), Victim and all others who may have relevant material to share.

I waive the requirements associated with confidentiality between the therapist/evaluator and myself.

I have been told that the material I share in the evaluation will be put in written form and shared with the Probation Office, Department of Social Services (if relevant) and Attorney(s).

I understand that my therapist will give regular updates to my probation officer on my progress in treatment, as well as any other concerns they may have.

I agree to proceed with Counseling and Forensic Services, Inc. for the purpose of evaluation/treatment, understanding the limits of confidentiality and the other aspects outlined above. **I understand I do not get a copy of my evaluation.**

_____ _____ _____
Client Name Signature Date

INTAKE FORM

DATE: _____

NAME:_____ **DOB:** _____

ADDRESS:_____ **SSN:**_____
CITY _____**ST**_____**ZIP** _____
PHONE: _____ **EMPLOYER:**_____
PHONE (WORK)_____

PRIMARY CARE PHYSICIAN:_____ **PHONE:**_____

E-MAIL ADDRESS:_____

SPOUSE NAME:_____ **SPOUSE DOB:** _____
SPOUSE SSN:_____ **EMPLOYER:**_____
PHONE: _____ **PHONE (WORK)**_____

☐ I agree to allow Counseling and Forensic Services to contact me using the above information.
☐ I do not want Counseling and Forensic to contact me using the above information. Please use the following information instead:
Address_____ Phone_____
_____

SUBSCRIBERS NAME:_____
INSURANCE NAME:_____
GROUP #_____
POLICY NUMBER: _____
AUTHORIZATION #_____
CO-PAY AMOUNT: _____
AUTHORIZED # OF SESSIONS:_____
REFERRED BY:_____
I HAVE CALLED FOR AUTHORIZATION: ☐**YES** ☐ **NO**

***Client is responsible for obtaining authorization from insurance companies for appointments. If authorization is not obtained before the appointment, you are responsible for the full fee or penalty, if applicable.**

EMERGENCY CONTACT:_____ **PHONE #** _____

- INFORMATION SHARED IN SESSIONS IS CONFIDENTIAL. ANY INFORMATION RELEASED TO A THIRD PARTY MUST BE AUTHORIZED BY YOU THROUGH WRITTEN CONSENT IN THE EVENT.
- COUNSELING AND FORENSIC SERVICES WILL NOT BE HELD LIABLE FOR COMPLICATIONS RESULTING FROM A CFS BASED REFERRAL.
- COUNSEING AND FORENSIC SERVICES DOES NOT ACCEPT INSURANCE FOR EVALUATIONS.
- COUNSELING AND FORENSIC SERVICES DOES NOT ACCEPT THIRD PARTY PAYMENTS FOR GROUP TREATMENT

_____ _____ _____
Client Name **Signature** **Date**

JUVENILE INTAKE FORM

DATE: _____
CLIENT NAME: _____ DOB: _____
PARENT/GAURDIAN NAME: _____ DOB: _____
_____ DOB: _____

ADDRESS:_____ SSN:_____
_____ PARENT/GAURDIAN SSN:_____

PHONE: _____ EMPLOYER OF INSURED :_____
PHONE (WORK)_____

☐ I agree to allow Counseling and Forensic Services to contact me using the above information.
☐ I do not want Counseling and Forensic to contact me using the above information. Please use the following information instead:
Address_____ Phone_____
_____

INSURANCE NAME:_____
GROUP #_____
POLICY NUMBER: _____
AUTHORIZATION #_____
CO-PAY AMOUNT: _____

AUTHORIZED # OF SESSIONS: _____
REFERRED BY:_____
I HAVE CALLED FOR AUTHORIZATION: ☐YES ☐ NO

EMERGENCY CONTACT:_____ PHONE # _____

PLEASE NOTE THAT APPOINTMENTS THAT ARE NOT CANCELLED WITHIN 24 HOURS WILL BE BILLED. YOU ARE RESPONSIBLE FOR YOUR FEE. YOU ARE ALSO RESPONSIBLE FOR COURT COSTS AND COLLECTIONS FEES IF APPLICABLE. IT IS YOUR RESPONSIBILITY TO CONTACT YOUR INSURANCE COMPANY FOR BENEFITS INFORMATION AND AUTHORIZATION. PLEASE MAKE CO-PAYMENT EACH TIME YOU ARRIVE FOR APPOINTMENT.

INFORMATION SHARED IN SESSIONS IS CONFIDENTIAL. ANY INFORMATION RELEASED TO A THIRD PARTY MUST BE AUTHORIZED BY YOU THROUGH WRITTEN CONSENT IN THE EVENT OF SUMMONS AND/OR SUBPOENAES.

I AGREE TO HAVE THIRD PARTY PAYMENTS TURNED OVER TO COUNSELING AND FORENSIC SERVICES, INC.

_____	_____	_____
Client Name	Signature	Date
_____	_____	_____
Parent/Gaurdian Name	Signature	Date
_____	_____	_____
Parent/Gaurdian Name	Signature	Date

Counseling and Forensic Services, Inc

9324 West Street
Suite 203
Manassas, VA 20110
Phone: (571) 292-1652

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www.cfsvirginia.com

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed by CFS and how you can access this information. Please review this notice carefully.

Understanding Your Protected Health Information (PHI)
When you visit us, a record is made of your symptoms, assessments, test results, diagnoses, treatment plan, and other mental health or medical information. Your record is the physical property of CFS, the information within which belongs to you. Being aware of what is in your record will help you to make more informed decisions when authorizing disclosure to others. In using and disclosing your protected health information (PHI), it is our objective to follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act (HIPAA) and requirements of Virginia law.

Your mental health and/or medical record serves as:
-A basis for planning your care and treatment
-A means of communication among the health professionals who may contribute to your care
-A legal document describing the care you received
-A means by which you or a third-party payer can verify that services billed were actually provided
-A source of information for public health officials charged with improving the health of the nation
-A source of data for facility planning
-A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Responsibilities of Counseling and Forensic Services
We are required to:
-Maintain the privacy of your protected health information (PHI) as required by law and provide you with notice of our legal duties and privacy practices with respect to the protected health information that we collect and maintain about you.
-Abide by the terms of this notice currently in effect. We have the right to change our notice of privacy practices and to make the new provisions effective for all protected health information that we maintain, including that obtained prior to the change. Should our information practices change, we will post new changes in the reception room and provide you with a copy, upon request.
-Notify you if we are unable to agree to a requested restriction.
-Accommodate reasonable requests to communicate with you about protected health information by alternative means or at alternative locations, e.g. you may not want a family member to know that you are being seen at CFS. At your request, we will communicate with you, if needed, at a different location.
-Use or disclose your health information only with your authorization except as described in this notice.

Your Protected Health Information (PHI) Rights

You have the right to:
-Review and obtain a paper copy of the notice of privacy practices upon request and of your health information, except that you are not entitled to access, or to obtain a copy of, psychotherapy notes and a few other exceptions may apply. Copy charges may apply.
-Request and provide written authorization and permission to release information for purposes of outside treatment and health care operations. This authorization excludes psychotherapy notes and any audio/video tapes that may have been made with your permission by your mental health clinician.
-Revoke your authorization in writing at any time to use, disclose, or restrict health information except to the extent that action has already been taken.
-Request a restriction on certain uses and disclosures of protected health information, but we are not required to agree to the restriction request. You should address your restriction request in writing to Dr. Stephanie Hardenburg. We will notify you within 10 days if we cannot agree to the restriction.
-Request that we amend your health information by submitting a written request with the reasons supporting the request to Dr. Hardenburg. We are not required to agree to the requested amendment.
-Obtain an accounting of disclosures of your health information for purposes other than treatment, payment, health care operations and certain other activities for the last six years but not before April 14, 2003.
-Request confidential communications of your health information by alternative means or at alternative locations.

Disclosures for Treatment, Payment and Health Operations

I. CFS will use your PHI, with your consent, in *the following circumstances:*

Treatment: Information obtained by your psychologist/counselor or from a nurse, physician, dentist or other member of your health care team will be recorded in your record and used to determine the management and coordination of treatment that will be provided for you.

For payment, if applicable: The information on or accompanying the bill may include information that identifies you, as well as your diagnosis to obtain reimbursement for your health care or to determine eligibility or coverage.

For health care operations. Members of CFS Administration may use information in your health record to assess the performance and operations of our services. This information will then be used in an effort to continually improve the quality and effectiveness of the mental health care and services we provide.

Disclosure to others outside of CFS: If you give us a written authorization, you may revoke it in writing at any time, but that revocation will not affect any use or disclosures permitted by your authorization while it was in effect. We will not use or disclose your health information without your authorization, except as described below to report serious threat to health or safety or child and adult abuse or neglect.

II. CFS will use your PHI, without your consent or authorization, in the following circumstances:

Child abuse: If we have reasonable cause to suspect that a child known to us in the course of professional duties has been abused or neglected, or have reason to believe that a child known to us in the course of our professional duties has been threatened with abuse or neglect, and that abuse or neglect of the child will occur, we must report this to the relevant county department, child welfare agency, police, or sheriff's department.

Adult and domestic abuse: If we believe that a vulnerable adult (ex. incapacitated or facility resident) is the victim of abuse, neglect or domestic violence or the possible victim of other crimes, we may report such information to the relevant county department or state official.

Serious threat to health or safety: If we have reason to believe, exercising best judgment and our professional care and skill, that you may cause serious harm to yourself or another person, we may take steps, without your consent, to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition in order to protect you or another person from harm. This may include instituting commitment proceedings.

Judicial or administrative proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and we will not release the information without written authorization from you or your personal or legally-appointed representative, or a subpoena/court order. The privilege does not apply when the evaluation/treatment is mandated/court ordered.

As required by law for national security and law enforcement: We may disclose to military

authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information for law enforcement purposes as required by law or in response to a valid court order.
Law/Health oversight: As required by law we may disclose your health information. For example, if the Virginia Board of Examiners of Psychologists requests that we release records to them in order to investigate a complaint against a provider, we must comply with such a request.
Research: We may disclose health information to researchers when a review board has reviewed and approved the research proposal and established protocols to ensure the privacy of your health information. This data is generally de-identified, which means that no one could connect it back to you.
Worker's compensation: We may disclose health information to the extent authorized by you and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law; we may be required to testify.
As required by law for purposes of public health: e.g. as required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
Business associates: There are some services provided to CFS through contracts with business associates. Examples include computer support for our scheduling system and scoring of tests. When these services are contracted, we may disclose your health information to our business associate so they can perform the job we've asked them to do. Business associates are required to safeguard your information.

For More Information or to report a problem
If you have questions and would like additional information, please ask your clinician. He/she will provide you with additional information or put you in contact with the Director of Counseling and Forensic Services, Dr. Stephanie Hardenburg at (703) 492-2994.

If you are concerned that your privacy rights have been violated, or if you disagree with a decision we have made about access to your health information, or if you would like to make a request to amend or restrict the use or disclosure of your health information, you may contact:

Stephanie Hardenburg at Counseling and Forensic Services
13000 Harbor Center Drive
Suite 302
Woodbridge, VA 22192
Phone: (703) 492-2994 Fax: (703) 490-5505

If you believe that your privacy rights have been violated, you can also file a complaint with the Secretary of the U.S. Department of Health and Human Services:

Office for Civil Rights
U.S. Department of Health & Human Services
150 S. Independence Mall West
Suite 372
Philadelphia, PA 19106-3499
(215) 861-4441; (215) 861-4440 (TDD) Fax: (215) 861-4431

This notice may be amended as needed to comply with federal, state and professional requirements. Counseling and Forensic Services respects your right to the privacy of your health information. There will be no retaliation in any way for filing a complaint with us or the U.S. Department of Health and Human Services.

_____ _____
Signature Date

_____ _____
Signature Date

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Informed Consent for Psychotherapy or Other Services

Welcome to Counseling and Forensic Services, Inc (CFS). Thank you for trusting us to assist you with your personal concerns. Please take the time to read and understand this document and ask your therapist about any portions which may be unclear to you.

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices. The accompanying Notice of Privacy Practices explains HIPAA and its application to your PHI in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information before we provide any services. You may revoke this agreement in writing at any time.

Services

The psychological services we provide include individual, couples, and group psychotherapy, as well as psychological testing. Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy calls for an active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what you will experience.

In your first session your therapist will offer you some sense of what therapy will entail and how she or he will work with you to address your concerns. You should evaluate this information and whether you feel comfortable working with your therapist. If you have questions about our procedures, you should discuss them with your therapist whenever they arise. You have the right to ask for the rationale for any aspect of your treatment or to decline any part of your treatment. You also have the right to request another therapist. While we encourage you to discuss your concerns with your current therapist to explore why things may not be working out, you are under no obligation to do so.

If you are here for psychological testing, you have the right to an explanation of what the test or tests being administered are for, and you may decline participation at any time. You also have the right to a summary (which may be either verbal or written) of any test results.

Please note that our office reserves the right to provide referrals for further or more specified treatment. Counseling and Forensic Services accepts no responsibility for any service provided, and the quality of services offered remains the responsibility of the individual practitioner. We therefore will not be held liable for any problems as a result of referrals.

Fees
CFS services vary in price. The self-pay fee for individual, couples, or family counseling is $150 per session. Cash, money orders, or Visa, Discover, and Master Card are accepted. We also use various insurance providers, as well as sliding-scale options. Please see your therapist for special circumstances. Your co-pay is expected at the time of service. Group fees are set prices which are not negotiable, and some groups require money order or cash payment only.

Policies Regarding Appointments
Individual, couples, and family therapy appointments are generally for 50 minutes and are typically scheduled once per week at a time you and your therapist agree on. If you cannot make a scheduled appointment, it is your responsibility to call (703) 492-2994 24 hours prior to your appointment time to cancel or you will be charged $55 for every missed appointment. If you forget an appointment, it is your responsibility to call as soon as possible to reschedule. If you miss your appointment and do not call to reschedule, there is no guarantee your therapist will have another available appointment time.

Therapy groups usually meet once a week for 90 minutes. CFS has several groups for spouses of military personnel, partners of those who are compulsive users of sex (i.e. internet pornography), and adult or juvenile sexual offenders.

Please note that email is not a secure form of communication and is not recommended as a means of contacting your therapist for any treatment-related concerns. Unless your therapist and you agree otherwise, please call to leave any messages. Note that any communication you have with a therapist outside of a regular appointment session may be recorded in your file. Communication could be information shared face-to-face with your therapist, email messages, phone calls, etc.

In an Emergency
In some instances, you might need immediate help at a time when your therapist is not at CFS or cannot return your call. These emergencies may involve suicidal thoughts, thoughts of wanting to hurt someone else, or thoughts of committing dangerous acts. If you find yourself in any emergency situation between 9 AM and 4 PM, Monday through Friday, call to talk with any available counselor. If you are unable to reach someone, please call 911. If for whatever reason that option is not available to you, visit the nearest Emergency Room and ask for the mental health professional on call.

Limits of Confidentiality
The law protects the privacy of all communications between a client and a psychologist. In most situations, we can only release information about your treatment to others if you sign a written authorization form. There are other situations that require only that you provide written, advance consent. Your signature on the accompanying Acknowledgment of Informed Consent to Treatment form provides consent for those activities, as follows:
- We train advanced graduate students from the mental health professions, and also employ counselors who are not yet licensed in Virginia. Licensed Professional Counselors on our staff supervise them, which includes reviewing treatment plans and progress, and signing off on all notes and other documents that go into your permanent file. You have the right to know the name of any supervisor and how to contact her or him; the staff member you meet with will provide this information at the outset.
- Because of our training mission, the staff member you meet with may ask your permission to record sessions for confidential supervisory and training purposes. Audiotapes and videotapes are erased after supervisory purposes are met and at the end of your treatment. Occasionally, tapes and other clinical materials (e.g. test results) may be presented in case conferences or other training seminars for our professional staff.
- Your therapist may also occasionally find it helpful to consult with other CFS professional staff members about a case. If you do not object, your therapist will not tell you about these consultations unless he or she feels that it is important to your work together.
- Finally, we employ administrative staff and we need to share protected information with them for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All staff members have been given training about protecting your privacy and have agreed not to release any information outside CFS without the permission of a professional staff member.

There are some situations where we are permitted or required to disclose information either with or without your consent or authorization:
- If you are involved in a court proceeding and a request is made for information concerning your treatment, we cannot provide such information without your (or your legal representatives) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to

order your therapist to disclose information.
- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
-If a client files a complaint or lawsuit against a therapist, we may disclose relevant information regarding that client in order to defend the therapist.
- If a client files a worker's compensation claim, we must, upon appropriate request, provide a copy of the client's record or a report of her/his treatment.
There are some situations in which the therapist is legally obligated to take actions which she or he believes are necessary to attempt to protect others from harm, and we may have to reveal some information about a client's treatment. If such a situation arises, your therapist will make every effort to fully discuss it with you before taking any action and will limit disclosure to what is necessary.
-If your therapist has reason to believe that a child or vulnerable adult is being neglected or abused, the law requires that the situation be reported to the appropriate state agency.
- If the therapist believes you present a clear and substantial danger of harm to yourself or another/others, he or she will take protective actions. These may include contacting family members, seeking hospitalization for you, notifying any potential victims), and notifying the police.
While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read our Notice of Privacy Practices for more detailed explanations, and discuss with the staff member you meet with any questions or concerns you may have.

If you are seeing a CFS counselor for marriage or family therapy, but decide to meet with the therapist on an individual basis, you may be encouraged to discuss what was talked about in the individual session with the other members, but the clinician is not permitted to disclose any information about individual session to other family members.

Professional Records
The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways in which your problem affects your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment-history, results of clinical tests (including raw test data), any past treatment records that we receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of your Clinical Record, if you request it in writing, except in unusual circumstances that involve danger to yourself and/or others or when another individual (other than another health care provider) is referenced and we believe disclosing that information puts the other person at risk of substantial harm. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. We therefore recommend that you initially review them in the presence of your therapist, or have them forwarded to another mental health professional so you can discuss the contents. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

In addition, your therapist may also keep a set of psychotherapy notes which are for his or her own use and designed to assist your therapist in providing you with the best treatment. They are not routinely released to others with your Clinical Record, except under rare legal circumstances.

Minors
If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. Before giving parents any information we will discuss the matter with you, if possible, and do our best to handle any objections you may have with what we are prepared to discuss.

In Conclusion
Your signature on the accompanying Acknowledgement of Informed Consent to Treatment form indicates you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____

Signature Date

Signature Date

COUNSELING AND FORENSIC SERVICES BILLING POLICIES
EFFECTIVE JANUARY 2015

- PLEASE NOTE THAT APPOINTMENTS THAT ARE NOT CANCELLED WITHIN 24 HOURS WILL BE CHARGED A $55 LATE CANCELLATION/NO SHOW FEE. YOU ARE RESPONSIBLE FOR YOUR FEE. YOU ARE ALSO RESPONSIBLE FOR COURT COSTS AND COLLECTIONS FEES IF APPLICABLE.

- IT IS **YOUR** RESPONSIBILITY TO CONTACT YOUR INSURANCE COMPANY FOR BENEFITS INFORMATION AND AUTHORIZATION. IF YOU ARE USING AN EAP, IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH THE FOLLOWING INFORMATION: NAME OF EAP, AUTHORIZATION NUMBER, EFFECTIVE DATES, NUMBER OF SESSIONS AUTHORIZED, AND PHONE NUMBER. IF THIS INFORMATION IS NOT PROVIDED TO US, WE WILL BILL THE INSURANCE COMPANY ON FILE AND YOU WILL BE RESPONSIBLE FOR ANY COPAYMENT OR COINSURANCE.

- ALL PAYMENTS ARE DUE AT THE TIME SERVICE IS RENDERED.

- SHOULD YOUR CLAIM BE DENIED BY YOUR INSURANCE COMPANY, YOU ARE RESPONSIBLE FOR THE FEE.

- IF BALANCES ARE NOT PAID WITHIN 30 DAYS OF THE DATE OF THE INVOICE, A 2% LATE FEE WILL BE CHARGED TO YOUR ACCOUNT. ANY BALANCE NOT PAID WITHIN 60 DAYS OF THE DATE OF THE INVOICE WILL BE CHARGED A 5% LATE FEE.

- ANY BALANCE UNPAID AFTER 90 DAYS WILL BE SENT TO COLLECTIONS AND AN ADDITIONAL FEE OF $100 WILL BE ADDED TO YOUR ACCOUNT.

- CFS DOES NOT ACCEPT INSURANCE FOR EVALUATIONS.

- COUNSELING AND FORENSIC SERVICES DOES NOT ACCEPT MEDICARE OR MEDICAID.

- I AGREE TO HAVE THIRD PARTY PAYMENTS TURNED OVER TO COUNSELING AND FORENSIC SERVICES, INC.

- FEE FOR COMPLETION OF FORMS, REPORTS AND LETTERS: THIS IS A NON-INSURANCE COVERED SERVICE; THEREFORE, A FEE IS CHARGED FOR THE COMPLETION OF FORMS OR THE WRITING OF LETTERS. THE FEE FOR A ONE PAGE STANDARD FORM OR LETTER IS $20.00. COMPLEX FORMS AND LETTERS THAT REQUIRE MORE TIME IN PREPARATION WILL BE SUBJECT TO A FEE RANGING FROM $25.00-$100.00. ALL FEES ARE DUE PRIOR TO THEIR COMPLETION.

- BY SIGNING BELOW YOU ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND COUNSELING AND FORENSIC SERVICES, INC'S BILLING POLICIES.

_____ _____ _____

Client Name **Signature** **Date**

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No-Show and Cancellation Agreement

In an effort to provide excellent client service to all of our clients, and to provide the best possible therapeutic environment, it is our policy to require a fee for no-show appointments and cancellations made less than 24 hours in advance of the scheduled appointment. *

The fee of $55.00 will be charged to the following credit card: ___ Visa ___ MasterCard

Credit Card #: _____

Expiration Date: ___/___ CCV (Credit Card Verification) _____

Name as it appears on Card:
_____

I _____, understand and agree that if I do not show up for my scheduled appointment or if I cancel my scheduled appointment with less than 24 hour notice, the above named credit card will be charged in the amount of $55.00.

Signature _____ Date_____

Printed Name _____

Address: _____

Daytime Ph.: _____

City: _____ Zip: _____

**Exceptions for emergencies are determined by your counselor; and cancellations made 24hrs prior to your time on Monday appointments must occur on Friday as weekend days do not count.*

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AGREEMENT FOR SERVICES

I AGREE TO RECEIVE SERVICES FROM COUNSELING AND FORENSIC SERVICES. I UNDERSTAND THAT THE HIPPA REGULATIONS APPLY TO MY TREATMENT. SHOULD OTHER FAMILY MEMBERS OR INTERESTED OTHERS PARTAKE IN THE SERVICES OFFERED; I UNDERSTAND THAT THEY WILL BE REQUIRED TO SIGN THIS AGREEMENT.

PLEASE INCLUDE DATE AFTER YOUR SIGNATURE:

_____ _____

_____ _____

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Counseling and Forensic Services, Inc
www.cfsvirginia.com

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Optional CREDIT CARD FORM

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Card member acknowledges receipt of goods and/or services in the amount of the total show hereon and agrees to perform the obligations set forth by the card member's agreement with the issuer. My signature as found grants permission to Counseling and Forensic Services, Inc. for using the provided credit card information in order to pay for services rendered.

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