DUFFY
COUNSELING
CENTER

1487 CHAIN BRIDGE ROAD, SUITE 300
MCLEAN, VIRGINIA 22101
OFFICE: 703.255.1091
FAX: 703.712.8354
WWW.DUFFYCOUNSELING.COM

DCC Insurance Policies

The Duffy Counseling Center does not accept any insurance nor does it participate in network benefits. The Duffy Counseling Center will provide each client with an itemized bill, per client's request, at the end of each month. It is the responsibility of the client to submit this itemized bill to their insurance company for possible reimbursement. By signing this document, you (the client or the guardian of the client) acknowledge and accept the Insurance Policies of the Duffy Counseling Center.

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Name Date

Confidentiality

What is discussed within the therapeutic session is protected under federal confidentiality regulations (42 FCR, Part 2). Confidentiality can be broken if the patient or client gives written consent, in the form of a release of information, for the therapist to exchange relevant information with designated parties. The client or patient has the right to revoke this release of information at any time. Confidentiality may also be broken in situations of harm or danger. If the client or patient is harming self or others, is the victim of harm, or is planning to harm self or others, the therapist has a duty to report. Harm is defined but not limited to physical, sexual, and emotional abuse. For quality assurance purposes, your record may be reviewed by The Duffy Counseling Center for completeness and compliance with the American Counseling Association (ACA) code of ethics. All identifying information will remain confidential. By signing this document, you indicate an understanding of the limits of confidentiality within the therapeutic setting.

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Name Date

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APPLICATION FOR SERVICES

Client's Name:_____

Legal Guardian (for minors):_____

Address: _____**City:**_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Mobile Phone:**_____

Work Phone:_____

Email address(s): _____

Do we have your permission to leave a message for you at the home/work phone # ?
Yes_____ **No**_____

Client's Date of Birth:_____ **Age:** _____ **Marital Status:**_____

Height:_____ **Weight:**_____ **School:** _____

Client or Guardian Occupation:_____

Employment:_____

Client's Education:_____

Client or Guardian's Social Security No.:_____

Who Suggested You Contact Us?_____

List The Members Of Your Family And All Others Living In Your Home:

Name: _____ Age/Birth Date: _____Relationship: _____

Name: _____ Age/Birth Date: _____Relationship: _____

Name: _____ Age/Birth Date: _____Relationship: _____

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Reason for Assessment:

List Any Medication(s), Dosage(s), and Frequency You Are Taking:

Have You Received Psychological Help Or Counseling Previously? If so, where?

List Any Major Health Problems For Which You Are Currently Being Treated:

Do You Have Any History Of Legal Involvement? Yes/No (Please Circle One)

If Yes, Please Explain:

Initial _____

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FOR MINORS

Parent/Legal Guardian, The Duffy Counseling Center is committed to delivering quality service for you and/or your children. Please take a moment to identify any important information or specific issues that you think may be vital to your child's treatment.

Is there anything you think we should know? **Yes/No (Please Circle One)**

_____
_____
_____
_____
_____
_____
_____

Initial _____

Parent/Guardian Signature _____ Date _____

Therapist Signature _____ Date _____

Please note that information discussed within therapy is CONFIDENTIAL. The Duffy Counseling Center is legally and ethically bound to uphold confidentiality at all times except when given written permission to exchange information with designated parties. Confidentiality may also be broken if there is any suspicion or mention of harm within the therapy session. Harm may be defined as physical, sexual, or emotional abuse.

*******The Duffy Counseling Center does not participate with any health insurance policy. Administrative obligations associated with filing insurance claims severely restrict the time available for your care. In most cases, visits are partially or completely reimbursed by your insurance company. In our private practice, less time spent on administrative and billing issues allows more time to be dedicated to your care. Services are tailored to your emotional needs. We are considered out-of-network providers when filing reimbursement claims with your insurance carrier. You will be provided after each visit a fully itemized and coded receipt that can be attached to your insurance reimbursement form*******

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POLICIES AND CLIENT INFORMATION:
The following information is a description of policies concerning appointments and cancellations. Please feel free to discuss these policies or other matters related to the services you receive with your therapist.

CONFIDENTIALITY: The services you receive are confidential, private and personal. Your written permission is required for the release of information **except** in situations of clear and imminent danger to yourself or others, court subpoena, or suspicion of child abuse or neglect and as required by law.

The Duffy Counseling Center also asks that you (the client) refrain from bringing cellular phones or recording devices into all therapy sessions. Should the therapist need to record a session for therapeutic purposes, the appropriate confidentiality paperwork will be presented to you.

APPOINTMENTS: All appointments are scheduled in advance. If you or any members of your family will be late for an appointment please call the office to inform your clinician. If there is no correspondence 15 minutes AFTER the scheduled appointment time, it will be considered a "No Show" and you will be billed for the full 45 minute session.

CANCELLATIONS: Cancellations are by **48 BUSINESS HOURS** prior to your appointment. If an appointment is canceled due to illness or an extenuating circumstance, you will not be charged.

Party Responsible for Payment

Name: _____

Telephone Number: _____

Address: _____

Relationship to Client: _____

It is Duffy Counseling Center policy to have a credit card on file. Your credit card WILL BE charged automatically within 48 business hours of your appointment. Your credit card WILL NOT be charged for cancellations beyond 48 business hours prior to the scheduled appointment. By signing here, you are agreeing to the DCC cancellation policy and to the use of the following credit card for the payment of each scheduled session. Additionally, you are acknowledging that regardless of the therapeutic outcome, you are responsible for the payment of the scheduled services.

Card #:_____ Exp: _____ Sec. Code: _____

Signature: _____ Date: _____

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AVAILABILITY: Your therapist may be reached through a voice mail system or email, which is checked several times throughout the day. We can be reached during work hours at **703-255-1091**. Your call will be returned as soon as possible. If you have an emergency, please call 911 or go to your nearest Emergency Room (ER)**.** If a session is scheduled during weekend hours, it is deemed an "emergency session" and you will be charged $250/45 min. _____ (initial)

TREATMENT FEES: Prior to your initial appointment, fees for the initial assessment ($250/45 min), individual therapy ($185/45 min), and family therapy ($190/45 min) were discussed. Weekend sessions ($190/45 min, Intake $260/45 min) were also discussed. Teletherapy is also offered at the same rates. _____ (initial)

COURT FEES: Preparation for appearances in legal disputes or correspondence with legal representation is $200/45 min. Additionally, lawyer fees for the Duffy Counseling Center are $360/45 min. By signing this form, you are agreeing to pay for court preparation fees and lawyer fees for the Duffy Counseling Center. An invoice for services rendered will be provided for you and legal representation. In addition, you agree that Duffy Counseling Center shall be entitled to recover all reasonable attorney's fees and costs incurred in connection with any lawsuit against you to recover unpaid treatment fees. _____ (initial)

OTHER FEES: In the event a clinician from the Duffy Counseling may be needed to appear and participate in meetings at schools or other locations. Fees for this service are $190/45 min and will include transportation time. Phone conferences may also be scheduled to reduce costs. Phone conferences are $190/45 min. There is also a $190/45 min fee for time spent preparing and writing letters of compliance, treatment summaries, and another other treatment related document. _____ (initial)

COVERAGE: When your therapist is out of town, or otherwise unavailable, you will be notified in advance and the necessary information will also be on your therapist's voice mail recording.

RETURNING PATIENTS: Returning patients are required to schedule a second intake session and pay the correlating fees if it has been more 90 days since their last appointment.

I understand and agree to the above terms:

_____ _____

Client/Patient Signature **Date**

_____ _____

For Duffy Counseling Center **Date**

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AUTHORIZATION FOR CREDIT CARD

CREDIT CARD ON FILE POLICY: we require keeping your credit or debit card on file as a convenient method of payment for services. Your credit card information is kept confidential and secure. Charges to your credit card on file will occur within 48 business hours of your appointment. All cancellations that occur beyond 48 business hours to the scheduled appointment will result in no charges to your card.

Additionally, you are acknowledging that regardless of the therapeutic outcome, you are responsible for the payment of the scheduled services. This authorization will remain in effect until you cancel this authorization. To cancel, you must give a 60-day notification to Duffy Counseling Center in writing and the account must be in good standing.

I agree to the above-mentioned terms and authorize Duffy Counseling Center to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ **Visa** ☐ **Mastercard** ☐ **Discover**

CARD #: _____ EXP: _____ SEC. CODE: _____

SIGNATURE: _____ DATE: _____

CANCELLATIONS: Continuity of treatment is important to your care. Your appointment time is reserved only for you. Please cancel at least 48 business hours in advance between business hours (9amET-5pmET via email AND phone) _____(Your Signature). If your therapist is unable to keep a scheduled appointment, you will be contacted as soon as possible.

APPOINTMENTS: All appointments are scheduled in advance. If you or any member of your family will be late for an appointment, please call the office to inform your clinician. If there is no correspondence 15 minutes AFTER the scheduled appointment time, it will be considered a "No Show" and you will be billed for the full 45 minutes.

Party Responsible for Payment:

Name: _____

Telephone Number:_____

Address: _____

Relationship to Patient: _____

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ATTENDANCE: The Duffy Counseling Center reserves the right to terminate treatment should the Patient remain absent for three consecutive appointments without 48 business hour cancellation or notification _____ (Signature).

Patient acknowledges that The Duffy Counseling Center reserves the right to terminate treatment should the Patient act in a manner contrary to the terms listed in this document and/or treatment compliance. _____ (Signature)

Patient acknowledges that if a session ends early at the request of the Patient (in person or on the phone), they will be billed for a full session. _____ (Signature).

AVAILABILITY: Your therapist may be reached through a voice mail system or email, which is checked several times throughout the day. We can be reached during work hours at the following phone number: **703-255-1091.** Your call will be returned as soon as possible. If you have an emergency, please call 911 or go to your nearest Emergency Room (ER). If a session is scheduled during weekend hours, it is deemed an "emergency session' and you will be charged at an emergency rate of $250/45 min. _____ (Signature).

PHOTOCOPIES OF FILE: Please note that patients requesting a copy of their file must fill out a form requesting a photocopy of their file. Patient acknowledges that files will be copied at a rate of $.25 per page and billed to patient. The office will give an estimate as to the cost of copying a Patient's file prior to any copies being made. _____ (Signature).

AUDIO/VIDEO RECORDING: Due to the confidential nature of the therapeutic process, audio and video recording are strictly prohibited without the verbal and written consent of all persons involved.

By signing this document, you agree to obtain both verbal and written consent from all persons involved with the therapeutic process and Duffy Counseling Center should audio or video recording be requested.

By signing this document, you are stating that you understand the possible legal ramifications that will result from the lack of disclosure of audio and video recording of the therapeutic process associated with the Duffy Counseling Center.

We require this document for the protection of both the client and the therapist. Thank you.

Individual's Signature: _____Date: _____

Other Signature: _____Date: _____

Therapist's Signature: _____Date: _____