Confidential Therapy Intake Form

Date:_____

Name:_____Name you wish to be called:_____

Gender:_____ Date of Birth:_____

Address:_____

Relevant Phone Numbers: _____

Email:_____Preferred Method of Contact: (phone, text, email, etc)_____

Do I have you permission to leave a detailed message at your preferred location? Yes No

*Occupation: _____

Emergency Contact: _____Relationship: _____ Phone: _____

Referred by: _____

Marital Status: Single Married Separated Divorced Widowed Cohabiting

*Spouse's/ Partner's Name & Occupation: _____

*Children's Names & Ages: _____

**if applicable*

Religious Denomination if any:

Are you presently seeing another psychotherapist? Yes No

If yes, therapist Name: _____Phone:_____

Do I have permission to contact your present therapist? Yes No

Previous Experience with Therapy?

With whom? For how long? Was it helpful? Why or why not?:

Are you currently or have you ever taken psychiatric medications? Yes No

If yes, may I contact the doctor that prescribes/d your medication? Yes No

Medications, dates, doses: _____

_____

Have you ever been hospitalized for a psychiatric problem or substance abuse? Yes No

If yes, hospital(s), date(s), reason(s): _____ Have you had any significant medical problems?

If yes, describe: _____ Approximate Date of last physical exam: _____

What stressors have you experienced in the past year? _____

_____

Which situations or people do you avoid because they make you anxious? _____

_____

Have you ever felt, or been told, you should reduce your alcohol or substance use? Yes No

How much do you exercise? _____

Describe your eating habits: _____

Ever struggle with an eating disorder? _____

How much caffeine do you consume a day? _____

Legal Problems: _____

What do you do for fun / recreation? _____

FAMILY HISTORY

Mother's Name: _____ Living Deceased (date/cause)_____

Occupation: _____ Psychiatric, Alcohol or Drug Problems? Yes No

Father's Name: _____ Living Deceased (date/cause)_____

Occupation: _____ Psychiatric, Alcohol or Drug Problems? Yes No

Sibling's Names / Ages / Occupations: _____

_____

Psychiatric, Alcohol or Drug Problems? Yes No

Please indicate any items for which you have concern:

Anxiety	Fear	Headaches	Violence	Conflict
Insomnia	Self-criticism	Aggression	Self-injury	Loneliness
Depression	Assertiveness	Suicidality	Shyness	Problem Solving
Panic	Eating	Anger	Regrets	Social Skills
Substance Use	Inactivity	Meeting People	Procrastination	
Friendships	Obsessive Thoughts	Odd Sensations	Hopelessness	
Weight Gain/Loss	Disturbing Thoughts	Decision Making	Past Trauma	
Relationships	Child Management	Low Energy	Sexual Issues	

Others:

Rational Therapeutics
Therapy Consultation
Charlottesville Virginia
LLC

1108 E. Market St. Charlottesville, VA 22901
www.Rational-Therapeutics.com
(434) 207-8773

Psychologist-Patient Services Agreement

Welcome! This document contains important information about my professional services and business policies. It also contains a brief summary of information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI). In compliance with HIPAA, I am also providing you with a Notice of Privacy Practices which explains this in much greater detail. It is very important that you read this document carefully, and we can discuss any questions you have at any time. After reviewing this information, please sign this form, which constitutes and agreement between us. You may revoke this Agreement in writing at any time.

The information on these pages is made available so that you will be fully aware of some important matters concerning the psychologist-patient relationship and office policies. Two copies are provided. Read and sign one and take the other one with you for reference. Read it again in a day or two since there is typically much that occurs during your first visit.

PSYCHOLOGICAL SERVICES

A therapeutic relationship does not exist between you and I until after the initial evaluation is complete and we have decided, together, to work in a treatment relationship. It is important that we both agree we are a good therapeutic match before establishing this relationship.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. 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.

There may be alternative treatments or modes of therapy to consider. We encourage you to become aware of these factors and to ask any questions you may have at any time as we work together.

MEETINGS

I will usually schedule one 50-minute session per week at a time you agree on. This time will be held for you each week. If you are unable to attend, you must provide 24 hours advance notice to avoid charges. Otherwise, once an appointment hour is scheduled you will be expected to pay the $40 late-cancelation

fee.

PROFESSIONAL FEES

Patricia Polgar-Bailey, PsyD, MPH, FNP, CDE has a fee of $140 for a 50-minute therapy session. The psychotherapy fees include note writing, short telephone conversations (less than 5 minutes), clinical reports that you request for insurance purposes and consulting with other professionals. If you require coaching calls during a week (these are other than short administrative conversations) you will be billed at a prorated rate based on the session fee. If you become involved in legal proceedings that require my participation you will be expected to pay for professional time, including preparation and transportation costs. Returned checks will incur a $25 returned check fee.

CONTACT

You may telephone me at (434) 260-0038 or send an email to Tish@Rational-Therapeutics.com (remember that email may not be a confidential form of communication). Due to my work schedule, I am often not immediately available to receive calls, but my phone will be answered by confidential voice mail. I will make every effort to return your call by the next business day. I do not provide formal emergency services, yet I wish to be available to you as much as is reasonably possible. If there is an emergency please contact the nearest emergency room for crisis treatment.

License

I currently work with and under the license of Dr. J. Nile Wagley who is a licensed clinical psychologist in the state of Virginia. You have access to him if you have questions or concerns pertaining to our work together if you and I can not resolve these concerns. He may be reached at (434) 207-8773 or nile@Rational-Therapeutics.com.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA and/or Virginia law. I will always take every precaution and measure to insure the privacy of your confidential information.

There are some situations in which a therapist is legally obligated to take some action which will likely involve revealing information to an outside party, possibly without your consent. These situations are unusual, and are limited to cases in which harm is likely, including:

- Cases in which a therapist has reason to believe a child under 18 may be abused or neglected
- Cases in which your therapist has reason to believe an adult over the age of 60 has been abused or neglected in the preceding 12 months
- Cases in which you have made a specific threat of violence against another, or if a therapist believes that you present a clear, imminent risk of serious physical harm to another or yourself. If such a situation arises, I will make every effort to fully discuss it with you before taking any action or releasing any information about you, and I will limit disclosure of information to only what is necessary. Confidentiality issues can be complicated, so if you have any questions about them, please feel free to ask them now or in the future as needed.

At times, I may discuss our work together in a confidential setting with the licensed therapist named above who is bound by the same requirements of confidentiality as myself. This discussion will be limited to clinical treatment development and identifying information will not be shared when it has no baring on clinical outcomes.

In addition, I want to protect your privacy if I happen to run into you in a public setting. If this occurs, I will not acknowledge you which will give you the option of remaining anonymous. If you speak first, I'll be happy to say 'hello.'

PATIENT RIGHTS

HIPAA provides you with a number of rights, which include the right to Amend the information in your record, to limit what information is disclosed and to whom, to request restrictions as to how you are contacted, and to receive and Accounting of Disclosures, or a list of all information that has been released about you. You also can file a complaint about our policies and procedures regarding your records with the federal Department of Health and Human Services.

BILLING AND PAYMENTS

You are responsible for the fees for your therapy, and are expected to pay for each session at the time of the session unless other arrangements have been made. We can provide you with a receipt or master bill, which you can submit to your insurance company which may result in reimbursement.

In the event that you encounter some unusual financial hardship, such as losing your job, we may be willing to negotiate a payment plan so you can continue receiving therapy during the difficult time. If your balance due becomes very large, or if no payments are made for several months, we have the option of resorting to legal means to obtain payment if we cannot negotiate a payment plan. This could mean involvement of a collection agency or small claims court, and the cost of this collection effort would be passed on to you. Such efforts typically require disclosure of some otherwise confidential information, but we will limit this to the minimum information necessary.

Your signature below indicates that you have read the information in this document, and agree to abide by its terms during our professional relationship and consent to treatment at Rational Therapeutics, LLC.

ATTENTION MEDICARE BENEFICIARIES

Please know that I do not participate in Medicare panels. Medicare requires me to inform you that by seeking services with me, we enter into a private contract. This means you agree to pay for services received through my clinic and you agree to follow Medicare rules which prohibit you from seeking reimbursement from them for these services.

Your signature below indicates that you have read the information in this document, and agree to abide by its terms during our professional relationship and consent to treatment at Rational Therapeutics, LLC.

Signature Date

1108 E. Market St. Charlottesville, VA 22901
www.Rational-Therapeutics.com
(434) 207-8773

Notice of Privacy Practices

My practice follows professional standards and laws to protect your privacy. Federal laws require me to provide you with a notice of my privacy practices. This notice ascribes how I may use medical information about you and how you can obtain access to this information. Please review it carefully and ask me if you have any questions. If I change or revise this notice, I am required by law to inform you of any such change.

By law, I am required to:

- Make sure medical information that identifies you is kept private
- Give you notice of my legal duties and privacy practices with respect to your medical information
- Explain how, when, and why I use and/or disclose this information
- Follow the terms of such notice

I will ask for your written permission to share with or obtain information from others about you. However, by law, your psychotherapist, physician, and their administrative support may use and disclose information regarding your medical information without your authorization for the purpose of providing health care services to you, pay your health care bills, support the operation of the practice, and any other use required by law.

For treatment: I may use information about you to coordinate my services with others who are involved in your health care.

For payment: I may use and disclose medical information about you so that the treatment services I render may be billed to and payments collected from you, an insurance company, or other third party. If payment is not received within 3 months of services rendered, the services of a collection agency may be used.

For health care operations: I may need to use or disclose information for my practice activities.
As required by law: I may disclose medical information about you when required to do so by federal, state, or local law.

To avert a serious threat to health or safety: I may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety, or the health and safety of the public, or another person including situations related to abuse, neglect, or domestic violence. I am required to take steps to prevent you from harming yourself or another person.

Workers compensation: I may release medical information about you and for workers compensation and similar programs.

Lawsuits and disputes: If you are involved in a lawsuit or dispute, I may disclose medical information about you in response to a subpoena, discovery request, or other legal process.

Psychotherapy notes: Notes have special protection under law. I will not release my notes without your permission, except as required by law.

Your Rights About Your Private Identifiable Information

Request Restrictions: You may request further restrictions on our uses and disclosures of your information. I may not be able to agree to all requested restrictions.

Different ways to communicate: Typically I will communicate by mailing or phoning your residence or mobile phone. Use of email communication is limited.

Right to see and copy information: You may see and receive copies of your information maintained in your designated record. You must submit your request in writing. There are situations in which your request may be denied.

Right to request amendment of your information: You may request that information about you be amended or changed. You must submit your request in writing. I may deny your request if I did not create the information or if I believe the information is correct. Denials will be written and will describe your rights for further review.

Listing of previous disclosures: You may request a list of certain disclosures of your information for up to the last six years. You must submit your request in writing. This list does not include disclosures related to your treatment, payments, or my practice operations, or those disclosures required by law.

Copy of this notice: You may request a copy of this notice at any time.

If you believe I have violated your privacy rights or you want to complain to me about my privacy practices, you may give me written notice and I will respond. You may also file a complaint with the U.S. Department of Health and Human Services at the following address:

Secretary of Health & Human Services
US Department of Health & Human Services 200 Independence Avenue SW
Washington, DC 20201

Should you file a complaint, action will not be taken against you nor will services to you be changed.

Use and Disclosure of Psychotherapy Notes

The information in this policy applies to all of Dr. J. Nile Wagley's staff and other contractors granted access to protected health information. You are referred to as “client” and I am “provider” or “psychotherapist”.

Psychotherapy Notes: Summary of information such as current state of the client, diagnoses, problems, symptoms, themes of psychotherapy sessions, and other information needed for treatment or payment shall be placed in the client’s designated record. Psychotherapy notes are kept separate from the rest of the client’s designated record.
Psychotherapy notes are defined as documentation that captures the provider’s impressions about the client, couple, or family containing details or the conversation to be inappropriate for the designated record and are used by the psychotherapist for future sessions. The provider who is documenting or analyzing the contents of the conversation during a private psychotherapy session or a group, joint, or family session can record the psychotherapy notes in any medium.

Release/Authorization of Psychotherapy Notes: Dr. J. Nile Wagley may not release psychotherapy notes, except in specific situations or if required by law. The client has the right to inspect or obtain a copy of the psychotherapy notes. The client may not request a review of Dr. J. Nile Wagley's denial of access to psychotherapy notes; however, the client may be provided access to a summary of treatment/psychotherapy. The authorization for psychotherapy notes may not be combined with an authorization for any other protected health information. Authorization for the disclosure of psychotherapy notes is not required in the following circumstances:

- For use of the provider for treatment
- For use in supervision or training for supervisees to learn to practice psychotherapy and counseling
- To defend a legal action brought by the client
- For the purposes of the Department of Health and Human Services in determining compliance with the privacy rule (HIPAA-Health Insurance Portability and Accounting Act)
- As otherwise required by law
- By an oversight agency for the lawful purpose related to oversight of the psychotherapist
- To law enforcement in instances of permissible disclosure related to a serious or imminent threat to the health and safety of a person or the public
- To a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death, or other duties authorized by law

Receipt and Acknowledgement of Notice of Privacy Practices

I acknowledge that I have received and have been given an opportunity to read Rational Therapeutics PLC's Notice of Privacy Practices. I understand that if I have any questions regarding this notice of my privacy rights, I may contact Dr. J. Nile Wagley, Ph.D. I understand that I may revoke, in writing, this authorization at any time except to the extent that action has already been taken in accord with it.

Client's Printed Name _____

Parent or Legal Guardian's Name (if Client is a Minor)_____

Client's Signature (Parent or Legal Guardian if Client is a Minor) _____

Date_____

If you refuse to acknowledge receipt of this notice, check this box. ☐
Rational Therapeutics, PLC Signature:

_____ Date_____