POTOMAC PSYCHOLOGICAL CENTER, LLC

PATIENT INFORMATION (PLEASE PRINT):

Full Name _____
Last First MI

Home address _____

City, State, Zip _____

PRIMARY Phone number _____ Other Phone #_____

Work Phone_____ Email:_____

Please note that we will leave general voicemail messages on the numbers provided. These messages will NOT include any personal health information. Please ask the front desk if you still would not like any messages left

Male or_Female Birth Date _____ Social Security#_____

Marital Status: Single Married Separated Divorced Other_____

Emergency Contact _____ Phone _____ Relation_____

Referred by_____ Are you the policy holder for your insurance? Y or N

SUBSCRIBER INFORMATION (if different from the patient)

Full Name _____
Last First MI

Relationship to Patient: Mother _____ Father _____ Other _____

Custody Status: Legal _____ Physical_____

Home Address _____

City, State, Zip _____

Primary Phone _____ Birth Date _____ Social Security #_____

Marital Status: Single___ Married ___ Separated____ Divorced___ Email: _____

OTHER PARENT / GUARDIAN INFORMATION (Required if patient is under 18 yrs): ***This information is required for both parents.

Full Name _____
Last First MI

Relationship to Patient: Mother _____ Father _____ Other _____

Custody Status: Legal _____ Physical: _____

Home Address _____

City, State, Zip _____

Primary Phone _____ Birth Date _____ Social Security #_____

Marital Status: Single____ Married ____ Separated_____ Divorced____ Email: _____

PRIMARY CARE PHYSICIAN /Pediatrician/ Etc.: _____

Office Phone: _____ Fax (if known) _____

Pharmacy Name:_____ Address:_____
Phone#:_____

By signing below, you agree that our health care providers can contact your primary care physician for continuity of care.

_____ _____
Print Patient Name Signature of Patient or Guardian Date

Informed Consent for Treatment

I, _____ (name of patient), agree and consent to participate in behavioral health care services offered at and provided by Potomac Psychological Center, LLC, behavioral health care providers. I understand that I am consenting and agreeing only to those services that the provider is qualified to provide within: (1) the scope of the provider's license, certification, and training: or (2) the scope of the license, certification and training of the behavioral health care provider directly supervising the services received by the patient. **No promises have been made as to the results of this treatment or of any procedures utilized within it**. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent to treatment, and I am legally authorized to initiate and consent to treatment on behalf of this individual.

Your confidentiality and privacy is important to us. However, there are situations in which we cannot guarantee confidentiality. These situations include, but are not limited to, if your clinician feels you are a harm to yourself or someone else, if there is a need for Child Protective Services to be involved, or if a judge subpoenas your records or the treating clinician.

Cancellation Policy

All appointments must be canceled by 3:00 p.m. the business day (Monday- Friday) before my scheduled appointment. This means a Monday appointment would need to be canceled by Friday at 3 PM to be considered a timely cancellation. Failure to do so will result in a missed appointment charge of **$90**. If a client arrives 20 or more minutes late to a therapy appointment, one may be charged for a missed appointment. In the event of **snow or inclement weather, my appointment can be canceled the same day with no charge, ONLY IF Loudoun County Government (not the school system) is closed AND ONLY IF I call to cancel my appointment prior to the appointment time.** In case you have to leave a message with the cancellation request, you WILL receive a return phone call. If you do not receive a return call, PLEASE call again since we may not have gotten your message. By signing this form, I acknowledge that I have read and fully understand the PPC policy for cancellation of appointments. X_____ (Please initial)

Missed Appointments

If the missed appointment/late cancel is due to a medical emergency, family emergency, transportation issue such as mechanical problems, or you believe the appointment was scheduled in error, you will need to fill out an appeal form **within 60 days** of the missed appointment date and provide a doctor's receipt, or any other supporting documentation. We are not obligated to accept appeals after the 60 day mark.
X_____ (Please initial)

Financial Responsibility

Payment for services, co-pays and deductibles, is **due at the time of services**. If your insurance does not cover your services within 60 days, you could be fully responsible for the charges. We are happy to arrange payment plans as needed. If you do not pay your fees within 60-90 days, your account is at risk of being outsourced to a collection agency. At that time, you will not be able to make future appointments until the balance is addressed or a payment plan in place. The additional collection fee that the agency charges of 30% is added to your account balance at the time it is outsourced.
X_____(Please initial)

You are responsible for updating your personal and insurance information periodically, which includes providing our office with copies of your insurance card. It is your responsibility to understand your coverage and benefits. You will be responsible for any services not paid by your insurance. We are not responsible for charges unpaid due to not being informed of a change in insurance coverage. Your insurance is a contract between you, your employer and the insurance company. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

I understand the PPC Patient Information Reference 2022 and the Notice of Privacy Practices (found in the portal) governs the policies that I am bound by in receiving services at this office.
My signature below constitutes acknowledgement and acceptance of these policies.

_____ _____

Print Patient Name Signature of Patient or Guardian Date