Elisa E. Nebolsine, LCSW
cognitive therapy for kids

CONFIDENTIAL CLIENT INFORMATION

Child Information:

Today's Date:_____ Referred By: _____

Child's Name:_____ Date of Birth:_____

Home Address:_____

City/State/Zip:_____

Parent/Guardian Information:

Parent/Guardian's Name:_____ Date of Birth:_____

Cell #:_____ Home #:_____ Work #: _____

Email Address:_____*

Parent/Guardian's Name:_____ Date of Birth:_____

Cell #:_____ Home #:_____ Work #: _____

Email Address:_____*

Address (if different from child's): _____

*Email is not a 100% secure form of communication. Please initial if okay to contact by email. _____

Parent/Guardian's Marital Status: S M D W

Emergency Contact and Phone Number: _____

Pediatrician Information

Pediatrician:_____ Phone #: _____

Address:_____

Date of last physical: _____

Permission to contact your pediatrician? _____yes _____no

I give consent for my child to receive assessment/psychotherapy services:

Signature of Parent/Guardian:_____ Date:_____

HIPAA NOTICE OF PRIVACY PRACTICES

Federal and state laws regulate privacy within the practice of psychotherapy. The following notice outlines how medical information about you may be used and disclosed. It also outlines how you are able to obtain access to this information.

Your protected health information (or PHI) includes the records that I create and, with your permission, obtain from other health professionals (such as psychological testing or medical reports). This information includes my clinical documentation, diagnoses, treatments, referrals, and your billing history and records. This information, in accordance with the law, is kept confidential and in accordance with this described notice of privacy practices. I am also required to give you a copy of this privacy practice for your own use or records.

I reserve the right to change my privacy practices as long as they remain in accordance with the current regulations. If I do change my privacy practices, I will provide you with written notification.

Permitted Uses and Disclosures of Protected Health Information: I am permitted, under federal law, to use and disclose your PHI without authorization for treatment, payment, or health care operations. Examples of such potential uses or disclosures are provided below:

- **Treatment:** For example, I may give information about your treatment to other health care providers to facilitate your treatment, referrals, or consultations. If or when I disclose information to other people or companies, I require them to protect your privacy as well.
- **Health Care Operations:** Your PHI may be used or disclosed as part of my internal health care operations. Examples of such health care operations may include, among other things, accreditation, training programs, certification, licensing, or other credentialing activities.
- **Payment:** I may use and disclose your PHI to bill and collect payment for the treatment and services that I have provided to you. For example, obtaining a pre-authorization for treatment may require that your PHI be disclosed to your health insurance plan.

I may use your mental health information for other purposes without your written consent in the following other situations. While legally I am entitled to do this, I will make every effort, when appropriate, to inform you that I have made such a disclosure or that I intend to do so.

Abuse, Neglect, or Domestic Violence: As required by law, I may disclose your PHI to report suspected abuse, neglect or domestic violence.
Communication: For appointments and services to remind you of an appointment or tell you about treatment alternatives or health related benefits of services.
Health Oversight: I may disclose your PHI for oversight activities authorized by law or to an authorized health oversight agency to facilitate auditing, inspection, or investigation related to my provision of health care or to the health care system.
Judicial and Administrative Proceedings: I may be required to disclose your PHI in the course of a judicial or administrative proceeding, in accordance with my legal obligations.
Law Enforcement: I may disclose your PHI to a law enforcement official for certain law enforcement purposes. For example, I may report certain types of injuries as required by law or make a report concerning a crime or suspected criminal conduct.
Minors: I may disclose information to individuals involved in your treatment, such as your parents or guardian, if you are a minor. Additionally, if you are an unemancipated minor under Virginia law, there may be circumstances in which I disclose your PHI to a parent, guardian, or other person acting *in loco parentis*, in accordance with my ethical and legal responsibilities.
Notification: I may use or disclose your PHI to notify a family member or other person responsible for your care about your location and about your general condition. If you are unavailable because, for example, you

are incapacitated or because of some other emergency circumstance, I will use my best professional judgment to determine what is in your best interest and whether a disclosure may be necessary to ensure an adequate response to the emergency circumstances.

Parents: If you are a parent of an unemancipated minor, and are acting as the minor's personal representative, I may disclose health information about your child to you under certain circumstances. For example, I am legally required to obtain your consent as your child's personal representative in order for your child to receive care from me. In some circumstances, I may not disclose health information about an unemancipated minor to you. For example, if your child is legally authorized to consent to treatment (without separate consent from you), consents to such treatment, and does not request that you be treated as his or her personal representative, I may not disclose your child's PHI to you without your child's written authorization.

Personal Representative: If you are an adult or an emancipated minor, I may disclose your PHI to a personal representative authorized to act on your behalf in making decisions about your health care.

Public Safety: Because of my legal and ethical obligations, I may disclose your PHI based on a good faith determination that such disclosure is necessary to prevent a serious or imminent threat to the health or safety of a person or the public to apprehend an individual sought be law enforcement.

Required by Law: I may be required by Federal, State or local law to disclose your PHI.

Worker's Compensation: I may disclose your PHI to comply with laws regarding workers' compensation.

Your Rights:

You have rights in regards to your PHI.

Requesting Restrictions: You have the right to ask me to limit my use or disclosure of your PHI. I am not required to agree with your request, but if I do agree to it, I will abide by your request except, as required by law, in emergencies or when the information is necessary for your treatment. Your request must be: in writing, describe the information that you want restricted, state if the restriction is to limit my use or disclosure, and state to whom the restriction applies.

Confidential Communications: You may ask that I communicate with you in a particular way, or at a certain location, to maintain your confidentiality. Your request must be in writing and must tell me how you intend to satisfy you financial obligation and specify an alternate way that I can confidentially contact you. You do not have to give a reason for your request.

Inspect and Copy: You may request to review or to receive a copy of your PHI that is maintained in my files. Federal law prohibits the inspection or copying of: psychotherapy notes, information compiled in reasonable anticipation of, or use, in a civil, criminal, or administrative action or proceeding; and PHI that is subject to the law that prohibits access to PHI. If I am unable to satisfy your request, I will tell in writing the reason for the denial and you right, if any, to request a review of the decision. I may charge you a fee for this service.

Paper Copy of this notice: You are entitled to receive a paper copy of my Notice of Privacy Practices by using the contact information supplied on the first page.

File a Complaint: If I have violated your privacy rights you may file a complaint directly with me using the contact information on the first page. You may also file a complaint directly with the Secretary of the Department of Health and Human Services. You will not be penalized for complaining.

Provide an Authorization for Other Uses and Disclosures: I will not disclose your PHI for any reason except those described in this notice, unless you provide me with a written authorization to do so. I may request such an authorization to use or disclose your PHI for any purpose, but you are not required to give me such an authorization as a condition of your treatment. Any written authorization from you may be revoked by you in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.

Effective Date: November 6, 2004

I have read and understand the above information about confidentiality and its limits:

_____

Signature

Elisa E. Nebolsine, LCSW
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Registration Policy & Financial Agreement

Initial Evaluation (60 min):	$250
Psychotherapy(45 min)	$180
Psychotherapy (20 min)	$120
Psychotherapy (60 min)	$210

All services, including (but not limited to): phone consultation, in-home exposure therapy, case management, report/letter preparation,

and school observation* will be billed at $210 an hour (prorated for actual time spent)

*All school consultations and offi site meetings are billed to include: preparation, time spent at location + travel time to and from (based on McLean office location), report writing, and any related follow up.

Case Management Fees

I understand that clinical work with children and adolescents often involves collateral contact with teachers, physicians, and other professionals. In order for Elisa Nebolsine to speak with other professionals I must sign a release form indicating that I give permission. I also understand that this is voluntary, and that I do not have to give permission for her to communicate with others. I understand that phone contact more than 10 minutes is billed at a prorated fee of $210 an hour. Phone contact includes communication with client, schools, other providers, etc.

Payment

I understand that payment in full at each visit. Payment may be made by check, VISA, or MasterCard. I understand and agree that I am to be charged directly and am personally responsible for payment of all services rendered to me (or the minor for whom I am responsible). I understand that the fee for returned checks is $40. I agree that if I default on payment, I will pay collections costs, attorney fees, and any and all court costs resulting.

Cancellations

I understand that I will be charged the full fee for any appointment missed or cancelled less than 48 hours ahead of time (other than illness). I understand that my insurance company will not reimburse costs incurred from an appointment missed or cancelled without sufficient notice.

Insurance

I understand that Elisa Nebolsine does not participate with any health insurance plans. I understand that I am responsible for submitting claims for reimbursement with my insurance carrier. I understand that some procedures such as, but not limited to, missed or late appointments, preparation of reports, school meetings and observations, in-home exposure work, and telephone consultations may not be reimbursable by an insurance company and are solely my responsibility.

Responsibility

I have read and agree to the above information. My signature below indicates that I both understand and agree to these policies.

_____ _____

Signature of Responsible Party **Date**

6723 Whittier Ave, Suite 403 • McLean, Virginia 22101 •
703.790.0035 www.CBTforKids.com

Elisa E. Nebolsine, LCSW
cognitive therapy for kids

AUTHORIZATION TO RELEASE INFORMATION

Client Name:_____DOB_____

I authorize Elisa Nebolsine, LCSW to exchange information with:

_____
Name of Person, Organization or Institution

_____
Address

_____
Phone Number Email Address

The following information is authorized to be shared:

____Verbal Exchange	____Psychological Evaluation
____ Email Exchange	____Academic Records
____Neurological Evaluation	____Behavioral Report
____Psychiatric Evaluation	____Medical Records
____Teacher's Report	____Other Information

Effective Date of Authorization:_____

I understand that to revoke this authorization I must put the request in writing and deliver to Elisa Nebolsine, LCSW at 6723 Whittier Ave, Suite 403, McLean, Virginia 22101. This authorization will automatically expire thirty days after the termination of treatment.

_____
Parent/Guardian's Signature Date

_____
Elisa E. Nebolsine, LCSW Date

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Medication Information

Name: _____

Medication:	Current Dose:	Reason Prescribed:	Prescribed By:

Form completed by: _____

Signature & Date: _____

6723 Whittier Ave, Suite 403 • McLean, Virginia 22101 • 703.790.0035

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VISA/MASTERCARD PAYMENT FORM

Name on credit card:

Billing Address (including zip code):

VISA or MASTERCARD Number (***unable*** *to accept American Express*):

Expiration Date:

CV # on the back of the card (3 digit code):

I authorize Elisa E. Nebolsine, LCSW to charge my credit card for services provided. I understand that this charge will occur at the time of the scheduled appointment. I also understand that I may continue to pay on a weekly basis by check if I prefer. I understand that Elisa E. Nebolsine, LCSW will keep my credit card information on file, and that the utmost caution will be taken in insuring the confidentiality of this information.

_____ _____

Signature Date

6723 Whittier Ave, Suite 203 • McLean, Virginia 22101 • 703.790.0035

Elisa E. Nebolsine, LCSW
cognitive therapy for kids

REQUEST FOR PERMISSION TO UTILIZE ART & WRITING MATERIAL

I understand that Elisa Nebolsine participates in on-going clinical supervision, presents clinical material to professionals, teaches, and writes about child and adolescent therapy topics. Occasionally she may ask me to use case material in the form of art or writing to be a part of the above content. I understand that the material will be presented in a confidential manner and that there will be no identifying information regarding my child. I understand that the content will be presented in a professional manner and for the purposes of education and research. This release will remain valid unless and until the parent or child revokes its consent.

Child's Name:_____

Age & DOB: _____

Parent Name:_____

Parent Signature:_____

Date:_____

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AUTHORIZATION TO RELEASE INFORMATION

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I authorize Elisa Nebolsine, LCSW to exchange information with:

_____
Name of Person, Organization or Institution

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Address

_____
Phone Number Email Address

The following information is authorized to be shared:

____Verbal Exchange	____Psychological Evaluation
____ Email Exchange	____Academic Records
____Neurological Evaluation	____Behavioral Report
____Psychiatric Evaluation	____Medical Records
____Teacher's Report	____Other Information

Effective Date of Authorization:_____

I understand that to revoke this authorization I must put the request in writing and deliver to Elisa Nebolsine, LCSW at 6723 Whittier Ave, Suite 403, McLean, Virginia 22101. This authorization will automatically expire thirty days after the termination of treatment.

_____
Parent/Guardian's Signature Date

_____
Elisa E. Nebolsine, LCSW Date