NOVA CHRISTIAN COUNSELING

Counseling with a Christian Perspective

INDIVIDUAL AND FAMILY THERAPY
FEE INFORMATION

Out-of-pocket fees for individual and family therapy are the following:

50-Minute Therapy Session (Licensed Prof. Counselor)	$160.00
50-Minute Therapy Session (Pre-Licensed / Resident Counselor)	$120.00

Fee for missed session or late cancellation:

$160.00

Fee for attendance at court proceedings:

$160.00 per hour (when counselor leaves office to travel)*

* Other expenses may occur in addition to the hourly rate.

Fee for special research, written reports for court, and disability applications for schools:

$160.00 per hour

We are in-network and accept the following insurance carriers:*

Anthem and Federal Blue Cross/Blue Shield	Tricare/Humana
Carefirst and Carefirst Blue Choice	Aetna
Anthem Healthkeepers	Virginia Medicaid

**Not all counselors accept the same insurance carriers. Please check with our office to confirm.*

****NOTICE****

All clients are required to provide a debit or credit card and/or Health Savings Account/Flexible Spending Account (HAS/FSA) card for us to keep on file. Client sessions are charged and payment is expected the day of service. Please read our fee and cancellation policy carefully.

Northern Virginia Christian Counseling (NOVA CC)
Office address: 10620 Crestwood Drive, Suite C Manassas, VA 20109
Website: www.novachristiancounseling.com
E-mail: officemanager@novachristiancounseling.com (administrative staff)
Phone: (571) 408-8986

Counselor name:
E-mail:
Phone:

Supervisor contact information (if applicable):
Office address:
E-mail:
Phone:

CLIENT INFORMATION

Client Name:______________________________Today's Date:_____/_____/_______

DOB:_____/_____/______Age:______Social Security # ________ Male:________Female: ________

Client Address:________________________City:______________State:_____Zip:________

Home Phone:______________Work:______________Cell:______________

Client Email:________________________________

Parent/Guardian Name:____________________Email:____________________

Home Phone:______________Work:______________Cell:______________

Parent/Guardian Name:____________________Email:____________________

Home Phone:______________Work:______________Cell:______________

INSURANCE INFORMATION

Insured's Name:________________DOB:____/____/____Social Security #:_____-_____-______

Male: ______Female:_____Relationship to Client:____________________

Insurance Co. Name:________________ID:____________Group #:__________

Insured's Employer:____________________Phone:________________

FEE POLICY

The out-of-pocket fee for each counseling session is $160.00 for licensed professional counselors, $120.00 for pre-licensed/resident counselors. Northern Virginia Christian Counseling requires all payments to be made on the day of treatment. Failure to keep an active credit card on file may result in termination of services. All unpaid co-pays, deductible payments, and rejected insurance claims will be billed to your credit card on file 30 days after the date of service. We will make every effort to resubmit rejected insurance claims, and will notify clients when rejected insurance claims become the responsibility of the client.

Fee schedules are reviewed annually and changes are made if necessary. Clients will be notified of fee changes.

CANCELLATION POLICY

There will be a charge of $160.00 for appointments that are not kept and for cancellations that occur less than 48 hours prior to the appointment. Please sign below to acknowledge understanding of the above information and consent for treatment.

I acknowledge receipt of a copy of the Fee Policy and Cancellation Policy and agree to the terms specified within.

____

Printed Name of Client or Authorized Person

____ ________________________________

Signature of Client or Authorized Person Date

____ ________________________________

If the client is a minor, please include the printed name *and* signature of the parent or guardian

CONFIDENTIALITY STATEMENT

With few exceptions, clinicians at Northern Virginia Christian Counseling will protect your privacy and confidentiality. It is important for you to understand that the American Association of Christian Counselors, Virginia Department of Health Professionals, and the Commonwealth of Virginia have ethical guidelines that define certain situations that do and do not fall under confidentiality, privacy standards, and privileged information. The following circumstances are the most common situations in which we cannot protect your confidentiality:

1) If you make statements that I determine to be a serious threat to harm yourself or other person(s), I am required by law to protect you or the other person(s). I will act in whatever way my professional judgment determines necessary to keep you or others safe, including reporting this to the proper authorities.

2) If I suspect or believe that a child or elderly person has been or will be abused or neglected, I am required by law to report this to the proper authorities.

3) If the court has sent you to me for treatment, the court expects a report or reports from me. If you are in that situation, please discuss this with me. You have the right to tell me only what you choose to disclose.

4) If you are a party involved in a lawsuit or have been charged with a crime, I may be ordered to show the court my records. This can occur if you disclose to the court that you are in treatment with me, or if a court of law issues a legitimate subpoena for your records.

5) If you provide written consent to release information about yourself and/or your family members.

____

Printed Name of Client or Authorized Person

____ ____________________________________

Signature of Client or Authorized Person Date

____ ____________________________________

If the client is a minor, please include the printed name *and* signature of the parent or guardian

CLIENT BILL OF RIGHTS

Every client has the right to:

- Respectful treatment that will be helpful to him/her and to make an informed choice and give informed consent to treatment
- A safe treatment setting that is free from harm, including sexual, physical and emotional abuse
- Report unethical or illegal behaviors by the therapist
- To be fully informed and to request and obtain information about a therapist's qualifications that include his/her license, education, training, experience, membership in professional groups, special areas of practice and limits on treatment
- Know about the conditions of therapy, including fees, cancellation policies, appointment times, and privacy issues
- Dignity, independence, and to refuse video/audio taping of sessions and/or be informed of any research he/she may be a part of and the right to decline
- Refuse to answer any questions or give any information that he/she does not choose to provide and receive effective communication from the therapist
- The right to quality services that comply with ethical standards and to know if the therapist will discuss your case with others for staffing purposes
- The right of support and to request that the therapist inform you of your progress

____

Printed Name of Client or Authorized Person

____ ____________________________________

Signature of Client or Authorized Person Date

____ ____________________________________

If the client is a minor, please include the printed name *and* signature of the parent or guardian

ELECTRONIC AND TELEPHONE CONTACT PERMISSION FORM

Communication that is transmitted over the telephone, internet or stored on external voicemail devices (voicemail on our cellphones for example) is not secure or confidential. While it is rare, there is always the possibility that someone working for the telephone company or e-mail provider will access your information. Because the information cannot be guaranteed secure we need your permission to contact you by phone or e-mail. If you are concerned about the content of any communication being read or listened to by someone other than our staff, you have the right to limit our contact with your through those forms of communication. We will not communicate detailed clinical information via email, text, or voicemail.

Please **INITIAL EACH LINE** for the form of communication you authorize Northern Virginia Christian Counseling to use to contact you.

Client:

______Cell______Home_____Work_____Text______Email

Parent/Guardian: Name____

______Cell______Home_____Work_____Text______Email

Parent/Guardian: Name____

______Cell______Home_____Work_____Text______Email

_____ When leaving a voicemail NOVA CC can only leave name and telephone number

_____ When leaving a voicemail NOVA CC can leave a detailed message

_____ In case of emergency, I authorize NOVA CC to contact:

______________________________ at (_____)_______________OR

______________________________ at (_____)_______________

____

Printed Name of Client or Authorized Person

______________________________________ ____________________________________

Signature of Client or Authorized Person Date

______________________________________ ____________________________________

If the client is a minor, please include the printed name *and* signature of the parent or guardian

CONSENT TO TREATMENT

I acknowledge that I have received and read copies of the Client Bill of Rights, Confidentiality Limitations and Fee and Cancellation Policies. I have had my questions answered fully.

I understand that by signing this consent, I,________________________________(client), agree to participating in treatment. I recognize that developing a treatment plan with this therapist and timely review of the work toward meeting treatment goals and objectives are in the best interest of the client.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I can stop treatment with this therapist at any time. I will remain responsible for payment of services already received. I understand that if I stop services before planned treatment is completed, the client may have unresolved issues to deal with on his/her own.

I know that I must call or e-mail to cancel an appointment at least 48 hours before the scheduled time. If I do not cancel or appear for the appointment, I will be charged for the appointment. I also understand that my insurance will not cover the above described fee.

I understand that all clients experience growth/healing in different ways and may have varying degrees of success, and that change/progress towards a client's goals is determined by each individual client.

I understand that my progress is determined by myself and that I will determine and decide the length of my treatment, progress towards goals, and issues or problems I wish to work on with my therapist. I also understand that I am not guaranteed to make progress towards these goals and that psychotherapy and/or counseling has certain risks, including the possibility that I may not achieve my goals or even feel worse after I conclude psychotherapy and/or counseling.

I am aware that an agent for my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s) and providers of the services or treatments I receive. I understand that if payment for the services I receive is not made, I may be responsible for payment and/or the therapist may stop treatment.

My signature indicates that I understand and agree with all these statements.

____

Printed Name of Client or Authorized Person

____ ____________________________________

Signature of Client or Authorized Person Date

____ ____________________________________

If the client is a minor, please include the printed name *and* signature of the parent or guardian