New Client Packet Checklist:

Welcome to Nest Psychological Services, PLLC. Full completion of this packet will enable us to provide you with the best possible service. This packet takes about 45 to 60 minutes to complete.

To enable us to provide you with the best care possible, please be sure to fill out all page's front and back and initial each page prior to the initial intake appointment or your appointment will need to be rescheduled. You may submit paperwork via fax, email, mail, or in person.

Please provide the following prior to your child's first appointment.

- Insurance card
- Guardian's Driver's License or Photo ID
- Any additional medical records or notes you may have from previous practitioners
- School evaluations for special education services and IEP
- Custody Agreements if applicable
- Copay or other payment required by your insurance company

Please note the following:

- All forms must be signed by the child's legal guardian. If there is a custody agreement in place, a copy of the agreement must be provided to our offices prior to the first appointment. Written consent must be given by both custodians if required in the custody agreement in order for the child to receive services. If services are court ordered, a copy of this order must be provided prior to the first appointment.

- Client Registration (next page) must be filled out completely. The date of birth of the insurance policy holder is required to submit insurance claims. If you do not have this information, we cannot bill your insurance. You would then be held responsible for charges that your insurance would otherwise cover.

- Please complete this packet in its entirety. This will help your practitioner understand more about your child's visit.

- The Authorized Release of Protected Information is the last page of the packet. Please fill in your child's name and date of birth and the name and demographic information of the person or entity with whom you wish to share your information.

- **Please review and check that each page has been signed and initialed.**

Thank you for your cooperation and patience in filling out these forms to help us better understand your needs and bill your insurance correctly.

We appreciate the opportunity to serve you.

CLIENT REGISTRATION

Today's Date: _____ Date of Birth _____

Child's Full Name:

_____

Sex: □ Male □ Female **Gender Identity**: □ Same as Sex □ Transgender Male

□ Transgender Female □ Transgender (as non-binary) □ Non-binary □ Two-Spirit

□ Questioning/not sure □ Other _____

Pronouns: □ He/Him □ She/Her □ They/Them □ Not Selected

Child's Home Address:_____

City: _____State: _____

Zip_____

Do we have authorization to send mail to the address listed above? □ Yes □ No

Parent/Guardian:

_____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Do we have authorization to leave voicemails, texts, and emails to the contacts listed above?

□ Yes □ No

Parent/Guardian:

_____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Do we have authorization to leave voicemails, texts, and emails to the contacts listed above?

□ Yes □ No

School Name:_____ Grade Level: _____

Child's Primary Physician: _____ Phone: _____

Emergency Contact Name: _____ Phone:_____

Is there a custody agreement in place? Yes/No.

If yes, please explain and provide required documents:

INSURANCE: All items in this section must be completed to bill your insurance

Policy Holder's Full Name: _____DOB: _____

Relationship to Client: _____

Home Address: _____Phone: _____

Employer and Address: _____ Phone: _____

Primary Insurance: _____

(Aetna Private/Corporate or Sentara Only)

ID # _____

Group # _____

Mental Health Phone # _____

OFFICE HOURS

Our office hours are by appointment only and vary in order to serve individuals across multiple locations. You may reach our office by phone at (540) 250-0582 to schedule an appointment. If we are unavailable, you may leave a message on our confidential voice mail box, and someone will return your call as soon as possible. Do not leave messages if you have a psychiatric emergency; please call ACCESS at (540) 961-8300, dial 911, or go to the Emergency Room.

COMMUNICATION

It is our normal practice to communicate with you about health matters, such as appointment reminders, using the home address and daytime phone number you provided when you scheduled your appointment. You have the right to request that our office communicate with you in a different way.

Please DO NOT provide phone numbers if you do not wish for us to leave messages. If a phone number is provided as a form of contact, the front office will leave a message at that number.

FINANCIAL/INSURANCE

As a courtesy, we will bill your insurance company if it is an in-network carrier with our office. All payments and/or co-payments are due at the time of each appointment. If you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover services, we request that you pay the balance due at that time. If the balance is not paid after 45 days, it will be charged 1.5% interest/month (18% APR). If the account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for collection fees charged to our office to collect the debt owed. Our office accepts personal checks, cash, Discover, Visa, and MasterCard-HAS account cards(not American Express). A returned check fee of $35.00 will be charged. If we receive more than one returned check from an individual, we may refuse future payment by check.

FEES FOR SERVICE

Initial Intake (45-55 minutes)	$150.00
Psychological Assessment Services (55 minutes)	$150.00
Psychological Evaluation Services (55 minutes)	$150.00
Developmental Evaluation Services (55 minutes)	$150.00
Educational Assessment Services (55 minutes)	$100.00
Individual Parent Coaching Session (30 minutes)	$70.00
Phone Consult (Brief <20 minutes)	$35.00
Phone Consults (30 minutes)	$70.00
Phone Consults (55 minutes) "	$120.00

Additional Fees for Services assessed according to your hourly rate:

- Extended appointments
- Telephone calls or email responses lasting longer than 5 minutes
- Consultation with another paid professional (with your prior approval)
- Professional correspondence to or about a client
- Letters, Documents, Records requests

A 6% finance charge will be added on any unpaid balance within 30 days from time of first invoice. If your account is left unpaid after termination of services and it goes to a collection agency, you will be responsible for any legal fees to obtain the unpaid balance. You will also be responsible for a $25 charge to cover handling fees on any checks returned for insufficient funds. Nest Psychological Services will attempt to collect any account balance up to 90 days. If no attempt to pay on balances is made, the account balance will be turned over to a collection agency. Clients agree to pay a collection fee of 30% to principal balance. No psychological evaluation reports will be released without payment in full of services.

Clients are responsible for obtaining accurate information from insurance carriers as to deductible, co-payments, and pre-certification. Any errors in information received, resulting in a balance owed to provider, will be the responsibility of the client to pay. Clients are also responsible for becoming aware of any changes in their coverage and notifying their psychologist. Co-payments are due when services are rendered. Clients are ultimately responsible for fee payment, regardless of coverage. Your signature below authorizes your insurance company to pay Nest Psychological Services, PLLC/ Heidi Hawkins directly for their share of fees. A 3.5% fee will be collected for credit card payments. Your signature below authorizes Nest Psychological Services, PLLC to charge the credit or debit card on file for fees and balances for services. For private pay clients a $500 deposit is due upon intake and scheduling of evaluation sessions with the remainer due upon conclusion of results. All remaining balance must be paid before the results report will be released.

Court Action/Legal Fees:

Clients are discouraged from having their psychologist subpoenaed. Even though you are responsible for the testimony fee, it does not mean that my testimony will be solely in your favor. I can only testify to the facts of the case and to my professional opinion. If services are requested or subpoenaed, the following fees are in effect:

Preparation time (including submission of records): $500/hr Phone calls: $500/hr
Depositions: $500/hr
Time required in giving testimony: $800/hr Mileage: $0.55/mile
Time away from office due to depositions or testimony: $800/hr
All attorney fees and costs incurred by the psychologist as a result of the legal action.
Filing a document with the court: $500
The minimum charge for a court appearance: $3,000 per day
A fee of $3,000 is due at the time subpoena is received due to the need to hold the date of testimony regardless of a change in date or if testimony is not needed. This fee is nonrefundable if the date changes for any reason. If a subpoena or notice to meet attorney(s) is received without a minimum of two week notice there will be an additional $1,000 "Express" charge. Also, if the case is reset with less than 72 business hours notice, then the client will be charged an additional $1,000. Finally, all fees are doubled if the psychologist had plans to go out of town.

NO SHOW AND LATE CANCELLATION POLICY

Please contact our office within 24 hours if you are not able to make your appointment. If you do not show for a scheduled appointment or cancel with less than 24 business hours' notice, a *NO SHOW/LATE CANCELLATION FEE of $75.00* will be charged for the cost of the missed appointment if permitted by your insurance company. This cost is not covered by insurance and is your responsibility and must be paid in full before your next appointment. If a second appointment is missed without canceling with a 24-hour notice, your provider will speak with you about future appointments. If a third appointment is missed your provider may not be willing to reschedule with you depending on your situation.

AUTHORIZATION

I authorize treatment deemed necessary by Nest Psychological Services, PLLC Practitioners. I authorize Nest Psychological Services to release to my health plan any and all information which deemed necessary regarding my care and treatment to ensure prompt payment of all charges for services provided. I hereby assign the payment for all insurance benefits to Nest Psychological Services, PLLC for any and all charges incurred in connection with services provided to me. I also consent to a copy of this authorization and assignment being used in place of the original.

I understand fully that I remain responsible to pay Nest Psychological Services, PLLC for all charges not paid by either my insurance companies and/or employer, subject to the rules of any federal or state health insurance program such as Medicaid, or to other contractual provisions that may limit a patient's responsibility to pay for medical costs and services. Payment shall be due at the time of the appointment or within thirty days of receipt of a statement.

Signature of client (or person acting for client) _____
Date _____

_____Initial

In order to ensure that the best care possible is provided to my child I _____ parent or guardian (please circle one) of _____(child's name) agree to comply with the following guidelines.

Please initial each line to indicate that you have read, understand and accept each statement.

_____ I understand that all phone consultations MUST be scheduled by calling the office. These consultations are not insurance billable and must be pre-paid at the time of scheduling. They can be scheduled in 30 minute and 55-minute appointments.

_____ I understand that unscheduled phone calls are not possible due to practitioner's schedules and that emergencies will be directed to emergency services and followed up on by the practitioner as soon as possible.

_____ I understand that all written correspondence requires pre-payment and is not insurance billable.

_____ I understand that written correspondence must be requested 7 business days prior to the date it is needed by contacting the office.

_____ I understand that all out of office appointments require pre-payment and are not insurance billable.

By signing I agree to comply with the above guidelines in order for my child to receive the best care possible. I acknowledge that my failure to comply so will lead to the discontinuation of services at Nest Psychological Services, PLLC.

_____

Signature Date

UNDERSTANDING PSYCHOLOGICAL EVALUATIONS AND INFORMED CONSENT

It is important for you to understand what services are about and what you may expect. Please read this material carefully and ask the provider to explain anything that is unclear to you.

What is a Psychological Evaluation?

A psychological evaluation is a comprehensive assessment conducted to understand a child's cognitive, emotional, and behavioral functioning. It involves a series of standardized tests, interviews, and observations to gather information about the child's mental health, learning abilities, and social interactions. The evaluation helps identify strengths and weaknesses, diagnose potential disorders, and develop tailored intervention plans. By providing a detailed understanding of the child's needs, a psychological evaluation supports parents, educators, and healthcare providers in promoting the child's overall well-being and development.

The Risks:

While psychological evaluations are generally safe and beneficial, there are some potential risks to consider. One risk is the possibility of misdiagnosis, which can lead to inappropriate or ineffective treatment plans. The evaluation process might also cause stress or anxiety for the child, especially if they find the tests challenging or feel pressured to perform well.

How an evaluation works?

Evaluations will involve several steps.

First, an intake will occur to review the child's full history, current concerns, and to develop an assessment plan.

You will then be scheduled to bring the child to in person appointments for formal assessment using individualized assessment instruments and techniques.

Following in person assessments, questionnaires may be sent to guardians and/or teachers for additional input and data collection.

Once all assessments and data is received and obtained, a review of results session will be scheduled. This typically follows 3-6 weeks after the final in person assessment session. During the review session, diagnostic conclusions and recommendations will be discussed and a final report documenting full results will be sent.

CONFIDENTIALITY AND EMERGENCY SITUATIONS

Your verbal communication and clinical records are strictly confidential except for situations covered in the Notice of Privacy Practices. Please note that confidentiality cannot be guaranteed if you use electronic communications with practitioners or office staff. This includes e-mail, instant messaging, social media and text. In addition, we will protect your privacy in public. We will not communicate with you in public unless you initiate contact nor disclose that you are a client. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact ACCESS services at (540) 961-8400, CONNECT at 1-800-284-8898, emergency services (911), or proceed to the nearest Emergency Room for assistance. Nest Psychological Services, PLLC providers are not on-call. Our Clinicians will follow up those emergency services with standard services and support to the client or the client's family.

_____Initial

For this reason, if you want your provider to release information about your participation in services, you will be asked to sign a “Release of Information.” The law does provide exceptions to client confidentiality where information may be released without your consent:

1. In the event of a medical emergency information deemed necessary for treatment may be released.
2. In the event of a threat of harm to oneself or someone else, if that threat is perceived to be serious, the proper individuals must be contacted. This may include the individual against whom a threat is made.
3. In the event of suspected abuse of a child, dependent adult or elder, the proper authorities must be contacted. The abuse does not have to be personally witnessed by the provider.
4. If you register a complaint with the Virginia Department of Health, information will be released as requested or required by the State to resolve the issue.
5. If ordered by a judge or other judicial officers, information regarding your treatment may be disclosed.
6. In the event of a client’s death or disability, information will be released as authorized by the client’s personal representative or beneficiary.
7. A provider is not required to treat as confidential a communication that reveals the contemplation or commission of a crime or harmful act.
8. Evidence that a minor client was a victim of a crime may be released to the proper authorities.

You have the right:

- To be treated in a humane and dignified way.
- To be informed of your treatment options, risks, and benefits.
- To take an active role in treatment planning.
- To have questions answered fully.
- To have confidentiality and privacy within legal/ethical guidelines.
- To facilitated review of your clinical information.

You have the responsibility:

- To be honest in providing information.
- To keep your appointments, to be on time, and to give a 24-hour notice if you should need to cancel your appointment.
- To be free of alcohol/drugs during your session.
- To respect the provider and facility, including supervision of children in the waiting room.
- To respect the privacy and rights of others.
- To know your insurance requirements, deductibles, and co-pays.
- To pay your co-pay, deductible, or full charge at the beginning of each appointment.

COORDINATION OF TREAMENT

It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. If you prefer to decline consent no information will be shared, however we do need your physicians name and demographic information for insurance billing.

____You may inform my physician(s) ____I decline to inform my physician

Physician's Name: _____
Clinic_____
Address: _____
Phone: _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

I/We have reviewed and received a copy of the Notice of Privacy Practices, if requested. The Notice of Privacy Practices is available on our website at www.nestpsychological.com or through the Office. Signing this acknowledgement does not mean you have agreed to any uses or disclosures of your protected health information outside the purposes outlined in the Notice of Privacy Practices.

Signature Date

CHILD SUPERVISION

Children's Names & Ages

_____ _____

_____ _____

_____ _____

Nest Psychological Services, PLLC strives to maintain a peaceful therapeutic environment to enhance well-being and healing. This includes keeping noise and activity levels to a minimum to avoid disrupting services. Many of our services are best provided in a quiet environment and may not be valid if disrupted.

We would prefer that a child always be supervised by a responsible parent or other adult at all times while at Nest Psychological Services, PLLC. Please keep the following in mind:

1. Nest Psychological Services will neither provide supervision nor assume liability for your children's safety.

2. Children under the age of 12 should never be left unsupervised.

3. Rough play or disruption to other Nest Psychological Services services, guests, or practitioners will not be tolerated. No climbing on any surfaces or furniture is permitted.

Initial _____

PRESENTING PROBLEM AND PAST TREATMENT

Biological Mother's Full Name: _____

Biological Father's Full Name: _____

Current Legal Guardian:_____

Is the child adopted? _____ Is the child in foster care? _____

If in foster care, list dates of all removals and placements with reasons:

_____

_____

_____

_____

_____

Please briefly describe why you are seeking services for you child: _____

_____

How long has your child had this problem? _____Did something happen before it started?_____

If your child has been diagnosed with a mental health disorder, please list here: _____

_____

Has your child received mental health treatment before? ____ If so, when? _____Where?_____

What was the reason for seeking treatment?_____

_____

What was most helpful about your child's mental health treatment? _____

_____

What was least helpful about your child's mental health treatment? _____

_____

Has your child had psychological testing before? _____ If so, when? _____
Where?_____

Is your child receiving other mental health services such as: Psychiatrist ____ Substance Abuse Treatment ___
Mental Health Supports _____ Case Management___ Crisis Services ____

If yes, Provider's name:_____Phone:_____Agency: _____

Is your child receiving services with Dept of Rehabilitative Services or other Agencies? _____

Has your child ever been hospitalized for psychiatric reasons? _____If so, when? _____

Where? _____ Briefly describe the reason: _____

_____

Has your child ever had suicidal thoughts? Yes/No Has your child ever attempted suicide? Yes/No
If so, when? _____ What was going on that lead to these feelings/thoughts?

Initial _____

SYMPTOMS: Please check any problems that your child currently has or had in the past:

Now	Past	
☐	☐	Change in appetite (more or less)
☐	☐	Feeling sad
☐	☐	Crying spells
☐	☐	Too little sleep (falling or staying asleep)
☐	☐	Sleep more than usual
☐	☐	Fatigue
☐	☐	Loss of interest &/or pleasure
☐	☐	Avoiding friends or family
☐	☐	Expect failure
☐	☐	Decreased concentration
☐	☐	Thoughts of death
☐	☐	Cutting or burning oneself
☐	☐	Suicide plan or attempt
☐	☐	Depression
☐	☐	Often sick
☐	☐	Loneliness
☐	☐	Slow moving
☐	☐	Hopelessness
☐	☐	Confusion
☐	☐	Worthlessness
☐	☐	Friendly
☐	☐	Lack of confidence/Low self-esteem
☐	☐	Guilt
☐	☐	Reckless or dangerous behavior
☐	☐	Racing thoughts
☐	☐	Pressured speech
☐	☐	Inflated self-esteem
☐	☐	Obsessive thoughts
☐	☐	Compulsive or repetitive behavior
☐	☐	Marital/family problems
☐	☐	Sexual problems
☐	☐	Relationship problems
☐	☐	Long term memory problems
☐	☐	Short term memory problems
☐	☐	Wound up or tense more days than not
☐	☐	Panic attacks
☐	☐	Irritable
☐	☐	Anxiety
☐	☐	Easy going
☐	☐	Muscle tension
☐	☐	Irrational fear of something or someone
☐	☐	Talking/acting w/out thinking
☐	☐	Fidgety, restless, overactive
☐	☐	Difficulty paying attention
☐	☐	Frequent day dreams
☐	☐	Bored easily
☐	☐	Learning difficulties
☐	☐	Often lose things
☐	☐	Excessive dieting/exercise
☐	☐	Obsessed with losing weight
☐	☐	Use of laxatives
☐	☐	Engage in self-induced vomiting
☐	☐	Eating things that are not food
☐	☐	Vandalism
☐	☐	Fire-setting
☐	☐	Lack of remorse for wrong-doing
☐	☐	Selfish
☐	☐	Bullies/gets in fights
☐	☐	Lying
☐	☐	Truancy
☐	☐	Theft
☐	☐	Argumentative/sudden anger
☐	☐	Defiant of authority
☐	☐	Temper tantrums
☐	☐	Stubborn
☐	☐	Avoid adults
☐	☐	Afraid to leave a loved one
☐	☐	Easily embarrassed
☐	☐	Upset by minor changes
☐	☐	Feeling detached from one's body
☐	☐	Feelings of unreality
☐	☐	See or hear things others don't
☐	☐	Believe things others tell you aren't true
☐	☐	Fear of strangers
☐	☐	Difficulty trusting
☐	☐	Believe others are out to get you
☐	☐	Intrusive thoughts
☐	☐	Avoid things related to traumatic event
☐	☐	Startle easily
☐	☐	Flashbacks
☐	☐	Nightmares

Other symptoms not mentioned above _____

_____

_____

How do these symptoms affect your child's life?

_____

_____

Initial _____

Have you ever been told that your child may suffer from any of the following?
□ ADHD □ Anxiety □ Depression □ Other, please explain:

_____

Do you feel your child understands directions and situations as well as other children their age? Yes/No
If no, please explain: _____

How would you rate your child's intelligence: □ Below average □ Average □ Above Average

Does your child play primarily with children: □ Their age □ Older □ Younger

Describe any problems your child has interacting with other children:

_____

_____

Describe any problems your child has interacting with adults:

_____

_____

If your child is currently using any substances, please describe when and where they typically use:

_____

_____

MEDICAL HISTORY

Physician's Name	Specialty	What are they treating your child for?	Dates of treatment
	Primary Care Physician		

Date of last physical exam: _____ Date of last dental exam: _____

Initial _____

Please list all prescription, non-prescription medications, and supplements below:

Name of Medication	Prescribed by	Dosage/Frequency	Helpful?	Side effects/comments	Taken as Prescribed?
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		

Please mark X if your child has ever experienced any of these conditions:

☐Hypertension
☐Heart disease
☐Arteriosclerosis
☐Arthritis
☐Kidney disease
☐Varicose veins
☐Phlebitis
☐Blood disorder
☐Cancer/Malignancy
☐Diabetes
☐Accident _____

☐PMS/painful menstruation
☐Easy bruising
☐Skin rash
☐Allergies_____
☐Asthma
☐Skin sensitivity
☐Environmental sensitivity
☐Numbness/Stabbing Pain
☐Sensitive to touch/pressure
☐Abscess or open sore
☐ Thyroid ☐ Hypo (low) ☐ Hyper (high) ☐ Other_____

☐ Seizures
☐ Head injury
☐ Headaches
☐ Back pain
☐ Chronic pain
☐ Fibromyalgia
☐ Chronic fatigue
☐ Digestive disorder
☐ Operations _____
☐ Infectious Diseases

How does your child's medical condition affect your life or theirs? _____
_____

Is your child on a special diet? If so, please explain: _____

What is your child's activity level? ___ Chores only **OR** ___ min moderate exercise: _____times/week
What is your child's highest weight? ____ Current? _____

Initial _____

How many hours does your child sleep at night? ___Does your child have trouble: falling asleep? ___ staying asleep? ___ Nightmares?____
Has your child ever had a neurological exam or EEG? □ Yes □ No
Does your child have problems with: □ Hearing □ Sight □ Speaking
If so, please explain: _____
_____
Are your child's immunizations up to date: □ Yes □ No

DEVELOPMENTAL HISTORY

Pregnancy □ planned □ unplanned
Did the mother use drugs or alcohol while pregnant? _____
Did the mother have problems during pregnancy? □ Yes □ No If no, please explain:
_____
Child's birth weight: _____ Was child premature? □ Yes □ No
Check one: □ Breast fed □ Bottle fed At what age was this type of feeding discontinued? _____
Was your child: □ Colicky □ Active Was there any problem with weight gain? □ Yes □ No
At what age did your child walk _____ Were there any difficulties? _____
At what age was the child toilet trained? _____ Were there problems with wetting or soiling afterwards? _____
What forms of discipline do you use when correcting your child? _____
_____

FAMILY HISTORY

Are the child's parents living together? □ Yes □ No If no, when did they separate? _____
What is the living/custody arrangements?_____
_____
Describe visitation arrangements: _____
_____

List all members of household, ages, and relationship to child:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Has any blood relative of your child (parent, sibling, grandparent, aunt, uncle, etc.) ever had issues or been diagnosed with any of the following:

Mental Illness Suicide Alcoholism Drug Problems Seizure Disorder
Mental Retardation/Intellectual Disability Chronic Illness ADD ADHD Bipolar Disorder

Has your child ever been emotionally/mentally, sexually or physically abused? _____
_____
Has your child ever been in a war zone or civil unrest? _____ Experienced a natural disaster? _____
Been a victim of a crime? _____ Had other traumatic experiences? _____

Initial _____

NEST
PSYCHOLOGICAL SERVICES, PLLC

SCHOOL

Name of School: _____

Address: _____

Phone: _____ Current Grade: _____ Teacher: _____

Does your child have an Individualized Education Plan or 504 Plan? Yes No

If yes, a copy is required to be submitted to the office asap.

Has your child ever had to repeat a grade? Yes No _____

Does your child's teacher report any problems at school? Yes No If so, please explain: _____

_____

Additional comments or concerns you would like your child's provider to be aware of:

_____

_____

SPIRITUAL

Is your child or family spiritual or religious in any way? Please explain activities:_____

_____

Has your child had any loss or death in your life that is currently causing him/her distress? If so, please describe: _____

_____

How do you cope with loss and/or death? _____

_____

CULTURAL

What language(s) are spoken in your household? _____

_____

How would you describe your child ethnically or culturally? _____

_____

Does your child have any physical disabilities? _____

_____

FINANCIAL HISTORY

What are your family's sources of income? _____

Does your family receive any kind of assistance with food, housing, or other necessities? _____

_____

Does your family struggle with your bills? _____Does your child have transportation? _____

Initial _____

HOUSING

Has your family been facing being homeless? _____ Do you have issues where you live now (unsafe housing or neighborhood, poor relationship with neighbors or landlord)?_____

_____

LEGAL HISTORY

□ No legal history

□ History of involvement in legal system (describe)

_____

□ Served detention time _____ For what crime(s)?_____

□ Current legal charges (describe) _____

□ Involvement with Child or Adult Protective Services (describe) _____

Thank you for the time and effort you invested in completing this paperwork. This will help me to understand your child more fully and be better able to assist you on our journey together.

I have answered all questions accurately to the best of my knowledge:

_____ _____

Guardian Signature Date

Initial _____

Authorization to Release Protected Health Information (PHI)

I, _____, parent/guardian of (child's name) _____

(Date of child's birth)_____ give permission to Nest Psychological Services to send and/or discuss confidential case records and/or test results, to send treatment summaries and diagnosis information to and to receive confidential information from my primary care physician, psychiatrist, or other person/entity:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

I understand my service record is protected under Federal and State regulations and that information to be released by my signature may contain information pertaining to medical, psychiatric, substance abuse treatment and/or confidential HIV/AIDS related information.

This consent shall be in effect from_____ until_____
(No longer than one year)

_____ _____
(Signature of Patient/Guardian) (Date)

_____ _____
(Signature of Witness) (Date)

Initial _____

Credit Card on File Agreement

I _____ agree to allow Nest Psychological Services to keep my credit card information on file. It is required by my insurance company for my co-pay to be paid prior to my appointment. Therefore, I agree and permit Nest Psychological Services to charge my credit card for mine or my minor child's co-pay in the event that prior to the appointment I am not able to be reached or should the front office be unavailable to take my payment. I understand that no one will contact me prior to making this charge as it is understood that if I owed a co-pay for an appointment that I have completed the co-pay charge will be charged to my credit card. I also agree to allow my card to be charged for a no-show appointment or missed appointment without a 24-hour prior notice to the office if I have missed an appointment more than 2 times.

Signature: _____

Date: _____

Witness: _____

Date: _____

Initial _____

TeleMentalHealth Consent Form

This form is to be completed in addition. It does not replace the standard Consent and Services Agreement.

I hereby consent to engaging in telehealth with a provider at Nest Psychological Services, PLLC. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/behavioral health information, both orally and visually, to health care practitioners located and licensed in the Commonwealth of Virginia.

I understand that I have the following rights with respect to telehealth:
-I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
-The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my services is generally confidential. However, there are both mandatory and permissive expectations to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my behavioral or emotional state an issue in a legal proceeding.
-I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychologist that: the transmissions of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
-I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.
-I understand that I have a right to access my medical information and copies of medical records in accordance with Virginia law.

Insurance reimbursement:
I understand that my insurance may not cover telehealth with my Provider. I understand it is my responsibility to contact my insurance company to find out if my policy covers telehealth with my provider. I also understand that Nest Psychological Services, PLLC will bill my insurance, but this does not guarantee that my insurance will pay for telehealth mental services with my provider. If my insurance does not pay, I accept full responsibility for any payment due for services rendered by my provider. If my insurance does not cover telehealth for my Provider, I understand that I can request face to face services or ask for a referral to a provider that my insurance covers.

Signature of Patient/Legal Guardian: _____

Print Name: _____

Date: _____

Initial _____