Relationship-based child & adolescent therapy groups

109 Park Washington Court • Falls Church , Virginia 22046 • T: (703) 533-5825 x 103 • F: (703) 533-8431

David F. Flohr, Ph.D., CGP
FIN 54-1763668
VA. Lic. No. 0701-001679

I hope this description of my professional services and billing procedures will answer any questions you may have. Please feel free to ask any unanswered questions and to discuss other concerns you have as the need arises.

1. Professional Services Offered:

I am engaged in the practice of individual, group, marital and family psychotherapy with adults, adolescents and children. I also provide training, consultation and supervision to individuals, groups and organizations.

2. Length of Treatment:

Goals of treatment are arrived at by mutual collaboration through exploring the issues and concerns you feel to be most pressing and important. The length of treatment depends upon the goals we establish together. Treatment typically involves meeting one or two times per week. In some instances, other treatment schedules maybe useful including daily or monthly sessions. The schedule of sessions will be agreed upon during the first few meetings, and may be modified during the course of treatment. It will be very important for you to keep your scheduled appointments in order to receive maximum benefit from treatment.

3. Appointments, Fees and Cancellations:

Each session is generally 45 minutes in length. Group sessions are generally 60- 75 minutes. Longer sessions are sometimes advisable for more intensive individual and couples work. Fees for services are described below. Fees generally reflect the usual and customary charges in our area. Please feel free to discuss the fee structure as well as any concerns you might have.

Fees for professional services may be reimbursable by most insurance carriers. It is usually best to contact your insurance company to inquire about the extent and provisions of your policy, so that your expectations of coverage are realistic. All insurance companies vary in their coverage for mental health and frequently change their policies annually. Although I prefer not to accept direct insurance reimbursement (unless previous arrangements have been made), I will complete any forms or documents necessary for you to obtain your reimbursements. My billing statement has all the information required by most insurance carriers. For reimbursement, please attach my statement to your claim form and submit it directly to your insurance company.

Full payment is due at the time services are rendered. As of 6/1/2010, a 1.5% monthly interest rate charge will be incurred for all accounts with outstanding balances for more than thirty (30) days. Payment becomes past due thirty (30) days after a statement has been issued. If collection becomes necessary, all reasonable expenses, including collection agency and attorneys' fees will be charged to the client. If the use of a collection agency or attorney becomes necessary, it is

109 Park Washington Court • Falls Church , Virginia 22046 • T: (703) 533-5825 x 103 • F: (703) 533-8431

David F. Flohr, Ph.D., CGP
FIN 54-1763668
VA. Lic. No. 0701-001679

important to be aware that your right to confidentiality is curtailed. While no clinical information would be revealed, your name and amount owed becomes available to these agents.

If there is an adverse change in your financial status, we may adjust the fee structure together to reflect this change accordingly. If there is an increase in fees, you will receive notice two months in advance.

Your appointment time is reserved solely for you. Sessions missed for pre-arranged vacations up to two sessions per calendar year are not billed. Up to two additional sessions per year may be canceled for any reason without charge. Because your appointment time is reserved solely for you all other missed sessions will be billed. If a missed session, for which you would have been billed, is able to be filled, then no charge will be made to you. **Payment for services is due at the end of each meeting.**

Please note, there will be a $20.00 charge for returned checks.

Fees for Services:

Initial evaluation and treatment planning: 75 minutes …….…. $260.00

Couples and Family psychotherapy for 45 minutes ………… $195.00

Couples and Family psychotherapy for 60 minutes ………… $225.00

Couples and Family psychotherapy for 75 minutes ………… $260.00

Individual psychotherapy: 45 minutes … …………………… $180.00

Group psychotherapy: 60-75 minutes ……….……………….... $ 80.00

ParentCircle sessions of 90 minutes …………………………. $ 75.00 per parent
(materials fee may apply) $125.00 coparent team

Case management, extended telephone consultations, extended insurance management, school visits and preparation of letters per 45 minutes ……………………………………………….. $180.00

Emergency psychotherapy services (sessions, phone calls, case coordination, etc) per 45 minutes …………………………….. $225.00

109 Park Washington Court • Falls Church , Virginia 22046 • T: (703) 533-5825 x 103 • F: (703) 533-8431

David F. Flohr, Ph.D., CGP
FIN 54-1763668
VA. Lic. No. 0701-001679

4. Telephone Accessibility:

You can leave a confidential message for me at the following number: (703) 533-5824 x 2. In case of serious emergencies you may dial 533-0332 24 hours a day and leave an emergency message. These messages will activate an emergency beeper and your message will be responded to as soon as possible. If your emergency is life threatening, proceed independently to the nearest hospital. Keep in mind that the emergency beeper system is electronic and therefore imperfect.

5. Medication:

If medication is indicated as part of your treatment, I will discuss various referral options with you. If it seems advisable to obtain a psychiatric consultation to assess the need for medication, I will refer you to one of the psychiatric consultants that I work with or talk with your family physician.

6. Confidentiality:

Confidentiality is your expectation about privacy concerning information you disclose during your consultations with me. I am bound to hold in confidence nearly all that is disclosed, including the fact that you consulted with me. In group or family sessions, where private information may be shared with other individuals in addition to myself, the limits and expectations about confidentiality will be made clear in advance, so that each participant understands who will know what. There are, however, situations where the rule is excepted. They are as follows:

(A) If it suspected that child abuse has occurred, the Commonwealth of Virginia requires that it be reported to the Department of Social Services. Child abuse includes neglect of medical needs, abandonment, sexual exploitation and physical or mental injuries that result in impaired functioning.

(B) If you are a Virginia licensed health care provider and that, due to substance abuse or emotional stress, you are unable to practice competently or pose a danger to your patients, the law requires that it be reported to the appropriate authorities.

(C) If you are in clear or imminent danger to yourself or another person, I must notify the appropriate authorities to prevent that occurrence.

(D) In a legal proceeding, patient-therapist communications are privileged with the following limitations: (1) only for civil actions; (2) only for individual therapy, not couple or family sessions; (3) not if your mental status is an issue before the court; (4) unless the judge believes that these communications are necessary to the proper administration of justice.

In addition to the above legal limitations on confidentiality, I ask that your grant me the permission to share information when necessary with my colleagues at Washington Square.

If I am out of town, one of my colleagues will be available to provide emergency coverage and may need access to relevant information to provide interim care, should the need arise.

Finally, if you are seeking third party reimbursement for psychological services, the third party payer has the right to request information for determination of your eligibility for payment. Your signature on the claim gives consent for me to disclose dates of treatment, type of treatment, and the nature of your problem or illness (diagnosis). If I am billing the third party payer, I will need your signature on file consenting to disclosure of the above information.

I HAVE READ THE ABOVE POLICIES, UNDERSTAND, AND AGREE TO THEM.

____ _______________________________

Your signature Today's date

I give David F. Flohr, Ph.D., P.C. permission to send me a brief follow-up therapy evaluation form six months after ending therapy. (This will assist me in improving my service to individuals over the years. Permission can be withdrawn at any time.) ______________ yes ________________ no

Relationship-based child & adolescent therapy groups

109 Park Washington Court • Falls Church , Virginia 22046 • T: (703) 533-5825 x 103 • F: (703) 533-8431

David F. Flohr, Ph.D., CGP
FIN 54-1763668
VA. Lic. No. 0701-001679

NEW PATIENT REGISTRATION INFORMATION

Date First Seen:____________________________________

PATIENT INFORMATION:
Patient's Name:____
Last First Middle
Address:____
Street Apt. City, State Zip
Home Phone #:( )____________________________________ Work/School #:( )____________________________________

Marital Status:_____S_____M____W____D____SEP Gender:____M____F

Date of Birth:___________________________________ Social Security #:____

Referred By:____
Name Phone #
EMERGENCY CONTACT:____
Name Phone #
FINANCIAL INFORMATION:
Financially Responsible Person:____

Relationship to Patient:______Self _______Parent ______Spouse _______________Other

Address:____
Street Apt# City, State Zip
Home Phone #:( )_______________________________________ Work #:( )____

INSURANCE INFORMATION:
(Please be advised that we do not file insurance, but this information is kept on file in case we are contacted by your insurance company)

Insured's Name:____
Last First Middle
Insured's Address:____
Street Apt# City, State Zip
Insured's Date of Birth:____________________ Social Security #:____

Relationship to Patient:______Self _______Parent ______Spouse ____Other

Primary Insurance or Program Name:____

Insurance Address for Claims Submission:____
____

Insured's Group #:_________________________________ Insured's ID #:____

Signature on File Authorization

"I____, request that payment of authorized insurance benefits be made to me or on my behalf to David F. Flohr, Ph.D.for any services furnished to me by that practitioner or supplier. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Beneficiary Signature____ Date:______________________________

Relationship-based child & adolescent therapy groups

109 Park Washington Court • Falls Church , Virginia 22046 • T: (703) 533-5825 x 103 • F: (703) 533-8431

David F. Flohr, Ph.D., CGP
FIN 54-1763668
VA. Lic. No. 0701-001679

REQUEST TO RELEASE\EXCHANGE RECORDS AND INFORMATION

I hereby authorize____ or

Name:____

Address:____

____

To release\ exchange the following information from the records of:

__________myself ________my child ________________DOB

Name: ____

Address:____

____

To\with:
Name\organization: ____

The following information from the records is requested:

_______ **Intake and Discharge Summaries** ______**Medical Records**

_______**Psychological Evaluations** ______**Developmental\Social History**

_______**Educational Records** ______**Progress Notes and Closing Summary**

_______**Other:**____

This authorization is signed with the understanding that the information will not be passed on to anyone else, or be used for any other purpose other than specified above. I understand that this authorization may be revoked at any time to the extent that the action based on this consent has been taken.

Authorization expires on:________________________________ ________________
(Maximum of 1 year from date of signing) Date signed

_________________________________ _____________________
Signature of Patient Date

_________________________________ _____________________
Signature of Parent\Guardian\Representative Date