# Lynn Blycher, 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 I will leave general voicemail messages on the numbers provided. These messages will NOT include any personal health information. Please inform me if you still would not like any messages left*****

Male _____Female_____ Birth Date _____ Social Security#_____

Marital Status: Single_____ Married _____ Separated_____ Divorced_____ Other _____

Employer _____ Job Title _____

Emergency Contact _____ Phone _____Relation_____

Referred by_____

**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 _____

Home Phone _____Cell Phone_____Work Phone_____

Birth Date _____Social Security #_____ Male _____ Female _____

Marital Status: Single_____ Married _____ Separated_____ Divorced_____ Other _____

Email: _____

**PRIMARY CARE PHYSICIAN INFORMATION:**

PCP/Pediatrician/Etc.: _____

Office Phone: _____ Fax (if known) _____

Reason for seeking therapy:_____

_____

_____

Household members:

Name Age Relationship

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any current (prescribed and over the counter) medications

Medication Dosage Purpose

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Major illnesses, injuries, and/or operations you have had:_____

_

_____

_____

Exercise/physical activity:_____

Sleep: how many hours typically? _____ Circle any that apply to you over the past 6-8 weeks:

Difficulty falling asleep Difficulty staying asleep Early morning waking

Do you reel well-rested when you wake up? Typically yes Typically no

Eating: Weight loss/gain?_____ Was this intentional?_____

# Informed Consent for Treatment

I, _____ (name of patient), agree and consent to participate in behavioral health care services offered at and provided by Lynn Blycher, LLC, Licensed Professional Counselor. 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. 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.

_____ _____

Signature Date

Lynn Blycher, LLC Lynn Blycher, LPC
44135 Woodridge Parkway Suite 260 Lansdowne, VA 20176

# FINANCIAL POLICY AGREEMENT

Therapy and Case Management Fees

Intake Appointment: $170/ 75-minute session

Individual Therapy: $135/ 60-minute session

Family Therapy: $135/ 60-minute session

Case management services: $160/ hour; $40/15 minute increments

Case Management services include reading reports/evaluations, writing a letter, telephone or face-to-face consultations with school personal, other therapists working with your family, attorneys, background investigators for your current or potential employment, psychiatrists or anyone else that may be helpful to speak with as mutually agreed upon. This fee also includes telephone calls with the client or family member, beyond simply rescheduling an appointment that is outside a scheduled therapy session. If a letter or other document is provided at your request, then payment is expected at the time of receipt. Fees accumulated for any other form of case management services will be collected in full at the next appointment. Please note that case management service fees are not covered by insurance.

Legal services (i.e., court appearance, conveying information to court, letter to an attorney) $300/hour. Fees will be charged for necessary time to prepare for court, travel time to the courthouse as well as Lynn Blycher, LLC time waiting for the court proceeding to begin. Reimbursement of any excess retainer fee will be provided after the court case is complete.

Cancellation Policies

Scheduled appointments consist of valuable time to all involved. Please provide 24 hour notice and call (703) 477-6649 to cancel appointments that cannot be met. If, for any reason, you are unable to provide such notice via telephone, you will be responsible for the full fee of the missed appointment, which is $135. In the event of snow or inclement weather, your appointment can be canceled the same day with no charge, only if Loudoun County Government (not the school system) is closed and only if you call to cancel your 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. By signing this form, you acknowledge that you have read and fully understand the policy for cancellation of appointments. X_____ (Please initial)

# Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

| **Credit Card Information** |
|---|
| Card Type: □ MasterCard □ VISA □ Discover<br>□ AMEX □ Other _____ |
| Cardholder Name (as shown on card): _____ |
| Card Number: _____ |
| Expiration Date (mm/yy): _____ |
| Cardholder ZIP Code (from credit card billing address): _____ |

I,_____, authorize Lynn Blycher, LLC to charge my credit card above for missed appointments or late cancellations. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer signature Date

# Release, Assignment, and Financial Responsibility

Individuals with Anthem Blue Cross Blue Shield, Federal Employee Program Blue Cross Blue Shield, Carefirst and Cigna: Lynn Blycher, LLC will file claims for your treatment. Your estimated co- pays and deductibles will be collected at each visit. Regardless of what the insurance policy pays or does not pay, you are fully responsible for any unpaid balance not paid by your insurance after 90 days. Please review your insurance coverage for outpatient therapy services prior to your first appointment.

*I accept financial responsibility for all clinical and administrative services provided by Lynn Blycher, LLC. Lynn Blycher, LLC will provide a receipt for services I have paid for. Unless otherwise specified, it is my responsibility to work with my insurance provider to be reimbursed. I acknowledge being informed that my insurance may not cover all services requested. When a denial of payment is received from my insurance carrier the charge will become my responsibility. My financial responsibility explicitly includes, but is not limited to, initial evaluations, medication management, individual therapy, marriage counseling, couples counseling, group therapy, assessments, psychological testing, professional fees, forensic fees, legal fees, or collection fees if my account goes to a third party. X_____*

***My signature below constitutes acknowledgement and acceptance of these policies.***

_____

Print Patient Name

_____ _____

Signature of Patient or Guardian Date

**Notice of Privacy Practices Receipt and Acknowledgment of Notice Patient/Client**

Name:_____

DOB: ___/___/_____ SSN: _____-____-_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Lynn Blycher, LLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Lynn Blycher, M.Ed., LPC, Privacy Officer, at (703) 477-6649.

_____ _____

Signature of Patient/Client Date

_____ _____

Signature of Parent, Guardian or Personal Representative Date

_____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

*I have read and understand Lynn Blycher, LLC Notice of Privacy Practices*

_____

Print Patient Name

_____ _____

Signature of Patient or Guardian Date

Patient/Client **refuses** to Acknowledge Receipt:

_____ _____

Signature Date

## Electronic Communication and Consent for Use

Be advised that the use of email, cell phone texting, and other forms of technology in psychotherapy may have security concerns and have not been defined as a best-practice strategy.

Any information exchanged electronically or with the use of technology increases the risk of confidentiality breaches. Communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed. Therefore, the therapist cannot guarantee protection from unauthorized attempts to access, use, or disclose personal information exchanged electronically. Do not include personal identifying information such as your birth date, or personal medical information in any emails you send.

Email/texting communication with Lynn Blycher, LPC will be used for the purpose of simplifying and expediting scheduling/administrative matters only. You should also know that any electronic communication I receive from you and any responses that I send to you may become a part of your legal medical record.

Email/texting communication is NOT to be used to provide/receive treatment services or take the place of therapy sessions. Therefore, email/texting should NOT be used to communicate: Suicidal or homicidal thoughts or plans, urgent or emergency issues, serious or severe side effects or concerns, or rapidly worsening symptoms. In a life-threatening emergency clients should: Call 911, proceed to the nearest hospital emergency room, and/or call a crisis hotline such as 703-777-0320 or 1-800-SUICIDE.

No one can diagnose your condition from email or other written communications, and communication via a website cannot replace the relationship you have with your mental health practitioner.

I have thoroughly considered all of the above information. By signing the Client Information form I consent to the use of email/cell phone texting as needed for scheduling and administrative purposes only, within the guidelines above. If more urgent help is needed, I will utilize the crisis services listed above. Furthermore, if at any time my therapist or I believe email/texting is interfering in my therapeutic process or being used ineffectively, either of us can revoke this consent verbally, refuse to respond to emails/texts, and insist upon a verbal conversation before proceeding.

_____ _____

Client signature Date

_____ _____

Printed name Date of birth

_____ _____

Parent / guardian signature Date

_____

Parent / guardian printed name

_____ _____

Parent / guardian signature Date

_____

Parent / guardian printed name

**Authorization to Bill and Release Information for Billing Records and information concerning;_____**

I understand that:

Services will not be denied if I refuse to sign this document.

The records of the individual named above are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without written consent unless provided for in Federal and State laws and regulations.

Authorization to Bill:

I authorize Lynn Blycher, LLC to bill my insurance carrier(s) for services rendered to me. I understand that Lynn Blycher, LLC cannot guarantee that an insurance plan will cover all service fees, and that I am responsible for:

Providing Lynn Blycher, LLC accurate and updated insurance information.

Remitting to Lynn Blycher, LLC any payment I receive from my insurance company for services provided by Lynn Blycher, LLC.

I hereby give Lynn Blycher, LLC authorization to release information to, communicate with, and disclose information to my insurance company for the purpose of billing for services provided by Lynn Blycher, LLC and determining benefits and reimbursement.

I authorize Lynn Blycher, LLC to release the minimum amount of information required to verify benefits and bill for eligible services. I understand that this will include demographic information, diagnosis, attendance information, service(s) provided, dates of service and treatment provided.

This authorization remains in effect until either I revoke the authorization in writing or until all services provided by Lynn Blycher, LLC have been billed to my insurance.

Assignment of Benefits: I authorize payment directly from my insurance company to Lynn Blycher, LLC for services provided for the duration of treatment or until I revoke this consent.

Revocation: I understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on it. (To revoke this authorization, please provide a written statement to that effect to Lynn Blycher, LLC.)

Re-disclosure: When Lynn Blycher, LLC releases information pursuant to this disclosure, it will include a prohibition of disclosure statement as required under 42 CFR: however, information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by 45 CFR Subtitle A. Subchapter C. Section 164.500 and 42 CFR Part 1.

_____

Signature of individual/parent/guardian/authorized requestor

_____

Printed name of signatory

Date:_____