TURNING POINT COUNSELING SERVICES

WHERE GROWTH BEGINS

Application for Services

Client Name:		Partner/Parent(s) Name(s):
Client phone Home #: ☐ Preferred contact number ☐ OK to leave message	Work #: ☐ Preferred contact number ☐ OK to leave message	Mobile #: ☐ Preferred contact number ☐ OK to leave message & text
Partner/Parent phone Home #: ☐ Preferred contact number ☐ OK to leave message	Work #: ☐ Preferred contact number ☐ OK to leave message	Mobile #: ☐ Preferred contact number ☐ OK to leave message & text
Client Email:		Partner/Parent(s) Email:
Street address:		
City:	State:	ZIP code:
Date of birth:		Partner's date of birth:
Client's relationship status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		Length of relationship:
Emergency contact info:		
Referred by:		
Person responsible for payment:	Address of person responsible for payment:	Street address: City: State: Zip:
Employment status: ☐ Employed ☐ Student ☐ Part-time ☐ Full-time ☐ Other		
Employer or School attending:		
Religious affiliation:		
What previous counseling have you had?		
What precipitated counseling?		
Goals & expectations for counseling:		
Family Composition: (names and ages of family members, roommates, and/or others living in the home)		
Family History of substance abuse, mental health, or behavioral issues:		

Current medications:
Current or past substance use or abuse:
Medical history and current symptoms:
Legal history: (litigation, detainment, DUI, arrest or other involvement)

Safety

☐ There is a firearm or other weaponry in the home. If so, please elaborate:

☐ I have previously harmed or thought about harming myself. If so, please elaborate:

☐ I currently harm or think about harming myself. If so, please elaborate:

☐ I currently harm or think about harming other people, animals, or objects. If so, please elaborate:

What else would you like me to know?

Authorization for therapy

Please sign after reading Informed Consent and Description of Services.

I/We (print names) _____ authorize Turning Point Counseling Services LLC to provide therapy to me, us, and/or my child(ren).

Signature of Client:	Date:
Signature of Client, Partner, Parent, or Guardian:	Date:

Turning Point Counseling Services LLC Agreement to Provide Therapy:

Signature of Therapist:	Date:
Signature of Therapist: Ashley Winter, Resident in MFT/Resident in LPC	Date:

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Informed Consent And Description Of Services:

Goals and Outcomes: Counseling is most useful in helping individuals help themselves or improve their relationships by changing feelings, thoughts, and/or behaviors. You determine the amount and nature of change you wish to make. The goals are set by the client and discussed with the therapist. Goals should be re-evaluated during the process to assess progress or to modify goals. Outcomes are impacted by a variety of factors including but not limited to openness/honesty, hard work, consistency, follow-through, physical health, expectations, etc. The therapist and Turning Point Counseling Services LLC cannot promise or guarantee change.

Benefits and Risks: The process of change takes time. It is important to have realistic expectations and to discuss them. At times, situations get worse before they get better, or they may get better and then get worse, or they may plateau. This is normal. It is also normal to experience some feelings of anxiety, depression, guilt, frustration, loneliness, etc. prior to or after a session. An additional risk may be encountering your therapist in a public place. Please advise your therapist on how you would like them to proceed if this happens. Turning Point Counseling Services LLC and your therapist cannot promise or guarantee change.

Length of Therapy: The length of therapy will vary on an individual basis due to goals and needs. This should be discussed throughout the counseling process.

Expectations and Other Areas of Discussion: Client is expected to be honest and open. Client is expected to communicate concerns, goals, expectations, etc. Client is expected to make an active effort to work on change both during and between visits. The first few sessions may involve an evaluation of your needs. Client is expected to pay at the time of service. Client is expected to notify the therapist of the need to cancel or reschedule at least 24 hours prior to the appointment. Therapist is not able to be Facebook friends with their clients.

If at all possible, client is expected to leave children at home. Children who accompany their parent(s) must be young enough to not be impacted by the content discussed in the session. Children should not be left in the waiting room unattended. Respect for the other tenants in the office building is important so please keep noise to a minimum and do not allow children to run around the building. Therapist is not responsible for the safety or health of anyone in the waiting area.

Termination of therapy may be based on but not limited to the following reasons: fraud/deceit, non-payment of services rendered, breaking of contracts, the need for referral to additional services/resources, wrong fit between client and therapist, etc. Therapy can be terminated by either the therapist or the client. However, it is recommended that a conversation regarding termination happen between both parties. Should you desire to seek another therapist, your therapist can provide you with alternatives. Please let the therapist know if you do not intend to return to therapy and the reasons for not returning. It is expected that you will talk to your therapist if you are unhappy with therapy as your needs may be better met after communicating misunderstandings, unmet expectations, disconnect between personalities, etc. A portion of therapeutic success is impacted by the relationship between client and therapist.

Please inform the therapist of any changes in address, phone, or other details. If you need to get ahold of your therapist between sessions for scheduling or general questions, please make contact through phone or email. Your therapist may not be immediately available so, if desired, leave a message. Your therapist will make every effort to return your calls within 24 hours unless it is a weekend, holiday or vacation. If you cannot get a hold of your therapist and it is an emergency, please go to the emergency room or call 911.

Payment for Services: Payment is expected at the time of service and can be made by check, cash, VISA, MasterCard or Discover. Returned check fee is $35.00. Cash only will be accepted after the second returned check. The clinical fee for a 50 minute session is $160.00. Additional time is charged in half hour increments. If the client is unable to pay this fee, a sliding scale ($120.00-160.00) based upon income and need may be used. If a sliding scale is used, the client may be expected to bring tax returns to verify income. If you are in need of a sliding scale, please talk to your therapist about the requirements and breakdown of fees. Payment by a charitable organization may be billed at $120.00. Charitable organizations will be billed monthly and are expected to pay in a timely manner. Ultimately, the client is responsible for payment if services are rendered even if someone else initially agreed to pay and now refuses to do so. There is an additional fee of $15.00 for the initial session as there are additional assessments, paperwork and outside session time required of the therapist. Group fees will be discussed at the beginning of the group.

Turning Point Counseling Services LLC does not bill insurance but will give the client the necessary information that their insurance company may require so that they can submit their claim to their insurance company for reimbursement. You may be eligible for out-of-network benefits or religious exemption clauses for in-network benefits. If you are planning on getting reimbursed through your insurance company, please check with them regarding what type of clinical license they require of your therapist.

Fees may be applied for any documentation or paperwork needed for employment, security clearances, school, court, insurance, progress reports, etc. Fees may also be assessed for any necessary appearance of the therapist at school, court, insurance, mediation, etc. It is Turning Point Counseling Services, LLC's policy to not go to Court; however, if absolutely necessary for the therapist to do so, there will be a fee. Fees may be assessed for phone calls over 15 minutes in length.

Any client that has a balance that is 60+ days overdue or an outstanding balance of $500 may not be scheduled for additional appointments until the balance is paid or therapy may be terminated and the client may be referred to community resources.

Confidentiality: The information you share in counseling can be very personal. Confidentiality is essential. A written Authorization for Release of Confidential Information is required to talk to or exchange information with another party. However, Turning Point Counseling Services LLC is mandated by law to report any suspicion or knowledge of any neglect or abuse of a child/elderly person or of any intent to harm self or others regardless of whether an Authorization for Release of Confidential Information is signed. Please refer to HIPPA/ Notice of Privacy Practices for additional information on your privacy regarding health matters. Information may also be discussed in connection with external and/or internal supervision/staffing and evaluation, billing or office management issues.

Billing: Turning Point Counseling Services LLC is able to do all billing and other administrative tasks in house. Kandy Howard is our billing and office manager. Please contact **billing@turningpointcounselinggroup.net** or your therapist with questions about your bill. It is expected that you will inform us if you would like to have your bills and other documents sent to a particular address other than your own.

Records: Clients are entitled to a copy of their paperwork, excluding process notes. Request for records must be sent in writing to Turning Point Counseling Services LLC. A Release for Medical Records may also have to be filled out. Your therapist and Turning Point Counseling Services LLC may have the right to deny a copy of paperwork if there is clinical justification to do so. It is Turning Point Counseling Services LLC's policy not to go to court. However, if appearing in court is necessary there will be a fee. Please talk to your therapist if you have questions or concerns with your paperwork.

Minors: If the client is under 18 years of age, the law may require that parents/ guardians may have the right to examine the minor client's treatment records. It is necessary to have an atmosphere where the minor can share without the fear of reprisal or misunderstanding by the parents/ guardians. It is important for the therapist to have a balance of confidentiality for the minor and the ability to access help through the parents/ guardians if there are serious concerns about safety, mental health or relationships.

Cancellation/ Reschedule of Appointment: Once time is allocated for the client's therapy session, that time is the client's. It is difficult to reallocate that time to another on short notice. It may also be difficult to reschedule in a timely manner as appointments fill up quickly. The client is expected to give at least 24 hour notice of the need to cancel or reschedule. The client will be charged half of the fee for an appointment when there is not 24 hours notice given. The payment will be expected at the next visit. The client, not a third party, will be billed in this situation. Insurance companies and charitable organizations will not reimburse for missed sessions.

In Case of Emergency: If you are experiencing a mental health emergency, go to the nearest emergency room or call 911. Please leave a voicemail message for your therapist with an update, so they will know how they can be helpful to you. Please provide emergency contact information to Turning Point Counseling Services LLC so that if any unforeseen circumstances happen during a session, your therapist can get you help.

For Clients of Ashley Winter Supervision Resident in MFT/Resident in LPC**:** Your therapist has a PhD in Medical Family Therapy and a Master's degree in Marriage and Family Therapy. She is completing the Licensed Professional Counselor and Licensed Marriage and Family Therapist credential. While completing licensure she is required by the Virginia Board of Counseling to be supervised. During supervision, your case file may be reviewed by the Clinical Supervisor, Marianne Coad, or by the Agency Director, Tiffanie Williams. Ms. Williams and Ms. Coad are under the same confidentiality and ethical rules that your therapist is. Their contact information is provided should you have any questions or concerns. Please also talk to your therapist about any questions and concerns you might have. Contact information is: Marianne Coad, MAMFC, LMFT, LPC, AAMFT Approved Supervisor Mentor, 10379-B Democracy Lane, Fairfax, VA 22030, 703.239.1510. Tiffanie A. Williams, LCSW, 500 N Washington Street, Alexandria, VA 22314, 571.245.6109.

Payment arrangements are as follows: client pay: $ _____ other pay: $_____

The above can be modified at any time and go into effect without prior notice. I understand the above information and agree to abide by its terms during our professional relationship. If there is anything in this form that I do not understand, it is my responsibility to seek clarification prior to signing.

Signature of Client:	Date:
Signature of Client, Partner, Parent, or Guardian:	Date:

Turning Point Counseling Services LLC
500 N. Washington St, Suite 306, Alexandria, VA 22314
4229 Lafayette Center Dr, Suite 1300, Chantilly, VA 20151

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Notice Of Privacy Practices

Please read through the information below carefully and sign at the bottom indicating that you have read and understood the information contained in this notice.

Why Turning Point Counseling Services LLC Provides You With This Notice:

Federal law requires me to give you this notice, and it is known as the Health Insurance Portability and Accountability Act (HIPPA). This Notice will tell you about the ways in which I may use and disclose health information about you and will describe your rights and my obligations regarding the use and disclosure of that information.

Your Health Information:

This notice applies to the information and records we have about your health, health status, and the health care services you receive from Turning Point Counseling Services LLC. This information and record relates primarily to counseling services you will receive from me.

How We May Use and Disclose Health Information About You:

For Treatment:

Turning Point Counseling Services LLC may use or disclose health information about you to facilitate counseling and other health treatment. For example, I may disclose information about you to another therapist or to a supervisor to determine the most appropriate care for you.

For Payment:

Turning Point Counseling Services LLC may use or disclose health information about you so that I can be paid by you, or any other party, if they are paying any portion of the fee for the services I provide for you.

For Operations:

Turning Point Counseling Services LLC may use or disclose health information about you in order to run the office and make sure that you and other clients receive quality care. For example, I may use your information for my employee to contact you to remind you of your appointments.

Special Situations:

Turning Point Counseling Services LLC may use or disclose health information without your permission for several reasons. These reasons include:

- Disclosing your health information in order to prevent a serious threat to your health and safety or the health and safety of another person.
- Disclosing your health information as required by law to prevent injury or suspected abuse or neglect.
- Disclosing your health information as required by federal, state or local law.
- Disclosing your health information in response to a court order, subpoena, warrant, summons or similar process.

Other Uses and Disclosures of Health Information:

Except where otherwise required or authorized by law, I will not use or disclose your health information for any purpose without your written authorization. If you authorize me to use or disclose health information about you, you may revoke your authorization, in writing, at any time. If you revoke your authorization, I will no longer use or disclose your health information for the reasons covered by your written authorization, but I cannot take back any uses or disclosures I have already made with your permission.

Your Rights Regarding Your Health Information:

- You may inspect and copy your health information (demographics and billing records) with certain exceptions (case process notes).
- If you believe that the health information we have about you may be inaccurate or incomplete you may ask us to amend the information. Request must be made in writing.
- You may obtain an accounting of the disclosures of your health information. This is a list of all our disclosures of your health information for the purposes other than treatment, payment and health care operations.
- You may request that we communicate with you about your health matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by mail.
- You have the right to receive a paper copy of this notice if you desire.

If you want to exercise any of these rights, please let your therapist know with a written request at any time.

Change to this Notice

Turning Point Counseling Services LLC has the right to change this notice. If a change happens, the new notice will apply to the health information we may already have about you and to the health information that we receive in the future. Turning Point Counseling Services LLC is required to abide by the most current notice that is in effect. You are entitled to receive a copy of the most current notice.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services.

Signature of Client:	Date:
Signature of Client,Partner, Parent, or Guardian:	Date:

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Authorization For Release Of Confidential Information

Client Name_____ Client Name_____

I authorize Turning Point Counseling Services LLC and the persons or entities listed below, or their representatives, to mutually release, exchange and disclose my health information.

I have received and reviewed the Notice of Privacy Practices.
I understand that only authorized representatives of Turning Point Counseling Services LLC may ask me to sign this authorization.

I understand that by signing this general authorization I am authorizing Turning Point Counseling Services LLC to disclose my health information to the persons and entities listed below and that any health information or other confidential information in the possession of the persons and entities listed below may be disclosed to Turning Point Counseling Services LLC. My health information includes, without limitation, any records, reports, test results, opinions, assessments and any other information relating to medical, emotional, educational, mental, social, spiritual or psychological condition. Disclosure may also be made to describe my condition and progress and to discuss treatment.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to Turning Point Counseling Services LLC. I understand that my revocation of this general authorization will not affect a disclosure that Turning Point Counseling Services LLC has already made under this authorization.

I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by Turning Point Counseling Services LLC confidentiality rules.

I waive any right of privacy that I may have in connection with the disclosures hereby authorized.

For parents of minors receiving services: I authorize _____ to receive services provided by Turning Point Counseling Services LLC. This release authorizes any necessary psychological and/ or psychiatric evaluation and treatment or release of any information regarding minor to disclosed persons or entities. My signature below indicates that I agree and give consent to the above services. I also understand that parental participation in one or more of the following ways may be required: assessment, individual counseling, marital counseling, family counseling, parenting skills training or group counseling.

This authorization is only valid until _____ (fill in date) or until six months after my file is closed by Turning Point Counseling Services LLC.

Name:	Address:	Phone:	Client's Initials:
Name:	Address:	Phone:	Client's Initials:
Name:	Address:	Phone:	Client's Initials:
Name:	Address:	Phone:	Client's Initials:
Name:	Address:	Phone:	Client's Initials:
Name:	Address:	Phone:	Client's Initials:
Name:	Address:	Phone:	Client's Initials:
Name:	Address:	Phone:	Client's Initials:

Signatures:

Client's Signature:	Date:	Client's Signature:	Date:
Print Name:	Date:	Print Name:	Date:
Parent/Guardian Signature:	Date:	Parent/ Guardian Signature:	Date:
Witness:	Date:	Witness:	Date:

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Adult Issues Checklist

Name:_____ Date:_____

To help me understand you better, please check the issues that apply to your situation. If there are two filling this out, please differentiate who has identified with the issue. Thank you.

____ Employment/ school problems
____ Legal problems
____ Problems with living arrangements
____ Financial problems
____ Anxious/ worried/ nervous
____ Increase/ decrease in appetite/ weight
____ Confusion
____ Unexplainable and/or uncontrollable crying
____ Extravagance with money
____ Fatigue
____ Forgetfulness
____ Frequent lying
____ Risk-taking behaviors
____ Generalized dissatisfaction
____ Guilt feelings
____ Difficulty being alone
____ Anxiety that limits activities
____ Mood swings
____ Hyperactivity
____ Panic attacks
____ Sadness/ depression
____ Shy, uneasy with others
____ Suicidal thoughts
____ Memory problems
____ Trouble sleeping
____ Unassertive, passive behavior
____ Aggressive behavior
____ Unwanted, compulsive behavior
____ Withdrawn
____ Worry about alcohol/ drug use
____ Physically abused
____ Sexually abused
____ Emotionally abused
____ Other abuse problems
____ Excessive fighting
____ Fears
____ Sexual problems
____ Sexual identity concerns
____ Physical problems
____ Relationship problems
____ Poor concentration

Place a check next to any of the following that have happened to you or any immediate family/ household members in the last two years.

____ Death of a spouse/ partner
____ Death of a close friend
____ Death of a family member
____ Major change in health
____ Marriage
____ Divorce/ separation
____ Reconciliation with spouse/ partner
____ School failure
____ Victim of a crime
____ Move
____ Death of a pet
____ Incarceration
____ Pregnancy/ new child
____ Unemployment
____ Change of Employment

Please list anything else that you would like me to know about you.

500 N. Washington St, Suite 306, Alexandria VA 22314
4229 Lafayette Center Dr, Suite 1300, Chantilly, VA 20151