Marguerite "Rita" Hursh, LPC

14143 Robert Paris Court
Chantilly, VA 20151
Telephone: 703-715-6077

CLIENT INFORMATION

Name _____

Address _____
_____

Email Address _____

Telephone: Home _____ Work _____ Cell _____

Date of Birth _____ Age _____ Marital Status S M D Sep

Referred By _____

Who currently lives at your residence	Age	Relationship
_____	____	_____
_____	____	_____
_____	____	_____

Please list previous counseling experiences for you or family members (include therapists' names and dates:_____
_____

All Current medical diagnoses	All Medications	Dosage (amount/day)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Hospitalizations (location)	Reason	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency Contact (name) _____ phone _____

Your Current Occupation, Place of Work, and Work Address _____

_____

_____ _____
Date Please initial

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CHECKLIST OF SYMPTOMS

Please check all that apply to how you are feeling.

- ❑ Sad or blue most of the day, nearly every day
- ❑ Lost interest in activities you once enjoyed
- ❑ Have problems with insomnia
- ❑ Have problems with oversleeping
- ❑ Recently experienced a significant gain in appetite
- ❑ Recently experienced a significant loss in appetite How much? ____
- ❑ Feel agitated
- ❑ Feel irritable
- ❑ Feel anxious
- ❑ Feel angry
- ❑ Experience feeling on edge
- ❑ Feel paranoid
- ❑ Have panic attacks
- ❑ Feel tired or fatigued
- ❑ Poor social skills
- ❑ Suffer from feelings of inappropriate guilt
- ❑ Suffer from feelings of hopelessness
- ❑ Suffer from feelings of inadequacy
- ❑ Recently experienced a loss of energy and motivation
- ❑ Have difficulty concentrating
- ❑ Have slowness of thought or speech
- ❑ Have suicidal thoughts
- ❑ Feel your heart race
- ❑ Have sweaty palms
- ❑ Feel nervous much of the time
- ❑ Experience chronic fatigue
- ❑ Experience wild mood swings
- ❑ Feel hostile or act abusively
- ❑ Lie chronically
- ❑ Suffer from domestic violence
- ❑ Have problems in school or at work
  If so, please list:
- ❑ Suffer from feelings of helplessness
- ❑ Hallucinations

List any other symptoms you think are important:

_____
Initial this page

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How many alcoholic drinks do you have per week?
0 – 1 2 – 5 more than 5

How many DWI/DUI's have you received? _____

Do you ever feel the need to cut down on drinking? Y N

Have you ever received comments, criticism regarding your drinking? Y N

Have you ever felt guilty about your drinking? Y N

Have you ever awakened the morning after some drinking the night before to find that you could not remember part of the evening before? Y N

Do you drink before noon? Y N

Have you ever felt the need for an Eye Opener when you first get up in the morning or first thing in morning? Y N Prior to social events? Y N

What non-prescription drugs do you use other than alcohol?

How many times a week do you use?

0 – 1 2 – 5 more than 5

When do you use?

Before breakfast morning afternoon at night weekends only

Have you ever felt the need to cut down on drug use? Y N

Have you ever received comments, criticism regarding your drug use? Y N

Have you ever felt guilty about your drug use? Y N

Please describe ***past*** alcohol/drug use: list all substances used, degree of intensity, dates used, last date used

_____

_____

_____

_____

Initial this page _____

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Please check the highest level of education you have attained:

_____ High School
_____ GED
_____ Some college (how much?)
_____ Bachelor's degree
_____ Graduate work
_____ Master's degree
_____ Ph.D.

Please list any significant psychiatric and physical disorders in the family in which you grew up – father, mother, siblings, aunts, uncles, cousins:

_____

_____

_____

Please list any traumatic events that occurred during your childhood:

_____

_____

_____

Please list any past or present substance use by family members (your family now and the family in which you grew up):

_____

_____

_____

Please briefly describe your current concern that brings you to counseling:

_____

_____

_____

_____

_____

_____

_____ _____

Date Signature

Marguerite (Rita) Hursh, LPC
5675 Stone Road, Suite 300
Centreville, VA 20120
Telephone: 703-715-6077

Authorization to Apply for Insurance Benefits

Client Information: **Date:** _____

Client Name _____

Home Address _____

_____

Home Phone _____ work phone _____ cell phone _____

Email Address _____

Date of Birth _____ Age _____

Insurance Information:

Primary Insurance Company Name _____

Address of Insurance Company _____

Phone Number of Insurance Company _____

Name of Policy Holder _____

Policy Holder Date of Birth _____

Insurance ID or Policy # _____ Group Code _____

Type of Policy (e.g., PAR or PPR) _____

Secondary Insurance Company Name _____

Secondary Insurance Company Address _____

Insurance Company Phone Number _____

Name of Policy Holder _____

Insurance ID or Policy # _____ Group Code _____

I certify that I, and/or my dependent(s), have insurance with _____ (name of insurance company(ies)) and assign directly to Rita Hursh, LPC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges if not paid by insurance. I authorize the use of my signature on all insurance submissions. I give permission for Rita Hursh, LPC, to use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Authorized Signature _____

Please print name _____ Date _____

HIPAA NOTICE OF PRIVACY PRACTICES

Marguerite "Rita" Hursh, LPC
14143 Robert Paris Court
Chantilly, VA 20151
Phone: 703-715-6077

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

By law, I am required to insure that your Private Health Information (PHI) is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office and on my website. You may also request a copy of this Notice from me, or you can view a copy of it on my website, www.ritahursh.com or in my office, which is located at 5676 Stone Road, Suite 300, Centreville, VA 20120.

HOW I WILL USE AND DISCLOSE YOUR PHI.

Requiring Your Authorization

For treatment. Your PHI may be disclosed to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care. I will ask for your authorization to do so.

To obtain payment for treatment. I may use and disclose PHI so I can receive payment for the treatment services provided to you. This will be done only with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For health care operations. I may use or disclose, as needed, your PHI in order to support my business activities including, but not limited to, quality assessment activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing services or computer repair) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI.

Other disclosures. I may disclose to agencies to whom you have given permission to request your PHI, i.e. Workman's Compensation or Family Medical Leave.

Without Your Authorization

Following is a list or categories of uses and disclosures permitted by HIPAA without your authorization. Applicable law and ethical standards permit me to disclose information about you without your consent in a limited number of situations.

Child or elder abuse or neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect or elder abuse or neglect.

Judicial and administrative proceedings. I may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Law enforcement. I may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Public health. If required, I may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public safety. I may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Specialized government functions. I may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Health oversight. If required, I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third party payers based on your prior consent) and peer review organizations performing utilization and quality control.

Deceased clients. I may disclose PHI regarding deceased clients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased clients may be limited to an executor or administrator of a deceased person's estate or the person identified as next of kin. PHI of persons that have been deceased for more that fifty (50) years is not protected under HIPAA.

Medical emergencies. I may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. I will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family involvement in care. I may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm. This may be done with only your verbal permission.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to me at 5675 Stone Road, Suite 300, Centreville, VA 20120.

Right of access to inspect and copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in your file. This file contains mental health/medical and billing records and any other records that have been used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. I will charge a reasonable, cost-based fee for copies.

Right to amend. If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment. If I deny your request for amendment, you have the right to

file a statement of disagreement with me. I may prepare a rebuttal to your statement and will provide you with a copy. Please contact me if you have any questions.

Right to an accounting of disclosures. You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12 month period.

Right to request restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.

Right to request confidential communication. You have the right to request that I communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests, I may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. I will not ask you for an explanation of why you are making the request.

Breach notification. If there is a breach of unsecured PHI concerning you, I may be required to notify you of this breach including what happened and what you can do to protect yourself.

Right to a copy of this notice. You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with me at 5675 Stone Road, Suite 300, Centreville, VA 20120 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201 or by calling (202) 619-0257. I will not retaliate against you for filing a complaint.

EFFECTIVE DATE OF THIS NOTICE:

September 23, 2013

By my signature, I acknowledge receipt of this HIPAA Notice of Privacy Practices.

Client Name: _____ Date: _____ Signature: _____
(Please print)

If being seen in a couple relationship, partner can sign below.

Client Name: _____ Date: _____ Signature: _____
(Please print)

Marguerite "Rita" Hursh, LPC
14143 Robert Paris Court
Chantilly, VA 20151
703-715-6077

Office Policies & General Information Agreement for Psychotherapy Services

This form provides you (client) with information that is additional to that detailed in the Notice of Privacy Practices.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. The provisions explaining when the law requires disclosure were described to you in the HIPAA Notice of Privacy Practices that you received with this form.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; and where a client presents a danger to self, to others, to property, or is gravely disabled (for more details see also HIPAA Notice of Privacy Practices form).

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by me. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless I am authorized to do so by **all** adult family members who were part of the treatment.

Emergencies: If there is an emergency during our work together or in the future after termination, where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the biographical sheet as your emergency contact.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct me, only the minimum necessary information will be communicated to the carrier. I have no control or knowledge over what use insurance companies make of the information I submit or who has access to this information. This is to make you aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information is entered into insurance companies' computers and soon will also be reported to the congressionally approved National Medical Data Bank. Be aware that accessibility to companies'

computers or to the National Medical Data Bank database may be vulnerable since break-ins and unauthorized access may occur in computer systems.

BILLING: Provider hires a billing professional to contact client's insurance company as necessary to obtain plan information specific to client. By signing this document, you agree to the release of PHI for the purpose of contacting your insurance company to determine benefits and to actually bill for services provided. Additionally the billing professional sends bills via the U.S. postal service to any client with an outstanding balance.

CONFIDENTIALITY OF E-MAIL, CELL PHONE AND FAX COMMUNICATION: It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized persons, and hence the privacy and confidentiality of such communication can be compromised. Be advised that I do not use an encrypted email system and any personal information you choose to put into an email to me will be subject to hacking. Provider requests that you restrict your use of email to correspond about logistical information only, i.e. changing appointment dates or times.

LITIGATION LIMITATION: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney, nor anyone else acting on your behalf may call upon me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested for such purposes.

CONSULTATION: Provider regularly meets with other professionals for consultation regarding clients. Unless a Release of Information document has been signed by you, your identity remains completely anonymous, and confidentiality is fully maintained. This includes clients undergoing couples' counseling. If you have objection to the sharing of your information, please inform me at this time. I will hold all information confidential.

ACCESSIBILITY: If you need to contact me between sessions, please leave a message on my voice mail or email, and your message will be returned as soon as possible. I check my messages several times a day unless I am out of town. When I am unavailable, I arrange for calls to be covered.

EMERGENCY PROCEDURES: If an emergency situation arises, please indicate it clearly in your message. **If you cannot reach me and need to talk to someone right away, please call 911 or go immediately to the nearest emergency room for assistance.**

PAYMENTS AND INSURANCE REIMBURSEMENTS: Clients are expected to pay the standard fees of $160 for initial intake session. Subsequent sessions are as follows: $130 per 50 minute session; $160 per 60 minute sessions. If client will be using insurance, payment will be dependent upon insurance stipulations for client under current plan. **It is your responsibility** to be aware of the benefits to which you are entitled under you insurance plan. Payment is due at the beginning of each session.

Important: A 24-hour cancellation is necessary to avoid a $130 charge. Only in the case of an emergency, i.e. illness of self or child, car malfunction, or traffic accident in route, will the $130 charge be waived. Work or other routine appointments scheduled at the last minute will not be considered an emergency. This fee will not be covered by your insurance.

Snow and Ice: All sessions will be held unless cancelled by telephone by either client or therapist. I do consider snow and ice to be an emergency situation if you feel unsafe on the roads. However, if you do not call to cancel and I am in the office waiting, there will be a $130 charge.

Out of Network Insurance: Clients who carry insurance for which I am out of network will be responsible for my full fee (see section on Payment and Reimbursement). Receipts for service will be provided, if requested.

Other Possible Charges: Lengthy telephone conversations, site visits, report writing and reading will be charged at the hourly rate stated above, unless indicated and agreed otherwise. Insurance will not cover these services.

THE PROCESS OF THERAPY/EVALUATION: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. I view therapy as a partnership and will ask for your comments and views on your therapy, its progress, what works for you and what does not. I would like you to respond openly and honestly.

During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. At times I may ask questions to challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged, or disappointed.

Attempting to resolve issues that brought you to therapy in the first place such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors regarding employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member may be viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and at times frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

During the course of therapy, I am likely to draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches may include behavioral, cognitive-behavioral, psychodynamic, existential, developmental (adult, child, family), psycho-educational, energy work, mindfulness, or emotionally focused therapy.

DISSCUSION OF TREATMENT PLAN: Within a reasonable period of time after the initiation of treatment I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives, and my review of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments.

TERMINATION: As set forth above, after the first couple of meetings, I will assess whether I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In such a case, I will give you a number of referrals that you can contact. If at any point during psychotherapy, I assess that I am not effective in helping you reach your therapeutic goals, I am obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case, I will give you referrals that may be of help to you in finding an appropriate therapist.

If you request and authorize it in writing, I will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, I will assist you in finding someone qualified, and if I have your written consent, I will provide that therapist with the essential information needed. You have the right to terminate therapy at any time.

DUAL RELATIONSHIPS: Not all dual relationships are unethical or avoidable. Consequently, you may bump into someone you know in the waiting room or run into me out in the community. I will never acknowledge working therapeutically with you without your written permission. It is your responsibility to communicate to me if the dual relationship becomes uncomfortable for you in any way. I will always listen carefully and respond accordingly to your feedback. I will discontinue the dual relationship if I find it to interfere with the effectiveness of the therapeutic process or the welfare of you, the client, and, of course, you can do the same at any time.

REMINDER: Since scheduling an appointment involves the reservation of time held specifically for you, a **minimum of 24 hours (one day) notice is required** for re-scheduling or canceling an appointment. Unless we reach a different agreement, my full fee of $130 will be charged for sessions missed without such notification. **Insurance companies do not reimburse for missed sessions.**

I/We have read the above Agreement and Office Policies and General Information carefully; I/we understand them and agree to comply with them:

Signature of Client: _____ Date: _____

If being seen as part of a couple relationship, partner can sign below.

Signature of Client: _____ Date: _____