NEW PATIENT CHECKLIST

Welcome to Inova Kellar Center! We recognize this is a stressful time and look forward to serving you and your family. The below information will assist you in completing the admissions process. Below are listed the forms and information needed in advance of your appointment. Please directly scan, drop off, mail in, or bring the completed paperwork prior to your first appointment.

Important Notes

1. Complete ALL paperwork blanks, including the DATE and TIME.

2. If you experience challenges completing virtual forms for any reason, please call the front desk at (703) 218-8500 ext. 5, and we can mail you a blank copy.

3. We request that both parents *and* patients sign the forms to encourage an active role by kids/teens in their own treatment. If too young to sign, please write “too young to sign” or “not applicable” on the patient signature lines.

Paperwork Checklist

- □ Patient Identification Form
- □ Developmental and Social History *or* Adult Social History (as applicable)
- □ Consent to Treatment
- □ Coordination of Benefits Questionnaire
- □ Authorization for Claims & Payments
- □ Outpatient Therapeutic Services Program Guidelines
- □ Notice of Rights of Individuals Receiving Behavioral Services
- □ Coordination of Treatment Consent
- □ Acknowledgement of Receipt of Notice of Privacy Practices
- □ Cancellation/Missed Appointment and Late Arrival Policy
- □ Telehealth Services Form
- □ Americans with Disabilities (ADA)/Special Needs Assessment
- □ Photo ID Scan (front and back)
- □ Insurance ID Scan (front and back)
- □ Legal Custody Order (medical decision-making) and/or Guardianship Order, if applicable
- □ OWL Emails Provided and Account Created

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3PTIDEN

This form will provide us the legal spelling of the patient's first name, middle initial, last name, and their date of birth. Accurate patient information is important for the patient's **safety** while receiving services at any Inova facility.

Please Print Clearly

PATIENT Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth (month/day/year): _____ Legal Sex: ☐ Male ☐ Female ☐ X

Address: _____ City: _____ State: _____ Zip Code: _____

Best Contact Phone Number: _____ ☐ Mobile ☐ Work ☐ Home

Email: _____

PARENT/GUARDIAN Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth (month/day/year): _____ Social Security Number: _____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Other: _____

Address ☐ Same as Patient If address is different, provide below:

Street: _____ City: _____ State: _____ Zip Code: _____

Best Contact Phone Number: _____ ☐ Mobile ☐ Work ☐ Home

Email: _____

PERSON BRINGING CHILD IN FOR TREATMENT Information: ☐ Same as Parent/Guardian

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Other: _____ (complete fields below)

First Name: _____ Middle Initial: _____ Last Name: _____

Best Contact Phone Number: _____ ☐ Mobile ☐ Work ☐ Home

My signature verifies that the information provided is correct to the best of my knowledge. I understand that this will be used as patient identification at Inova.

Signature: _____ Date: _____ Time: _____

Witness (signature): _____ Date: _____ Time: _____

Witness (print name): _____

Interpreter Information (To be completed by Inova staff, if applicable):

☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____

☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Inova Health System

Patient Identification - Pediatric

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

☐ Outpatient Location: _____

CAT # 30366/R091923 • PKGS OF 100

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Child's Name:_____ Date of Birth:_____

What are your current concerns? _____

_____

How long have you had this concern? _____

Prenatal History

1. How was mother's health during pregnancy? ☐ Good ☐ Fair ☐ Poor
2. Did mother smoke, consume any alcohol, or use prescription or nonprescription drugs during her pregnancy? ☐ Yes ☐ No If yes, please describe: _____

_____

Birth History

3. Were there any difficulties with labor or delivery? ☐ Yes ☐ No

If yes, please describe: _____

_____

4. Was your child born on schedule? ☐ Yes ☐ No

If no, when was he/she born? _____

5. What was your child's birth weight and length? _____

6. Were there any health complications following birth? ☐ Yes ☐ No

If yes, please explain: _____

_____

Developmental Milestones and Early Temperament

7. Were there any difficulties with motor development, language development, or toilet training?

☐ Yes ☐ No If yes, please describe: _____

_____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova Kellar Center

Developmental and Social History

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8. Would you describe your child's early temperament as:
   - ☐ Easy (regular sleeping and eating patterns, adaptable to change, average activity level, average mood)
   - ☐ Difficult (irregular sleeping and eating patterns, poor adaptability, highly active, wide range in mood)
   - ☐ Other _____

_____

School History

9. Has there been any concern expressed by either teachers or yourself regarding your child's academic progress or behavior in school? ☐ Yes ☐ No If yes, please describe: _____

_____

_____

_____

10. What school does your child currently attend?_____

11 What is your child's current grade placement?_____

12. Has your child ever received special education services? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Family Composition

13. Please provide the following information in regard to everyone living at home.

Name	Age	Relationship	Occupation	Education

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14. Please provide the following information in regard to significant family members not living at home:

Name	Age	Relationship	Occupation	Education

15. Are parents presently married? ☐ Yes ☐ No

Please comment on the relationship each parent has with the child: _____

_____

_____

16. Who has custody of the patient? _____

Stressful Events in the Child's and/or Family's Life

17. Please list any stressful events which have occurred in the past. Also include when these events took place and your child's reaction to them: _____

_____

_____

_____

18. Does your child have any known history of physical or sexual abuse? ☐ Yes ☐ No

If yes, please describe: _____

19. Do you or does your child have any concerns about his/her sexual history and orientation?
☐ Yes ☐ No

If yes, please describe: _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova Kellar Center

Developmental and Social History

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20. Has any family member had prior contact with the court system, protective services or any other legal/social service agency? ☐ Yes ☐ No If yes, please explain _____

_____

_____

21. Are there weapons in the house? ☐ Yes ☐ No

If yes, describe type and method of storage: _____

_____

_____

_____

_____

Family History

22. Please indicate any family history of behavioral, emotional, or substance abuse, and/or academic difficulties:

Mother and/or Maternal Relatives

_____

_____

Father and/or Paternal Relatives

_____

_____

Siblings

_____

_____

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Support System

23. Please list resources which you find helpful in coping with your child/family's difficulties (*e.g.* church, extended family, friends, *etc.*) _____

_____

_____

Spirituality in Family

24. Are you affiliated with a religious organization, church or synagogue? ☐ Yes ☐ No

Name: _____

Level of involvement: ☐ Minimal ☐ Sporadic ☐ Regular ☐ Very Active

Do you have a belief in a Spiritual Being or Higher Power? ☐ Yes ☐ No

25. Please indicate any and all cultural, religious and spiritual factors that may influence your treatment and progress.

_____

_____

Social History

26. Does your child have any difficulty making or keeping friends? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

27. Do you have any concerns about the type of friend(s) your child has? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

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28. What are your child's favorite play activities, hobbies or pastimes? _____

_____

_____

Strengths

29. What are your child's strengths? _____

_____

_____

Medical History

Height: _____ feet _____ inches Weight: _____ lb/kg

List allergies to medication or food: _____

30. How would you describe your child's current general health? ☐ Good ☐ Fair ☐ Poor

31. Does your child have any current medical problems? ☐ Yes ☐ No

If yes, please describe: _____

32. Has your child had any recent major accidents or illnesses? ☐ Yes ☐ No

If yes, please describe: _____

33. Has your child had any recent surgeries or hospitalizations? ☐ Yes ☐ No

If yes, please describe: _____

34. Does your child have any past history of seizures or other medical problems? ☐ Yes ☐ No

If yes, please describe: _____

35. Is your child's immunization status current? ☐ Yes ☐ No

36. Please list your child's primary care physician's name and phone #: _____

37. When was your child's last physical exam? _____

38. Do you see any reason to have your child undergo a physical examination at this time? ☐ Yes ☐ No

If yes, indicate reason: _____

39. Are there any dental concerns? ☐ Yes ☐ No If yes, indicate concern: _____

_____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova Kellar Center

Developmental and Social History

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Nutritional Screening

40. Without reason, has your child gained or lost more than 10 lbs. in the last 3 months? ☐ Yes ☐ No
41. Does your child take laxatives or vomit after eating? ☐ Yes ☐ No
42. Does your child frequently have diarrhea or constipation? ☐ Yes ☐ No

Pain Screening

43. Is your child experiencing any physical pain? ☐ Yes ☐ No

On a scale of 0 to 10, (0 being no pain and 10 being the most) what is your child's pain level?

Circle one: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

If yes, please describe: _____

Functional Screening

44. Does your child have any significant difficulty moving about or problems with coordination? ☐ Yes ☐ No

If yes, please describe: _____

45. Does your child have any significant difficulty playing sports? ☐ Yes ☐ No

If yes, please describe: _____

Other Screenings

46. Does your child have any significant difficulties with vision or hearing? ☐ Yes ☐ No

If yes, please describe: _____

47. Do you have any concerns regarding your child's oral health or hygiene? ☐ Yes ☐ No

If yes, please describe: _____

If you answered yes to any of the prior questions or indicated your child's health is fair or poor, is he/she under the care of a physician or other healthcare provider? ☐ Yes ☐ No

Condition for which he/she is being treated: _____

Name of physician/healthcare provider and phone #: _____

Mental Health Treatment History

48. Has your child had any prior treatment for emotional/behavioral difficulties? ☐ Yes ☐ No

If yes, please list the name of the provider(s), date(s) seen and outcome: _____

_____

_____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova Kellar Center

Developmental and Social History

CAT # 30256/R090623 • PKGS OF 100

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49. Was medication prescribed? ☐ Yes ☐ No

If yes, please list: _____

_____

_____

Other Concerns

50. Are any destructive, self-destructive or risky behaviors present (examples: threats to hurt oneself or others; killing or harming animals; fire setting; use of illicit substances; participation in gangs; sexual activity or other actions) which may put the child in harm's way? If yes, please describe:

_____

_____

_____

51. Please list any other concerns or ideas you have regarding your child's current behavioral, emotional or academic functioning: _____

_____

_____

52. Does your child have any preference that may affect or should be incorporated into their treatment? _____

_____

53. What do you hope will be different at the end of this treatment? _____

_____

_____

Completed by: _____ Date/Time: _____

Clinician: A yes to any question numbered 37 - 43 indicates that a referral is to be made to the appropriate healthcare provider unless the patient is currently being treated for that condition.

Referral needed: ☐ Yes ☐ No

If yes, for: ☐ Pain ☐ Nutrition ☐ Physical out of date ☐ Substance Abuse

Referred to: _____

Reviewed by: _____ Date/Time: _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova Kellar Center

Developmental and Social History

CAT # 30256 / R090623 • PKGS OF 100

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1TRTCNT

I, _____, and _____,
(preferred name of patient) (name of parent/guardian)

- Voluntarily give my consent to the admitting physician, members of Inova Kellar Center staff, and other physicians or consultants designated to conduct medical and psychiatric evaluation and provide diagnostic procedures and treatment.
- Understand that my treatment may include, but not be limited to, the potential benefits and risks documented below. See your specific Program Policy or Handbook for further details.
  - **Potential benefits and outcomes**: Improved mood, reduction in symptoms of diagnosis as well as depression and anxiety, enhanced ability to address problems of daily living, strengthened family relationships, greater personal awareness and insight, the opportunity to address trauma, and improvement in communication skills and positive coping skills as well as emotional regulation.
  - **Potential risks and complications**: Increased experiences of uncomfortable thoughts and feelings during some phases of the program (depression, anxiety, guilt, or sadness), discomfort with necessary lifestyle changes or diagnoses, additional financial burden, delay in progression as behavioral health treatment often requires varied treatment models for different patients.
  - **Alternative Services** to the proposed treatment for my condition, including the benefits and risks of each and the option of no treatment, have been discussed with me. These include but are not limited to referral to other services for care, testing, or no treatment.
- Understand that I may leave treatment on my own initiative at any time. I understand that I will be encouraged to discuss this with my provider.
- Understand that I may, on my own initiative, request and/or obtain a second opinion on any recommendations made.
- Consent to emergency treatment or transportation to an Emergency Department for medical care as deemed necessary by Inova Kellar Center staff.
- Am aware that if I am involved in more than one Inova Kellar Center service, information will be exchanged among involved staff for the purpose of coordinating treatment and/or educational services (day school).
- Am aware that providers at Inova Kellar Center are mandated to report suspected child abuse and neglect.
- Understand and agree to abide by current Center for Disease Control (CDC) guidelines, state or local regulations, and Inova Health System policies related to COVID-19 or other emerging health crises that pertain to healthcare settings as directed by Inova Kellar Center staff. By signing this agreement, I acknowledge the contagious nature of COVID-19 and on behalf of myself, my child, my child's co-parent or siblings (collectively, our "Family"), we voluntarily assume and accept responsibility for the risk that the patient or Family may be exposed to or infected by COVID-19 while attending activities at the Inova Kellar Center.

This consent has been fully explained to me and I understand its content. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction.

Patient (signature)	**Patient** (print name)	Date	Time
Parent/Guardian (signature)	**Parent/Guardian** (print name)	Date	Time

Parent/Guardian Relationship to Patient: _____

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Inova Kellar Center

Consent to Treatment

CAT # 20374DT/R120822 • PKGS OF 50

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1COB

Complete a health insurance section for each of your health plans/coverages.

Health Insurance - 1

Subscriber Name: _____ Subscriber Date of Birth: _____

Name of Health Insurance Company: _____

ID/Policy Number: _____ Group Number: _____ Effective Date of Policy: _____

Patient Relationship to Subscriber: _____

Is Insurance through Subscriber's Current Employer? ☐ Yes ☐ No

If Yes, Employer Name: _____

Does patient have additional health insurance or Medicare:

☐ Yes. If yes, please complete corresponding sections, sign, print name and date.

- Health insurance - complete box 2
- Medicare – complete box 3

☐ No. If no, please sign, print name and date.

If you have an additional plan/coverage, please complete the box below.

Health Insurance - 2

Subscriber Name: _____ Subscriber Date of Birth: _____

Name of Health Insurance Company: _____

Address of Health Insurance Company: _____

ID/Policy Number: _____ Group Number: _____ Effective Date of Policy: _____

Patient Relationship to Subscriber: _____

Is Insurance through Subscriber's Current Employer? ☐ Yes ☐ No

If Yes, Employer Name: _____

If you have Medicare, please complete the box below.

Medicare - 3

Medicare Number _____

Hospital (Part A) Effective Date _____ Medical (Part B) Effective Date _____

Entitlement Reason: ☐ Age ☐ Disability ☐ End Stage Renal Disease

If Disability: Date Disability Began: _____

If End Stage Renal Disease: Date of First Dialysis: _____ Kidney Transplant Date _____

Are you Currently Employed? ☐ Yes ☐ No If no, Date of Retirement: _____

Patient/Parent/Legal Guardian (signature): _____ Date: _____

Patient/Parent/Legal Guardian (print name): _____

Interpreter Information (To be completed by Inova staff, if applicable):

☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____

☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

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Coordination of Benefits Questionnaire

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

☐ Outpatient Location: _____

CAT # 30524 / R091923 • PKGS OF 100

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1PMTREV

Department/Location: _____

1. For Medicare Recipients:
I certify that the information provided to me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to Inova (or its affiliates) for any services furnished to me during the applicable periods of medical care.

2. Assignment and Coordination of Insurance Benefits:
I agree to provide information regarding all health insurance benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from insurance carrier(s) health benefit plan to Inova (or its affiliates) for services rendered to the patient. I hereby authorize payments directly to Inova, including any benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to Inova (or its affiliates) for services rendered to me during the applicable periods of medical care.

3. Unauthorized, Non-covered, or Out of Plan Services:
I understand and acknowledge:

- If my insurance carrier or administrator of benefits does not consider any services rendered covered services, or has not authorized these services, they will not pay and I agree to pay for these services.
- **One or more of my physicians may not accept insurance or may be out of network with my health insurance.**
- In the case of out of plan/network physician or services, there may be reduced benefits and I may be required to pay a higher co-pay, deductible or co-insurance amount.

4. Responsibility for Payment:
In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including but not limited to health benefit deductibles, copayments, co-insurance and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorneys' fees and other collection costs.

5. Automobile Accident Patients - Notice regarding the assignment of medical expense benefits will be provided to you in a separate document.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered, and accept the above conditions and terms; and I agree to pay all charges for which I may be legally and/or contractually responsible, including but not limited to health insurance deductibles, co-payments, and non-covered services. **I understand that Inova, its affiliates, agents (including but not limited to debt collectors) or designees may contact me about outstanding balances through various methods including the use of manual representative outbound calls and voice messages and/or automated dialing services and pre-recorded artificial voice messages, at any telephone number I provide to Inova.** I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Inova. *I understand and agree this document will remain in effect for my present outpatient visit and any future outpatient or physician office visits to Inova, unless specifically cancelled in writing by me.* I understand that I will be asked to review and sign this form once per calendar year as long as I remain a patient of Inova.

_____	_____	_____	_____
Patient/Guardian/etc. (signature)	**Patient/Guardian/etc.** (print name)	Date	Time

_____
Relationship to Patient (if not signed by patient)

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova
Authorization for Claims, Payment, and Reviews - Ambulatory

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH
☐ IMG: _____ ☐ Other: _____

White: Medical Records • *Yellow:* Patient Copy

CAT # 30083-2PT/ R092523 • PKGS OF 25

Outpatient Therapeutic Services
Practice Guidelines

HOURS

An administrative staff member is present from 7:30am – 6:30pm Monday, Wednesday, and Thursday; Tuesday from 7:30am – 5:00pm; and 7:30am – 4:00pm on Fridays. If the office is closed, please call back during regular business hours.

THERAPEUTIC RELATIONSHIP

The relationship you have with your therapist is a professional, cooperative partnership in which the therapist and patient/family have responsibilities to work toward the agreed-upon goals. The goals are your goals and will be reviewed periodically to ensure treatment is proceeding in a constructive way. We understand that the therapeutic alliance is an important one. If you have questions or concerns about the relationship, please address these directly with your therapist. Persistent questions or concerns will be addressed with the Director of Outpatient Family Services and/or Director of Psychological Services. The Director of Outpatient Family Services or Director of Psychological Services must authorize a therapist change. We do not provide an option to see another therapist unless there are extenuating circumstances such as the need for someone with a specialty (i.e., eating disorders, DBT, etc.).

REQUIRED REPORTING

All staff (therapists, administrative staff, directors, etc.) at Inova Kellar Center are mandated reporters of suspected child abuse, neglect, and exploitation. This means that we are required by law to notify Child Protective Services of suspected abuse or neglect. Clarification of this requirement can be discussed with your therapist.

BENEFITS AND RISKS OF TREATMENT

There are many benefits to counseling and psychotherapy, but it is important to also be aware of and discuss potential risks. Treatment is based on individual needs and goals, using evidence-based practice. The therapists at Inova Kellar Center are extensively trained in assessment, diagnosis, treatment planning and evidence-based models of treatment, with clinical specialties in disciplines such as trauma, eating disorders, or anxiety/depression. Listed below are common benefits and risks you can expect during treatment. For more information, please see the Consent to Treatment Form.

The benefits may include a reduction in feelings of distress, increased satisfaction in relationships, greater personal awareness and insight, increased skills for managing stress and low mood, and resolutions of specific problems. It may help strengthen relationships and improve communication among family members. However, there are no guarantees about what will happen. Therapy requires a very active effort from both you and your child.

Psychotherapy and counseling can involve some risk in certain situations. The desired results or goals from psychotherapy and counseling may not be accomplished or completed in the time expected, which

can result in frustration and dissatisfaction. During the process of therapy, emotional pain and distress can arise as difficult issues are addressed.

The therapist may recommend a referral for supplemental care when appropriate. If adequate progress is not being made in therapy or if it becomes apparent specialized skills are needed for treatment, the therapist may either refer for more specialized care or discontinue therapy and assist with a referral to an appropriate therapist, health care professional, or therapy program.

CONFIDENTIALITY AND MANDATORY DISCLOSURES OF TREATMENT INFORMATION

Session content and all materials relevant to your child's treatment will be held confidential unless a completed Authorization for Request/Disclose Protected Health Information is provided. However, in certain situations, your child's therapist is required by law or by the guidelines of their profession to disclose information, whether or not they have your or your child's permission.

Your child's therapist will disclose information when:

- Minor patients tell the therapist that they plan to cause serious harm or death to themselves, and the therapist believes that the child has the intent and ability to carry out this threat in the very near future. The therapist must take steps to inform a parent or guardian or others of what the child has said and how serious they believe this threat to be and to try to prevent the occurrence of such harm.
- Minor patients tell the therapist that they plan to cause serious harm or death to someone else, and the therapist believes the child has the intent and ability to carry out this threat in the very near future. In this situation, the therapist must inform a parent or guardian or others and may be required to inform the person who is the target of the threatened harm and the police.
- Minor patients are doing things that could cause serious harm to themselves or someone else, even if they do not intend to harm themselves or another person. In these situations, the therapist will need to use their professional judgement to decide whether a parent or guardian should be informed.
- Minor patients tell their therapist, or the therapist otherwise learns, that it appears that a child, including the patient, is being neglected or abused—physically, sexually or emotionally—or that is appears that they have been neglected or abused in the past. In this situation, the therapist is required by law to report the alleged abuse to the appropriate state child-protective agency.
- The therapist is ordered by a court to disclose information.

DISCLOSURE OF A MINOR'S TREATMENT INFORMATION TO PARENT/GUARDIAN

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents or guardians. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is Inova Kellar Center's practice for your child's therapist to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to your therapist without your child's agreement. This includes activities and behavior that you would not

approve of – or might be upset by – but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then your child's therapist will need to use their professional judgement to decide whether your child is in serious and immediate danger of harm. If the therapist feels that your child is in such danger, the therapist will communicate this information to you or others as appropriate and/or required by applicable law.

Even when you and your child's therapist have agreed to keep your child's treatment information confidential from you, the therapist may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, the therapist will encourage your child to tell you, and the therapist will help your child find the best way to do so. Also, when meeting with you, your child's therapist may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

In the course of the therapist's work with your child, the therapist may meet with the child's parents or guardians either separately or together. Please be aware, however, that at all times, the therapist's patient is your child – not the parents or guardians nor any siblings or other family members of the child.

LIMITATIONS TO SERVICE

Our services are therapeutic in nature, and our assessments are conducted to establish a plan of care. The scope of services does not include assessment for forensic evaluations or custody recommendations. Any court appearance may come with additional fees that will be discussed with the family at that time. If you are seeking these services, ask your therapist for a referral.

PARENT/GUARDIAN AGREEMENT REGARDING CUSTODY LITIGATION

You agree that in any child custody or visitation proceedings, you will not attempt to compel your child's therapist to serve as a retained expert witness. Please note that your agreement may not prevent a judge from requiring the therapist's testimony, even though the therapist will not do so unless legally compelled. If your therapist is required to testify, they are ethically bound not to give their opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, the therapist will provide information as needed, if appropriate releases are signed or a court order is provided. However, the therapist will not make any recommendation about the final decision(s).

APPOINTMENTS

The first appointment is an intake interview, during which you will review the intake forms you have completed and be asked questions that are relevant to treatment. Follow-up appointments will be scheduled directly by your therapist, and ideally, on the same day/time as your intake appointment. In general, appointments will be scheduled each week, although availability and your schedule will be taken into consideration. Your therapist will offer you a later appointment time (after-school/evening) as availability permits. Due to the overwhelming demand for afternoon, after school, and evening appointments, you will be offered a daytime appointment to begin treatment unless a later opening exists on an available therapist's schedule; however, this availability is not guaranteed.

Telehealth appointments are provided if deemed to be clinically appropriate. However, a telehealth appointment cannot be substituted for an in-person appointment unless agreed upon with your

therapist in advance. For additional guidelines and information, please see the Telehealth Services Consent Form.

Prior to the first appointment and at periodic appointments thereafter, all patients must complete questionnaires sent to you from Owl 48 hours (about 2 days) in advance. Owl Insights (Owl) is an online, measurement-based care platform that allows you and your therapist to follow progress in treatment based on objective evidence-based therapy questionnaires. Essentially, Owl Insights allows you and your therapist to track patient progress throughout treatment. As an integral part of your care, it is critical to complete these questionnaires in advance of the appointment to allow the therapist time to review relevant assessment of functioning.

LATE APPOINTMENTS

It is very important that you arrive on time to ensure you have every opportunity to discuss your or your child's needs with the therapist. Instances in which patients **who arrive 15 minutes or more after their scheduled appointment time** will be considered a missed appointment and the appropriate fee assessed (see below).

CANCELED OR MISSED APPOINTMENTS

When you schedule an appointment at Inova Kellar Center, the therapist blocks a specific time for you and your child. To efficiently serve the community, Inova Kellar Center has instituted a 24-hour cancellation policy. If you need to cancel or reschedule an appointment, please contact your therapist directly at least 24 hours in advance to avoid a charge. **The charge for missed appointments or appointments canceled or changed with less than 24-hour notice is $75**. This fee cannot be billed to your insurance. You will be directly responsible for the remittance of this fee at or prior to your next scheduled appointment. **Two or more missed or canceled appointments within a three-month period can result in your child being discharged as a patient and you will be provided with referrals to other therapists who may be better suited to meet your and your child's scheduling needs.**

EMAIL

To protect the privacy of our patients and families, Inova Kellar Center electronically communicates protected health information (e.g., treatment plans, patient names and dates of birth) through an encryption portal. Patients or their representatives may request to communicate with their provider by unencrypted email. For associated risks and additional information, please see the Telehealth Video Visit Consent.

PAYMENT

All relevant payments/co-payments are due at the time of service. Personal checks, exact cash (no change is maintained), and most credit cards will be accepted. There will be a $25 fee for any returned check.

If you are using insurance, we will submit the claims directly to your insurance provider. Please note that you are ultimately responsible for what is covered and what is out-of-pocket.

If you have any questions regarding - your bill, please contact Inova Patient Financial Services at 571-472-5750.

RECORDS

There is generally no fee for copying and mailing records of fewer than five pages. Beyond this, there may be a charge of $.50 per page plus postage, to cover costs and staff time. Each request requires a completed and signed Authorization to Release Protected Health Information form.

LETTERS/FORMS

A $25 fee may be assessed on a letter or form (e.g., school forms, FMLA, disability) that the therapist is requested to complete outside of your family or child's scheduled appointment. You will be notified in advance of the applicable fee.

DISCHARGE

Inova Kellar Center provides services to a large community of children and families and maintains a waiting list for those services. This need in the community requires Inova Kellar Center to adhere to a discharge policy when:

- New patients are not seen within the recommended timeframe for follow-up as determined by the therapist based on the patient's presenting needs, preferences, schedule, and safety concerns.
- Established patients have two or more missed or canceled appointments within a three-month period, without prior consult and approval from the therapist.
- Any patient consistently declines or refuses to follow recommended course of treatment.

Should a discharge occur, and you would like your child to receive services in the future, he or she will be considered a new patient. This will require the parent to schedule a new patient intake assessment. ***Intake appointments with therapists are based on availability and a review of past compliance with practice policy guidelines.***

EMERGENCIES

Inova Kellar Center provides an afterhours on call therapist for non-life-threatening crises to assist with situational assessment and guidance. This service is available for current Inova Kellar Center patients and can be reached by calling the main phone line (703) 218-8500. The therapist will assist you by assessing your concerns and providing recommendations to best manage your concerns, which may include referring you to the appropriate resources. Emergency therapy services are not provided, but your concerns will be shared with your provider. On-call is not available for medication refill requests or scheduling matters. During business hours, please call your therapist directly.

Please note that Inova Kellar Center is not an emergency department facility. If you have an immediate or life-threatening emergency, call 911 or go immediately to the nearest emergency room. Regional emergency services are available below.

If you are experiencing a mental health emergency, please contact emergency services within your area.

Resources for Emergency Services:

- lnova Fairfax Hospital (703) 777-7776
- National Suicide and Crisis Lifeline 988 (Free Call or Text 24-hour hotline) OR 1-800-273-TALK
- Arlington County Emergency Mental Health Services (703) 228-5160
- Children's National Medical Center (202) 476-5000
- Dominion Hospital (703) 538-2872
- Fairfax County CrisisLink Hotline (703) 527-4077 or text "CONNECT" to 855-11
- Loudoun County Emergency Mental Health (703) 777-0320 (24 hours a day, 7 days a week, V/TTY available)
- Merrifield Center (703) 559-3000
- North Spring Behavioral Health Care (703) 777-0800
- Prince William Emergency Services - Manassas (703) 792-7800
- Prince William Emergency Services - Woodbridge (703) 792-4900
- Rappahannock Rapidan Community Services 24-hour Crisis Line (540) 825-5656
- Snowden at Fredericksburg (540) 741-3900

Thank you for taking the time to read this important information. Please refer to this document when you have questions regarding your child's care.

I have had the opportunity to read and review the Outpatient Therapy Practice Guidelines and the corresponding policies. All questions have been asked and answered to my satisfaction.

_____ _____

Patient Signature Date

_____ _____

Parent Signature Date

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1PTRCR

It is your Right:

- To be treated with dignity and respect
- To be told about your treatment
- To have a say in your treatment
- To speak to others in private
- To have your complaints resolved
- To say what you prefer
- To ask questions and be told about your rights
- To get help with your rights

If you believe your Rights have been violated, you may:

- Contact Inova Kellar Center Executive Director or designee at (703) 218-8500; or
- Contact the Regional Human Rights Advocate, Diana Atcha, at (804) 426-3279; or
- Contact the Department of Behavioral Health and Developmental Services at P.O. Box 1797, Richmond, VA 23218-1797

I have received a copy of these Rights, which I have read and understand.
I have had an opportunity to ask questions regarding these Rights.
I have had my questions answered to my satisfaction.

Individual Receiving Services (signature)	**Individual Receiving Services** (print name)	Date/Time
Parent/Guardian (signature)	**Parent/Guardian** (print name)	Date/Time

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Inova Kellar Center

Rights of Individuals Receiving Behavioral Services

CAT # 30239 / R011224 • PKGS OF 100

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1TRTCNT

In accord with Federal and State confidentiality laws, it is necessary for those involved in your or your child's treatment to be able to exchange information. Your signature on this form will allow outside groups and individuals to exchange confidential information necessary to your or your child's treatment.

Note: No medical records will be released without a signed Release/Disclosure of Protected Information form.

_____ _____
Name of Patient *Date of Birth*

_____
Patient Address *City* *State* *Zip Code*

I authorize the following identified members of my/my child's treatment team to communicate with the Inova Kellar Center staff for the purpose of ongoing care.
Please complete below and check all that apply.

		Mental Health	Alcohol & Drug
Parent or Guardians	*Phone*	☐	☐
Primary Care Physician	*Phone*	☐	☐
Individual/Agency Name	*Phone*	☐	☐
Individual/Agency Name	*Phone*	☐	☐
Individual/Agency Name	*Phone*	☐	☐
Name of School			
Contact Person(s)/Department	*Phone*	☐	☐

I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. Such revocation will be discussed and may result in an inability to treat. I understand written notification is necessary to cancel this authorization and must be addressed to the Medical Record Department. I understand that this consent automatically expires 90 days after the end of treatment at Inova Kellar Center.

_____ _____
Patient's Signature *Date / Time*

I acknowledge that the clinical and legal purpose and intent of this form have been explained to me.

_____ _____
Parent/Guardian Signature *Date / Time*

PATIENT IDENTIFICATION

Inova Kellar Center

Coordination of Treatment Consent

CAT # 30227 / R092523 • PKGS OF 100

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NOTICE OF PRIVACY PRACTICES

Effective Date: November 15, 2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AT INOVA AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Inova's Chief Privacy Officer by calling the Compliance Department at 571-472-8187.

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This information is considered protected health information (PHI). The Health Insurance Portability and Accountability Act (HIPAA) requires that we provide you with a notice regarding how your PHI may be used or disclosed and your rights concerning that information. This notice applies to all of the records of your care generated by and as part of the care furnished to you in an Inova facility or through an Inova service, whether made by Inova personnel, agents of Inova and its affiliated facilities, or by your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

Inova's Responsibilities

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised copy by accessing our web site www.inova.org, calling 571-472-8187 and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. If any major change is made to this Notice, it will automatically be provided to you at the time of your next visit to an Inova facility. It will also be posted on our website at the time of the change.

Uses and Disclosures

How we may use and disclose Medical Information about you.

The following categories describe examples of the way we use and disclose medical information:

For Treatment: We may use medical information about you to provide you treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at Inova. For example, we may provide a physician at an Inova hospital with information regarding your prior treatment at an Inova facility if it might have bearing on the current condition for which you are being treated. Different Inova departments also may share medical information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.

We may disclose medical information about you to people outside of Inova who provide services that are related to your care. We may also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you are discharged from an Inova facility.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose your PHI in order to support the business activities of Inova. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fund raising activities, and conducting or arranging for other business activities.

For example, we may disclose your PHI to medical school students that see patients at our facilities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when we are ready to assist you. We may use or disclose your PHI as necessary to contact you to remind you of your appointment.

We may use or disclose your PHI as necessary to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your PHI for other marketing activities. For example, your name and address may be used to send you a newsletter about the services we offer or to send you information about products or services that we believe may be beneficial to you. These activities are not considered to be marketing under the HIPAA Privacy Rule.

Use of your PHI for activities that would be considered marketing or disclosures that would constitute the sale of PHI may not be made without a signed authorization from you.

If you do not want to receive the materials described above, please contact our Chief Privacy Officer by calling our Compliance Department at 571-472-8187 and request that these marketing materials not be sent to you.

We may use certain information to contact you in the future to raise money for Inova. We may also provide this information to our institutionally related foundation for the same purpose. The money raised will be used to expand and improve services and programs we provide the community.

Information that may be used about you for fundraising purposes includes your name, address, telephone number, dates of service, age, gender, general information about the department in which you received care, the identity of your treating physician and general outcome of your treatment.

If you do not wish to be contacted for fund-raising efforts, please notify the Inova Health System Foundation, at 8095 Innovation Park Drive, Fairfax, VA 22031, or by calling 703-289-2072.

Business Associates: Some of the services provided by Inova are provided through contracts with business associates. Examples may include transcription services or outside billing services with which we contract. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information. Inova's requirements for safeguarding your information are included in Business Associate Agreements with each such entity. In addition, all business associates are subject to oversight by the Secretary of Health and Human Services (HHS) and must adhere to all requirements of the HIPAA Privacy and Security Rules.

Directory: We may include certain limited information about you in a facility directory while you are a patient at the facility. The information may include your name, location in the facility, your general condition (*e.g.*, good, fair, etc.) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. If you would prefer not to be included in the facility directory please request the *Request to be Excluded* Form from the Registration staff or from the Chief Privacy Officer.

Individuals Involved in Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you desire to limit disclosure of such information to friends or family members, we will ask that you designate one individual to whom we may make such disclosures. It will then be up to you to instruct that individual as to how they may disseminate information about you to other interested parties.

Research: Your medical information may be used or disclosed for research purposes without your permission if an Institutional Review Board (IRB) approves such use or disclosure. We may disclose medical information about you to researchers preparing to conduct a research project. In addition, researchers may contact you directly about participation in a study. The researcher will inform you about the study and give you an opportunity to ask questions. You will be enrolled in a study only after you agreed and signed a consent form indicating your willingness to participate in the study.

Future Communications: We may communicate to you via newsletters, mailings or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our facilities are participating.

Organized Health Care Arrangement: Inova's facilities, including but not limited to its hospitals, deliver care in clinically integrated settings in which individuals typically receive care from more than one health care provider including Inova's workforce; physicians and allied health practitioners who are in private practice and have clinical privileges at Inova facilities; hospital-based physician groups such as anesthesia; radiology, pathology and emergency medicine; department chairs and medical directors; and other health care entities affiliated with Inova. These are all part of Inova's Organized Health Care Arrangement (OHCA) and may utilize a shared electronic health record database. We are presenting you this document as a joint notice for these purposes. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to PHI in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Health Information Exchange: We may make your protected health information available electronically through an information exchange service to other health care providers that request your information. Participation in information

exchange services also lets us see health care information about you from other health care providers who participate in the exchange.

Single Covered Entity: For purposes of HIPAA only, all covered entities that are owned or controlled by Inova shall be considered to be a Single Covered Entity. PHI will be made available to personnel at other facilities included in this Single Covered Entity, as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to PHI at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Chief Privacy Officer for further information on the specific sites included in this affiliated covered entity.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or legal authorities charged with preventing or controlling disease, injury or disability
- Correctional institutions
- Workers Compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Funeral directors, coroners and medical directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes:

- in response to a court order, subpoena, warrant, summons or similar process;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at an Inova facility; and
- about wounds made by certain weapons.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If Virginia Law is more stringent than Federal privacy laws, Virginia law preempts the Federal law.

Uses or disclosures of your PHI not described in this notice will be made solely upon written authorization from you or your personal representative. Written authorizations may be revoked by contacting the department originally authorized to use/disclose the information.

Your Health Information Rights:

Although your health record is the physical property of the health care practitioner or facility that compiled it, you have the **Right to**:

- **Inspect and Copy:** You have the right to inspect and copy medical information in our possession that may be used to make decisions about your care. As a rule, this includes medical and billing records, but does not include psychotherapy notes. You may request an electronic copy of your PHI maintained in Inova's electronic health record (EHR). Access to your records must be provided within 15 days of the receipt of your request. We may deny your request to inspect and copy your records in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. A licensed health care professional not involved in the original denial of your request will be chosen by Inova to review your request and the denial. We will comply with the outcome of the review.

- **Request an Amendment of Your Information:** If you feel that your medical information we have on file is incorrect or incomplete, you may ask us to amend that information. You have the right to request an amendment for as long as Inova retains the information. We may deny your request for an amendment and, if this occurs, you will be notified of the reason for the denial and will be provided with your options as defined in the HIPAA Privacy Rule.

- **Request an Accounting of Disclosures:** You have the right to request an accounting of any disclosures we make of your medical information for purposes other than treatment, payment or health care operations.

- **Right to Restrict Release of Information For Certain Services**

    - You have the right to request a restriction on disclosure of health information about services you paid for out of pocket in full. This request should be made prior to the service being provided and applies only if the disclosure is to a health plan for purposes of payment or health care operations.

    - You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information

we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not disclose information about your surgical procedure. Restrictions should be requested in writing by completing a **Request for Confidential Communication and/or Disclosure Restriction.** You may obtain a copy of this form at the time you register for your service or you may obtain one on our web site www.inova.org.

- **With the exception of restrictions regarding services or procedures that you pay for out of pocket, we are not required to agree to your request.** Requests for restrictions or limitations on the medical information we use or disclose about you for treatment, payment or health care operations must be forwarded to the Chief Privacy Officer. Only the Privacy Officer or his/her designee can agree to such restrictions or limitations. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

- **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at a location other than your home or by U.S. Mail. Such requests must be made in writing and must include a mailing address where bills for services and related correspondence regarding payment for services will be received. It is important that you note that Inova reserves the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

- **Breach Notification:** You have a right to be notified following a breach of your unsecured PHI.

- **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time, even if you have agreed to receive this notice electronically.

You may obtain a copy of this notice at our web site http://www.inova.org.

To exercise any of your rights under this notice, please obtain the required forms from the Registration Department in the facility where you received your services and submit your request in writing. You may also access these forms at our web site http://www.inova.org.

Changes to this Notice

We reserve the right to change this notice at any time. The revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in Inova's facilities and will include the effective date. In addition, each time you register at or are admitted to Inova for treatment or health care services as an inpatient or outpatient, we will provide access to the most recent version. You may always access the most recent version at our web site http://www.inova.org or may call 571-472-8187 and request that a copy of the most recent version is mailed to you.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Inova by contacting the Compliance Department at 8095 Innovation Park Drive, Fairfax, VA 22031 Attention: Chief Privacy Officer. You may file a complaint with the Secretary of the Department of Health and Human Services. Instructions for filing a complaint with the Secretary are found at: www.hhs.gov/ocr/privacy.

All complaints must be submitted in writing. **You will not be penalized for filing a complaint about Inova's Privacy practices.**

Other Uses of Medical Information

We are required to retain our records of the care that we provided to you. Inova will make other uses and disclosures of medical information not covered by this notice or the laws that apply to us only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If we receive written revocation of your permission, we will cease the use or disclose medical information you originally authorized. We would not be able to take back any disclosures we had already made with your permission.

Chief Privacy Officer

Telephone Number: 571-472-8187

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1HIPAA

I certify that I have received Inova's **Notice of Privacy Practices** and that I have a right to receive an additional copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Inova's health care operations. The Notice also describes my rights and Inova's duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Inova's web site at www.inova.org. I may request that a copy be mailed to me by calling **703-204-3342.**

Inova reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Inova's web site listed above to view the most current version.

_____ _____ _____

Patient or Personal Representative (signature) Date Time

_____

Patient or Personal Representative (print name)

_____

Description of Personal Representative's Authority

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova

Acknowledgement of Receipt of Notice of Privacy Practices

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

☐ IMG: _____ ☐ Other: _____

CAT # 31245 / R090623 • PKGS OF 100

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1PATP

When an individual is scheduled at Inova Kellar Center, our mental health clinicians hold a specific block of time (unit) for you. In order to efficiently serve the community, we have a cancellation/missed appointment and late arrival policy. All new clients must arrive 15 minutes prior to the time of their scheduled appointment to allow sufficient time to complete new client paperwork. All Kellar programs require a 24-hour notice for cancellation. Each program has a specific grace period for late arrivals. **The fees incurred due to a cancelled/missed appointment or late arrival cannot be billed to insurance.**

- **Partial Hospitalization Program (PHP):** Patients must be present to bill the insurance company. There is a charge of $390 for missed appointments. See your PHP handbook for further details.

- **Intensive Outpatient Program (IOP):** a patient must arrive at the time established by the center to be considered present. The fee for a missed day is $130. See your IOP handbook for further details.

- **Medication Management:** a patient must arrive within 15 minutes of the scheduled appointment time to be seen in the clinic. The fee for a missed appointment is $75. Two appointments rescheduled in a month are grounds for discharge at the discretion of the clinician. See medication management policy for further details.

- **Psychotherapy Services:** a patient must arrive within 15 minutes of the scheduled appointment time to be seen for an appointment. The fee for a missed appointment is $75. If you miss more than two appointments within a three-month period, at the clinician's discretion you may be discharged from treatment and provided with referrals.

- **Psychological Testing:** Psychological services bills by the unit. A patient who arrives more than 20 minutes late will be charged a late fee of $75 for that unit. Any remaining time will be used to complete a portion of the evaluation and only that time will be billed to any applicable insurance company. If the clinician determines that the evaluation cannot be completed within the remaining time, an additional session may need to be scheduled. Cancellation of an evaluation appointment without 48 hours notice will result in a charge of $250. See psychological testing information sheets for further details.

By signing this policy I acknowledge that I have read and understand my responsibilities.

Patient (signature)	Date	Time
Parent or Guardian (signature)	Date	Time
Parent or Guardian (print name)		

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova Kellar Center

Cancellation/Missed Appointment and Late Arrival Policy

CAT # 30226 / R092023 • PKGS OF 25

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2CNT

Welcome to Inova Kellar Center. For the convenience of our patients and families, we provide a model of care that may include online, real-time behavioral health care service.

Telehealth Services are not for use for medical or behavioral health emergencies or urgent situations. In the event of a medical or behavioral health emergency, please call 911 immediately.

Use of Telehealth Services is conditioned upon your acceptance of these terms and conditions. By proceeding with Telehealth Services, you are indicating that you carefully reviewed and agree to these terms and conditions. If you do not agree to these terms and conditions, you may choose to schedule an appointment for an in-person visit at Inova Kellar Center.

Please be advised that the laws of the state where the patient is physically located at the time of the virtual visit will apply. Inova providers are licensed in Virginia and may not be licensed or otherwise meet a professional licensure to provide Telehealth Services to patients physically located outside of Virginia during the appointment. By going forward with Telehealth Services, you expressly acknowledge and attest that you desire to receive Telehealth Services from an Inova provider who is licensed in Virginia. You also understand and agree that any dispute, including personal injury claims, related to Telehealth Services will be subject to the exclusive jurisdiction of Virginia courts and governed by Virginia law.

Behavioral Health Telehealth Services Terms and Conditions

Description of Video Services

- Telehealth Services at Inova Kellar Center may include the use of various virtual formats such as Epic Video Client, Microsoft Teams, Doxy.me, telephone, etc.
- Your remote health care provider or clinician will determine whether the condition being diagnosed or treated is appropriate for Telehealth Services. Activities permitted using Telehealth Services include consultation, diagnosis, treatment, prescriptions (if applicable), and patient education. Telehealth Services do not guarantee that the nature of your problem is suitable for remote care or that care will achieve any specific effect.
- Inova considers Telehealth Services to be private, therefore your remote practitioner will be in a private area during the visit. Similarly, you should be in a private location that does not allow others to see or hear you or the Telehealth Services practitioner.
- The level of privacy and security of the Telehealth Services visit depends on the location that you select, and you accept sole responsibility for choosing a private area during the visit.
- To ensure the privacy of your records and telehealth sessions, Inova will take security measures such as password protected screen savers, encrypted data and file sharing, and maintenance of all records in an Electronic Health Record (EHR).
- For minor patients, your remote health care provider or clinician may require a parent and/or legal guardian to be present for all Telehealth Service visits. This determination is based on the service utilized and related factors.

Representations and Warranties

- You are at least 18 years old or you are an authorized parent/guardian/representative of a minor or patient seeking behavioral health care during the Telehealth Services.

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2CNT

Representations and Warranties (continued)

- The patient will be physically located in Virginia. Patients physically located in another state (outside of Virginia) at the time of the visit may use Telehealth Services only if it is confirmed that the Inova practitioner is licensed to provide care in that other state.
- You consent for your treating practitioners to exchange information with other remote health care practitioners to facilitate the provision of Telehealth Services to the extent permitted by law.
- **Inova makes no warranty that Telehealth Services will meet your requirements, or that the session will be uninterrupted, timely, 100% secure, or error free. Inova is not responsible for transmission errors or corruption or compromise of data carried over local cellular or interchange telecommunication carriers.**

Service-Specific Requirements

- **Outpatient Family Services/Medication Management:** To ensure the continuity of care, in-person appointments cannot be replaced with a virtual session (or vice versa) unless requested at least 24-hours prior to the scheduled appointment and approved at the clinician's discretion.

- **Group Therapy:** Group Therapy providers will designate the meeting format (in-person or virtual) at the first group session and said format will remain for the duration of the group meetings. To maintain group dynamics, designated in-person group therapy sessions will not be offered alternative virtual participation for any reason. Designated virtual groups will not be offered in-person participation for any reason.

Encrypted Email Communications

To protect the privacy of our patients and families, Inova Kellar Center electronically communicates protected health information (e.g., treatment plans, patient names and dates of birth) through an encryption portal. Patients or their representatives may request to communicate with their provider by unencrypted email. While this method may be more convenient for patients and families, there is an added risk to the security of your protected health information. By signing below, you understand that you must request in writing to communicate by unencrypted email, and you understand that Inova makes no guarantee that unencrypted electronic communications will be 100% secure or error free. You further understand that Inova is not responsible for transmission errors or corruption or compromise of data carried over local cellular or interchange telecommunication carriers.

This Acknowledgement and Consent has been fully explained to me and I understand its content. I have had the opportunity to ask questions and my questions have been answered to my satisfaction.

Patient (signature): _____ Date: _____ Time: _____

Patient (print name): _____

Parent/Guardian (signature): _____ Date: _____ Time: _____

Parent/Guardian (print name): _____ Relationship: _____

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Inova Kellar Center
Telehealth Services

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Inova™

1HEAR

Inova Staff:
1. **If accommodations are requested, page interpreter services at 98824 within 15 minutes of completing this form.**
2. **A new form should be used at every visit and any time a change in accommodations is requested.**

Name of Person Requesting/Declining Accommodations: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Family Member ☐ Friend ☐ Other _____

Do you and/or your companions have any special needs that require accommodations? ☐ **YES (complete boxes A and B)** ☐ **NO (complete box B)**

A. If you require special accommodations, please check as appropriate:

Deaf and Hard of Hearing:
☐ Sign language interpreter ☐ Notepad and pen ☐ Speak loudly
☐ Sound amplifier (ex. PockeTalker® or disposable Posey®)
☐ Uses hearing aid(s): ☐ Left ☐ Right ☐ Bilateral
☐ Amplified phone with flasher (if admitted)
☐ Video Remote Interpreter (VRI) (where available)
☐ Other: _____

Vision:
☐ Magnifying sheet ☐ Request an escort
☐ Braille phone ☐ Documents read out loud
☐ Other: _____

Mobility:
☐ Uses service animal ☐ Walking escort
☐ Wheelchair escort ☐ Extra-wide wheelchair escort
☐ Accessible exam table ☐ Accessible weight scale
☐ Other: _____

Speech:
☐ Point-to-Speak cards ☐ Point-to-Speak alphabet ☐ Notepad and pen
☐ Other: _____

Other or Special Instructions: _____

B. All Patients, Representatives and Companions, please read and sign:

By my signature below I hereby certify that: (1) I have been given an opportunity to communicate whether I and/or my companions have any special needs; (2) I have had the opportunity to select appropriate accommodations; (3) I have reviewed the above selections; (4) those selections are true, accurate and complete; (5) those selections reflect my and/or my companions' choices; and (6) I have received or can request a copy of the process for filing a complaint if I am unsatisfied with my own and/or my companions' accommodations. I understand that if my and/or my companions' needs change during my visit, I can request service changes from my caregiver free of charge.

☐ Patient's medical condition does not allow completion at this time.

Patient/Representative/Companion (signature)	**Patient/Representative/Companion** (print name)	Date	Time

Relationship to Patient: ☐ Self ☐ Parent ☐ Family Member ☐ Friend ☐ Other: _____

Staff Witness (signature)	**Staff Witness** (print name)	Date	Time	Contact #	Department

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID# (if applicable) _____
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver Signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova

Americans with Disabilities Act (ADA)/ Special Needs Assessment

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH
☐ IMG: _____ ☐ Other: _____

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