NARKIA M. RITCHIE, LMFT, LLC
Individuals. Couples. Families

Family Therapy Intake Package - New Client Forms

Use these forms instead of the General Intake Package, if the therapy includes any one person under the age of 18

INSTRUCTIONS FOR ENCLOSED FORMS

Parent(s) should complete forms 1 through 8 below. If only one parent is attending, then only that parent need complete the forms (with the exception that both parents may still need to sign the "Policy Working with Minors" form if the parents are separated or divorced and are bound by a custody agreement or court order that requires it). If both parents are attending, they should both complete the forms 1-8 together and review and sign. Parents should include anyone under the age of 18 to help complete form 9.

1. **"Contact Information."** This form provides me with your contact information and allows you to specify how you would like to be contacted in the future.

2. **"Therapist-Client Service Agreement"**. This form summarizes important information about confidentiality, fees, cancellation policies, and other practices and policies.

3. **"Notice of Therapist's Policies and Practices to Protect the Privacy of Your Health Information."** This form describes how mental health/medical information about you may be used and disclosed and how you can get access to this information.

4. "**Credit Card Authorization: Cancellation and Services**." This form authorizes your credit card to be used as a method of payment for therapy services and late cancelations/no-show fees.

5. **"Confidential Release Form."** If you are working with another provider, please complete this form to allow me to communicate information about treatment to help coordinate and collaborate services with those providers.

6. **"Policies Regarding Counseling, Legal Issues & Court Related Services."** This form outlines policies related to any legal or court related services, including preparation.

7. **"Intake Questionnaire."** This questionnaire aids assessment and treatment planning by giving me a quick overview of your background and current situation at a glance. Each parent attending counseling should complete the Adult form.

8. **"Policy Working with Minors."** This form provides parental or guardian consent for me to provide treatment services to a minor.

Plus:

9. **"Intake Questionnaire – Minor."** One parent should complete this form for each child that is the focus of treatment. Be sure to check in with your child for help with answering some of the questions.

Please bring these forms with you to your initial session. All information you provide in this form will be kept as part of your confidential file. Feel free to discuss any questions with me before signing.

CONTACT INFORMATION

Printed Name: _____ Birthdate: _____

Mailing Address: _____
Street Address City Province Postal Code

This must be an address to which we can send correspondence, as needed. The name "Narkia M. Ritchie, LMFT, LLC" will be displayed on the envelope, until otherwise checked below on this form.

Home Phone: (_____) _____ May a message be left at this number? Yes □ No □

Cell Phone: (_____) _____ May a message be left at this number? Yes □ No □

Work Phone: (_____) _____ May a message be left at this number? Yes □ No □
(Optional)

Email Address: _____
(Optional)

□ I do not want "Narkia M. Ritchie, LMFT, LLC" displayed on any postal mailing envelopes.

Please Check <u>One</u> of the Following Two Statements:

□ *<u>I give consent to Narkia M. Ritchie, LMFT, LLC to use the email above</u>* to correspond with me in all matters directly related to the provision of services (includes invoicing; appointment bookings, confirmations and reminders; follow-up on services; invitations to complete feedback surveys, etc.). This consent also applies to any new or updated email address that I provide to Narkia M. Ritchie, LMFT, LLC.in the future.

□ *<u>I have not provided my email address in this consent form</u>*, but I understand that if I were to send an email to Narkia M. Ritchie, LMFT, LLC in the future I am giving implied consent to Narkia M. Ritchie, LMFT, LLCto respond to that email, as often as needed, in order to address my inquiry.

Would You Like to be on my Monthly Email Newsletter List?(Please Check One of the Statements below):
My monthly newsletter contains articles on building strong relationships, family dynamics, and mental and emotional wellness, links to online resources and book recommendations that you can use to improve your situation, and notices of upcoming workshops or new services.

□ Yes, I would like to receive monthly email newsletters from Narkia M. Ritchie, LMFT, LLC.

□ No, I do not wish to receive monthly newsletters (using the email address above).

Referral Source: Please let me know how you learned about "Narkia M. Ritchie, LMFT, LLC."

□ Internet search / website
□ Word of mouth (family/friend)
□ Another professional (physician, lawyer, etc.)
□ Workshop or seminar
□ I am a returning client
□ My employer or health insurance provider
□ Other

Your Signature

_____ _____
Signature Date

Therapist-Client Services Agreement

Confidentiality

Everything discussed in session is confidential. I will disclose information about your treatment to others only with your written authorization. The only exceptions to this are suspected abuse or neglect of a child or an elderly person, the expressed intention to harm yourself or someone else, or an order by a judge. Confidentiality and the above exceptions are determined by federal and state laws and by the ethical practices outlined by the professional licensing board. If several members of your family attend sessions with me, or when working with partners in couples therapy, information shared with me by one family member is not necessarily confidential from others in treatment.

As part of the assessment phase of couples, family therapy or as otherwise indicated, I may request to meet with each of you on an individual basis for one or more sessions. Unless you have collectively made a different agreement ahead of time with me and documentation of such an agreement is attached to this form. Thus you must assume that I will disclose to your spouse, partner, parent or family member in therapy with you any information that you've shared privately and that such disclosure is not considered a breach of confidentiality.

In addition, no information obtained from multiple family members may be released to an outside party without the prior written consent of each person from whom the information was obtained, unless 1) a different agreement has been established ahead of time and documentation of such an agreement is attached to this form or 2) information about the non-consenting party can be entirely removed from the information that is shared. If you are a young adult and your parent(s) is/are financially responsible for therapy, I may share a general treatment plan with them and treatment recommendations as appropriate.

Further exceptions to confidentiality are outlined in the "Notice of Therapist's Policies and Practices to Protect the Privacy of Your Health Information" form.

Record-Keeping

I will keep a confidential file containing your private health information (PHI) in a HIPPA compliant location. Your file will include your client forms, financial and contact information, treatment goals, progress notes, and copies of any correspondence or medical records that have been compiled or obtained on your behalf. My purpose in maintaining records is to aid therapy by recording the topics discussed and my impressions. I make an effort to summarize what we discuss in each session, but I make no effort to capture sessions verbatim. I must maintain written or electronic clinical records for *a minimum of five years* following the last patient encounter with the following exceptions: a.) At minimum, records of a minor child shall be maintained for five years after attaining the age of majority (18) or ten years following termination, whichever comes later; b.) Records that are required by contractual obligation or federal law to be maintained for a longer period of time; or c.) Records that have transferred to another mental health service provider or given to the client or his legally authorized representative. Your records can only be destroyed in a manner that protects patient confidentiality, such as by shredding.

Gottman Relationship Checkup only*:* I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. The Gottman Institute or its agents have no responsibility for the services you receive. We understand that by using the Gottman Relationship Checkup, a web-based service provided to licensed, advanced clinicians, we grant consent for use of unencrypted email as a source of communication. The Gottman Relationship Checkup Website has been developed to be compliant with HIPAA regulations. The site uses 256 bit SSL encryption to secure the connection. No personally identifiable health information is transmitted via email. The software that the site runs on is actively monitored and kept up to date with prompt application of the latest security patches stored in a cloud. Fees are outline below regarding completing this assessment.

Fees and Payments
Clients receiving individual therapy are expected to pay the fee of $140 per 45-50-minute session; or $220 for 75-minute session. Clients receiving couple or family therapy are expected to pay the fee of $150 per 45-50-minute session; or $230 for 75-minute session. Fees for couple or family therapy remain the same even if you are seen during an individual session without your partner, spouse, parent or other family member.

Payment is expected to be collected at each session at the time of that session and is accepted in the form of credit card, cash, or personal check; I cannot extend credit to patients. Please note that credit card payments, including those used for no-show appointments, incur a small processing fee.

Gottman Relationship Checkup only:
The relationship checkup consists of an on-line questionnaire/assessment and two feedback session with recommendations tailored to your specific situation from the questionnaire.

The online questionnaire/assessment a one-time $58 fee for accessing the online assessment. The fee charged once the email link is sent. The one-time fee covers the digital scoring of the assessments, as well as feedback and specific recommendations that I will review in our session.

The fees for the feedback sessions is the cost of two, 50-minute couples therapy sessions; extended sessions are also available. In order to receive the results of the assessment, each partner must schedule their feedback session independently of each other so that each partner can review and discuss their personal results that inform the relationship. The feedback sessions are required as results from the assessment can only be discussed in person to protect your confidentiality; assessment results are neither given through the Gottman website nor through email.

You are free to use the information from this relationship check-up as you wish. Research has shown that many couples are able to enhance the quality of their relationship following a relationship check-up without further need for outside intervention. In other cases, a referral for couples therapy may be recommended, in which case, your therapist will provide you with several referral options. There is no obligation to continue working with us.

Checks are made payable to Narkia M. Ritchie, LMFT, LLC. There is a $30 charge for returned checks/credit card payments. Regardless of payment option, credit card information will be maintained confidentiality on file for any missed or cancelled sessions within 48 hours of your appointment time. Your credit card information will not be used for any other purposes unless you indicate therapy services can be billed to your credit card. If you would like your sessions to be automatically billed to your credit card, please authorize by initialing in the credit card authorization form.

I do not currently accept insurance. I am a fee-for-service provider and although I do not participate with insurance companies, I am considered an out-of-network provider. Only when requested, I will provide you with a receipt at the end of each month so that you can submit it to your insurance provider. It is the client's responsibility to complete and file their insurance forms. For further clarification please discuss with me before initial consultation session. If your account is overdue (unpaid), I may use legal or other means (courts, collection agencies, etc.) to obtain payment. I reserve the right to change payment fees which may occur annually. You will receive an updated payment agreement.

Litigation Limitation
Due to the nature of the therapeutic process, or otherwise indicated, and the fact that it often involves making a full disclosure with regard to many matters, which may be of 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 will call me to testify in court or at any proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon in advance. If agreed upon, additional fees will apply for testifying in legal proceedings.

Telephone Calls
I do not charge for brief telephone conversations to schedule, change, or confirm appointments. Extended phone calls (excess of 15 minutes) and other services such as preparation of special reports or telephone consultations are billed at the prorated 45 minute session rate (for either individual or couple/family) per 15 minute increments.

I will return telephone calls as promptly as my schedule allows. Weekend calls will be returned the following business day. Calls received on Friday will be returned the following business day (Monday; except if a holiday the next business day) unless otherwise arranged. If you have an emergency and cannot wait for my return call, go to your nearest emergency room or call 911 or call your local community service board emergency numbers. Another useful resource is Crisis Link1.800.273.TALK or 703.527.4077 which is a 24-hour crisis hotline. I do not have the ability to provide 24-hour emergency contact. If you believe that you situation will require a therapist that has a 24-hour support, please discuss this with me as soon as possible.

Cancellations/Weather emergencies
Continuity is crucial to the effectiveness of therapy. Please notify me as far in advance as possible if you need to cancel a session so that I may offer the time to another client. You will be charged the full fee for appointments you do not cancel two (2) business days (Monday-Friday) in advance. If you are late for your appointment, you will still be charged for the entire time allotted for the meeting and we will need to finish at the scheduled time. For weather emergencies/cancellations please call my number: 571-982-6724 to find out if I am canceling sessions. If I need to cancel or reschedule our appointment I will contact you within 48 hours of your scheduled session. I will strive to reschedule our appointment as soon as feasible.

> **Cancellation schedule example:** If your appointment is scheduled for Saturday at 9 am, you must cancel no later than Wednesday 9 am of the preceding week. If your appointment is scheduled for Sunday at noon, you must cancel no later than Tuesday by noon of the preceding week. If there is an illness or other medical emergency preventing you or a family member(s) whom is also receiving my services (e.g., spouse, domestic parent, minor, etc.) from attending our scheduled session, I will need a doctor's note so waive the missed appointment fee.
>
> **Weather emergencies:** I will close for inclement weather if the Federal Government is closed. If the Federal government does not close, yet I find the weather unsafe to travel in, I will cancel appointments. If the road conditions are clear and safe at the time of your appointment, and you are not able to make your appointment, your missed session will be treated as a late cancellation and a full session fee will be charged. For inclement weather, I offer one time, free pass to waive the session fees, if I am in the office, the roads are clear and you feel unsafe driving to your session. As always use your best judgement for taking the best self-care of you. As always I will send out an email alert/update my voicemail prior to 7am to make a decision for the day, if we are experiencing a weather issue. If the weather becomes nasty during the day, I will contact you to alter your appointment time as soon as I am are aware of the inclement weather.

Social Media & Messaging Policy
Social media accounts associated with the private practice are named "Narkia M. Ritchie, LMFT, LLC." Use your discretion to "like," request, follow, or the otherwise accounts linked to the practice name. Please be mindful when commenting, communicating, sharing, or disclosing your personal information as social media is not confidential; any content you chose to disclose on those sites are not protected by me or my practice.

I do not accept friend requests on my personal accounts from current or former clients on any social networking site; such as Linked In, Google Reader or Google +, Facebook, Twitter, or the like. I believe that adding clients as friends on these sites can compromise client confidentiality and privacy. Additionally, it may blur the boundaries of the therapeutic relationship. Clients are not to use messaging on Social Networking sites such as Linked In, Facebook, Twitter, other social media or vender outlets not listed, or cell-phone texting or app texting, face-time, or skype, etc. to contact me regarding

your treatment/scheduling related concerns. These sites are not secure and I may not read these messages in a timely fashion. The best way to reach me, between sessions, is by phone or direct email. This policy is in keeping with ethical guidelines that prohibit the formation of dual relationships between therapist and client. A dual relationship occurs when a therapist and client form another type of relationship outside of the therapist-client relationship (i.e. mutual friendship, business associate, teacher, student, family member, etc.), or enter into a therapist-client relationship after another type of relationship has already been established. Such dual relationships have the potential for creating conflicts of interest, possible exploitation, and problems associated with unhealthy boundaries.

Email Policy

E-mail is not completely secure or confidential and I cannot guarantee the privacy of information exchanged via email. Although it adds convenience and expedites contact, it is very important to be aware that email communications can be accessed relatively easily by unauthorized individuals and consequently can compromise the privacy and confidentiality of such communication.

Therapeutic services will not be provided via e-mail. Email may be used to exchange information only or to schedule or modify appointments. Also, please do not use email for emergencies. If you communicate confidential or private information via e-mail, I will assume that you have made an informed decision, and will honor your desire to communicate on such matters via e-mail.

E-mails I receive from clients and former clients along with any responses that are related to treatment and diagnosis may be printed out kept in respective treatment records. Emails also become a part of your legal records and may be revealed in cases where your records are summoned by a legal entity. Please be assured that current and former client e-mail information is always kept secure and not shared with any third parties.

The Process of Therapy and Termination

Participation in therapy can result in a number of benefits to you. Working towards these benefits requires effort on your part. There is no guarantee that psychotherapy will yield positive or intended results and it is normal to experience some unpleasant feelings from therapy. On the other hand, psychotherapy may help you change your unhealthy or maladaptive thoughts and behaviors and give you more rewarding interpersonal relationships. Please note that making an initial contact with me does not necessarily begin a therapy/counseling relationship.

Therapy/counseling begins after the initial evaluation/session and the required forms are completed and reviewed in your first session. At that time, we will both evaluate this information and assess whether or not I am the appropriate provider for your therapy/counseling needs and if you want to work with me going forward. Thereafter, our collaboration in addressing you problems will be enhanced by the amount of time and effort you devote to our work outside of our therapy sessions as well as during our appointment. Sessions are usually scheduled on a weekly or biweekly basis. During our sessions it is important you are forthcoming with feedback about how you are feeling about my work so that we can decide together if changes in your treatment should be made.

After the first few meetings, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help because more specialized services may be needed, we have a dual-relationship or conflicts of interest that could jeopardize your therapy, I deem that services you need are outside of my scope of expertise, or that more intensive services are needed. In such cases, I will give you a number of referrals that you may contact. You have the right to withdraw from therapy at any time. You or I can initiate termination of services at any time. Please discuss any plans or desire so I can provide you with any discharge recommendations/referrals you may need.

If you cancel or miss scheduled appointments and do not contact me for more than 30 days, it is understood that you have terminated treatment. Once treatment is terminated, the therapist has no further obligation to the client.

Therapist-Client Services Agreement Acknowledgement

Your signature below indicates that you have read this agreement for services fully, and that you understand and agree to its contents. Please ask for clarification of any points.

Your name (print)	Date	Signature
Therapist name (print)	Date	Signature

EFFECTIVE DATE: January 27, 2016

Notice of Therapist's Policies and Practices to Protect the Privacy of Your Health Information

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.

I understand that your privacy is important. I am not required to abide by the specific guidelines set out in the Federal Health Insurance Portability and Accountability Act of 1996. However I believe that HIPPA provides clients with a clear understanding of their rights and offers practical steps to protect your privacy thus I choose to offer HIPPA compliant guidelines for all clients. I will handle your health information only as allowed by Federal/State laws and adhering to the most stringent law that protects your health information.

Protected health information (PHI) is 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 provided to you, or the payment for such health care. This Notice explains 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 of my practice. With some exceptions, I may not use or disclose more of your PHI than necessary to accomplish to purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

If at any time you believe your privacy rights have been violated, you may make a complaint. Names, addresses and phone numbers are available at the end of this notice. You will not suffer any change in services or retaliation for filing a complaint, cooperating in an investigation, or refusing to agree to something that you believe to be unlawful.

I. Confidentiality: Uses and Disclosures of Information Requiring Your Authorization or Consent

As a rule, I will disclose no information about you, or the fact that you are my client/patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. To help clarify these terms, here are some definitions:

- Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
- Payment is when I obtain reimbursement for your healthcare (if applicable). Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within our office, clinic, practice group, etc. such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- Disclosure" applies to activities outside of our office, clinic, practice group, etc., such as releasing, transferring, or providing access to information about you to other parties.

I may "use" or "disclose" PHI for purposes outside of treatment, payment, and health care operations only when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information.

I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about conversations during a private, group, joint, or family counseling session, which have been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations of PHI or psychotherapy notes at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have previously relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy. Other uses and disclosures not described in the Privacy Notices will be made only with authorization from the individual. You may revoke your permission, in writing, at any time, by contacting me.

Patients have the right to restrict certain disclosures of PHI to health plans/insurance companies if the patient pays out of pocket in full for the health care service. Affected patients have the right to be notified following a breach of unsecured protected health information.

II. "Limits of Confidentiality:" Possible Uses and Disclosures of Mental Health Records with Neither Consent nor Authorization

There are some important exceptions to this rule of confidentiality - some exceptions created voluntarily by my own choice, [some because of policies in this office/agency], and some required by law. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and consent to accept my policies about confidentiality and its limits. I will discuss these issues now, but you may reopen the conversation at any time during our work together.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

- **Emergency** If you are involved in in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.
- **Child Abuse Reporting:** If I have reason to suspect that a child is abused or neglected, I am required by Virginia law to report the matter immediately to the Virginia Department of Social Services**.**
- **Adult Abuse Reporting:** If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Virginia law to immediately make a report and provide relevant information to the Virginia Department of Welfare or Social Services.
- **Health Oversight:** By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make a report to the licensing board. If you are yourself a health care provider, I am required by law to report to your licensing board if I believe your condition places the public at risk. Virginia Licensing Boards have the power, when necessary, to subpoena relevant records for investigating a complaint of provider incompetence or misconduct.

- **Court Proceedings:** If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so that you (or your attorney, or I) can file a motion to quash (block) the subpoena and can give reasons why I think your records should be protected from disclosure. However, while awaiting the judge's decision, I may be required to place said records in a sealed envelope and provide them to the Clerk of Court. In Virginia, parents' records may not be used as evidence (i.e., are privileged) in child custody cases), including records about parents held by a child's therapist; but a child's records do not have that same protection. NOTE: In civil court cases, therapy information or records are not protected by patient-therapist privilege in child abuse cases, in cases in which your mental health is an issue, or in any case in which the judge deems the information to be "necessary for the proper administration of justice." In criminal cases, Virginia has no statute granting therapist-patient privilege, although records can sometimes be protected on another basis. Protections of privilege may not apply if I do an evaluation for a third party or where the evaluation is court- ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** Under Virginia law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety.
- **Workers Compensation:** If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.
- **Records of Minors:** Virginia has a number of laws that limit the confidentiality of the records of minors. For example, parents, regardless of custody, may not be denied access to their child's records; and CSB evaluators in civil commitment cases have legal access to therapy records without notification or consent of parents or child. Other circumstances may also apply, and I will discuss these in detail if deemed necessary in the course of treatment.
- **Prenatal Exposure to Controlled Substances :** I am required to report admitted prenatal exposure to controlled substances that are potentially harmful.
- **Insurance Providers** (when applicable) Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission. You may revoke all such disclosures, provided each revocation is in writing. You may not revoke an authorization to the extent that I have previously relied on that authorization.
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III. Patient's Rights and Therapist's Duties:

Patient's Rights:

- **Right to Request Restrictions-**You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations --** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.
- **Right to an Accounting of Disclosures -** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section II of this Notice). On your written request, I will discuss with you the details of the accounting process**.**
- **Right to Inspect and Copy** - In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.
- **Right to Amend** - If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted dot me. In addition, you must provide a reason that supports s your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.
- **Right to a copy of this notice -** You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

All requests must be made in writing to: Narkia M. Ritchie, M.S., LMFT, LLC

Therapist's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will inform my clients/patients with a notice and they may download it from my website.

IV. Other Provisions: Personal Representatives and Minors

Personal Representatives. The Privacy Rule requires a covered entity to treat a "personal representative" the same as the individual, with respect to uses and disclosures of the individual's protected health information, as well as the individual's rights under the Rule. A personal representative is a person legally authorized to make health care decisions on an individual's behalf or to act for a deceased individual or the estate. The Privacy Rule permits an exception when a covered entity has a reasonable belief that the personal representative may be abusing or neglecting the individual, or that treating the person as the personal representative could otherwise endanger the individual.

Special Case: Minors. In most cases, parents are the personal representatives for their minor children. Therefore, in most cases, parents can exercise individual rights, such as access to the medical record, on behalf of their minor children. In certain exceptional cases, the parent is not considered the personal representative. In these situations, the Privacy Rule defers to State and other law to determine the rights of parents to access and control the protected health information of their minor children. If State and other law is silent concerning parental access to the minor's protected health information, a covered entity has discretion to provide or deny a parent access to the minor's health information, provided the decision is made by a licensed health care professional in the exercise of professional judgment.

V. Complaints

If you believe your privacy rights have been violated, you may discuss your concerns with me or file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

If you are concerned that I have violated your privacy rights, or you disagree with a decision I have made about access to your records, you may file a complaint with Narkia M. Ritchie, M.S., LMFT, LLC or with the Secretary of the Department of Health and Human Services. To file a complaint with my office, please send a written complaint Narkia M. Ritchie, M.S., LMFT, LLC at 10474 Armstrong St, Suite #104, Fairfax, Virginia 22030. Upon your request, I will provide you with the appropriate address if you choose to send a written complaint to the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

VI. Changes to Privacy Practices

I reserve the right to change privacy policies and related practices at any time, as allowed by Federal and State laws and to make the change effective for all health information that I maintain. You will be given a copy of the Revised Privacy Notices. You may also request a copy of this notice from me at any time.

EFFECTIVE DATE: January 27, 2016

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Provide information to a third party for the patient to be reimbursed.
- Conduct normal healthcare operations. For example, to evaluate the quality of care you receive from me.

I acknowledge that I have received a copy of Narkia M. Ritchie's, M.S., LMFT, LLC's Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review Narkia M. Ritchie's, M.S., LMFT, LLC's Notice of Privacy Practices prior to signing this consent.

I understand that Narkia M. Ritchie's , LMFT, LLC has a right to change its Notice of Privacy Practices from time to time and that I may contact Narkia M. Ritchie's, M.S., LMFT, LLC at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that Narkia M. Ritchie's, M.S., LMFT, LLC restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand Narkia M. Ritchie's, M.S., LMFT, LLC is not required to agree to my requested restrictions.

I consent to accept these policies as a condition of receiving services.

Your name (print)	Date	Signature
Therapist name (print)	Date	Signature

EFFECTIVE DATE: January 27, 2016

Credit Card Authorization Agreement

Cancellation and Services- Required for all clients

- I agree to pay the full session fee of session date for an individual, couple, or family therapy for any missed/cancelled appointments if I have not cancelled with 48 hours' notice before the scheduled appointment date in accordance with the cancellation policy (stated in the Therapist-Client Services Agreement). Please note that credit card payments, including those used for no-show appointments, incur a small processing fee. **Initial** _____

- Returned credit card/check fee of the initial charge amount and the additional $35 fee. **Initial** _____

- I agree that telephone contact or other counseling/consultations services (stated in the Therapist-Client Services Agreement) with Narkia M. Ritchie, LMFT, LLC, in excess of 15 minutes other than that associated with normal scheduling services will be billed at the prorated 45 minute session rate per 10 minute increments. **Initial** _____

Credit Card Type: MasterCard____ Visa___ Discover___ American Express ___ Debit Card____

Credit Card Number: _____

Security Code: _____ Expiration Date: _____

Name as Printed on Card: _____

Zip Code: _____

ALL Credit Card payments incur the following processing fee
(for striped cards: 2.75%/transaction;
for manually entered card information: 3.5% +15cents/transition)

- **(Optional)** Please charge my card on file for each counseling session rendered until I notify of a change in this payment option/method. Please note that credit card payments incur a small processing fee. **Initial** _____

  □ I wish to opt out of this option: _____
  (sign)

The above confidential information will be kept on file in a secured and locked location. By signing this agreement I am authorizing, Narkia M. Ritchie, LMFT, LLC, to charge the above credit card account for the above professional services rendered to me, my spouse/partner or on behalf of other family members. This information is complete and correct. I agree to update any information regarding the above account.

Responsible Party for Services (print) Date Signature

Disclaimer: All credit card information will be maintained and locked in a HIPPA compliant location. This information will only be accessed or used if a no-show service is required. This document will be destroyed by shredding once all therapy services are completely terminated.

Consent for Release of Confidential Information

I give permission for Narkia M. Ritchie, LMFT to share information with and receive information relative to the clinical aspects of my treatment in therapy.

Provider Name	**Provider Type** (therapist, psychiatrist, school counselor, etc.)	**Mailing Address**	**Phone #**	**Fax #**

In regards to: _____.
(client name)

The purpose for exchange of information is to:

☐ **Discuss treatment progress**
☐ **Obtain medical records and/or progress notes**
☐ **Release medical records and/or progress notes**
☐ _____

All consent for release expires 90 days after signing the consent for release of confidential information unless other otherwise noted with the following expiration date: ____/____/_____.

This authorization is signed with the understanding that my records and treatment are confidential and will not be disclosed without my written consent under legal compulsion. Further, it is understood that I may withdraw this authorization in writing any time prior the expiration date.

Today's Date: _____

Client Signature(s)_____

Parent/Guardian Signature (if applicable): _____

Therapist Signature: _____

Policies Regarding Counseling, Legal Issues & Court Related Services

As your therapist, I am providing counseling services to either you, your child, or family members. There are times when relationships end and couples decide to separate and/or divorce. There are times when issues of child custody and parental visitation arise. **As your therapist, I provide counseling treatment. I do not provide court related services or evaluations of any type.**

Please read each statement paragraph. By initialing, you are stating that:

"I understand that Narkia M. Ritchie provides counseling services and treatment, and does not act as a psychological evaluator or an evaluator for custody or visitation issues." **Initial ____**

"I agree to not involve her in any psychological/custody/violation disputes. I understand it would not be in the best interest of my treatment relationship, or my child's, or any family member, and it would be counterproductive to my therapeutic process." **Initial ____**

"I agree to not call her as a witness (subpoenaed) at any court hearing or trail, arbitration, mediation or any other tribunal. I understand that my therapist is not obligated to respond, return, or relay any professional opinions to others, and I agree to these terms. If my therapist does respond to any request for an opinion, it shall not serve to waive this clause." **Initial ____**

"I understand that I am expected to pay for all Narkia M. Ritchie's professional time in phone consults/writing, all preparation for consults or court services if subpoenaed, transportation costs, and any legal fees incurred, even if I am called to testify by another party. Payment is expected in advance, and any payment exceeding hours spent will be returned to the client. **Initial ____**

OTHER FEE SCHEDULE:

For any legal or court related services, including preparation:
My Fee is: $500. per hour

If I am called to testify by you or another party, and go to court:
My Fee is: $5,000. per day

Fees are collected prior to services, and will be prorated for reimbursement if hourly time is less than originally expected.

I have read this statement of policies and fees and understand and agree to the terms of Narkia M. Ritchie's policies and practices.

_____ _____

Signature(s) **Printed Name(s)**

Date _____ **Therapist's Signature** _____

Policy Working with Minors

I value our counseling relationship with your child. The best relationships are based on respect and understanding. It is important that you understand our policies and procedures regarding the treatment of minors at the beginning of service so that you can make an informed decision about receiving services.

1. Individual or family therapy/counseling services are provided are for children age 10+. I will work with a family system that has younger children only within the family therapy process. I currently do not provide individual therapy/counseling services to children under the age of 10.

2. A parent or guardian must consent to their child's treatment. At times, a court order to verify that you arethe legal parent or guardian may be necessary.

3. Initially, minors must be brought to therapy sessions by a parent or guardian. For the initial and second session, the parent or guardian must remain in the office during the time your child is being seen. It is in the best interest of the child for the adult to remain in the office for any and all subsequent sessions thereafter. The therapist reserves the right to require the parent/guardian to remain in the office for all counseling sessions.

4. A parent session is required every month. It is recommended that both parents attend. Confidentiality of the minor is respected.

5. Virginia Law allows for either parent to have access to their child's records or information, unless there is a court order limiting access or terminating parental rights. If one parent makes a request, attempts to notify the other parent will be made.

6. As your child's therapist, the counselor's goal is to establish a solid therapeutic relationship with your child and to provide quality treatment and care. If in the event of parental conflict, it is counterproductive to involve the counselor in any type of legal proceedings against a parent or family member. By initialing this paragraph, and by giving your signature below to this policy document, you agree not to involve your therapist in any type of legal proceeding against a parent or family member. _____ **Initial**

I acknowledge that I have read and agree to all of the above provisions about seeking services for my child. I certify that I am the legal parent/guardian and have the authority to consent to services.

_____ _____
(Name of minor/dependent adult) (Date of birth)

_____ _____
(Name of minor/dependent adult) (Date of birth)

Please select the appropriate custodial arrangement that applies to your situation: Check one

☐ Biological parents residing together - Consent for treatment form can be signed by one biological parent

☐ Biological parents not residing together – sole custody agreement - Consent for treatment form must be signed by the parent with sole custody

☐ Biological parents not residing together – joint custody agreement- Consent for treatment form must be signed by *both* biological parents

_____ _____
(Signature of Biological/Custodial Parent / guardian) (Date)

_____ _____
(Signature of Biological/Custodial Parent / guardian) (Date)

Adult Intake Questionnaire

Legal Name: _____
Preferred Name: _____
Birthdate: _____ **Age** _____

Consider myself *(check all and any that apply)*
Female ____ Transgender Female ____
Male ____ Transgender Male ____ Other ____

Sexual Orientation, consider myself:
Straight/Heterosexual ____ Bisexual ____ Gay____
Lesbian ____ Other ____

I am currently: *(Check any that currently apply to you, even if more than one.) Enter the time frame and circle "months" or "years".*
□ Single □ Never married □ Widowed
□ Dating for _____ months / years
□ Cohabiting for _____ months / years
□ Married for _____ months / years
□ Separated for _____ months / years
□ Divorced for _____ months / years

Have you been married previously (not counting at present)?
□ Yes □ No If yes, how many times? _____

Do you have biological children of your own? □ Yes □ No
If yes, how many children do you have? _____
How many of your bio-children live with you? _____

Do you have step-children? □ Yes □ No
If yes, how many step-children do you have? _____
How many of your step-children live with you? _____

Education: *(highest level)*
□ Some high school □ High school
□ Technical / Trades □ 2-vear associate degree
□ Some undergraduate college or university
□ Undergraduate degree □ Some graduate level
□ Graduate degree: _____

Current Occupation: _____
Years at Current Job: _____ Hrs per week: _____
Do you enjoy your work? □ A lot □ Moderately □ Very little

SYMPTOM CHECKLIST

On a scale of 0-4 (0=none or not applicable, 1=a little, 2=moderate, 3=a lot, 4=extreme) rate how much you have experienced each symptom over **the past two weeks**.

1. Feeling sad, down or depressed	0	1	2	3	4
2. Avoiding certain people or places	0	1	2	3	4
3. Loss of interest in activities I used to enjoy	0	1	2	3	4
4. Low energy/feeling tired	0	1	2	3	4
5. Sleep problems (insomnia, not staying asleep, or early waking)	0	1	2	3	4
6. Eating too much or too little	0	1	2	3	4
7. Not able to think clearly	0	1	2	3	4
8. Feeling no pleasure or joy in life	0	1	2	3	4
9. Anxiety attacks	0	1	2	3	4
10. Worrying about things	0	1	2	3	4
11. Angry outbursts	0	1	2	3	4
12. Low self-esteem or low self-confidence	0	1	2	3	4
13. Feeling guilty	0	1	2	3	4
14. Feeling too stressed	0	1	2	3	4
15. Thoughts of suicide	0	1	2	3	4
16. Drinking too much or abusing drugs (i.e. street drugs or prescribed medications)	0	1	2	3	4
17. Acting out other compulsive behaviors (i.e. gambling, sex, porn, shopping, etc.)	0	1	2	3	4
18. Not getting my work done	0	1	2	3	4
19. Feeling unhappy with my workplace	0	1	2	3	4

If you are in a relationship with a spouse, boyfriend, girlfriend or partner, please rate how much you have experienced each of these additional six symptoms in your relationship over **the past two weeks**. If you are single, circle all 0's in the next six statements and enter the total of 1 through 25 in the box below.
(Circle a number)

20. Not talking to each other	0	1	2	3	4
21. Having bad arguments	0	1	2	3	4
22. Lack of trust between us	0	1	2	3	4
23. Feeling lonely in the relationship	0	1	2	3	4
24. Lack of affection and caring between us	0	1	2	3	4
25. Feeling unhappy about our relationship	0	1	2	3	4
Symptom Total (sum of all 25 symptoms)					**/ 25**

Medical: Do you have any medical problems? □ Yes □ No
If yes, please list them: _____
_____

Do you take any prescription **Medications**? □ Yes □ No
If yes, please list them:

Medication	*Dose*	*Purpose*	*Since*

Do you Exercise? □ Yes □ No.
If yes, what do you do?_____

Do you drink alcohol? □ Yes □ No
If yes, estimate how many times you typically drink in a month (i.e. how many drinking occasions):_____
Estimate how many standard drinks you typically drink per occasion (estimate your range if it varies): _____

Do you smoke tobacco? □ Yes □ No
If yes, please estimate quantity per day: _____

Do you drink coffee/ tea? □ Yes □ No
If yes, please estimate quantity per day: _____

Do you use any illicit drugs? □ Yes □ No
If yes, please specify: _____

If you drink alcohol or use illicit drugs, please answer the following questions:

C. Have you ever thought you should **Cut down** on your drinking/ drug use? □ Yes □ No

A. Have people **Annoyed** you by criticizing your drinking/ drug use? □ Yes □ No

G. Have you ever felt bad or **Guilty** about your drinking/ drug use? □ Yes □ No

E Have you ever had a drink / used drugs in the morning (**Eye opener**) to steady your nerves or to get rid of a hangover? □ Yes □ No

Are you concerned about the alcohol and/or drug use of anyone close to you? □ Yes □ No If yes, who?
_____

Adult Intake Questionnaire

In any of your <u>current</u> relationships, have you been:

Physically assaulted (hit, slapped, kicked, pushed, held down)?
□ Yes □ No If Yes, By? _____

The subject of demeaning, degrading comments or put downs?
□ Yes □ No If Yes, By? _____

Sexually abused or coerced into unwanted sexual activity?
□ Yes □ No If Yes, By? _____

In any of your <u>past</u> relationships, have you been:

Physically assaulted (hit, slapped, kicked, pushed, held down)?
□ Yes □ No If Yes, By? _____

The subject of demeaning, degrading comments or put downs?
□ Yes □ No If Yes, By? _____

Sexually abused or coerced into unwanted sexual activity?
□ Yes □ No If Yes, By? _____

REASONS FOR SEEKING COUNSELING

Check those that apply (*using the left column*).
If you check more than one, please select your <u>top three</u> and rank them (*using the right column*) from highest to lowest in terms of the priority you place on resolving them (1=highest priority, 2=second highest, 3=third highest).

(√) (Check all that apply)	Rank
___ Depressed Mood	_____
___ Anxiety	_____
___ Anger Management	_____
___ Self-Esteem or Confidence	_____
___ Social Difficulties	_____
___ Stress Management	_____
___ Substance Abuse (Alcohol/Drugs)	_____
___ Gambling Difficulties	_____
___ Other Addictions (i.e. Porn, Sex, Shopping)	_____
___ Eating Disorder	_____
___ Weight Management / Body Image	_____
___ Spiritual Problems	_____
___Gender/Sexuality	_____
___ Bereavement/ Loss	_____
___ Work problems	_____
___Education/ Career Concerns	_____
___ Financial Concerns	_____
___ Legal Concerns	_____
___Medical Issues	_____
___ Domestic Violence or Abuse (Current)	_____
___ Premarital Counselling	_____
___Communication Problems/Relationship Conflict	_____
___ Sexual Intimacy Concerns	_____
___Emotional or Sexual Infidelity/affairs	_____
___Emotionally disconnected from spouse/partner	_____
___Other Marital/Relationship Concerns	_____
___Separation / Divorce / Relationship Break-Up	_____
___Custody Concerns	_____
___Parenting	_____
___Parent-Adult Child Relations	_____
___Blended Family Issues	_____
___Family Conflict	_____
___Child – Behavioral Problems	_____
___Child – Mood / Anxiety Problems	_____
___Child – Academic Problems	_____
___Child – Social/ Relational	_____
___Other_____	_____

PREVIOUS TREATMENT

Have you participated in therapy or counseling in the past?
□ Yes □ No If yes, please specify:

Date	Duration	Therapist / Location	Was it Helpful?

Who do you turn to for social support (e.g. for encouragement, advice, friendship, etc.)?

_____

_____

_____

Are there any organizations or agencies that you are currently receiving assistance or support from? □ Yes □ No If yes, please specify: _____

_____

_____

EXTENDED FAMILY HISTORY OF PSYCHOSOCIAL / HEALTH DIFFICULTIES

Please check any of the conditions below that are or have been present in your extended family. Please write any additional explanatory comments that may be helpful for your therapist to understand.

	Who? When?
□ Depression	_____
□ Bipolar Disorder	_____
□ Schizophrenia	_____
□ Other psychiatric disorders (i.e. psychosis, hallucinations)	_____
□ Suicide	_____
□ Physical / Sexual Abuse	_____
□ Substance Abuse (Alcohol/Drugs)	_____
□ Autism/Asperger's Syndrome	_____
□ Eating Disorder	_____
□ Chronic Illness (please specify illness)	_____
□ Accidental or Untimely Death	_____
□ ADHD or Learning Disorders	_____
□ Other	_____

OTHER INFORMATION

Please include here any additional background information you feel would be helpful for your therapist to know:

_____

_____

_____

_____

Thank-you very much for taking the time to fill out this questionnaire.

Minor Intake Questionnaire
(each minor completes separate form)

Minor's **Legal Name:** _____
Minor's **Preferred Name:**_____
Birthdate: _____ **Age** _____
Minor consider self as *(check all and any that apply)*
Female ____ Transgender Female ____
Male ____ Transgender Male ____ Other ____
Sexual Orientation of minor:
Straight/Heterosexual ____ Bisexual ____
Gay____ Lesbian ____ Other ___

Child Primarily Resides With:
□ Biological Mother and Father in same house
□ Biological Mother □ Biological Father
□ 50/50 Biological Mother & Father

Name of School: _____
Grade Level: _____
Average Grades: _____

Does your child have a job? □ Yes □ No

Current job title: _____

Years at Current Job Hrs per week

Symptoms Checklist

On a scale of 0-4 (0=none, 1=rarely, 2=sometimes,

3=frequently, 4=many times) rate how much you have observed each symptom in your child over **the past year** (circle the number).

a. Withdrawal from family	0	1	2	3	4
b. Irritability or mood changes	0	1	2	3	4
c. Stealing	0	1	2	3	4
d. Lying	0	1	2	3	4
e. Loss of interest in extracurricular activities	0	1	2	3	4
f. Being secretive	0	1	2	3	4
g. Defying parents/house rules	0	1	2	3	4
h. Angry outbursts	0	1	2	3	4
i. Negative attitude to school	0	1	2	3	4
j. Drop in grades	0	1	2	3	4
k. Frequent change in friends	0	1	2	3	4
l. Worrying excessively	0	1	2	3	4
m Difficulties sleeping	0	1	2	3	4
n. Loss of drive/motivation	0	1	2	3	4
o. Difficulties making friends	0	1	2	3	4
p. Low self-image	0	1	2	3	4

How much do these symptoms interfere with the following?

Personal well-being	0	1	2	3	4
School performance	0	1	2	3	4
Family relationships	0	1	2	3	4

Does your child
Have any **Medical** problems? □ Yes □ No
If yes, please list them: _____
_____

Take any prescription **Medications**? □ Yes □ No
If yes, please list below:

Medication	*Dose*	*Purpose*	*Since*

PREVIOUS TREATMENT

Has your child participated in therapy or counseling in thepast? □ Yes □ No If yes, please specify:

Date	Duration	Therapist / Location	Was it Helpful?

Are you concerned that your child is using alcohol and/or illicit drugs? □ Yes □ No

Has your child ever threatened self-harm? □ Yes □No
If yes, when?_____
Is this current? □ Yes □No

Has your child ever threatened suicidal ideation? □ Yes □No
If yes, when?_____
Is this current? □ Yes □No

Has your child ever threatened harm to someone else? □ Yes □No
If yes, when?_____
Is this current? □ Yes □No

Has your child ever threatened harm to someone else? □ Yes □No
If yes, when?_____
Is this current? □ Yes □No

Has your child experienced any past **trauma**? □ Yes □ No
If yes, please specify: _____

OTHER INFORMATION

Please include here any additional background information you feel would be helpful for your therapist to know:

_____
_____
_____

Thank-you very much for taking the time to fill out this questionnaire