DONNA C. FORTNEY, NCC, LPC
Certified Imago Relationship Therapist

703-869-3589 (Phone)
571-766-2613 (Fax)

Donna@ConsciousPartners.com
ConsciousPartners.com

CLIENT INFORMATION (please print)

Client Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Evening Phone: _____ Daytime Phone: _____ Cell/Pager: _____

Employer/Profession: _____

Work Address: _____

Email Address: _____

Social Security: _____Date of Birth: _____Age: _____

MEDICAL INFORMATION

Physician Name/Address: _____

Physician Phone: _____ Date of Last Visit/Reason: _____

List all medications/doses you have taken in the 12 months: _____

_____

Please note any medical conditions/concerns: _____

_____

_____

Emergency Contact Person (other than partner): _____

Phone(s):_____

You are responsible for payment at the time services are rendered.

The above information is accurate and complete.

_____ _____

Client/Responsible Party Signature Date

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INFORMATION AND CONSENT

This document is designed to inform you about my background and about the counseling relationship you will be entering.

I have my Bachelor's and Master's degrees in Counseling Psychology from Marymount University. I am a National Certified Counselor (NCC) and a Licensed Professional Counselor (LPC) in the State of Virginia. I am also a Certified Imago Relationship Counselor and certified in Solution Oriented Brief Therapy and working toward certification in Eye Movement Desensitization and Reprocessing (EMDR) and Emotional Freedom Techniques (EFT). I work with a variety of perspectives in my therapy work with clients including Voice Dialogue, and my specialty areas include: gifted/talented adolescents, individual and couple relationships including gay and lesbian issues, life transitions, blended families, separation/divorce, depression, anxiety and trauma.

The work that we do will be kept confidential, with the following exceptions: (a) you sign a consent form giving permission for me to talk to someone, (b) I determine you are in danger to yourself or others, and/or (c) I am ordered by a court to disclose information. By signing this form, it is understood that you have had an opportunity to also read the HIPPA form and ask any questions.

I check my voice mail messages often during the week and return calls within 24 hours. I see clients in Centreville, VA Tuesday through Saturday. Another licensed therapist will be on call in case of any client emergency when I am out of town. Their name and phone number will be available to you by dialing my phone number 703-869-3589. In case of a clinical emergency you should first call 911 or go to your nearest emergency room and give them my name and phone number:
(703) 869-3589.

I expect that you will attend, on time, each arranged session. In the event that you will not be able to keep an appointment, I require at least **24 hours notice** in advance or you will be charged the **full amount** for the missed session. If an EAP referred you, and you do not give 24 hours notice, you will be responsible for the payment.

Payment is expected at time of your session. I accept cash, check, and credit cards (VISA, MasterCard & Discover). Fees for services are: **$210.00 for a 90 minute** Assessment session and **$180.00 for a 75 minute** Regular session, including phone sessions.

For any session, including phone sessions, an additional payment of $30.00 will apply for each additional 15 minutes over the specified session time.

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Some health insurance companies will reimburse clients for counseling services and some will not. Please contact your insurance company to determine their process for reimbursement. I will provide any documentation your insurance company requires to process a claim. As the Client, you are responsible for submitting insurance forms.

My staff will treat all client information with strict confidentiality. At present, Daniel R. Fortney, my husband, and business partner, is responsible for managing all business aspects, including billing, processes, website maintenance, and business development.

If you understand the information described above, please sign and date this document.

_____
Print Client Name

_____ _____
Client Signature Date

_____ _____
Counselor Signature (Donna C. Fortney, NCC, LPC) Date

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PROTECTED HEALTH INFORMATION-PLEASE READ AND SIGN (HIPAA)

This notice describes how medical/mental health information about you may be used and disclosed, and how you can get access to this information. Please read.

I have a duty to maintain privacy of your health information and to provide you with this notice. You will be asked to sign a Consent Form. Once you have signed the Consent Form, I may use or disclose your Protected Health Information for purposes of diagnosis, treatment, obtaining payment, or to conduct healthcare operations. For example, if you choose to use insurance, to receive payment I must provide information about you to your insurance company.

Other permitted and required uses and disclosures that may be made without you consent, authorization or opportunity to object are as follows:

Abuse or Neglect: If I suspect abuse or neglect of a child or elder, I am mandated to report this information to the proper authorities.

Danger: If I suspect you are in imminent danger of harming yourself or someone else, I am mandated to report this information to the person at risk and the authorities.

Legal Proceeding: I may disclose Protected Health Information in response to a court order or subpoena or in certain other legal proceedings.

Right to Inspect and Copy: You have the right to inspect and request copies of information that may be used to make decisions about your care. Usually this includes demographic and billing records but does not include psychotherapy notes. To inspect and/or receive copies of information, you must submit a request in writing. If you request a copy of information, I will charge a fee to cover expenses associated with your request.

Right to Amend: If you feel that health information about you is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment for as long as I keep the information. Your request must be in writing and must provide a reason supporting your request.

Right to an Accounting of Disclosures: You have the right to request and Accounting of Disclosures I have made of information about you. You must submit your request in writing, state a time period for the disclosures and it may not include dates prior to April 14, 2003.

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Right to Request Restriction on Uses and Disclosures: You may request that disclosures of confidential information be limited.

Right to Limit Reception of Confidential Information: You may request that I only contact you at certain telephone numbers or addresses.

Other uses and disclosures of Protected Health Information and any disclosure of Psychotherapy Notes will be made only with your written authorization. After such authorization is given, you may revoke that authorization at any time. This Notice may be amended as needed to comply with federal, state and professional regulations.

_____

Print Client Name

_____ _____

Client Signature Date

_____ _____

Counselor Signature (Donna C. Fortney, NCC, LPC) Date

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Client Consent to Release Information

I, _____, give my permission

for _____ Phone Number _____

Fax Number _____

to release information to, and speak directly with Donna C. Fortney, LPC.

I understand that the information exchanged is for professional counseling purposes only and I hereby grant my consent and understanding.

This release expires on _____.

_____
Print Client Name

_____ _____
Client Signature Date

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Credit Card Charge Authorization Form

I (we) hereby authorize Donna C Fortney, LPC to make recurring charges to my Credit Card listed below, and, if necessary, initiate adjustments for any transactions credited or debited in error. This authority will remain in effect until Donna C. Fortney is notified by me (us) in writing.

Name (as it appears on card): _____

Billing Address:

Street: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Email: _____

Select One: ◯ Visa ◯ MasterCard ◯ Discover

Card Number: _____

Card Verification Number: _____

Expiration Date: _____

_____ Signature

_____ Effective Date