Vine Psychiatric Associates (VPA)

14631 Lee Highway Suite 209, Centreville, VA 20121
Tel: 703-830-1800 * Fax: 703-830-1801 * email- vinepsychiatric@gmail.com

Client Intake Information

Name : ______________________________ *Date of Birth :* __________________

Social Security # : ________________________ *Phone# :* ______________________

Address : ____

City : _______________________ *State :* _________ *Zip :* __________

Email Address : ____

*Employer:*______________________________*Position :* ____________________

*For how long?*___________________ *Education :*____________________

Who shall we contact in case of emergency? *Name :* ______________________

*Relationship :*_________*Contact number :* _________________

*Marital Status :*_______*Significant other's name :* ______________________________

Age : _________ *Sex :* _________ *Years together :* _______

Name and ages of all individuals in the home: ________________________________

____

Who referred you to Vine Psychiatric Associates? ________________________________

Insurance Information

Insurance Name : ______________________ *Member ID # :* _______________________

Policy Holder's Name : ___________________ *Policy Holder's Date of Birth:* ______________

All clients using health insurance please sign below.

I hereby grant authorization to Vine Psychiatric Associates, to release any Protected Health Information that is necessary for billing (except Psychotherapy Notes) to my insurance company, or to process my claim for payment of services. I authorize my insurance company to send payment directly to VCTC for all services provided. I agree that a photocopy of this authorization shall be as valid as the original.

Signature:___________________________ ***Date:***____________________

Primary care information

*List any allergies you have:*______________________________________*None:* (_____)

*Primary Care Physician:*_______________________________________*Phone number:* ____________________

*Approximate date of your most recent physical examination:*____

To Female, Pregnancy : *Yes* (_____) *No* (_____) *N/A* (_____)

We do not provide any services which require FMLA, SSD, any other paper related to work or legal issues: *Please initial here* ***Yes* (______)**

***The main reason for the visit:*____**

**List all current medications and dosages, including supplements:*

Name of Medication	***Reason Taking Medication***	***Dosage***	***Prescribing Doctor***	***Date Started***

**List all current or past health problems, and any major operations:*

Health Problem or Surgery	***Date***	***Current Problems?***	***Doctor***

Drinking Pattern and substance Abuse:* ***Yes**: fill up below.* ***No:*** *Not necessary to fill.*

Total number of drinks per week you consume	
Number of times in the past 30 days when you drank enough to get drunk	
Have you ever had alcohol withdrawal?	
Have you ever had legal conflicts due to alcohol?	

**List any substance abuse treatment or inpatient psychiatric treatment and dates:*

Name of Program or Psychiatric Hospitalization	***Dates***	***Inpatient/ Outpatient***

***Printed Name:*_______________________ *Signature:* ___________________ *Date:* ____________**

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Fee Agreement with Physician

1. FEE: *Initial appointment lasts from 50 to 70 min. Follow up sessions last 30 minutes. Although health insurance may aid in payment, you are responsible for paying for all services and appointments at Vine Psychiatric Associates. If you cancel or do not keep an appointment* ***without giving 48 Hours advance notice,*** *you must pay* ***$50.00 for the time you have reserved****. Insurance companies do not pay for canceled appointments. If you are ill and call in advance to cancel your appointment, there will be no charge.*

Please initial here __________

Report writing, hospital visits, consultation with other professionals, home visits, telephone counseling, school meetings and any court-related services (such as consultations with lawyers, depositions, or attendance at courtroom proceedings) are ***not*** *covered by insurance. These services may require payment in advance. Please inform me in advance if you anticipate that you will require my services in a court or school proceeding.*

Please initial here __________

If Vine Psychiatric Associates has contracted with your insurance company to accept a lower fee, your deductible and any uninsured portion of each session's fee will be based on that contracted amount. If the company decides to increase the fee that Vine Psychiatric Associates is allowed to charge, your deductible and any uninsured portion of each session's fee will be based on the increased amount. Sometimes managed care companies will authorize more sessions than your insurance benefits will pay for. If you see your Dr for visits that are authorized but not paid for by your insurance benefits, by signing this form you agree to pay Vine Psychiatric Associates' 's fee, as listed above, for each authorized visit that is not covered by your insurance benefits.
If your insurance company requires you to get authorization from them before seeing a Dr and you do not do so, you are responsible for payment in full of the fees listed above.

2. PAYMENT ARRANGEMENT*:*
Payment for any deductible is due at the time of each session.

3. COLLECTIONS PROCEDURES*: Vine Psychiatric Associates reserves the right to collect any unpaid balance due to them. If a client is not making regular monthly payments on the account balance, Vine Psychiatric Associates may use a collection agency or take legal action to secure payment, as authorized by state or federal law, and the collections action will become a part of your credit record. Clients will be notified in writing before Vine psychiatric Associates takes action to collect.*

4. LIMIT ON UNPAID BALANCE: *Vine Psychiatric Associates may terminate treatment and refer the client elsewhere for continued care if the unpaid balance exceeds $300.00.*

HIPAA: Your Information. Your Rights. Our Responsibilities:
Per your request. HIPAA will be offered to you.

I have read and understood the above fee agreement, and I agree to abide by its terms.

Printed Name:___________________Signature:___________________Date:__________