POTOMAC PSYCHOLOGICAL CENTER, LLC

PATIENT INFORMATION (PLEASE PRINT):

Full Name _____
Last First MI
Home address _____

City, State, Zip _____

PRIMARY Phone number _____Other Phone #_____

Work Phone_____ **Email:**_____
*****Please note that we will leave general voicemail messages on the numbers provided. These messages will NOT include any personal health information. Please ask the front desk if you still would not like any messages left*****

Male or_Female Birth Date _____ Social Security#_____

Marital Status: Single Married Separated Divorced Other_____

Emergency Contact _____ Phone _____Relation_____

Referred by_____Are you the policy holder for your insurance? Y or N

SUBSCRIBER INFORMATION (if different from the patient)
Full Name _____
Last First MI
Relationship to Patient: Mother _____ Father _____ Other _____

Custody Status: Legal _____ Physical_____

Home Address _____

City, State, Zip _____

Primary Phone _____ Birth Date _____Social Security #_____

Marital Status: Single_____ Married _____ Separated_____ Divorced_____ Other _____

Email: _____ Other phone #_____

OTHER PARENT / GUARDIAN INFORMATION (Required if patient is under 18 yrs): ***This information is required for both parents.
Full Name _____
Last First MI
Relationship to Patient: Mother _____ Father _____ Other _____

Custody Status: Legal _____ Physical: _____

Home Address _____

City, State, Zip _____

Primary Phone _____Birth Date _____Social Security #_____

Marital Status: Single_____ Married _____ Separated_____ Divorced_____ Other _____

Email: _____ Other phone #_____

PRIMARY CARE PHYSICIAN /Pediatrician/Etc.: _____

Office Phone: _____ Fax (if known) _____

Informed Consent for Treatment

I, _____ (name of patient), agree and consent to participate in behavioral health care services offered at and provided by Potomac Psychological Center, LLC, behavioral health care providers. I understand that I am consenting and agreeing only to those services that the provider is qualified to provide within: (1) the scope of the provider's license, certification, and training: or (2) the scope of the license, certification and training of the behavioral health care provider directly supervising the services received by the patient. If the patient is under the age of eighteen or

unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent to treatment, and I am legally authorized to initiate and consent to treatment on behalf of this individual.

Your confidentiality and privacy is important to us. However, there are situations in which we cannot guarantee confidentiality. These situations include, but are not limited to, if your clinician feels you are a harm to yourself or someone else, if there is a need for Child Protective Services to be involved, or if a judge subpoenas your records or the treating clinician.

Cancellation Policy

All appointments must be canceled by 3:00 p.m. the business day (Monday- Friday) before my scheduled appointment. Failure to do so will result in a missed appointment charge of **$75** . If I arrive 20 or more minutes late to my therapist's appointment, I may be charged for a missed appointment. In the event of **snow or inclement weather, my appointment can be canceled the same day with no charge, ONLY IF Loudoun County Government (not the school system) is closed AND ONLY IF I call to cancel my appointment prior to the appointment time.** Anytime I properly cancel an appointment I can ask for a cancellation number from a PPC employee. If there is any question about a cancellation, I understand that I may be inquired to provide the cancellation number. In case you have to leave a message with the cancellation request, you WILL receive a return phone call. If you do not receive a return call, PLEASE call again since we may not have gotten your message. By signing this form, I acknowledge that I have read and fully understand the PPC policy for cancellation of appointments. X_____ (Please initial)

Missed Appointments

If the missed appointment/late cancel is due to a medical emergency, family emergency, transportation issue such as mechanical problems, or you believe the appointment was scheduled in error, you will need to fill out an appeal form **within 60 days** of the missed appointment date and provide a doctor's receipt, or any other supporting documentation. We are not obligated to accept appeals after the 60 day mark.
X_____ (Please initial)

I have received the handout PPC Patient Information Reference 2016 and understand that these are the policies that I am bound by in receiving services at this office.
My signature below constitutes acknowledgement and acceptance of these policies.

Print Patient Name	Signature of Patient or Guardian	Date

I have read and understand Potomac Psychological Center, LLC
Notice of Privacy Practices Sheets (attached to clipboard)

Print Patient Name	Signature of Patient or Guardian	Date