Charis Institute for Psychological and Family Services
21 Southgate Court, Suite 101
Harrisonburg, VA 22801

Phone: 540.568.1876
Fax: 540.574.6076

## General Information - Adult

Thank you for choosing Charis Institute. We sincerely hope this will be a place of healing for you. Please take the time to fill out all of these forms and read all of the information regarding your treatment, the payment, and your insurance policy.

***When 24-hour notice is not given there will be a charge of $35 for missed appointments.***

Where did you hear about our services or who referred you?____________________________________

**Client Information**

| | | |
|---|---|---|
| Name | Date of Birth ___/___/___ | Social Security Number ___-___-___ |
| Mailing Address | Home Phone (___)________ | Cell Phone (___)________ |
| City / Zip Code | Occupation | |
| Employer/School | Work Phone (___)________ | |

**For your comfort and assurance of confidentiality we ask that you please read over the following and sign:**

- I give permission for charis institute to call my cell or home and leave a message on the answering maching or with anyone who answers the phone.
- I give permission for charis to call my work number if I need to be reached.

______________________ ______________

Signature Date

**Marital Status**: __Single ___Married __Divorced __Separated **If you are married, please state how many years**______

| | | | | |
|---|---|---|---|---|
| Spouse's Name | Social Security Number ___-___-___ | Age | Date of Birth ___/___/___ | Employer |

**If you have children please list (include ages)** ____________________________________

**Person Responsible For Account (If other than the client, by providing this information you are allowing us to release relevant information to this individual, regarding billing)**

| | | |
|---|---|---|
| Name | Date of Birth ___/___/___ | Social Security Number ___-___-___ |
| Mailing Address | Home Phone (___)________ | Cell Phone (___)________ |

**Insurance Information**

| | | |
|---|---|---|
| Insurance Company | Policy Number/Member ID | Group Number |
| Insurance Company Address | Name of Cardholder | Cardholder DOB ___/___/___ |

Mailing Address of Cardholder City State Zip

**Method of Payment** *Please check the method of payment that you will be using.*

Cash Charge Payment Plan Insurance/Co-Pay or Deductible

You should be aware that different insurance companies vary greatly in the types of coverage available. Some insurances require prior authorization for treatment. Prior to your appointment it is your responsibility to contact your insurance to see if authorization is required. We ask that you look upon your insurance realistically as a device which helps you pay for your care here at Charis Institute. Please understand that assisting you with your insurance claim is done willingly but that regardless of the insurance coverage, the obligation for the fee for the services rendered is yours. All fees will be due on the day of treatment even if you have insurance unless arrangements are made in advance with our office. Insurance companies typically limit their coverage to services that *they* consider medically necessary. In the event that you receive services and your insurance determines it did not meet their criteria, you understand that you are responsible for payment for these services. I hereby authorize treatment. I authorize Charis Institute to furnish insurance carriers with any medical information necessary to process this claim. I hereby assign to Charis Institute all payments for services rendered to my dependents or myself. I acknowledge that insurance claims pending beyond 60 days are my responsibility and I agree that I will not delay payment and that I will pay the balance if a claim is pending more than 60 days. I understand that if I make a payment and payment is received later by Charis from my insurance company, I will be reimbursed. If a check is returned to Charis Institute, I understand that I will be responsible of paying the fee that bank charges them. I have read and understand the Privacy Policy that is posted is the office.

______________________ ________/________/________

(Signature/Guarantor) (Date)

# Adverse Childhood Experience (ACE) Questionnaire

***(Ages 0-8yrs form to be completed by parents)***

While you were growing up, during your first 18 years of life:

1. **Did a parent or other adult in the household often …**
   Swear at you, insult you, put you down, or humiliate you?
   **or**
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 ________
2. **Did a parent or other adult in the household often** …
   Push, grab, slap, or throw something at you?
   **or**
   **Ever** hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 ________
3. **Did an adult or person at least 5 years older than you ever…**
   Touch or fondle you or have you touch their body in a sexual way?
   **or**
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 ________
4. **Did you often feel that …**
   No one in your family loved you or thought you were important or special?
   **or**
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 ________
5. **Did you often feel that …**
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   **or**
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 ________
6. **Were your parents ever separated or divorced?**
   Yes No If yes enter 1 ________
7. **Was your mother or stepmother:**
   **Often** pushed, grabbed, slapped, or had something thrown at her?
   **or**
   **Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard?
   **or**
   **Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 ________
8. **Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?**
   Yes No If yes enter 1 ________
9. **Was a household member depressed or mentally ill or did a household member attempt suicide?**
   Yes No If yes enter 1 ________
10. **Did a household member go to prison?**
    Yes No If yes enter 1 ________

**Now add up your "Yes" answers: _______ This is your ACE Score**

**Confidential Adult Biosocial History**

**Please take the time to complete this information as it will assist your therapist in understanding and treating you and your problems.** Completing this information in advance allows you to spend less time on information gathering activities during your first session. If you need help in completing these forms, please let your therapist know. *Please Check All That Apply.*

1) What is your education? ____ Elementary ___High School ____ College ____Graduate School ____Vocational Training
2) What is your estimated reading level? ___Cannot Read ___Elementary School ___Middle School ____High School or above
3) Please list current or past significant medical problems (also previous mental health diagnoses)________________________________________
4) List all of your allergies________________________________________
5) List all prescription drugs you are now taking (include name, amount, how often taken, and how long taken):_______________
________________________________________
6) Check current non-prescription drug use (if you mark "other" please specify on line provided).
*Alcohol:* ____Beer ____Wine ____Whiskey
***Sedatives:***___Nerve Pills ___Tranquilizers
***Hallucinations:*** ____LSD ____PCP __Acid
***Stimulants:*** ___Pep Pills ___Diet Pills ___ Cocain ___Speed ____ Soft Drinks ____Coffee ____Tea
***Pain Killers:*** ___Darvon ___Codeine ___Demerole
***Inhalants:***___Paint thinner ___ Glue ___Other________________
***Narcotics:***___ Marijuana ____Hash ___ Heroin ___ Other __________________
***Other:*** ____Over the Counter ____Home Remedies ____ Street Drugs _____Other ___________

List accidents or broken bones:________________________________________
*Did any accidents result in periods of unconsciousness?* ______ Yes ________ No

8. List hospitalizations and surgeries and give the dates: ____________________
9. Previous outpatient mental health treatment (List name of therapist, address, dates of treatment, and frequency of sessions)_____
________________________________________
10. Previous inpatient mental health treatment (List facility, address, and dates of treatment)________________________________________
11. Give a brief sexual history, at what age became sexually active, description of current sexual behavior, along with any sexual problems/concerns________________________________________
12. As a mother or a father, please check if you have had any of the following and on the line state how many of each:
___Abortion(s) ___Miscarriage(s) _____ A child die
13. List last physical examination and the name of the Doctor seen for the examination.____/___/____ __________________
14. What is your religious background?_______________________ Name of Home Church______________________
How important are religious/spiritual practices to you? ___Very Important ____Important ____Neutral____ Unimportant
15. Please check any of the following that you participate in or attend. ___Support Group ____12 Step Program ____Church or Religious Group _____Social Clubs/Organizations Other______________________
16. Please check the status of your parent's marriage: ___Married/Living Together ___Separated ___Divorced___One Deceased ___Both/All Deceased
Mother's Age:_______ Father's Age_______
How old were you at the time of your parent's (Separation, Divorce, Mother's Death, or Father's Death)______________
If your parents are divorced, did either remarry, and when? Mother _________ Father _________
17. List ages of older brothers:________________ List ages of younger brothers:______________________
List ages of older sisters: ________________ List ages of younger sisters:______________________
18. Give any general comments on childhood Issues: ______________________
19. During most of your childhood, who did you live with?____ Both Natural Parents ____Single Parent ___Parent and Step Parent ___Relatives ___ Adoptive or Foster Family ____Other______________________
20. Check the problems that you had when you were growing up:____ Alcohol or Drug Use __Trouble w/ Law ___Few Friends__Emotional Problems ___Physically Abused __Sexually Abused __Emotionally Abused ___Moved Frequently___Neglected___Eating Disorder__ Shyness ____Serious Illness ___Other______________ ___None
21. How did you see yourself while growing up?___ Never Fitting In ___Stayed in the Background____ As "Ugly" ___As an Outsider ___As a "Failure" ___As "Stupid" ___Unpopular ___Well Liked ___As "Pretty" ___ Felt Accepted ___As "Smart" ____Took Part in Activities ___Your needs were ignored ___Your needs were not important ___You felt you could count on those around you to tend to your needs ___You could never please your parents ___You had to fight for whatever you wanted ___ You ended up taking care of others **Other**______________ *Do you see yourself differently now?* ____Yes ___ No
22. How did your family related to the rest of the world?___Enjoyed being with people, whether at home or in the community ___Unknown___Had some contact with friends and family ___Isolated and seldom were with people in an enjoyable way ____Suspiciousness of others
23. Has any other family member ever had any of the following problems : ____ Alcohol/Drug ____Physical Illness ____Financial

**Confidential Adult Biosocial History**

___Emotional/Psychiatric ____Legal ____Sexually Abusive ____Physically, Emotionally Abusive ____Attempted Suicide ____Committed Suicide Other_________________________ Did they receive help for the problems?__________________

24. Which of the following describes your father's health?___ Excellent ____Good __Fair ____Poor ___Deceased ____Unknown
    Which of the following describes your mother's health? ___ Excellent __Good __Fair ____Poor __Deceased _____Unknown
25. How would you describe your relationship with your father now? __Very satisfied __Satisfied__Dissatisfied __Very Dissatisfied ___No Relationship
    How would you describe your relationship with your mother now? __Very satisfied __Satisfied__Dissatisfied __Very dissatisfied ___No Relationship
    How would you describe your relationship with your siblings now?__Very satisfied __Satisfied__Dissatisfied __Very dissatisfied ___No Relationship
26. Did you ever serve in the military?___Yes ___No **If yes, how long did you serve?**__What kind of discharge did you receive __________
27. What do you like to do in your free time? ___ Sports ___TV/Radio ___Gardening ___Reading ___Exercise ___ Crafts ___Hunting/Fishing Other_______________________________________________
28. Which describes your family's understanding of your seeking services? ______Your family does not know you are here. ____Your family knows you are seeking services and are willing to participate. ____Your family knows that you are seeking services but they do not want to participate.
29. How do you feel about coming in for services?___ Positive ____Uninterested ____Scared./Nervous ___Neutral
30. What are your current stressors? __Work __Family __Marital/Relationship __Housing ___ Parenting ____Divorce/Break Up __Recent Mov___Financial __Legal __School/Educational ___Health/Physical ___Religious/Spiritual___Sexual abuse ___Physical Abuse__Spousal Abuse___Serious Illness of Loved One ____Death/Loss Other___________________________
31. Which of the following problems do you feel you need help with? __Depression __Anxiety __ Parenting __ Intense Anger ___ Compulsive Behaviors __ Eating Disorder/Body Image __ Loss, Death ___Divorce/Separation ___Sexual Problems ___Religious/Spiritual Concerns ___Abusing Others ___ Drug/Alcohol ____ Issues Related to Past Abuse ____ Problems with Sleep or Appetite ___ Unexplained Frequent Changes in Moo ___Recurring Thoughts of Death ____Hearing Voices or Seeing Strange Visions ___ Very Fast Thoughts or Feeling ___Difficulty with Memory, Concentration, or Decision Making ___ Other_______________________________________________________
32. Have you ever seriously injured another person? ____Yes ____ No
33. Do you ever think of harming someone else? ____Yes ____ No
34. Have you ever:____Thought of Suicide ____Attempted Suicide____ Hurt/Cut Yourself **If so, how many times** ______________
35. Marital History: First marriage date__________, **If divorced**: Date_______, brief description of problem:_______________
    Second marriage date__________, **If divorced**: Date_______, brief description of problems_______________________
36. Who do you live with? ___Spouse __Significant Other ___Children ___Grandchildren ___Parent ___Grown Children ___ Grandparents ___Roommate ___Pets ____Alone Others_______________________________________________
37. Which of the following describes your marriage/significant relationship? ____Very Satisfied ____Satisfied ____Dissatisfied ____Extremely Dissatisfied _____No Current Relationship
38. Please check any of the problems that you may be having in your marriage/relationship:____ Recently Ended ____Too much arguing ___Poor Sexual Relations ___Spouse has physical problems ____ Jealousy ___ Financial Problems ___Spouse has a problem with the law ___ Lack of Trust ____Spouse has problems with affairs ____Have few or no common interests ___Spouse has/has had Drinking Problems ___ Cannot Share or Discuss Problems ____Spouse is/has been Physically Abusive ____Spouse does have/has had problem with drug abuse ____Spouse has concerns about my drinking/drug use **Other**________________
39. Please check the problems that may apply to your children. ___Behavior___ School ___ Emotional___Medical____ Legal ____Drug/Alcohol Other____________________None of These Listed___________________
40. Do you feel you need vocational training, education or assistance with employment?____Yes ____ No
41. Which of the following have been work problems?____ Missing Work ____Work Related Injuries ____Changing Jobs Often ____Workman's Compensation ____Problems Getting Along with Co-Worker ____Problems Getting Along with Boss ____Pending Disability Claim ____Fired From Job _____Never Employed
    Other________________________________________No Work Problems______________
42. Did the problems that you have/had at work involve alcohol/drug use? ____Yes ____ No

______________________________ ______/______/______

**Psychologist Signature** **Date**

**Charis Institute for Psychological and Family Services**
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**Harrisonburg, VA 22801**

**Phone: 540.568.1876**
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## Client Information

We would like to take the opportunity to let you know about some very important aspects of the services we will be providing for you at Charis. We would also like you to signify your acceptance of these arrangements by signing this form.

### Confidentiality

Your identity and any information shared by you will be held in the strictest confidence. The right to release information about you belongs to you. No information, including the fact that our office is seeing you, will be released to anyone without your written or verbal permission. Exceptions to this confidentiality policy are made as a result of legal requirement to report any of the following:

- The abuse or neglect of a child or dependent adult.
- Imminent danger of hurting yourself or someone else.
- In the case of court involvement, if the court would order it.
- Information regarding your involvement in treatment (i.e. Dates of treatment and billing records) if legal collection action becomes necessary by our office.
- Information regarding your treatment, dates of service, diagnosis, and treatment plans if you submit claims for these services to your insurance company and your insurance company requires such information.
- For the purpose of ensuring quality services, our staff is involved in on-going training and supervision. For this reason, confidential information will be shared among staff to enhance therapeutic effectiveness.
- For the purpose of scheduling appointments and receiving notice of cancellations when necessary, you give permission for us to leave a message at your home or work with numbers to call.
- Unethical or illegal practices of other psychologist that have provided care to you.

### Appointments and Fees

- You will see your therapist on an appointment basis. You should check with the office before your session or before you leave to confirm your next appointment.
- **Please notify us at least 24 hours prior to your appointment if you cannot keep your scheduled time. If we do not receive a 24 hour notice for a cancellation or if you do not show up for your appointment, you will be charged a $35 fee and we will remove any future appointments you have scheduled.** After two cancellations with insufficient notice or two "no shows," you may be given a referral elsewhere. Insurance will not pay for "no show" fees, and you are responsible for payment.
- **There is a charge of $200.00 for your first session** (which involves various intake procedures.) **Subsequent sessions are $130.00 for 40-45 minute sessions** (other session fees available upon request). **You agree to pay in full for services not covered by your insurance and for your portion of covered services.** We will file insurance claims for you if you wish. If you file your own claim, and pay in full at the time of service we will give you a 25% discount. We will also give the same discount for those who do not have insurance and wish to pay cash at the time of the visit.
- You may be billed for additional services, reports and telephone contact that are not covered by your insurance.
- **We will provide you with a regular statement on your account. You agree to pay 1.5% interest (18% per year) on a balance that is 120 days or more past due. We understand that due to conditions of employment, health, or other factors, a payment plan or other necessary arrangement will need to be made. If this should occur please bring this to the attention of the Accounts Manager to avoid collection action. If collection is necessary you will be charged the collection fees in addition to your account balance.**

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**Emergency**

- If I need professional help between sessions, you agree to call the Charis office at 540.568.1876. If you should need assistance and are unable to reach the therapist, you agree to go for help to the Rockingham Memorial Hospital Emergency Room, or to a Hospital Emergency Room near you. If you am unable to do so, you agree to call 911 for assistance.

**Release of Information/Records**

- You may request copies of your notes, reports, or any other information that we have concerning your records. At times it is necessary for the clinicians to write reports concerning your treatment. Please know that there will be a small fee for processing any of the above.
- In the event of unplanned or planned retirement of the psychologist or closure of the practice, your records will be maintained for the amount of time determined by state law. If you need to access them, you should be able to contact your psychologist by sending a message through the Charis Institute Facebook page (to be developed at that time) or Linked In or the psychologist's cell numbers (used for emergencies only at this point). You may be billed for the cost of providing your records.

**Termination, Legal, Court Issues**

- If you should be dissatisfied with the services you receive, you agree to discuss this with your therapist and express the extent of your dissatisfaction.
- You understand that you may terminate treatment at any point, and may request a referral to another qualified therapist.
- In the event that you should make an ethical or legal complaint to any source regarding treatment rendered, and it is determined that the therapist is not found in error, you understand that you are liable for reimbursement of any costs incurred and income lost by the therapist in pursuing the matter.
- The psychologist will not participate in legal proceedings except under very limited circumstances. If the psychologist is required to respond to court proceedings or requests related to your records or your care, you are responsible for these costs and this time, even after your therapy has terminated. The usual fee for court-related activities is typically a different higher rate.

## Informed Consent to Treatment

I give my consent for the provision of psychotherapy and/or psychological evaluation services to **myself/my child** ________________________________. I have read the policies and procedures on the preceding pages and I have discussed with my therapist any area(s) I do not understand. I agree to these provision. I understand that this consent will continue in effect as long as the individual noted above continues in treatment, unless I should notify my therapist in advance in writing that, as of a certain date, I am no longer consenting to further treatment, or any of the provisions listed above. I may request a copy of this form for my own records.

**My therapist will discuss with me the specifics of my treatment plan in our intake session.** I understand and am satisfied with my therapist's qualifications to treat the difficulties for which I am seeking help. I understand that my therapist will conduct him/herself in a manner consistent with ethical, legal, and professional standards of practice. **If I have any concerns, it is my responsibility to communicate these to my therapist.**

______________________________
(Client/Guardian Signature) **(Date)** ________/________/________

______________________________
(Psychologist Signature) ________/________/________
(Date)

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## Authorization to Disclose Information to Primary Care Physician

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. Until I revoke my consent, this authorization is valid.

I hereby authorize on behalf of myself/my child ____________________________________

**Please Check One:**

_______ To release or to exchange any applicable information with my Primary Care Physician.

_______ To release or to exchange medication information only with my Primary Care Physician.

_______ Not to release or exchange any information to my Primary Care Physician.

______________________________________________ ____________
(Patient or Patient's Guardian, please sign) (Date)

______________________________________________ ____________
(Please print the name signed above) (Date)

______________________________________________ ____________
(Psychologist Signature) (Date)

**Primary Care Physician's Name, Address & Phone**

______________________________________________________
(Please Print Physician's Name)

______________________________________________________
(Street/Mailing Address)

______________________________________________________
(City) (Zip)

______________________________________________________
(Area Code) (Phone)

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**Release/Exchange of Information**

I, ____________________________________, authorize Charis Institute regarding myself /child

____________________________________________________________________________ to
(Name of self and child)

______ Release information *including* medical, psychiatric, alcohol and /or drug abuse, HIV testing, and /or AIDS information to
______ Receive information, *excluding* medical, psychiatric, alcohol and/or drug abuse, HIV testing, and/or AIDS information from
______ *Exchange* information on an ongoing basis with:

| | | | |
|---|---|---|---|
| (Name of individual or agency) | Phone | (Name of individual or agency) | Phone |
| (Name of individual or agency) | Phone | (Name of individual or agency) | Phone |
| (Name of individual or agency) | Phone | (Name of individual or agency) | Phone |

**This information will be released for the purpose of:**

___ obtaining information
___ exchanging information with the above agencies
___ evaluating service needs
___developing and maintaining a treatment plan
___ongoing service coordination
___continuity of care
___ psychological evaluation

**The specific records/reports to be disclosed shall include:**

___Complete Records (including progress notes)
___Discharge Summary
___Psychological Evaluations
___Psychological Records
___Medical Records
___Psychiatric Evaluation
___School Records
___Other -Specify type:___________________________

*I understand that the records and information released/exchanged shall be regarded as confidential communication except when public safety is threatened or when a release of such information is court ordered. I further understand that the purpose of this release is to assist the staff of Charis Institute to plan, implement, and to conduct follow up evaluations on the outcome of the counseling program. I know that I may request to receive a copy of this authorization. I agree that this authorization shall be valid for two years from the date in which I sign it and that a photographic copy of this authorization shall be as valid as the original. I understand that I may revoke this release /exchange of information in writing.*

*Alcohol, drug, HIV, ARC, and /or AIDS information, if present, will be disclosed from records whose confidentiality is protected by Federal Law which prohibits any further disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. Copies or faxes of this authorization are acceptable. I understand I may be charged a service fee for requesting copies of any records.*

______________________________ ______________________________
*Patient signature (if over 14 years of age)* *Print name of person who released information*

______________________________ ___/______/____
(Patient/Guardian, or authorized signature if patient is a minor) (Date)

______________________________ ______/______/______
Psychologist Signature (Date)

***Charis Institute for Psychological and Family Services***
**21 Southgate Court, Suite 101**
**Harrisonburg, VA 22801**

**Randy Weber, Ph.D.**
**Ronda Weber, Ph.D.**
**Fax: 540.574.6076**
**Phone: 540.568.1876**
**Email: charisinst@gmail.com**
**Website: Charisinst.org**

## Credit Card Authorization Form

Please complete all fields. You may Cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

| **Credit Card Information** |
|---|
| **Card Type**:____ Master Card____VISA____DISCOVER_____OTHER_____ |
| **Cardholder Name (as shown on Card)**: |
| **Credit card Numbers:**<br>***Expiration Date*** *(MM/YY)*:<br>**Security code in the back:** |
| **Cardholder Zip Code (from credit card billing address):** |

I, _________________________, authorize **Charis Institute** to charge my credit card above for my copay's, deductibles, or any balances on my account not covered by my insurance. I understand that my information will be saved to file for future transactions on my account.

______________________________      ____________________

Client signature      Date