Jessica L. Cardwell, Psy.D., LLC
Licensed Clinical Psychologist
503 Carlisle Dr., Suite 225-E
Herndon, VA 20170
(571) 335-0893

Adult Client Registration Form

Client's Information

FIRST NAME	LAST NAME	M.I.	NICKNAME
BIRTHDATE	AGE	GENDER	MARITAL STATUS
STREET ADDRESS	CITY	STATE	ZIP CODE
PHYSICIAN	EMPLOYER		
REFERRAL SOURCE	REASON(S) FOR TREATMENT		

The above information is true to the best of my knowledge.

Client Signature: ___________________________________ Date: ___________________

AUTHORIZATION FOR TELEPHONE MESSAGES

I authorize that telephone messages may be left by Dr. Cardwell on my (please initial Yes or No for each item):

	Number		
Home Answering Machine/Voicemail	_______________________	**-------Yes**	**-------No**
Work Voicemail	_______________________	**-------Yes**	**-------No**
Cell Phone Voicemail	_______________________	**-------Yes**	**-------No**

Jessica L. Cardwell, Psy.D., LLC
Licensed Clinical Psychologist
503 Carlisle Dr., Suite 225-E
Herndon, VA 20170
(571) 335-0893

Consent for Treatment and Recipient's Rights

I, ______________________________ the undersigned, hereby attest that I have Voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, by Jessica L. Cardwell, Psy.D., LLC, hereby referred to as Dr. Cardwell. Further, I consent to have treatment provided by Dr. Cardwell. I understand that I am consenting and agreeing only to those services that Dr. Cardwell is qualified within the scope of her license, certification, and training. If the client is under the age of 18 or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. Dr. Cardwell encourages that this decision be discussed with her to help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the Recipient's Rights Advisor.
Nonvoluntarily Discharge from Treatment: A client may be terminated from treatment with Dr. Cardwell nonvoluntarily if: (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at Dr. Cardwell's office or towards Dr. Cardwell or her family, and/or (B) the client refuses to comply with Dr. Cardwell's policies and procedures, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the nonvoluntary discharge by letter. The client may appeal this decision with Dr. Cardwell or request to reapply for services at a later date.
Client Notice of Confidentiality: The confidentiality of client records maintained by Dr. Cardwell is protected by federal and/or state law and regulations. Generally, Dr. Cardwell may not say that a client receives treatment with her or disclose any information identifying a client as an alcohol or drug abuser unless: (1) the client consents in writing, (2) the disclosure is allowed by a court order, or (3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of federal and/or state law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or state law and regulations do not protect any information about a crime committed by a client either at Dr. Cardwell's office, against any person who works at Dr. Cardwell's office, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under federal and/or state law to appropriate state or local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is Dr. Cardwell's duty to warn any potential victim when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above-stated policies and agreements with Jessica L. Cardwell, Psy.D., LLC.

____ ______________________________
Signature of Client or Custodial Parent / Guardian Date

Jessica L. Cardwell, Psy.D., LLC

Licensed Clinical Psychologist
503 Carlisle Dr., Suite 225-E
Herndon, VA 20170
(571) 335-0893

This information is being provided as required by the federal Health Insurance Portability and Accountability Act.

NOTICE OF PRIVACY PRACTICES
Effective April 14, 2003

This notice describes the confidentiality of your medical/mental health records, how the information is used, your rights, and how you may obtain this information. Please review it carefully.

Dr. Cardwell's Legal Duties

State and Federal laws require that I keep your medical records private. Such laws require that I provide you with this notice informing you of my privacy of information policies, your rights, and my duties. I am required to abide by these policies until replaced or revised. I have the right to revise my privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to Dr. Cardwell in an evaluation, intake, or therapy session are covered by the law as private information. I respect the privacy of the information you provide me and I will abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information

Information about you may be used by Dr. Cardwell for diagnosis, treatment planning, treatment, and continuity of care. Dr. Cardwell may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing and insurance companies.

Both verbal information and written records about a Client cannot be shared with another party without the written consent of the Client or the Client's legal guardian or personal representative. It is the policy of Dr. Cardwell not to release any information about a Client without a signed release of information except in certain emergency situations or exceptions in which Client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect

When a Client discloses intentions or a plan to harm another person or persons, Dr. Cardwell is required to warn the intended victim and report this information to legal authorities. In cases in which the Client discloses or implies a plan for suicide, Dr. Cardwell is required to notify legal authorities and make reasonable attempts to notify the family of the Client.

Public Safety

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse

If a Client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, Dr. Cardwell is required to report this information to the appropriate social service and/or legal authorities. If a Client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, Dr. Cardwell may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

In the event of a Client's death, the spouse or parents of a deceased Client have a right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings

Health care professionals are required to release records of Clients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor Clients have the right to access the Client's records.

Other Provisions

When payment for services are the responsibility of the Client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the Client's credit report may state the amount owed, the time-frame, and the name of the practice or collection source.

Information about Clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the Client, or any identifying information, is not disclosed. Clinical information about the Client is discussed. Some progress notes and reports are dictated/typed by Dr. Cardwell or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the Dr. Cardwell must telephone the Client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify me in writing where I may reach you by phone and how you would like me to identify myself. For example, you might request that when I call you at home or work, I do not say the name of the name of the practice or the nature of the call, but rather my first name only. If this information is not provided to me (below), I will adhere to the following procedure when making phone calls: First I will ask to speak to the Client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information I will say that it is a personal call. I will not identify myself (to protect confidentiality). If I reach an answering machine or voice mail I will identify myself as Dr. Jessica or Dr. Cardwell unless you have requested in writing that I not do so.

Your Rights

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $25 plus postage.

You have the right to cancel a release of information by providing me a written notice. If you desire to have your information sent to a location different than my address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if I do not agree with these restrictions, I am not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to me in writing.

You have the right to disagree with the medical records in my files. You may request that this information be changed. Although I might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to request an Accounting of Disclosures I have made of information about you. You must submit your request in writing to the above address. Your request must state a time period for the disclosures, which may not be longer than six years and may not include dates before April 14, 2003.

If you believe your privacy rights have been violated, please let me know either in writing or by talking with me. Such a complaint will not result in any retaliation by me. You may also file a complaint with the Secretary of the United States Department of Health and Human Services.

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

____ __________________________

Signature of Client or Custodial Parent / Guardian Date

____

Printed Name of Client or Custodial Parent / Guardian

Jessica L. Cardwell, Psy.D., LLC
Licensed Clinical Psychologist
503 Carlisle Dr., Suite 225-E
Herndon, VA 20170
(571) 335-0893

CLIENT AGREEMENT TO POLICIES AND PROCEDURES

I, ______________________________, have reviewed and agree to abide by the Policies and Procedures of Jessica L. Cardwell, Psy.D., LLC.

Parent/Guardian/Client Signature:____

Printed Name:____ Date: ___________________________

Printed Client Name (if client is a child): ____

CLIENT ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY OF INFORMATION POLICIES

I, ______________________________, have been offered a copy of the Privacy of Information Policies by Jessica L. Cardwell, Psy.D., LLC.

Parent/Guardian/Client Signature:____

Printed Name:____ Date: ___________________________

Printed Client Name (if client is a child): ____

Jessica L. Cardwell, Psy.D., LLC
Licensed Clinical Psychologist
503 Carlisle Dr., Suite 225-E
Herndon, VA 20170
(571) 335-0893

Primary Care Doctor Release of Information

It is often necessary for Dr. Cardwell to consult with physicians and nurse practitioners regarding medical/ medication issues pertaining to her clients to insure the highest quality of care. As a result, it is helpful to have a signed release of information to your or your child's primary care physician (PCP) or nurse practitioner. In today's world it is typically the role of the PCP to be aware of all treatment you or your child receive to help insure proper coordination of care. Dr. Cardwell may need to make your PCP aware of any referrals that need to be made for medication evaluations, to discuss the need for ruling out medical causes for observed behavioral symptoms, and to make him/her aware of your basic treatment plan (not typically the details of your case, just the general symptom presentation and treatment approach). Your signature on this form indicates that you give consent for Dr. Cardwell to consult with your PCP/ nurse practitioner or your child's pediatrician, **(insert name) _________________________,** regarding medication, substance abuse, medical, and mental health issues pertaining to this case.

You hereby give consent for Dr. Cardwell to exchange verbal information, written information, school records, medical records, and any pertinent substance abuse history with the above named treating primary care medical provider. By signing this form you acknowledge that you understand that you may refuse to authorize release of confidential information to others if you so choose. You understand that you may revoke this consent at any time in writing, except to the extent that action has been taken in reliance on it and that in any event that this consent expires automatically as described above. You are also acknowledging you understand that this information may be subject to re-disclosure by the party receiving the information and may no longer be protected. By signing this form you are allowing your primary care medical provider to accept a copy of this form as a valid consent to release information. This consent includes information, which is placed in the record after the date this consent was signed, unless noted otherwise. Your signature acknowledges that this consent expires when your case is closed OR as specified here on/when ____.

Parent/Guardian/Client Signature:_____________________________ Date:_________

Printed Name of Client: ____

Jessica L. Cardwell, Psy.D., LLC
Licensed Clinical Psychologist
503 Carlisle Dr., Suite 225-E
Herndon, VA 20170
(571) 335-0893

FINANCIAL POLICY

Jessica L. Cardwell, Psy.D., LLC (hereafter referred to as Dr. Cardwell) is committed to providing caring and professional mental health care to all of my clients. The *Person Responsible for Payment of Account* is required to sign this form, which explains the fees and collection policies of this practice.

CLIENTS ARE RESPONSBILE FOR PAYMENTS AT THE TIME OF SERVICES.

Dr. Cardwell does not accept insurance and will not submit claims to your insurance company. All fees for service are out-of-pocket and due at the time of service. If requested, I will provide you with detailed receipts so that you may file claims yourself under Out of Network benefits. However, please be aware that you will be responsible for paying for services at the time they are rendered and I cannot guarantee that your insurance company will agree to reimburse you.

The adult accompanying a minor is responsible for payments for the child at the time of the service. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved charge card or unless payment is provided at the time of service.

The Person Responsible for Payment of Account is financially responsible for paying funds at the time of service. Payments not received after 120 days are subject to collections. A 5% per month interest rate is charged for accounts over 60 days.

Missed appointments or cancellations less than 48 hours prior to the appointment are charged at a rate noted in my office policies. Payment methods include check, cash, credit card, or debit card.

______ I have read, understand, and agree with the provisions of this Financial Policy.
Initial I understand that Jessica L. Cardwell, Psy.D., LLC does not accept my insurance. I understand that Jessica L. Cardwell, Psy.D., LLC does not guarantee that my insurance company will reimburse me/pay for out-of-network services if I submit claims independently.

_______________________________________ Date____/______/______
Person Responsible for Account