

# Sterling Behavioral Health Services, LTD

## 2010 Patient Information Update and Contact Agreement

### Patient

Last Name:		First name:	
Date of Birth:		Social Security Number:	
Marital Status:		Sex:	
Address:			
City:		State:	Zip Code:
Employer:			
Home Phone:		Fax:	
Work Phone:			
Cell Phone:		Home e-mail:	
Other Phone:		Work e-mail:	

### Emergency Contact

Name:	
Home Phone:	
Work Phone:	
Cell Phone:	
E-mail Address:	
Relationship:	

### Parent / Guardian Information - Required if the patient is under 18 years of age

Last Name:			
First name:			
Date of Birth:		Social Security Number:	
Custody Status:		Legal:	Physical:
Address:			
City: State: Zip:			

Other Custodial Information:

# Sterling Behavioral Health Services, LTD

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### Primary Insurance Information (SBHS will need a copy of both sides of the insurance card)

Relationship to insured:	Employer:
Group Number:	
Member ID Number:	
Effective Dates:	To: From:

### Insured's Information (if not self)

Relationship to insured:		
Last Name:	First name:	
Date of Birth:	Social Security Number:	
Marital Status:	Sex:	
Address:		
City:	State:	Zip Code:

### Secondary Insurance Information

(If Applicable, SBHS will need a copy of both sides of the insurance card)

Sterling Behavioral Health Services, LTD does not bill secondary insurance except as required by law.

Insurance Company:	
Group Number:	
Member ID Number:	
Effective Dates:	To: From:

### Insured's Secondary Information (if not self)

Relationship to insured:	Employer:	
Last Name:	First name:	
Date of Birth:	Social Security Number:	
Marital Status:	Sex:	
Address:		
City:	State:	Zip Code:

I authorize Sterling Behavioral Health Services to contact me and leave messages for me using any of the above listed contact information except as individually excluded below.

\_\_\_\_\_  
Patient / Parent / Guardian

\_\_\_\_\_  
Date

Sterling Behavioral Health Services, LTD  
20905 Professional Plaza, Suite 220  
Ashburn, VA 20147  
Voice: (703) 858-9841 Fax: (703) 858-9446  
[www.sbhsva.com](http://www.sbhsva.com)

# Sterling Behavioral Health Services, LTD

## Cancellation Policy Agreement

Revised: 05/15/2010

**This agreement supersedes all previous related agreements.**

**My signature below is my acknowledgement that I have read the SBHS cancellation policy and that I agree to adhere to the guidelines and fee schedule as set forth in this policy:**

**Because SBHS does not overbook appointments and your time is especially set aside for you, these charges are necessary. Your therapist and other patients are directly affected if you fail to show up for your scheduled appointment. Every effort is made to see you on time and if you do not come or cancel in a timely manner, your therapist loses that income and can not effectively fill that appointment time. Consequently:**

- All appointments must be canceled by 11:00 a.m. of the business day before the scheduled appointment.
- Failure to do so will result in a missed appointment charge. The fees are as follows:
  - \$75.00 for therapists
  - \$100.00 for psychiatrists (M.D.)
  - \$100.00 for psychologists (PhD)
  - \$100.00 per scheduled unit of psychological testing, 3 units would be \$300.00
- I understand if I leave within 30 minutes of my scheduled appointment with a psychiatrist (M.D.), I will be charged \$100.00
- I understand if I arrive 20 or more minutes late for an appointment, I will be charged for a missed appointment.
- I understand that if I arrive for an appointment without the proper copay I will be assessed a \$20.00 administrative fee to cover the additional administrative cost to the practice.
- I understand that if I have a balance on my account that it needs to be paid before my appointment and that failure to pay the debt may result in me not being seen and a missed appointment fee being added to my account. If you are unsure of your balance you may call SBHS.
- SHBS will not refuse to see a patient if it is medically necessary, regardless of the account status.
- I understand that it is my responsibility to check the appointment card at the time that it is issued to verify the proper date and time are listed on the card. SBHS will not waive a missed appointment fee because of an error on a card.
- I understand that in the event of snow or inclement weather I may cancel an appointment with less than the required notice if and only if both of the following criteria are met.
  - a. Loudoun County Government (NOT THE SCHOOL SYSTEM) is closed
  - b. I call to cancel my appointment PRIOR to the appointment time (If I can't get through, I understand I must leave a voice mail message).
- I understand that if a patient is unable to make an appointment due to illness that they may cancel the appointment with less than the required notice if and only if all of the following criteria are met.
  - a. The patient is seen on the same day as the scheduled appointment
  - b. SBHS needs a note from the doctor or hospital with the date and time of the appointment
  - c. I call to cancel my appointment PRIOR to the appointment time

\_\_\_\_\_  
Patient or Guardian Initials

\_\_\_\_\_  
Date

# Sterling Behavioral Health Services, LTD

## How to Cancel an Appointment

- **By Phone at (703) 858-9841 extension 100**

I understand that if I cancel an appointment by phone, before the required notice, that I will receive a cancellation code from the SBHS staff member.

I agree that it is my responsibility to get and keep that number.  
No fees will be retracted without that number.

I understand that due to high call volume, all voice mail calls are logged as to time and date received and a timely voice mail will constitute cancellation.

I agree that if I leave a voicemail cancellation message that I will call the following business day to receive a cancellation number.

I agree that it is my responsibility to get and keep that number.  
No fees will be retracted without that number

- **In person at the SBHS office**

I understand that if I cancel an appointment in person, before the required notice, that I will receive a cancellation code from the SBHS staff member.

I agree that it is my responsibility to get and keep that number.  
No fees will be retracted without that number.

I understand that I may ask for SBHS to review a missed appointment fee:

If I pay half of the fee pending the outcome of the appeal.  
If I submit the appeal, in writing, within 30 days of the missed appointment.  
That all appeal decisions are final.  
Appeals will not be handled over the phone

By signing this form, I acknowledge that I have read, fully understand and agree to abide by the policies and fees on both pages of this SBHS policy for canceling appointments.

Patients Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Parent / Guardian's Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

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# Sterling Behavioral Health Services, LTD

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Financial Policies Agreement Revised: 5/15/2010

**This agreement supersedes all previous related agreements.**

### Insurance

If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our payment policy. You will be asked to update your personal and insurance information periodically, including providing our office with copies of your insurance card and driver's license. We are required by law to obtain your signature for permission to release information to your insurance carrier. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please assist us in complying with your insurance requirements. We will gladly submit fees for your covered medical services to your insurance company, if your provider is considered in-network. However, we expect payment of all services rendered within 60 days. **It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days.** It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements. We will, however, assist you to ensure that all plan requirements are met. X\_\_\_\_\_ (Please initial)

I understand that SBHS will file and attempt to collect from my insurance company. I further understand that if the claim is not paid within 60 days that I will be billed for the remaining balance. I agree to waive any insurance company policy rights that would prevent me from being responsible for these unpaid charges. X\_\_\_\_\_ (Please initial)

If your insurance coverage or your insurance carrier changes and you do not notify SBHS within 30 days of that change, SBHS reserves the right to NOT issue a refund. I agree to waive any insurance company policy rights that require refund of the aforementioned monies. X\_\_\_\_\_ (Please initial)

### Payment for Services

**Payment for services, including co-payment and deductible amounts, is due at the time services are rendered unless payment arrangements have been approved in advance by our staff.** We accept cash, checks, MasterCard and Visa. Our failure to collect these amounts may be a violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from your insurance plan. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage and we may report your refusal to pay these amounts to your employer and/or insurance company representative. X\_\_\_\_\_ (Please initial)

Failure to pay your co-pay at the time of service will result in a charge of \$20.00 to help cover the additional administrative costs. You will be asked to sign a promissory note for the co-pay amount plus the service fee. X\_\_\_\_\_ (Please initial)

**Returned checks will result in a \$50.00 fee that will be posted to your account.** Returned checks, balances older than 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees. We may investigate your credit record to determine your ability to pay your debt. SBHS has a "One Bad Check" Policy. If your account has one returned check then you will not be allowed to write checks for future services. **SBHS is a partner in the Loudoun County Commonwealth Attorney's check enforcement program and as such we are required to note a current / valid ID on each check.** X\_\_\_\_\_ (Please initial)

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## Sterling Behavioral Health Services, LTD

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company.

**Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.** X\_\_\_\_\_ (Please initial)

1. I accept financial responsibility for all clinical and administrative services provided by Sterling Behavioral Health Services, LTD.
2. I authorize the release of any medical, mental health, or other information necessary to process a claim with my insurance carrier.
3. I authorize payment to Sterling Behavioral Health Services, LTD for all services rendered. I authorize the use of this signature on all my insurance submissions whether manual or electronic.
4. In many cases, there is a need for us to exchange information with other parties, such as other treating physicians. If you do NOT wish to give us permission or have any doubts about granting this permission at this point to exchange information with other physicians, please cross out this paragraph. If you cross out this paragraph, we will ask you to sign separate release of information forms when and where appropriate.
5. Ancillary services, including exchange of information, as in #4 are billed as follows: Psychiatrists bill at an hourly rate of \$300.00 per hour. Legal services are billed at a rate of \$350.00 per hour. Psychologists bill at a rate of \$180.00 per hour and \$45.00 per 15 minutes for ancillary services. Legal services are billed at a rate of \$300 per hour. Therapists or Master’s level licensed clinicians will bill at a rate of \$150.00 per hour and \$40 per 15 minutes for ancillary services. Legal services are billed at a rate of \$250 per hour.
6. If my account goes to a third party for collections, I am responsible for all fees incurred.
7. I understand that if I have a balance on my account that it needs to be paid before my appointment and that failure to pay the debt may result in me not being seen and a missed appointment fee being added to my account. If you are unsure of your balance you may call SBHS.

By signing this form, I acknowledge that I have read, fully understand and agree to abide by the policies and fees in this agreement.

Patients Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Parent / Guardian’s Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

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# Sterling Behavioral Health Services, LTD

## **Informed Consent for Treatment**

Revised 5/15/2010

I, \_\_\_\_\_ (name of patient), agree and consent to participate in behavioral health care services offered at and provided by Sterling Behavioral Health, LTD, 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.

### **Length of Services**

Initial Evaluation and Diagnosis: 45-50 minutes  
Subsequent Counseling Sessions: 45-50 minutes  
Medication Management Follow-Ups: 10-15 minutes  
Marriage and Family Sessions: 45-50 minutes

We will make every effort to ensure that you are seen in a timely manner; however, the doctor may be called for an emergency consult. Please arrive for your appointment on time, or we may need to reschedule your appointment. We appreciate your cooperation and understanding.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Signature Patient/Parent/Guardian

\_\_\_\_\_  
Date

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## Sterling Behavioral Health Services – Notice of Privacy Practices

### **THIS NOTICE DESCRIBES HOW PROTECTED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**This notice covers all information in our written or electronic records which concerns you, your care and payments for your care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing your care, or manage some of our administrative operations.**

Sterling Behavior Health Services (SBHS) physicians, clinicians and staff may use and disclose medical information (protected health information or PHI) about an individual for:

- a) Mental Health Treatment – i.e.; providing mental health care services, sending/coordinating care information with other health care providers caring for you, ordering and obtaining off site tests/results, writing prescriptions, etc.
- b) Payment – i.e.; submitting insurance claims on your behalf for treatment rendered.
- c) Health Care Operations – i.e.; internal business planning activities and quality of care evaluation.

Sterling Behavioral Health Services is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization, including, but not limited to:

- a. **Disclosures required by law**
- b. **Disclosures to avert serious threats to health and safety**
- c. **Disclosures with reference to Workers' Compensation or Food and Drug Administration**

Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization. (Please see below for identifying persons to whom you would allow disclosures of otherwise protected information).

Sterling Behavioral Health Services (SBHS) may contact the individual to provide appointment reminders or information about treatment or other health-related benefits and services that may be of interest to the individual or patient. SBHS will routinely contact patients via telephone or secured e-mail at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments, test results, etc.

Our patients have the following rights regarding their protected health information:

- a) The right to request restrictions on certain uses and disclosures of protected health information. SBHS is not required to agree to a requested restriction, however.
- b) The right to receive confidential communications of protected health information, as applicable.
- c) The right to inspect and copy protected health information, as provided in the Privacy Regulation.
- d) The right to amend protected health information, as provided in the Privacy Regulation.
- e) The right to receive an accounting of disclosures of protected health information.
- f) The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.

SBHS is required by law to maintain the privacy of the protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information. SBHS is required to abide by the terms of the Notice currently in effect.

SBHS reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains. SBHS will provide individuals or patients with a revised Notice by posting new regulations in each office.

Individuals may complain to SBHS and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. SBHS's contact person for matters relating to complaints is:

Wayne Villeneuve - CEO - Sterling Behavioral Health Services (SBHS) Privacy Official  
20905 Professional Plaza, Suite 220  
Ashburn, Virginia 20147 703-858-9841

**Please provide the name(s) of person(s) if any, to whom you would permit Sterling Behavioral Health Services (SBHS) to disclose personal health information as necessary for your continued health care. Please also note if specific health care information cannot be disclosed (i.e.; test results, appointment information, etc.) Otherwise, we will disclose only what is necessary for your continued health care in accordance to the Privacy Policy.**

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List below those individuals (family, friends, interpreter services, etc.) you will allow disclosure of your personal health information from SBHS as necessary during the course of your health care services:

<b>Name and Relation (circle one)</b>	<b>Allowed Disclosure(s) Please circle ALL or specify</b>
Spouse: _____	All or Specify: _____
Family/Friend -Name _____	All or Specify: _____
Family/Friend -Name _____	All or Specify: _____
Family/Friend - Name _____	All or Specify: _____
Family/Friend – Name _____	All or Specify: _____

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Initial if you will allow interpreter services if necessary for communication with health care providers

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\_\_\_\_ (Initial) I acknowledge and understand that Sterling Behavioral Health Services' policy is to send copies of test results and/or other medical information to physicians who either ordered the procedure/consult or are in need of this health information to ensure coordinated and effective diagnosis and treatment. i.e.; your designated primary care provider or physicians/dentist seen for consult/treatment. SBHS's policy is to only disclose specific information necessary for coordination of your health care or mental health treatment.

List below physician providers who you **DO NOT** want specified private health information sent which could be sent in the usual course of facilitating or coordinating medical treatment.

DO NOT SEND PHI: Provider Name: \_\_\_\_\_ All or Specify \_\_\_\_\_

DO NOT SEND PHI: Provider Name: \_\_\_\_\_ All or Specify \_\_\_\_\_

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\_\_\_\_ (Initial) I acknowledge and understand Sterling Behavioral Health Services' policy to contact me by various means when necessary for my health care services which may include by home/work/cell phone, fax, and/or email. I also understand that private health information may be included in that communication to me.

I **DO NOT** want SBHS to use the following methods of communication which may include my private health information: **Please list:**

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I hereby acknowledge that I have read pages 1 and 2 of Sterling Behavioral Health Services Notice of Privacy Practices and received a copy (if requested).

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_