Betty Eastman
LCSW & Associates, Inc.

360 Wythe Creek Road, Suite C
Poquoson, VA 23662
(757)868-0072

www.bettyeastman.com
info@bettyeastman.com

Patient's Name: _____ Email address_____

May we add you to our mailing list Yes_____ No_____?

Responsible Person if Patient is a minor_____

Address_____
Street Address City State Zip

Phone Numbers:

Home: _____Work:_____ Cell: _____

Patient Date of Birth: _____ Patient Marital/Relationship Status: _____Education: _____

Social Security Number_____Employer/Occupation_____

Emergency Contact: Name: _____ Relationship to Patient: _____Phone Number: _____

If there is additional Contact Information that we should be aware of, such as, Co-Parent, Foster Parent, Guardian, Case Manager, etc. - please list on the back of this page. Please attach all legal custodial documents, adoption etc.

Primary Care Physician_____ Allergies_____

Primary Insurance Co_____ Secondary insurance_____

Insured's name_____ Insured's name_____

Insured's Date of Birth _____ Insured's Date of Birth _____

Insured I.D. #_____ Insured I.D. #_____

Service Agreement

Individual and family sessions last 45 minutes. Please be ready to begin at the time scheduled. There is a 24-hour cancellation policy. **You will be charged $50 for missed appointments and cancellations with less than a 24 hour notice.**

Except for extreme situations (usually criminal or legal), what you share in your sessions is confidential. You must sign a release of information form in order for me (Betty Eastman) to consult with relatives, employers, or other contacts.

The Initial Assessment (first session) is $150.00. The Fee for a 45-minute psychotherapy session is $124.00. Group therapy is $50.00 for one hour to one and a half-hour session. All fees are unless otherwise agreed. Full payment is expected at the time of service unless you have insurance for which we are approved providers. In most cases, your co-payment is all that will be required at the time of the session. A claim for services rendered will be sent to your insurance company if we are a participating/In-Network provider with that company. If we do not participate with your insurance company, you are responsible for paying the full fee for services rendered unless otherwise arranged. We will provide you with documentation of services and payments that you can submit to your insurance company for reimbursement. Clients are responsible to resolve any problems that may arise with insurance carriers. Ultimately, you are responsible for any charges not covered by your insurance and/or charges denied by your insurance for any reason.

Payment is due at the time of your appointment. Interest will be imposed on all past due accounts. An interest rate of 1.75% per month (21% APR) will be charged. Rates are subject to change without notice. If you fail to pay you account in a reasonable time, you will be responsible for any additional charges that are accrued for collections, including agency fees, interest, and fees for legal action, and or court fees. Any returned checks will be subject to a $50.00 returned check charge.

Your signature provides consent for treatment, indicates agreement with the above terms, authorizes to furnish information to health care plans that is necessary to process your claims and authorizes assignment of benefits for payment directly to Betty Eastman, LCSW and Associates, Inc.

I have read the foregoing and agree to the terms set forth above.

Patient or Responsible Party's Signature_____ Date_____

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757-868-0087 fax

TREATMENT CONSENT FORM

I, _____, for _____, do voluntarily
(Patient or Responsible Party) (Patient if a minor)

consent to care and treatment by Betty Eastman, LCSW and Associates, Inc., their assistants, or designees. I am aware that the practice of clinical social work is not an exact science and I acknowledge that no guarantees have been made as to the results of evaluation or treatment.

I am aware that I am an active participant in this endeavor and I share the responsibility for the treatment process, including goal setting and termination.

This form has been read by me and I certify that I understand its contents.

_____ _____
Person agreeing to treatment/Patient Date

_____ _____
Parent/Guardian Date

_____ _____
Witness Date

Release for Coordination with Primary Care Physician:

For the purpose of coordinating care, my mental health provider may wish to release pertinent information about my current treatment to my primary care physician. This release shall be valid until sixty (60) days after my last date of treatment or until the time I revoke this release, which can be done at any time.

(Check one) I do ( ) I do NOT ( ) give my permission to Betty Eastman, LCSW and Associates, Inc. to release information about my current treatment to my primary care physician.

I have read the above, and marked my decision.

_____ _____
Patient (Guardian) Signature Date

_____ _____
Signature of Witness Date

Patient Name_____ Date of Birth_____ Sex_____

People Who Live with You

Name	Age/Birth date	Relationship	Occupation

Briefly describe your reason for seeking help:

_____

_____

Who referred you? _____

When were you last examined by a physician? _____

Primary Care Doctors Name/ Phone_____

Current Medications and dosages_____

Any major health Problems for which you currently receive treatment

_____

Have you ever received psychiatric, psychological help, or counseling of any kind before? _____

If yes, please explain_____

Please Circle any of the following problems that pertain to you:

Nervous	Temper/ Violence	PMS	Unhappiness
Shyness	Children	Tiredness	Inferiority Feelings
Separation	Bowel Troubles	Ambition	Work
Drug use	Depression	Career Choices	Headaches
Anger	Sexual Problems	Nightmares	Making Decisions
Sleep	Divorce	Appetite	Concentration
Relaxation	Alcohol Use	Being a Parent	Health Problems
Legal matters	Self-Control	Fears	Marriage
Energy	Stress	Pain	Suicidal Thoughts
Loneliness	Sexual Assault	Guilt	My Thoughts
Boredom	Gambling	Parents	Stomach Trouble
Bad Luck	Memory	School	Low sexual desire
Shifting Moods	Friends	Death /Grief	Relationships
Weight	Panic	Smoking	Anxiety
Education	Eating Disorder	Finances	Childhood memories

Other_____

_____

HIPAA Record of Release of Personal Health Information

Please list any family member with whom we may discuss your or your child's appointment dates.

Please Print.

Patient Information:

_____

First Name Last Name Date of Birth

Family Member(s)

_____

First Name Last Name Relation to Client

_____

First Name Last Name Relation to Client

_____

First Name Last Name Relation to Client

_____ _____

Patient / Responsible Party Signature Date

For office use

Date	To Whom	Reason

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Notice of Privacy Practices
Acknowledgement of Receipt Form

Your signature below indicates that you have been offered a copy Notice of Privacy Practices.

I have been offered the Notice of Privacy Practices.

_____

Patient Signature Date

_____

Print Patient Name Date of Birth

_____

Responsible Party Signature (If Patient is a minor) Date

Staff Signature: _____

Date