Don Chiappinelli, LCSW - 2217 Princess Anne St - Fredericksburg, VA 22401

Personal Information

Name(s): _____ Date: _____

Preferred name: _____

Address: _____

Home Phone : _____ OK to call at work? Y N Work Phone: _____

Mobile Phone Number: _____ E-mail: _____

Date of Birth: _____ Age: _____ Ethnicity: _____

My gender Identity is: _____. My sex assigned at birth is: _____

My marital status is: _____. My sexual orientation is: _____

My pronoun is: _____

Occupation: _____

Employer/School: _____

Referral Source: _____ Phone : _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home/Cell Phone: _____ Work Phone: _____

Responsible Party Information *(if different from above)*

Responsible Party Name: _____

Relationship to client: _____

Address: _____

City: _____ State: VA Zip Code: _____

☐Home ☐Mobile Phone: _____ ☐Mobile ❒ Work Phone : _____

Insurance Information (if applicable)

Policyholders Name: _____

Policyholders Address: _____

City: _____ State: _____ Zip Code: _____

Policyholder date of birth: _____

Clients Relationship to Policyholder: _____

Insurance Carrier Name: _____

Insurance Address: _____

Insurance Phone Number: _____

Policy Number: _____ Group Number: _____

Policy Effective Date: _____

Special Conditions/Needs/Questions

_____

_____

(**Please continue on reverse side**)

Legal Custody of Client (*if applicable*)

Legal Guardian:_____

Address:_____

_____ City:_____State:_____

Zip Code: _____ Employer:_____Occupation: _____

_____ Visitation Privileges, etc. of Non-Custodial Caregiver(s)/

Parent(s):_____

Criminal Justice Status (*if applicable*)

Charges Pending Y/N _____ In Probation Y/N _____ Other _____

Explain:_____

Contact Name:_____Relationship: _____

Address:_____

Phone Number: _____

Special Conditions/Needs/Questions

_____

_____

_____

Consent to Treatment

I do hereby seek and consent to take part in the treatment by Don Chiappinelli, LCSW. I understand that developing a treatment plan with him and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by Don Chiappinelli, LCSW.

I am aware that I may stop my treatment with Don Chiappinelli, LCSW at any time. The only thing I will still be responsible for is paying for the services I have already received. I am aware that any outstanding balances due will be charged interest at 1.9% monthly. I understand that I may lose other services or may have to deal with other problems if I stop treatment.

I understand that Don Chiappinelli, LCSW may disclose information about me in consultations with other professionals in order to provide the best possible treatment. In such cases my name, or any identifying information about me, is not disclosed. Clinical information about me is discussed.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged in full for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given Protected Health Information about the type(s), cost(s), date(s), of any services or treatments I receive as well as diagnosis(s) and treatment progress. I thereby authorize payment of medical benefits to Don Chiappinelli, LCSW. I understand that if payment for the services I receive here is not made, Don Chiappinelli, LCSW may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, Don Chiappinelli, LCSW have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Don Chiappinelli, LCSW Date

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Consent to use and disclose your health information

This form is an agreement between you, _____ and myself, Don Chiappinelli, LCSW. When I use the word "you" below, it can mean your child, relative, or other person if you have written her or his name here _____ .

When I consult, diagnose, treat, or refer you, I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information here to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let me use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how I can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices I cannot treat you.

In the future I may change how I use and share your information and so may change our Notice of Privacy Practices. If I do change it, you can get a copy from me by contacting me.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but I may already have used or shared some of your information and cannot change that.

_____ _____

Signature of client or his or her personal representative Date

_____ _____

Printed name of client or personal representative Relationship to the client

_____

Description of personal representative's authority

Date of NPP: 01/01/2018 Copy ☐ given to ☐ refused by client/parent/personal representative.

Notice of Privacy Practices – Brief Version

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

My commitment to your privacy

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. **I am also are required by law to keep your information private**. These laws are complicated, but I must give you this important information. This is a shorter version of the full, legally required NPP which you can request from me at any time and refer to it for more information. However, I can't cover all possible situations so please talk to me, as the designated Privacy Officer (see below) about any questions or problems.

I will use the information about your health which I get from you or from others mainly to provide you with **treatment**, to arrange **payment** for my services, and for some other business activities which are called, in the law, health care **operations.** After you have read this NPP I will ask you to sign a **Consent Form** to let me use and share your information. If you do not consent and sign this form, I cannot treat you.

If I or you want to use or disclose (send, share, release) your information for any other purposes I will discuss this with you and ask you to sign an Authorization form to allow this.

Except in the specific instances mentioned below, I will not release any PHI about you without your specific written permission, even though the HIPPA laws may allow me to do so. Another way of stating this is that though the HIPPA laws may allow me as a healthcare professional to release PHI about you in many circumstances, it is my privacy policy and my professional ethics not to release any PHI about you without your specific written permission and authorization to do so.

Here are examples of when the laws require me to use or share your information:

When required by law
There are some federal, state, or local laws which require me to disclose PHI.

- I have to report suspected child or elder abuse.
- If you are involved in a lawsuit or legal proceeding and I receive a subpoena, discovery request, or other lawful process I may have to release some of your PHI. I will only do so after trying to tell you about the request, consulting your lawyer, or trying to get a court order to protect the information they requested.
- I have to disclose some information to the government agencies that check on me to see that I am obeying the privacy laws.

To Prevent a Serious Threat to Health or Safety. If I come to believe that there is a serious threat to your health or safety or that of another person or the public I can disclose some of your PHI. I will only do this to persons or organizations who are able to help prevent or reduce the threat or danger.

For specific government functions
I may be required to disclose PHI to government benefit programs relating to eligibility and enrollment, including Workers Compensation and Disability programs.

Your rights regarding your health information

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask me to call you at home, and not at work to schedule or cancel an appointment. I will try my best to do as you ask.
2. You have the right to ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends. I will do so except if it is against the law, or as required above, or when the information is necessary to treat you.

3. You have the right to look at the health information I have about you such as your medical and billing records. You can even get a copy of these records but I may charge you. You can discuss this with me, as the Privacy Officer, at any time to arrange how to see your records. See below.

4. If you believe the information in your records is incorrect or missing important information, you can ask me to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to me as the Privacy Officer. You must tell me the reasons you want to make the changes.

5. You have the right to a copy of this notice. If I change this NPP I will post the new version in my waiting area and you can always get a copy of the NPP from me.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with me as the Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way.

If you have any questions regarding this notice or my health information privacy policies, please contact me as the designated Privacy Officer; I can be reached by phone at 540-455-7401 or by e-mail at *dclcsw1@gmail.com.*

The effective date of this notice is January 1, 2018