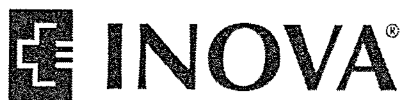
Medication Management Clinic
Patient Policy Handbook Acknowledgment

I have read and accept the Medication Management Patient Handbook and the included policies.
All questions have been answered to my satisfaction:

Patient	Date/Time
Patient or Guardian	Date/Time

PATIENT IDENTIFICATION	**Inova Kellar Center** **Medication Management Clinic** **Patient Policy Handbook Acknowledgment**



Medication Management Clinic
Patient Policy Handbook

HOURS

An administrative staff member is generally present during the following hours. If the office is closed, please call back during regular business hours:

Fairfax: 7:30am – 6:30pm Monday, Wednesday and Thursdays (Summer 7:30am – 6:00pm)
7:30am – 5:00pm Tuesdays
7:30am – 4:00pm Fridays

Loudoun: 8:00am – 5:00pm Monday – Thursday and 8:00am – 4:00pm Fridays

EMERGENCIES

Please note Inova Kellar Center is not an emergency facility. If you have an immediate life-threatening emergency, call 911 or go immediately to the nearest emergency room. During office hours, a staff member will return calls as soon as possible. Every effort is made to return all patient calls within 24-hours M-F. If you have not received a call within 48 business hours, call the Center and inform the administrative staff when you last left a message.

STAFF SUPPORTING MEDICATION MANAGEMENT CLINIC:

Designated Administrative Staff & Nurse

Any medical or clinical questions and concerns related to your child's care will be addressed by the nurse or designated administrative staff, under the direction of the physician. Calls will generally be returned by a nurse or designated administrative staff within 24 hours. Please note that messages left on our nurse line are for non-emergency matters only.

Practice Manager

The Practice Manager, or designee, is an administrative manager who maintains the physician schedules and appointments. The Practice Manager can provide information regarding the services provided by Inova Kellar Center, schedule initial appointments, and answer follow up administrative questions.

This person cannot answer medical or clinical questions related to the child's care but is available on a limited basis to discuss any unique accommodations that a child and family may need.

APPOINTMENTS

New patient appointments will be scheduled by the Practice Manager. Follow-up appointments may be scheduled by the front desk administrative staff. New patients are generally seen in the mornings or early afternoons, and the first session is typically one and one-half hour in length. Availability for follow-up appointments varies with morning, afternoon and early evening appointments generally available on a weekly

basis. You may not always be able to schedule an after-school appointment. Inova Kellar Center does not over-book or double-book appointments.

A second session to complete the evaluation may be necessary. ***Please be aware that the psychiatrist may not prescribe medications at the first appointment if additional information is required prior to recommending medications.***

Depending upon the exact type of medication prescribed, and the clinical symptoms present, patients are generally seen at least monthly at first, and then up to every two months, and when well established, up to every three months.

DOCTOR-PATIENT RELATIONSHIP

Following an initial evaluation, our physicians may become your child's psychiatrist if and when a mutual agreement is made to work together toward agreed upon goals (usually one to three appointments). This relationship is a professional, cooperative partnership in which we both have responsibilities to work toward the agreed-upon goals. Because of the nature of psychiatric treatment and the practice of our physicians, a person or family must be seen at least every three months to be considered an active or current patient.

LATE APPOINTMENTS

It is very important that you arrive on time to ensure you have every opportunity to discuss your child's needs with the physician. Psychiatrists will not be able to accommodate appointments for those patients **who arrive 15 minutes or more after their scheduled appointment.**

CANCELED OR MISSED APPOINTMENTS

When you schedule an appointment at Inova Kellar Center, a physician blocks a specific time for you and your child. In order to efficiently serve the community, Kellar has instituted a 24-hour cancellation policy. If you cannot or do not plan to keep your appointment, please let us know 24 business? (we use business above, so I'm just not sure if working hours is different) hours in advance to avoid a charge. **The charge for missed appointments, cancelled, or changed with less than 24 business? hours of notice is $75.** This fee will not be billed to your insurance. You will be directly responsible for the remittance of this fee at or prior to your next scheduled appointment.

Two or more missed or cancelled appointments can result in your child being discharged as a patient and you will need to seek services elsewhere. In addition, if a scheduled appointment is rescheduled twice within a two-month period, your child may be discharged as a patient and will be provided referrals to other providers in the area. Please notify us promptly if you must cancel your appointment in order to offer the appointment time to another client.

EMAIL

Inova Kellar Center physicians do not use or respond to email because of internet privacy concerns, email communication problems, and time limitations. Medical records may be sent encrypted upon the receipt of a

properly completed Authorization (see below), but due to the sensitivity of our records, we do not release them via unencrypted email.

PAYMENT

All relevant payments/**co-payments are due at the time of service**. Personal checks, exact cash (no change is maintained) and most credit cards will be accepted. There will be a $25 fee for any returned check. Payments are not available to pay via MyChart.

PRESCRIPTION REFILLS

All prescription refills require a scheduled appointment. Changes in medication(s) must be adequately considered, explained and discussed with the patient and family during an appointment time. **Please note controlled medications** (Ritalin, Adderall, Concerta, etc.) **can only be filled during an appointment**. If your child is prescribed one of these medications, you will need to schedule monthly follow up appointments. Please allow 7 business days for prior authorizations of medications. Prescriptions for controlled medications may have to be picked up by a parent or authorized person with valid ID.

In the event an exception occurs, please call the office during open office hours **at least 3 business days** before the prescription will run out. This allows your physician time to review and approve the medication refills.

***A $25 fee will be charged for prescriptions written outside a regularly scheduled appointment.** This fee will be collected over the phone when the request is made or when the paper prescription is picked up by the family representative with a valid ID.

Inova Kellar Center physicians will only write the prescription(s) to cover the patient's needs until your next appointment. Attending all scheduled appointment will ensure there is no need for additional refills.

Emergency refill requests schedule:
Monday – Wednesday: Requests received after 4:00 pm will be addressed the following business day.
Thursday: Requests after 4:00 pm will be addressed on Monday.
Friday: Requests after 12noon will be addressed on Monday.

NOTE: Physicians will only approve medication refills for active patients with scheduled follow-up appointments during regular office hours. Emergency on call system after hours must not be used for medication refill requests.

MEDICAL RECORDS

Requests for medical records require a signed Authorization for Request/Release of Protected Healthcare Information form to be completed and submitted to our medical records department. To make a request, please contact Rebecca Neville at Rebecca.neville@inova.org.

LETTERS/FORMS

A charge will be assessed on any letter or form that the physician is requested to complete. The fee schedule is as follows:

Letters	$25
Forms (e.g. school forms, FMLA, Disability)	$25

DISCHARGE POLICY

Inova Kellar Center provides medication management services to hundreds of children in the community and maintains a waiting list for those services. This need in the community requires Kellar to adhere to a discharge policy when patients have not been seen in a given period or are non-compliant in their treatment. The following will result in a patient discharge:

- **New patients not seen within 45 days of their recommended follow-up are not considered active or current patients and may be discharged as a patient from the clinic.**
- **Established patients not seen within 90 days of their last appointment (or longer) are not considered active or current patients and may be discharged from the clinic.**
- **If the patient/parent is not compliant with Treatment Recommendations, the patient may be discharged form treatment at the psychiatrist discretion.**

Should a discharge occur and you would like your child to receive services in the future, he or she will be considered a new patient. This will require the parent to schedule a new patient intake assessment/psychiatric evaluation. ***Intake appointments with physicians/clinicians are based on availability and a review of past compliance with practice policy guidelines.***

INSURANCE

The insurance policy you hold that provides a mental health benefit is a contract between you and your insurer. Parents may have to contact the insurance provider to ensure there is appropriate coverage for the services they are seeking.

Inova Kellar Center physicians accept many (but not all) insurance plans. The parent will be notified if the physician being scheduled is "in network" with their insurance provider. Assuming the physician working with your child is in network, with your specific insurance carrier, Inova Kellar Center will bill the insurance for services rendered. ***Please be aware you are ultimately responsible for all charges incurred, as well as for any services not covered by your policy. If you have inquiries, you should also contact your insurance company to determine coverage.***

If you have any questions regarding to your bill, please contact Inova Centralized billing department at 571-423-5750.

MEDICATION MANAGEMENT RISKS AND BENEFITS

We make every effort to ensure that your experience is a positive one. There are, however, both risks and benefits to Medication Management services. Please discuss all these with your provider.

The risks and benefits include:

Benefits:

- Improvement in mood symptoms
- Improvement in anxiety symptoms
- Improve activities of daily living
- Reduction in psychotic symptoms
- Management of substance concerns
- Decrease irritability associated with Autism Spectrum Disorder
- Improve attention, focus and or hyperactivity in Attention Deficit Hyperactivity Disorder

Risks:

- May experience side effects of medication that could affect sleep, appetite, weight, mood, heart rate, and worsening of safety concerns
- There can be a delay in response to medication
- Not all medications are effective for everyone
- There may be effects related to discontinuation of a medication
- Some medications may result in idiosyncratic reactions such as allergic reactions, rashes, and autoimmune responses.

Thank you for taking the time to read this important information. Please refer to this document when you have questions regarding your child's care.

If you are experiencing a mental health emergency, please contact emergency services within your area.

Mental Health Emergency Services	
Fairfax County/ City of Falls Church (24-Hour) Phone: 703-573-5679 | TTY: 703-207-7737 Crisis Link: 703-527-4077 **Arlington County** 703-228-5160 (24-hour Emergency Line: 703-228-4256) **Alexandria City** 703-746-3401 (ask to speak to an Emergency Services Clinician)	**Loudoun County (24-Hour)** Emergency Services: 703-777-0320 **Prince William County (24-Hour)** 703-792-7800 (Manassas) or 703-792-4900 (Woodbridge) **National Suicide and Crisis Lifeline** 9-8-8 A free 24-hour hotline available by phone or text to anyone in suicidal crisis or emotional distress. The previous Lifeline phone number (1-800-273-8255) remains operational.

INOVA HEALTH SYSTEM

INOVA NOTICE OF PRIVACY PRACTICES

Effective Date: November 15, 2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AT INOVA AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Inova's Chief Privacy Officer by calling the Compliance Department at 703-205-2337.

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This information is considered protected health information (PHI). The Health Insurance Portability and Accountability Act (HIPAA) requires that we provide you with a notice regarding how your PHI may be used or disclosed and your rights concerning that information. This notice applies to all of the records of your care generated by and as part of the care furnished to you in an Inova facility or through an Inova service, whether made by Inova personnel, agents of Inova and its affiliated facilities, or by your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

Inova's Responsibilities

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised copy by accessing our web site www.inova.org, calling 703-204-3342 and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. If any major change is made to this Notice, it will automatically be provided to you at the time of your next visit to an Inova facility. It will also be posted on our website at the time of the change.

Uses and Disclosures

How we may use and disclose Medical Information about you.

The following categories describe examples of the way we use and disclose medical information:

For Treatment: We may use medical information about you to provide you treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at Inova. For example, we may provide a physician at an Inova hospital with information regarding your prior treatment at an Inova facility if it might have bearing on the current condition for which you are being treated. Different Inova departments also may share medical information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.

We may disclose medical information about you to people outside of Inova who provide services that are related to your care. We may also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you are discharged from an Inova facility.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose your PHI in order to support the business activities of Inova. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fund raising activities, and conducting or arranging for other business activities.

For example, we may disclose your PHI to medical school students that see patients at our facilities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when we are ready to assist you. We may use or disclose your PHI as necessary to contact you to remind you of your appointment.

We may use or disclose your PHI as necessary to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your PHI for other marketing activities. For example, your name and address may be used to send you a newsletter about the services we offer or to send you information about products or services that we believe may be beneficial to you. These activities are not considered to be marketing under the HIPAA Privacy Rule.

Use of your PHI for activities that would be considered marketing or disclosures that would constitute the sale of PHI may not be made without a signed authorization from you.

If you do not want to receive the materials described above, please contact our Chief Privacy Officer by calling our Compliance Department at 703-205-2337 and request that these marketing materials not be sent to you.

We may use certain information to contact you in the future to raise money for Inova. We may also provide this information to our institutionally related foundation for the same purpose. The money raised will be used to expand and improve services and programs we provide the community.

Information that may be used about you for fundraising purposes includes your name, address, telephone number, dates of service, age, gender, general information about the department in which you received care, the identity of your treating physician and general outcome of your treatment.

If you do not wish to be contacted for fund-raising efforts, please notify the Inova Health System Foundation, at 8110 Gatehouse Road, Falls Church, VA 22042, or by calling 703-289-2072.

Business Associates: Some of the services provided by Inova are provided through contracts with business associates. Examples may include transcription services or outside billing services with which we contract. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information. Inova's requirements for safeguarding your information are included in Business Associate Agreements with each such entity. In addition, all business associates are subject to oversight by the Secretary of Health and Human Services (HHS) and must adhere to all requirements of the HIPAA Privacy and Security Rules.

Directory: We may include certain limited information about you in a facility directory while you are a patient at the facility. The information may include your name, location in the facility, your general condition (*e.g.*, good, fair, etc.) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. If you would prefer not to be included in the facility directory please request the *Request to be Excluded* Form from the Registration staff or from the Chief Privacy Officer.

Individuals Involved in Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you desire to limit disclosure of such information to friends or family members, we will ask that you designate one individual to whom we may make such disclosures. It will then be up to you to instruct that individual as to how they may disseminate information about you to other interested parties.

Research: Your medical information may be used or disclosed for research purposes without your permission if an Institutional Review Board (IRB) approves such use or disclosure. We may disclose medical information about you to researchers preparing to conduct a research project. In addition, researchers may contact you directly about participation in a study. The researcher will inform you about the study and give you an opportunity to ask questions. You will be enrolled in a study only after you agreed and signed a consent form indicating your willingness to participate in the study.

Future Communications: We may communicate to you via newsletters, mailings or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our facilities are participating.

Organized Health Care Arrangement: Inova's facilities, including but not limited to its hospitals, deliver care in clinically integrated settings in which individuals typically receive care from more than one health care provider including Inova's workforce; physicians and allied health practitioners who are in private practice and have clinical privileges at Inova facilities; hospital-based physician groups such as anesthesia; radiology, pathology and emergency medicine; department chairs and medical directors; and other health care entities affiliated with Inova. These are all part of Inova's Organized Health Care Arrangement (OHCA) and may utilize a shared electronic health record database. We are presenting you this document as a joint notice for these purposes. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to PHI in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Health Information Exchange: We may make your protected health information available electronically through an information exchange service to other health care providers that request your information. Participation in information

exchange services also lets us see health care information about you from other health care providers who participate in the exchange.

Single Covered Entity: For purposes of HIPAA only, all covered entities that are owned or controlled by Inova shall be considered to be a Single Covered Entity. PHI will be made available to personnel at other facilities included in this Single Covered Entity, as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to PHI at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Chief Privacy Officer for further information on the specific sites included in this affiliated covered entity.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or legal authorities charged with preventing or controlling disease, injury or disability
- Correctional institutions
- Workers Compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Funeral directors, coroners and medical directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes:

- in response to a court order, subpoena, warrant, summons or similar process;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at an Inova facility; and
- about wounds made by certain weapons.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If Virginia Law is more stringent than Federal privacy laws, Virginia law preempts the Federal law.

Uses or disclosures of your PHI not described in this notice will be made solely upon written authorization from you or your personal representative. Written authorizations may be revoked by contacting the department originally authorized to use/disclose the information.

Your Health Information Rights:

Although your health record is the physical property of the health care practitioner or facility that compiled it, you have the **Right to:**

- **Inspect and Copy:** You have the right to inspect and copy medical information in our possession that may be used to make decisions about your care. As a rule, this includes medical and billing records, but does not include psychotherapy notes. You may request an electronic copy of your PHI maintained in Inova's electronic health record (EHR). Access to your records must be provided within 15 days of the receipt of your request. We may deny your request to inspect and copy your records in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. A licensed health care professional not involved in the original denial of your request will be chosen by Inova to review your request and the denial. We will comply with the outcome of the review.

- **Request an Amendment of Your Information:** If you feel that your medical information we have on file is incorrect or incomplete, you may ask us to amend that information. You have the right to request an amendment for as long as Inova retains the information. We may deny your request for an amendment and, if this occurs, you will be notified of the reason for the denial and will be provided with your options as defined in the HIPAA Privacy Rule.

- **Request an Accounting of Disclosures:** You have the right to request an accounting of any disclosures we make of your medical information for purposes other than treatment, payment or health care operations.

- **Right to Restrict Release of Information For Certain Services**

    - You have the right to request a restriction on disclosure of health information about services you paid for out of pocket in full. This request should be made prior to the service being provided and applies only if the disclosure is to a health plan for purposes of payment or health care operations.

    - You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member

or friend. For example, you could ask that we not disclose information about your surgical procedure. Restrictions should be requested in writing by completing a **Request for Confidential Communication and/or Disclosure Restriction.** You may obtain a copy of this form at the time you register for your service or you may obtain one on our web site www.inova.org.

- o **With the exception of restrictions regarding services or procedures that you pay for out of pocket, we are not required to agree to your request.** Requests for restrictions or limitations on the medical information we use or disclose about you for treatment, payment or health care operations must be forwarded to the Chief Privacy Officer. Only the Privacy Officer or his/her designee can agree to such restrictions or limitations. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

- **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at a location other than your home or by U.S. Mail. Such requests must be made in writing and must include a mailing address where bills for services and related correspondence regarding payment for services will be received. It is important that you note that Inova reserves the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
- **Breach Notification:** You have a right to be notified following a breach of your unsecured PHI.
- **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time, even if you have agreed to receive this notice electronically.

You may obtain a copy of this notice at our web site http://www.inova.org.

To exercise any of your rights under this notice, please obtain the required forms from the Registration Department in the facility where you received your services and submit your request in writing. You may also access these forms at our web site http://www.inova.org.

CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. The revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in Inova's facilities and will include the effective date. In addition, each time you register at or are admitted to Inova for treatment or health care services as an inpatient or outpatient, we will provide access to the most recent version. You may always access the most recent version at our web site http://www.inova.org or may call 703-204-3342 and request that a copy of the most recent version is mailed to you.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Inova by contacting the Compliance Department at 8110 Gatehouse Road, Falls Church, VA 22042 Attention: Chief Privacy Officer. You may file a complaint with the Secretary of the Department of Health and Human Services. Instructions for filing a complaint with the Secretary are found at: www.hhs.gov/ocr/privacy.

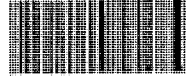
All complaints must be submitted in writing. **You will not be penalized for filing a complaint about Inova's Privacy practices.**

OTHER USES OF MEDICAL INFORMATION

We are required to retain our records of the care that we provided to you. Inova will make other uses and disclosures of medical information not covered by this notice or the laws that apply to us only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If we receive written revocation of your permission, we will cease the use or disclose medical information you originally authorized. We would not be able to take back any disclosures we had already made with your permission.

CHIEF PRIVACY OFFICER

Telephone Number: 703-205-2337



I certify that I have received Inova's **Notice of Privacy Practices** and that I have a right to receive an additional copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Inova's health care operations. The Notice also describes my rights and Inova's duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Inova's web site at www.inova.org. I may request that a copy be mailed to me by calling **703-204-3342.**

Inova reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Inova's web site listed above to view the most current version.

______________________________ Patient or Personal Representative (signature)   ________ Date   ________ Time

______________________________ Patient or Personal Representative (print name)

______________________________ Description of Personal Representative's Authority

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ______________________

Date of Birth: ____________ Medical Record # ____________

Gender: ☐ Male ☐ Female

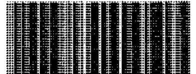
Inova

Acknowledgement of Receipt of Notice of Privacy Practices

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

☐ IMG: ________ ☐ Other: ________

CAT # 84498 / R102919 • PKGS OF 100



3PTIDEN

This form is to correctly identify the legal spelling of the patient's first name, last name, middle initial and your date of birth. The correct patient identification is important for the patient's **safety** while receiving services at any Inova facility.

Please Print Clearly

First Name of Patient: ______________________ Middle Initial of Patient: __________

Last Name of Patient: ______________________

Address: ______________________
City State Zip Code

Phone Number: ______________________

Date of Birth (Month / Day / Year): ______________________ Gender: ☐ Male ☐ Female

Patient's Primary Care Physician: ______________________

Physician's Group Practice Name: ______________________

OR

__________ I do not have a Primary Care Physician

Name of person bringing child in for treatment: ______________________
First Name Last Name

Name of parent/guardian: ______________________
First Name Last Name

Parent/Guardian relationship to patient: ☐ Mother ☐ Father ☐ Other: __________

Does parent/guardian reside at the same address as child: ☐ Yes ☐ No

If address is different, please provide address:

____
City State Zip Code

Responsible Party's Date of Birth: __________ Responsible Party's Social Security Number: __________

Email address: ______________________

Signing this form acknowledges the above information is correct and will be used as patient identification at Inova Health System.

______________________ Signature

______________________ Date/Time

______________________ Relationship to patient

______________________ Witness

______________________ Date/Time

PATIENT IDENTIFICATION

Inova Health System

Patient Identification Form - Pediatric

CAT # 20368DT/R030515 • PKGS OF 100

Este formulario consiste en identificar correctamente la ortografía legal de su nombre y apellido, inicial de su segundo nombre y su fecha de nacimiento. La correcta identificación del patiente es importante para su **seguridad** mientras recibe atención en cualquier instalación de Inova.

Por favor escriba claramente en letra imprenta

Primer nombre del paciente: ____________________ Letra inicial del segundo nombre del paciente: __________

Apellido del paciente: ____________________

Dirección: ____________________
Ciudad Estado Código Postal

Número de teléfono: ____________________

Fecha de nacimiento (mes / día / año): ____________________ Sexo: ☐ Hombre ☐ Mujer

Médico de atención primaria: ____________________

Nombre del consultorio médico: ____________________

O BIEN,

__________ No tengo médico de atención primaria.

Nombre de la persona que trae al niño para tratamiento: ____________________
Nombre Apellido

Nombre del padre/de la madre/del tutor ____________________
Nombre Apellido

Padre/madre/parentesco del tutor con el paciente: ☐ Madre ☐ Padre ☐ Otro: __________

¿Reside el padre/la madre/el tutor en la misma dirección que el niño? ☐ Sí (Yes) ☐ No

Si la dirección es diferente, por favor indíquela: ____________________
Ciudad Estado Código Postal

Fecha de nacimiento de la parte responsable: ____________________ N° de seguro social de la parte responsable __________

Correo electrónico: ____________________

Al firmar este formulario usted declara que la información anterior es correcta y que se empleará como identificación del paciente en el servicio médico Inova Health System.

____
Firma
(Signature)

____
Fecha/hora
(Date/time)

____
Parentesco con el paciente
(Relationship to patient)

____
Testigo
(Witness)

____
Fecha/hora
(Date/time)

PATIENT IDENTIFICATION

Inova Health System

Formulario de Identificación del paciente pediátrico

Patient Identification Form - Pediatric **Spanish**

CAT # 20366DT/R030516 • PKGS OF 100

INOVA®

Child's Name:______________________________ Date of Birth:____________

What are your current concerns? ______________________________

____

How long have you had this concern? ______________________________

Prenatal History

1. How was mother's health during pregnancy? ☐ Good ☐ Fair ☐ Poor
2. Did mother smoke, consume any alcohol, or use prescription or nonprescription drugs during her pregnancy? ☐ Yes ☐ No If yes, please describe: ______________________________

____

Birth History

3. Were there any difficulties with labor or delivery? ☐ Yes ☐ No

If yes, please describe: ______________________________

____

4. Was your child born on schedule? ☐ Yes ☐ No

If no, when was he/she born? ______________________________

5. What was your child's birth weight and length? ______________________________

6. Were there any health complications following birth? ☐ Yes ☐ No

If yes, please explain: ______________________________

____

Developmental Milestones and Early Temperament

7. Were there any difficulties with motor development, language development, or toilet training?

☐ Yes ☐ No If yes, please describe: ______________________________

____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ______________________________

Date of Birth: ____________ Medical Record # ____________

Gender: ☐ Male ☐ Female

Inova Kellar Center

Developmental and Social History

CAT # 20256DT/R061318 • PKGS OF 100

INOVA

8. Would you describe your child's early temperament as:
   - ☐ Easy (regular sleeping and eating patterns, adaptable to change, average activity level, average mood)
   - ☐ Difficult (irregular sleeping and eating patterns, poor adaptability, highly active, wide range in mood)
   - ☐ Other ______________________________

____

School History

9. Has there been any concern expressed by either teachers or yourself regarding your child's academic progress or behavior in school? ☐ Yes ☐ No If yes, please describe: ______________________________

____

____

____

10. What school does your child currently attend? ______________________________

11 What is your child's current grade placement? ______________________________

12. Has your child ever received special education services? ☐ Yes ☐ No

If yes, please describe: ______________________________

____

____

Family Composition

13. Please provide the following information in regard to everyone living at home.

Name	Age	Relationship	Occupation	Education

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ______________________________

Date of Birth: ______________ Medical Record # ______________

Gender: ☐ Male ☐ Female

Inova Kellar Center

Developmental and Social History

CAT # 20256DT/R061318 • PKGS OF 100

INOVA®

14. Please provide the following information in regard to significant family members not living at home:

Name	Age	Relationship	Occupation	Education

15. Are parents presently married? ☐ Yes ☐ No

Please comment on the relationship each parent has with the child: ____________________

____

____

16. Who has custody of the patient? ____________________

Stressful Events in the Child's and/or Family's Life

17. Please list any stressful events which have occurred in the past. Also include when these events took place and your child's reaction to them: ____________________

____

____

____

18. Does your child have any known history of physical or sexual abuse? ☐ Yes ☐ No

If yes, please describe: ____________________

19. Do you or does your child have any concerns about his/her sexual history and orientation?
☐ Yes ☐ No

If yes, please describe: ____________________

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ____________________

Date of Birth: ____________ Medical Record # ____________

Gender: ☐ Male ☐ Female

Inova Kellar Center

Developmental and Social History

CAT # 20256DT/R061318 • PKGS OF 100

INOVA

20. Has any family member had prior contact with the court system, protective services or any other legal/social service agency? ☐ Yes ☐ No If yes, please explain ______________________

____

____

21. Are there weapons in the house? ☐ Yes ☐ No

If yes, describe type and method of storage: ______________________

____

____

____

____

Family History

22. Please indicate any family history of behavioral, emotional, or substance abuse, and/or academic difficulties:

Mother and/or Maternal Relatives

____

____

Father and/or Paternal Relatives

____

____

Siblings

____

____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ______________________

Date of Birth: ______________ Medical Record # ______________

Gender: ☐ Male ☐ Female

Inova Kellar Center

Developmental and Social History

CAT # 20256DT/R061318 • PKGS OF 100

INOVA

2HP

Support System

23. Please list resources which you find helpful in coping with your child/family's difficulties (*e.g.* church, extended family, friends, *etc.*) ______________________________

____

____

Spirituality in Family

24. Are you affiliated with a religious organization, church or synagogue? ☐ Yes ☐ No

Name: ______________________________

Level of involvement: ☐ Minimal ☐ Sporadic ☐ Regular ☐ Very Active

Do you have a belief in a Spiritual Being or Higher Power? ☐ Yes ☐ No

25. Please indicate any and all cultural, religious and spiritual factors that may influence your treatment and progress.

____

____

Social History

26. Does your child have any difficulty making or keeping friends? ☐ Yes ☐ No

If yes, please describe: ______________________________

____

____

27. Do you have any concerns about the type of friend(s) your child has? ☐ Yes ☐ No

If yes, please describe: ______________________________

____

____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ______________________________

Date of Birth: ________________ Medical Record # ________________

Gender: ☐ Male ☐ Female

Inova Kellar Center

Developmental and Social History

CAT # 20256DT/R061318 • PKGS OF 100

INOVA

2HP

28. What are your child's favorite play activities, hobbies or pastimes? ______

______

______

Strengths

29. What are your child's strengths? ______

______

______

Medical History

Height: ______ feet ______ inches Weight: ______ lb/kg

List allergies to medication or food: ______

30. How would you describe your child's current general health? ☐ Good ☐ Fair ☐ Poor

31. Does your child have any current medical problems? ☐ Yes ☐ No

If yes, please describe: ______

32. Has your child had any recent major accidents or illnesses? ☐ Yes ☐ No

If yes, please describe: ______

33. Has your child had any recent surgeries or hospitalizations? ☐ Yes ☐ No

If yes, please describe: ______

34. Does your child have any past history of seizures or other medical problems? ☐ Yes ☐ No

If yes, please describe: ______

35. Is your child's immunization status current? ☐ Yes ☐ No

36. Please list your child's primary care physician's name and phone #: ______

37. When was your child's last physical exam? ______

38. Do you see any reason to have your child undergo a physical examination at this time? ☐ Yes ☐ No

If yes, indicate reason: ______

39. Are there any dental concerns? ☐ Yes ☐ No If yes, indicate concern: ______

______

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ______

Date of Birth: ______ Medical Record # ______

Gender: ☐ Male ☐ Female

Inova Kellar Center

Developmental and Social History

CAT # 20256DT/R061318 • PKGS OF 100

INOVA

2HP

Nutritional Screening

40. Without reason, has your child gained or lost more than 10 lbs. in the last 3 months? ☐ Yes ☐ No
41. Does your child take laxatives or vomit after eating? ☐ Yes ☐ No
42. Does your child frequently have diarrhea or constipation? ☐ Yes ☐ No

Pain Screening

43. Is your child experiencing any physical pain? ☐ Yes ☐ No

On a scale of 0 to 10, (0 being no pain and 10 being the most) what is your child's pain level?

Circle one: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

If yes, please describe: ______________________________

Functional Screening

44. Does your child have any significant difficulty moving about or problems with coordination? ☐ Yes ☐ No

If yes, please describe: ______________________________

45. Does your child have any significant difficulty playing sports? ☐ Yes ☐ No

If yes, please describe: ______________________________

Other Screenings

46. Does your child have any significant difficulties with vision or hearing? ☐ Yes ☐ No

If yes, please describe: ______________________________

47. Do you have any concerns regarding your child's oral health or hygiene? ☐ Yes ☐ No

If yes, please describe: ______________________________

If you answered yes to any of the prior questions or indicated your child's health is fair or poor, is he/she under the care of a physician or other healthcare provider? ☐ Yes ☐ No

Condition for which he/she is being treated: ______________________________

Name of physician/healthcare provider and phone #: ______________________________

Mental Health Treatment History

48. Has your child had any prior treatment for emotional/behavioral difficulties? ☐ Yes ☐ No

If yes, please list the name of the provider(s), date(s) seen and outcome: ______________________________

____

____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ______________________________

Date of Birth: ________________ Medical Record # ________________

Gender: ☐ Male ☐ Female

Inova Kellar Center

Developmental and Social History

CAT # 20256DT/R061318 • PKGS OF 100

INOVA

49. Was medication prescribed? ☐ Yes ☐ No

If yes, please list: ______________________________

____

____

Other Concerns

50. Are any destructive, self-destructive or risky behaviors present (examples: threats to hurt oneself or others; killing or harming animals; fire setting; use of illicit substances; participation in gangs; sexual activity or other actions) which may put the child in harm's way? If yes, please describe:

____

____

____

51. Please list any other concerns or ideas you have regarding your child's current behavioral, emotional or academic functioning: ______________________________

____

____

52. Does your child have any preference that may affect or should be incorporated into their treatment? ________

____

53. What do you hope will be different at the end of this treatment? ______________________________

____

____

Completed by: ______________________________ Date/Time: ______________

Clinician: A yes to any question numbered 37 - 43 indicates that a referral is to be made to the appropriate healthcare provider unless the patient is currently being treated for that condition.

Referral needed: ☐ Yes ☐ No

If yes, for: ☐ Pain ☐ Nutrition ☐ Physical out of date ☐ Substance Abuse

Referred to: ______________________________

Reviewed by: ______________________________ Date/Time: ______________

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ______________________________

Date of Birth: ______________ Medical Record # ______________

Gender: ☐ Male ☐ Female

Inova Kellar Center

Developmental and Social History

CAT # 20256DT/R061318 • PKGS OF 100

I, ____, and ____,
(preferred name of patient) (name of parent/guardian)

- Voluntarily give my consent to the admitting physician, members of Inova Kellar Center staff, and other physicians or Advanced Practice Practitioners designated to conduct medical and psychiatric evaluation and provide diagnostic procedures and treatment.
- Understand that my treatment may include, but not be limited to, the potential benefits and risks documented below. Please see the Medication Management Clinic Practice Policies for further details.
    - **Potential benefits and outcomes:** Improvements in mood and anxiety symptoms; enhanced capabilities for emotional regulation; improvement in activities of daily living; reduction in psychotic symptoms; strengthened family relationships and communication skills; greater personal awareness and insight; management and reduction of substance related concerns; and decreased irritability associated with Autism Spectrum Disorder.
    - **Potential risks and complications:** Recommendations for alternative modalities of treatment if there is inadequate or delayed response to medication; experiencing side effects of medication that could affect sleep, appetite, weight, mood, heart rate, and worsening of safety concerns; potential idiosyncratic reactions such as allergic reactions, rashes, and autoimmune responses; increased experiences of uncomfortable thoughts and feelings during some phases of treatment, additional financial burden.
    - **Alternative Services** to the proposed treatment for my condition, including the benefits and risks of each and the option of no treatment, have been discussed with me. These include but are not limited to referral to other services for care, testing, or no treatment.
- Understand that I may leave treatment on my own initiative at any time. I understand that I will be encouraged to discuss this with my provider.
- Understand that I may, on my own initiative, request and/or obtain a second opinion on any recommendations made.
- Consent to emergency treatment or transportation to an Emergency Department for medical care as deemed necessary by Inova Kellar Center staff.
- Am aware that if I am involved in more than one Inova Kellar Center service, information will be exchanged among involved staff for the purpose of coordinating treatment and/or educational services (day school).
- Am aware that providers at Inova Kellar Center are mandated to report suspected child abuse and neglect.
- Understand and agree to abide by current Center for Disease Control (CDC) guidelines, state or local regulations, and Inova Health System policies related to COVID-19 or other emerging health crises that pertain to healthcare settings as directed by Inova Kellar Center staff. By signing this agreement, I acknowledge the contagious nature of COVID-19 and on behalf of myself, my child, my child's co-parent or siblings (collectively, our "Family"), we voluntarily assume and accept responsibility for the risk that the patient or Family may be exposed to or infected by COVID-19 while attending activities at the Inova Kellar Center.

This consent has been fully explained to me and I understand its content. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction.

Patient (signature)	**Patient** (print name)	Date	Time
Parent/Guardian (signature)	**Parent/Guardian** (print name)	Date	Time

Parent/Guardian Relationship to Patient: ____

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) ____________________
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ______________________________

Date of Birth: ______________ Medical Record # ______________

Inova Kellar Center

Consent to Treatment Medication Management

CAT # 21100DT / R121422 • PKGS OF 50

Department/Location: ______________________

1. **For Medicare Recipients:**
I certify that the information provided to me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to Inova (or its affiliates) for any services furnished to me during the applicable periods of medical care.

2. **Assignment and Coordination of Insurance Benefits:**
I agree to provide information regarding all health insurance benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from insurance carrier(s) health benefit plan to Inova (or its affiliates) for services rendered to the patient. I hereby authorize payments directly to Inova, including any benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to Inova (or its affiliates) for services rendered to me during the applicable periods of medical care.

3. **Unauthorized, Non-covered, or Out of Plan Services:**
I understand and acknowledge:
   - If my insurance carrier or administrator of benefits does not consider any services rendered covered services, or has not authorized these services, they will not pay and I agree to pay for these services.
   - **One or more of my physicians may not accept insurance or may be out of network with my health insurance.**
   - In the case of out of plan/network physician or services, there may be reduced benefits and I may be required to pay a higher co-pay, deductible or co-insurance amount.

4. **Responsibility for Payment:**
In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including but not limited to health benefit deductibles, copayments, co-insurance and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorneys' fees and other collection costs.

5. **Automobile Accident Patients** - Notice regarding the assignment of medical expense benefits will be provided to you in a separate document.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered, and accept the above conditions and terms; and I agree to pay all charges for which I may be legally and/or contractually responsible, including but not limited to health insurance deductibles, co-payments, and non-covered services. **I understand that Inova, its affiliates, agents (including but not limited to debt collectors) or designees may contact me about outstanding balances through various methods including the use of manual representative outbound calls and voice messages and/or automated dialing services and pre-recorded artificial voice messages, at any telephone number I provide to Inova.** I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Inova. *I understand and agree this document will remain in effect for my present outpatient visit and any future outpatient or physician office visits to Inova, unless specifically cancelled in writing by me.* I understand that I will be asked to review and sign this form once per calendar year as long as I remain a patient of Inova.

______________________	______________________	________	________
Patient/Guardian/etc. (signature)	**Patient/Guardian/etc.** (print name)	Date	Time

____
Relationship to Patient (if not signed by patient)

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) ______________________
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ______________________

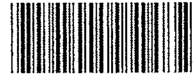
Date of Birth: ______________ Medical Record # ______________

Gender: ☐ Male ☐ Female

Inova
Authorization for Claims, Payment, and Reviews - Ambulatory

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH
☐ IMG: ____________ ☐ Other: ____________

CAT # 20083DT/R050420 • PKGS OF 25



1HEAR

Inova Staff:
1. **If accommodations are requested, page interpreter services at 98824 within 15 minutes of completing this form.**
2. **A new form should be used at every visit and any time a change in accommodations is requested.**

Name of Person Requesting/Declining Accommodations: ____________________

Relationship to Patient: ☐ Self ☐ Parent ☐ Family Member ☐ Friend ☐ Other ____________________

Do you and/or your companions have any special needs that require accommodations? ☐ **YES (complete boxes A and B)** ☐ **NO (complete box B)**

A. If you require special accommodations, please check as appropriate:

Deaf and Hard of Hearing:
- ☐ Sign language interpreter ☐ Notepad and pen ☐ Speak loudly
- ☐ Sound amplifier (ex. PockeTalker® or disposable Posey®)
- ☐ Uses hearing aid(s): ☐ Left ☐ Right ☐ Bilateral
- ☐ Amplified phone with flasher (if admitted)
- ☐ Video Remote Interpreter (VRI) (where available)
- ☐ Other: ____________________

Vision:
- ☐ Magnifying sheet ☐ Request an escort
- ☐ Braille phone ☐ Documents read out loud
- ☐ Other: ____________________

Mobility:
- ☐ Uses service animal ☐ Walking escort
- ☐ Wheelchair escort ☐ Extra-wide wheelchair escort
- ☐ Accessible exam table ☐ Accessible weight scale
- ☐ Other: ____________________

Speech:
- ☐ Point-to-Speak cards ☐ Point-to-Speak alphabet ☐ Notepad and pen
- ☐ Other: ____________________

Other or Special Instructions: ____________________

B. All Patients, Representatives and Companions, please read and sign:

By my signature below I hereby certify that: (1) I have been given an opportunity to communicate whether I and/or my companions have any special needs; (2) I have had the opportunity to select appropriate accommodations; (3) I have reviewed the above selections; (4) those selections are true, accurate and complete; (5) those selections reflect my and/or my companions' choices; and (6) I have received or can request a copy of the process for filing a complaint if I am unsatisfied with my own and/or my companions' accommodations. I understand that if my and/or my companions' needs change during my visit, I can request service changes from my caregiver free of charge.

☐ Patient's medical condition does not allow completion at this time.

Patient/Representative/Companion (signature) ____ **Patient/Representative/Companion** (print name) ____ Date ____ Time ____

Relationship to Patient: ☐ Self ☐ Parent ☐ Family Member ☐ Friend ☐ Other: ____________________

Staff Witness (signature) ____ **Staff Witness** (print name) ____ Date ____ Time ____ Contact # ____ Department ____

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID# (if applicable) ____________________
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver Signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ____________________

Date of Birth: ____________ Medical Record # ____________

Gender: ☐ Male ☐ Female

Inova

Americans with Disabilities Act (ADA)/ Special Needs Assessment

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH
☐ IMG: ________ ☐ Other: ________

CAT # 20328DT/R022420 • PKGS OF 50

INOVA

It is your Right:

- To be treated with dignity and respect
- To be told about your treatment
- To have a say in your treatment
- To speak to others in private
- To have your complaints resolved
- To say what you prefer
- To ask questions and be told about your rights
- To get help with your rights

If you believe your Rights have been violated, you may:

- Contact Inova Kellar Center Senior Director or designee at (703) 218-8500; or
- Contact the Regional Human Rights Advocate, Ann Pascoe, at (877) 600-7431; or
- Contact the Department of Behavioral Health and Developmental Services at P.O. Box 1797, Richmond, VA 23218-1797

I have received a copy of these Rights, which I have read and understand.
I have had an opportunity to ask questions regarding these Rights.
I have had my questions answered to my satisfaction.

______________________	______________________	______________
Individual Receiving Services (signature)	**Individual Receiving Services** (print name)	Date/Time

______________________	______________________	______________
Parent/Guardian (signature)	**Parent/Guardian** (print name)	Date/Time

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ______________________

Date of Birth: ______________ Medical Record # ______________

Gender: ☐ Male ☐ Female

Inova Kellar Center

Rights of Individuals Receiving Behavioral Services

CAT # 20239DT / R042519 • PKGS OF 100

INOVA®

1PATP

When an individual is scheduled at Inova Kellar Center, our mental health clinicians hold a specific block of time (unit) for you. In order to efficiently serve the community, we have a cancellation/missed appointment and late arrival policy. All new clients must arrive 15 minutes prior to the time of their scheduled appointment to allow sufficient time to complete new client paperwork. All Kellar programs require a 24-hour notice for cancellation. Each program has a specific grace period for late arrivals. **The fees incurred due to a cancelled/missed appointment or late arrival cannot be billed to insurance.**

- **Partial Hospitalization Program (PHP):** Patients must be present to bill the insurance company. There is a charge of $390 for missed appointments. See your PHP handbook for further details.

- **Intensive Outpatient Program (IOP):** a patient must arrive at the time established by the center to be considered present. The fee for a missed day is $130. See your IOP handbook for further details.

- **Medication Management:** a patient must arrive within 15 minutes of the scheduled appointment time to be seen in the clinic. The fee for a missed appointment is $75. Two appointments rescheduled in a month are grounds for discharge at the discretion of the clinician. See medication management policy for further details.

- **Psychotherapy Services:** a patient must arrive within 15 minutes of the scheduled appointment time to be seen for an appointment. The fee for a missed appointment is $75. If you miss more than two appointments within a three-month period, at the clinician's discretion you may be discharged from treatment and provided with referrals.

- **Psychological Testing:** Psychological services bills by the unit. A patient who arrives more than 20 minutes late will be charged a late fee of $75 for that unit. Any remaining time will be used to complete a portion of the evaluation and only that time will be billed to any applicable insurance company. If the clinician determines that the evaluation cannot be completed within the remaining time, an additional session may need to be scheduled. Cancellation of an evaluation appointment without 48 hours notice will result in a charge of $250. See psychological testing information sheets for further details.

By signing this policy I acknowledge that I have read and understand my responsibilities.

______________________________ ____________ ____________
Patient (signature) Date Time

______________________________ ____________ ____________
Parent or Guardian (signature) Date Time

____
Parent or Guardian (print name)

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ______________________

Date of Birth: ____________ Medical Record # ____________

Gender: ☐ Male ☐ Female

Inova Kellar Center

Cancellation/Missed Appointment and Late Arrival Policy

CAT # 20226DT/R043019 • PKGS OF 25

INOVA

In accord with Federal and State confidentiality laws, it is necessary for those involved in your or your child's treatment to be able to exchange information. Your signature on this form will allow outside groups and individuals to exchange confidential information necessary to your or your child's treatment.

Note: No medical records will be released without a signed Release/Disclosure of Protected Information form.

Name of Patient ______________________ _Date of Birth_ ____________

Patient Address ____________ _City_ ____________ _State_ ______ _Zip Code_ ______

I authorize the following identified members of my/my child's treatment team to communicate with the Inova Kellar Center staff for the purpose of ongoing care.
Please complete below and check all that apply.

		Mental Health	Alcohol & Drug
Parent or Guardians	_Phone_	☐	☐
Primary Care Physician	_Phone_	☐	☐
Individual/Agency Name	_Phone_	☐	☐
Individual/Agency Name	_Phone_	☐	☐
Individual/Agency Name	_Phone_	☐	☐
Name of School			
Contact Person(s)/Department	_Phone_	☐	☐

I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. Such revocation will be discussed and may result in an inability to treat. I understand written notification is necessary to cancel this authorization and must be addressed to the Medical Record Department. I understand that this consent automatically expires 90 days after the end of treatment at Inova Kellar Center.

Patient's Signature ______________________ _Date / Time_ ____________

I acknowledge that the clinical and legal purpose and intent of this form have been explained to me.

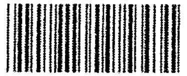
Parent/Guardian Signature ______________________ _Date / Time_ ____________

PATIENT IDENTIFICATION

Inova Kellar Center

Coordination of Treatment Consent

CAT # 20227DT/R082013 • PKGS OF 100



Complete a health insurance section for each of your health plans/coverages.

Health Insurance - 1

Subscriber Name: ______________________ Subscriber Date of Birth: __________

Name of Health Insurance Company: ______________________

ID/Policy Number: __________ Group Number: __________ Effective Date of Policy: __________

Patient Relationship to Subscriber: ______________________

Is Insurance through Subscriber's Current Employer? ☐ Yes ☐ No

If Yes, Employer Name: ______________________

Does patient have additional health insurance or Medicare:

☐ Yes. If yes, please complete corresponding sections sign, print name and date.

- Health Insurance - complete box 2
- Medicare – complete box 3

☐ No. If no, please sign, print name and date.

If you have an additional plan/coverage, please complete the box below.

Health Insurance - 2

Subscriber Name: ______________________ Subscriber Date of Birth: __________

Name of Health Insurance Company: ______________________

Address of Health Insurance Company: ______________________

ID/Policy Number: __________ Group Number: __________ Effective Date of Policy: __________

Patient Relationship to Subscriber: ______________________

Is Insurance through Subscriber's Current Employer? ☐ Yes ☐ No

If Yes, Employer Name: ______________________

If you have Medicare, please complete the box below.

Medicare - 3

Medicare Number ______________________

Hospital (Part A) Effective Date __________ Medical (Part B) Effective Date __________

Entitlement Reason: ☐ Age ☐ Disability ☐ End Stage Renal Disease

If Disability: Date Disability Began: __________

If End Stage Renal Disease: Date of First Dialysis: __________ Kidney Transplant Date __________

Are you Currently Employed? ☐ Yes ☐ No If no, Date of Retirement: __________

Patient/Parent/Legal Guardian (signature): ______________________ Date: __________

Patient/Parent/Legal Guardian (print name): ______________________

PATIENT IDENTIFICATION

If label is not available, please complete

Patient Name ______________________

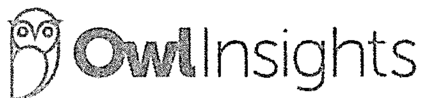
Date of Birth __________ Medical Record # __________

Gender ☐ Male ☐ Female

Inova

Coordination of Benefits Questionnaire

CAT # 20534DT (R110717 • PKGS OF 100



Patient Registration

FOR PATIENTS

How to activate your Owl account

*When you begin treatment, **your provider collects your contact information,** email and/or mobile number. This allows us to send you reminders that you have questions to complete in the Owl.*

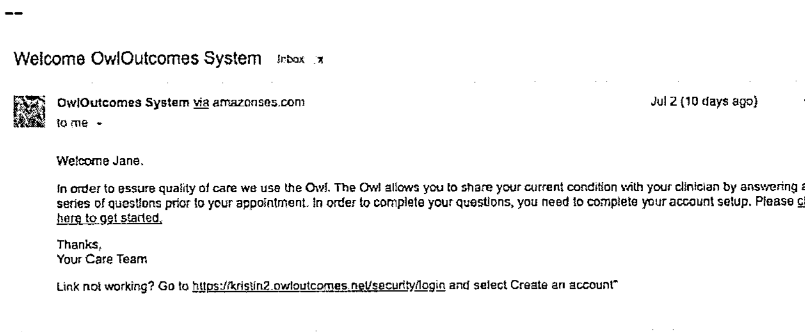
*Before you can set-up your account in the Owl, your provider must have already registered you in their system. Then, you must **activate your account** in the Owl. Be sure to use the **same contact information** you gave your provider during the intake.*

*If you would like to **change your contact information in the Owl**, you can do so after you have activated your account from the **My Account** section of the Owl.*

Please follow the steps below to complete your Owl account registration.

Step 1

Check your email inbox for the **Owl** welcome email. Click on '**click here to get started**.'



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Welcome OwlOutcomes System Inbox

OwlOutcomes System via amazonses.com — Jul 2 (10 days ago)
to me

Welcome Jane.

In order to essure quality of care we use the Owl. The Owl allows you to share your current condition with your clinician by answering a series of questions prior to your appointment. In order to complete your questions, you need to complete your account setup. Please cl here to get started.

Thanks,
Your Care Team

Link not working? Go to https://kristin2.owloutcomes.net/security/login and select Create an account"

Step 2

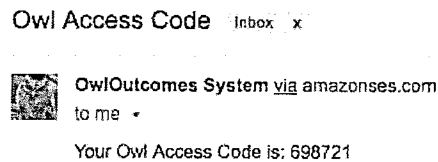
This will open up the **Owl** in your web browser.

Select **EMAIL** or **MOBILE NUMBER** and then **Get Code**.

Step 3

Check your email inbox (or text messages) to get your account access code. Enter your **Access Code** provided.

Tip: You can copy and paste your access code into the **Owl**.



Step 4

Create your personal **Username** and **Password**. Select **Continue.**

Please Create a Username and Password

Password must be at least 8 characters and include a number, an upper and lower case letter, and a symbol

●●●●●●●

●●●●●●●

Continue

By clicking continue you are accepting Owl Insight's Terms & Conditions

Step 5

Read the important '**Welcome to Owl**' message from your provider. Select **Next**.

Welcome to Owl!

Here at OWL we want you to get the best care possible. With Owl, you answer questions about your condition. Your providers see your answers and can share the results with you so together you can make good decisions about your care.

Next

Step 6

If your provider has scheduled questions for you, you will see a message from them that lets you know when they are due.

If an **Owl Session** is due, click **Start**.

Step 7

If prompted, read the security message from your provider and select '**I understand**' to begin your **Owl Session**.

If you are filling out these measures from any location other than this Demo Owl System, please remember that your therapist may not see your answers immediately.

If you are in crisis or in immediate danger of hurting yourself or someone else, please do not fill out these online measures. Instead, please call 9-1-1, or the Clinic's answering service.

I understand