Therapeutic Ventures, LLC
Nancy E Kirk, LCSW, CSAC, CSAT, CPTT, EMDR
Phone: 703.577.3299
Nkirk@therapeuticventures.com

Welcome to my practice!

I am looking forward to working with you. Enclosed are forms that will help us get started in the process. Please take a moment to review these documents and sign those that require your signature.

If you have any questions, please don't hesitate to ask.

Sincerely,

Nancy Elise Kirk, LCSW, CSAC, CSAT, CPTT, EMDR

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Your Contact Information

Today's Date: _____

Last Name: _____

First Name: _____

Type your te

Preferred First Name: _____

Phone	Telephone Number	May I leave a message for you at this number?
Home		Yes No
Cell		Yes No
Work		Yes No

Your Mailing Address: _____

_____

Your E-mail: _____

Date of Birth: _____

Person to contact in case of emergency:

Name: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Address: _____

How did you hear about me: _____

_____

_____

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Reasons for seeking services

Please briefly describe the main reasons for seeking my services: _____

_____
_____
_____
_____
_____
_____
_____
_____

Please check any of the following concerns you have at this time:

___ Abuse: emotional, physical, verbal, sexual, neglect	___ Concentration, decision-making, indecisiveness	___ Health or medical concerns	___ Relationship concerns
___ Academic or work issues	___ Grief issues	___ Hallucinations	___ Self-injury, mutilation
___ Aggression/violent behavior	___ Depression, sadness, crying	___ Identity issues	___ Self-neglect, poor self-care
___ Alcohol or drug use	___ Divorce, separation	___ Legal problems	___ Sexual assault
___ Anxiety, nervousness	___ Eating problems	___ Loneliness, withdrawal, or	___ Sexual concerns
___ Body image	___ Family relationships	___ Mood swings	___ Sexual orientation/ identity
___ Career concerns	___ Fears, phobias	___ Motivation issues	___ Sleep problems
___ Childhood issues (yours)	___ Financial problems	___ Panic attacks	___ Stress
___ Children/parenting issues	___ Gambling	___ Pregnancy-related issues	___ Suicidal thoughts
___ Compulsive behaviors	___ Guilt	___ Repeated troubling thoughts	___ Violent thoughts

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Please add any other information you may want me to know here: _____
_____
_____
_____
_____
_____
_____
_____

Relevant History

Psychological history: List all past psychological treatment, including hospitalizations, and describe reasons, locations, and dates: _____
_____
_____

Name and phone of current Psychiatrist: _____
_____

List any psychiatric medications you currently take (name, dosage): _____
_____
_____

List any psychiatric medications taken in the past (name, dosage): _____
_____
_____

Medical history: List any significant medical issues you have now, or had in the past (e.g. chronic conditions, accidents, major illnesses, surgeries): _____
_____ _____
_____

Name and phone of current Primary Care Provider: _____
_____

List medications you currently take (name, dosage): _____
_____
_____

Family history: Medical problems in family (parents, spouse/partner, children)? __ Yes __ No __ Unsure

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If yes, list: _____
_____
_____

Family history: Emotional problems in family members? ___ Yes ___ No ___ Unsure

If yes, list: _____
_____
_____

Family history: Alcoholism/substance abuse in family? ___ Yes ___ No ___ Unsure

If yes, list: _____
_____
_____

Occupation and place of employment: _____

Numbers of years of employment in current position: _____

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Client Consent Agreement

Working with me, you can expect courtesy, respect, and strict adherence to professional ethics and standards. Please feel free to ask questions and suggest ways l can better serve you.

Confidentiality: The privacy and confidentiality of your treatment is extremely important to me. Professional ethics, State law, insurance and managed-care companies require me to maintain clinical records and to safeguard them. Your clear consent, generally written, is necessary for me to discuss your case or to release any records about you. You can revoke permission for this at any time simply by writing to me. lf you would like me to confer with another healthcare professional, you will need to sign a “ReIease of Information" form. This permission may be revoked at any time.

The law may require me to release confidential information under some uncommon circumstances. These include the neglect or abuse of children, court-ordered services, a subpoena, when your mental health becomes an issue in litigation, or when there is a serious risk of harm to yourself or another person.

Length of Sessions: Session length is as agreed with me. Adult psychotherapy sessions usually run approximately 55 minutes. Sessions for families and couples may be scheduled for longer periods, with fees based accordingly.

No-show and Cancellation Policy: Continuity is crucial to the effectiveness of services you receive and I reserve your appointment exclusively for you. Please notify me as soon as possible if you do not expect to attend your appointment. l require at least 48 hours notice of cancellation. ALL Appointments missed, or cancelled late will be subject to the full fee. Monday appointments must be cancelled by 5pm on the preceding Thursday. For psychotherapy clients, it is important to note that insurance companies do not pay for missed sessions. YOU will be charged the rate of the insurance session ($150 or more).

Contacting Therapist in Emergencies: I do not provide continuous 24 hour/7 days a week coverage. However, I do check voice mail and email on a regular basis and return calls as soon as I can, during my business hours. lf you should experience a mental health emergency, please call 911, or go to the nearest emergency room before trying to reach me.

Discontinuing Services: Ending is an important part of the therapeutic process. Please discuss with me any plan or desire to discontinue therapy.

Litigation Limitation: It is agreed that, should there be legal proceedings (such as, but not limited to divorce, custody disputes, injuries, etc.) neither you nor your attorney will call me to testify in court or at any proceeding, nor will a disclosure of my records concerning you be requested.

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Psychotherapy Services Rate Schedule:

Initial Interview (Intake): $250 to $300
Individual session of 55 minutes: $180; 90 minute session for $270.
Couples sessions: $190 for 55 minutes; $285 for 90 minutes; sessions over 90 minutes will be pro-rated. I will be available for telephone conversations with attorneys, family members, etc., once you have signed a release form. Standard fee will be charged for telephone conversations on a pro-rated basis.

Payment of Fees:

Payment is due at the end of each session, unless other arrangements are made. Payment is accepted in the form of cash, Amex, Mastercard, Discover, HSA/FSA and Visa. If I am compelled by subpoena to appear for any legal or law enforcement proceedings involving your case, you will be billed for such an appearance at $500 per hour. Fees are subject to change annually.

If requested, a "superbill receipt" will be emailed to you to file for reimbursement with your insurance provider.

If there are forms requested by your insurance provider, I will complete the forms once you have signed a release of information authorizing the release of information regarding your treatment. Each insurance company has its own procedures for handling and storing information. There is, unfortunately, no assurance that I can make that it will be handled with proper discretion.

Please sign our agreement:

CLIENT CONSENT AGREEMENT

I, _____ (print name), understand and agree to the policies, procedures, fees, and payment arrangements as described above, and I consent to receiving services at a fee of $ _____ per session.

Date: _____

Signature:
_____

Parent's Signature (if client is under 18):

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Therapist's Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI) for treatment, payment and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

"***PHI***" refers to information in your health record that could identify you.

"***Treatment***" is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a psychologist.

"***Payment***" is when I obtain reimbursement for your health care. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

"***Health Care Operations***" are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

"***Use***" applies only to activities within my practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"***Disclosure***" applies to activities outside of my (office, clinic, practice group, etc.), such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent which permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes.

"Psychotherapy notes" are notes I have made about our conversation during a private, group, joint or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than "PHI". You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that: (1) I have relied on that authorization, or (2) if the authorization was

obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If l have reason to suspect that a child is abused, neglected, or exploited I am required by law to report the matter immediately to the Virginia Department of Social Services.

Elder Abuse: lf I have reason to suspect that an elder adult is abused, neglected or exploited, I am required by law to report and provide relevant information to the Virginia Department of Social Services.

Court order: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and l will not release information without the written authorization of you or your legal representative, or a subpoena (of which you have been serviced, along with the proper notice required by state law). If you or your counsel subpoena the records, that will constitute your consent to produce the records. If another person subpoenas your records and you object to the records being produced, you must contact me immediately to tell me of your objection and must file a motion to quash the subpoena in court to bar the production of records. If you do not object within the period set forth in the subpoena or within 14 days of the service of the subpoena, whichever is longer, then that shall constitute your consent that the records may be produced. If I find it necessary to obtain counsel to file pleadings in court or to appear in court to contest a subpoena, then you will be responsible for those reasonable attorney's fees. Finally, if I am subpoenaed to appear in court or at a deposition to testify in any legal proceeding in which you are a party about matters related to you, then you agree to pay for my time at a rate of $400 per hour.

Serious Threat to Health or Safety: If I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious body injury or death to an identified, or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I must take steps to protect the third party. These precautions may include: (1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18; or (2) notifying a law enforcement officer.

IV. Patient's Rights and Therapist's Duties

Patient's Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, l am not required to agree to a restriction you request.

Patient's Right to Receive Confidential Communication by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations (for example, you may not want a family member to know that you are seeing me). Upon your request, I will send bills and communications to an address you give me.

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Patient's Right to Inspect and Copy: You have the right to inspect, and/or obtain a copy of, PHI and psychotherapy notes in my mental health and billing records used to make decisions about you, for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have the decision reviewed. On your request, I will discuss with you the details of the request and the denial process.

Patient's Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Patient's Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss the details of the accounting process.

Therapist's Duties: I am required by law to maintain the privacy of PHI, and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide my clients with notice at the next scheduled session.

Patient's Right to a Paper Copy: You have the right to obtain a paper copy of notices from me upon request, if you have asked to not recieve them electronically.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice is in effect as of January 1, 2025

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice at the first scheduled treatment visit after any revisions occur.

Print Your Name: _____ Today's Date: _____

Client Signature: _____