CLIENT REGISTRATION & INFORMATION
ANGELA BACH, LPC
AMB LLC

Please complete prior to first appointment.

Name: _____

Address: _____

City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Preferred method of contact:_____Your Email:_____

Emergency Contact:_____Phone:_____Relationship: _____

Date of Birth:_____Age:____Gender:_____Pronoun:_____Education:_____

Occupation:_____Employer:_____

Who referred you? _____

Marital Status: ___Single ___Married ___Divorced: ___Widowed

Responsible Party:_____Relationship:_____

Please complete the following section if you wish to access insurance benefits for services.*

Primary Insurance Carrier: _____

ID#:_____Group#:_____

Subscriber Name:_____Date of Birth:_____

Subscriber Employer: _____

Secondary Insurance Carrier:_____

ID#:_____ Group#:_____

Subscriber Name:_____ Date of Birth:_____

Subscriber Employer: _____

**** Note: We will bill most insurance companies as a courtesy to you; however, the signed responsible party is ultimately responsible for payment of this account.***

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Medical History:

Primary Care Physician Name:_____Phone:_____

Last Visit:_____Reason:_____

Weight:_____Height:_____Medical Conditions:_____

_____

Allergies: _____

DO YOU WANT ME TO INFORM YOUR PRIMARY CARE DOCTOR THAT YOU ARE IN TREATMENT?
_____YES _____NO, I do not wish to have my doctor notified.

DO YOU WISH TO HAVE YOUR PSYCHIATRIST OR PSYCHIATRIC NURSE NOTIFIED THAT YOU ARE IN TREATMENT? _____YES _____NO

Psychiatrist Name:_____Phone:_____

Please list all prescribed and over the counter medications:

Medication	Dosage	Prescribing MD	Date Prescribed	Reason Prescribed

Have you been seen by a mental health professional in the past for assessment, testing, medication or counseling? If yes, please explain:_____

_____

Have you ever been hospitalized for medical or psychiatric reasons? Yes____ No ____
If yes, please provide the following information:

Date Facility Name &Location Reason

_____

_____

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Please check any of the following you have experienced:

____	Health Problems	____	Frequent Crying	____	Memory Difficulties
____	Trauma	____	Substance Abuse	____	Nightmares
____	Allergies	____	Weight Loss/Gain	____	Suicide Attempts
____	Head trauma	____	Problematic Anger	____	Drug/Alcohol Difficulties
____	Depression	____	Sexual Difficulties	____	Suicidal Thoughts
____	Headaches	____	Self-control difficulties	____	Self-Harming Behaviors
____	Relationship Distress	____	Low Motivation	____	Fatigue/low energy
____	Sleep (onset/maintenance)	____	Eating (anorexia/bulimia/binge)	____	Obsessive Thoughts/Behaviors
____	Sexual Abuse	____	Parenting Difficulties	____	Concentration/Focus Issues
____	Social Difficulties	____	Grief/loss	____	Sadness
____	Anxiety	____	Loneliness	____	General Stress
____	Psychosis (auditory/visual)	____	Employment/Career	____	Other: _____

Please check any of the following that have been present in the family (including extended family on mother and father's sides: Indicate with an 'M' for maternal side and 'P' for paternal side of family).

_____	Drug/Alcohol Abuse	_____	Learning/Developmental Disabilities	_____	Anger/violence
_____	Sexual Abuse	_____	Mental Illness	_____	Eating Disorders
_____	Physical Abuse	_____	Suicide	_____	Attention Deficit

_____ Other(explain): _____

Family History of Psychiatric, Substance Abuse, or Medical Concerns (i.e. Depression, Anxiety, Alcoholism, Drug Abuse, High BP, Diabetes, etc.):

Name Condition

_____

_____

Briefly state why you are seeking help at this time:

_____

_____

_____

Please estimate the severity of your current problem using the scale below:

Mild:_____ Moderate:_____ Severe:_____ Extremely Severe:_____ Incapacitating:_____

CLIENT REGISTRATION & INFORMATION
ANGELA BACH, LPC
AMB LLC
NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Angela Bach, LPC is required by law to maintain the privacy of protected health information. We are required to notify you of our legal duties and privacy practices with regard to protected health information. We are required to adhere to the terms of this notice. We will handle your protected health information only as allowed by the federal and state law according to the practice's policies, using the most rigorous law that protects your health information.

Each time you receive services from AMB, LLC, your provider makes a record of the visit. This record contains assessment information, diagnoses, and any changes in functioning, interventions, plans for future care or treatment, and billing-related information. You should be aware of the following rights concerning your protected health information.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of AMB, LLC you have the right to:

Inspect and Copy: You have the right to request to inspect and/or obtain a copy of your medical record. You must make the request via your provider or owner of AMB, LLC in writing. The right is not absolute. If access could cause harm, your request can be denied. If denied, you will be given a timely written notice that includes reason for denial. The notice will become part of your record.

Amend: You have the right to request an amendment of your medical record if you believe the information in the record is inaccurate or incomplete. You have the right to request an amendment for as long as the information is kept by or for AMB, LLC. The request must be made in writing to AMB, LLC. We reserve the right to deny your request for appropriate reasons and you will be provided a written explanation.

An Accounting of Disclosures: You have the right to request an accounting of disclosures. This pertains to disclosures we make of your health information for purposes other than treatment where an authorization was not required.

Request Restrictions: You have the right to request from your provider a restriction regarding the use or disclosure of your protected health information. Your request will be given serious consideration. You will be promptly informed as to whether we can honor the requested restriction while continuing to offer effective services, receive payment and maintain health care operations. We are not legally required to agree to your request. If we agree to do so, we are bound by agreement except under certain emergency situations.

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 work instead of our home. Creative Awakenings will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services and related

correspondence. We reserve the right to contact you by the 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.

A Paper Copy of this Notice: You have the right to a paper copy of this notice at any time upon request. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION RIGHTS

Upon signing AMB, LLC's consent form and financial agreement you are allowing us to see the disclosure and necessary information about you within the practice and with business associates in order to provide treatment/services, receive payments and conduct day to day health care operations. Some examples of this are listed below.

Fair Treatment: We may use and disclose health information about you via consultation with other providers in an effort to render the best possible services to you without providing any identifying information such as name, location, place of business, etc.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, the designated responsible party or a third party insurance payer. If applicable, we may also tell your health plan about treatment you are going to receive to determine whether your plan will cover services.

For Health Care Operations:

- In scheduling efforts
- Other professional staff within the office may view or handle your chart in the course of daily office operations. When disclosing information, primarily appointment scheduling and billing/collections efforts, we may leave messages on your answering machine/voicemail.

Emergencies: We may use or disclose necessary protected health information about you in an emergency situation. In the event that this occurs, we will notify you as soon as reasonably possible.

Specific Circumstances for Disclosures: Federal and state law allows AMB, LLC to disclose health information about you in the following specific circumstances:

- Help with public health and safety issues, preventing disease, reporting suspected abuse, neglect or domestic violence.
- Preventing or reducing a serious threat to anyone's health or safety
- Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests: For workers' compensation claims; For law enforcement purposes or with a law enforcement official; With health oversight agencies for activities authorized bylaw;

- For special government functions such as military, national security, and presidential protective services
- Respond to lawsuits and legal actions: We can share health information about you in response to a court order from a judge.
- We will never sell your information; use your information for marketing or fundraising.
- In most circumstances we will not share psychotherapy notes.

Substance Abuse Regulations: The use and disclosure of protected health information for substance abuse patients is subject to additional regulations under federal law. Some regulations may prohibit the uses and disclosures provided in this notice. If such a case occurs, adherence to the more restrictive regulation will apply.

Other Uses of Health Information: Other uses and disclosures of health information not covered by this notice or the laws that apply may be made only with your written permission. If you provide permission to disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain your records of the care provided to you.

Changes to Privacy Practices: We reserve the right to change this notice at any time.

For additional information concerning our Privacy Policy or the federal and state laws pertaining to our policy, please contact:

Angela Bach, LPC/AMB, LLC
3111 Northside Avenue, Suite 101
Richmond, VA23226
804-840-6176

Regional Advocate
Virginia Secretary of Health & Human Services
202 North 9th Street, Suite 622
Richmond, VA23219
804-786-7765

Secretary of Health and Human Services
Hubert Humphrey Building
2000 Independence Avenue, SW
Washington, DC 20201
202-690-7000

Your signature below indicates that you have received and read this privacy notice.

Signature_____Date:_____

CLIENT REGISTRATION & INFORMATION
ANGELA BACH, LPC
AMB LLC

Informed Consent for Treatment

I,_____, do voluntarily consent to the professional services provided by Angela Bach, LPC. I understand that therapy, like other healing arts, is not an exact science and no guarantees are made as a result of evaluation and service provision.

I understand that this process carries inherent risks to my sense of well-being, like everything in life, and that I may experience emotional discomfort or psychological pain as a part of the treatment and growth process. I recognize and accept that it my responsibility to communicate any such occurrences to Angela Bach, LPC, and I accept this as a reasonable risk.

In the event that I should ever feel the risks of the professional services provided outweighs the benefits, I will immediately bring this to the attention of Angela Bach, LPC. I understand that I can withdraw my consent at any time for any reason and that I can refuse any service that I wish for any or no reason.

I understand that information shared by me and material kept in my formal client file will remain confidential unless I give written permission for its release or there is a legal requirement for its release. Samples of such legal requirements include but are not limited to: 1) a strong indication of abuse or neglect to a child, elder, or dependent adult, 2) a strong indication that I am currently a danger to myself or others, 3) a strong indication that I have a sincere plan to harm myself or others in the immediate future.

I also understand that professional counselor ethics require that counselors not practice in isolation and that my counselor may consult with other professionals about my case. It is my understanding that identifying information about me will not be revealed and that such consultations shall occur in instances where my counselor feels it will benefit the work with me.

My signature given here indicates that I have read carefully and completely this informed consent. I understand each part completely and have no questions about any part at this time. I understand the nature and limits of the professional services offered, as well as the nature and limits of confidentiality, and I am in agreement with this document as it is written at this time. Should a question or concern arise, I agree to inquire about it in person as soon as I become aware of it and before the next service provision whenever possible.

- I am aware of scheduling policies; fees to be charged; policies regarding missed appointments; and if applicable, matters related to insurance.

- I acknowledge that I have been given the AMB, LLC Notice of Privacy Practices.

I have read and fully understand the above and give consent for treatment:

_____ _____
Signature Date

CLIENT REGISTRATION & INFORMATION
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AMB LLC

INFORMATION TECHNOLOGY POLICIES

Please read each of the following policies carefully. These policies exist to protect your personal information and to maintain appropriate professional therapeutic boundaries. They are informed by professional counseling ethics, Commonwealth of Virginia law, and my own understanding of best practices for my occupation.

Text Messaging Policy:
I use text messages in instances of arranging or confirming appointments with clients or when a client must alert me they are running late or have a scheduling issue. In such an instance, I will respond to acknowledge receipt and address the scheduling issue. It is my policy not to provide counseling or consultation to clients via text messaging. It is also mutually understood that texting is not a secure form of communication and privacy and confidentiality cannot be guaranteed.

By initialing here, you indicate that you understand my text messaging policy and agree to adhere to it as described _____

Telephone & Automated Voice Messaging Policy:
I could call you for a variety of professional reasons including 1) to provide an appointment reminder, 2) to provide a brief fifteen (15) minute phone consultation, 3) to return a phone call you have placed to me. Note that these are only sample reasons I may call, though any reason shall be professional in nature. In the event that I call you and you do not answer, I will leave a voice message if such a feature is available.

By initialing here, you agree to allow me to call and leave voice messages for professional reasons:_____

In the event that I call you and someone other than you answers the phone, I will ask to speak with you. If they ask who is calling, I shall provide my name but not my title or credentials. If they inquire about my reason for calling, I shall not provide a reason without your permission. It is best if you help me understand who could potentially answer and instruct me if I am to speak with this person or not. In any case, I will not reveal you are receiving services from me even with your consent to do so.

By initialing here, you agree to allow me to call and ask to speak with you for professional reasons:_____

Email Policy:
I am willing to correspond with you by email for limited purposes. Such emails shall be professional in nature and generally limited to 1) scheduling appointments, 2) providing supportive comments or feedback, 3) responding to specific administrative or consulting requests not of a psychotherapeutic nature. Note that there may be other professional purposes that may be suitable and these are samples.

It is also important to note that 1) I shall not provide professional counseling services by email. 2) emergencies shall not be addressed by email with the above noted exception of scheduling, 3) I shall not accept any forwarded emails from clients or any emails from clients not professional in nature including but not limited to chain letters, links to websites, or multiparty ad hoc discussion forums, 4) I do not wish to be carbon copied (cc) or blind carbon copied (bcc) on any email. In the event that you have an email, forward, or other piece of online information you wish to share with me, please bring it in person to our next appointment.

It is also mutually understood that emailing is not a secure form of communication and privacy and confidentiality cannot be guaranteed.

By initialing in the space provided, you indicate that you understand my email policy and agree to adhere to it as described _____

Social Media Policy:
I do not currently participate in social media services with clients (e.g., Facebook, Twitter, Google+, LinkedIn, and similar sites and services). Any requests to join such a network will be declined. Please understand that this is a matter of professional counseling boundaries and best practice and not a reflection on your desirability as a friend. Our professional relationship prohibits us from being friends, even in the social media sense of the term.

By initialing here, you indicate that you understand my social media policy and agree to adhere to it as described _____

My signature given here indicates that I have read carefully and completely the above polices. I understand them completely and have no questions at this time. Should a question arise, I agree to inquire about it in person before acting.

_____ _____
Signature Date

FINANCIAL AGREEMENT

Effective 5/1/23

Fee Schedule

Initial Individual Assessment(**90**minutes)	$210.00
Individual Psychotherapy(60 minutes)	$140.00
Couples Initial Assessment (120 min)	$375.00
Couples or Family Therapy(60 minutes)	$160.00
Couples or Family Therapy(90 minutes)	$240.00
Couples or Family Therapy(120 minutes)	$320.00
Sliding Scale Rate (as per agreement with therapist)	$_____
No Show/Late Cancel (less than 24 business hours):	full self-pay fee or negotiated insurance rate
Returned Check	$50.00
Telephone Therapy Session	$140.00/hour (not reimbursable by insurance)
Urgent Situations Only - Phone call for lasting more than10minutes	$35/quarter hour
Correspondence/Collateral Contacts	$35/quarter hour
Letters	$100.00
Medical Records sent	$100.00
Court Appearances/Legal Communication/Letters or Records request	$200.00/ hour

Please note, I only participate with Cigna and Optima insurances. This means I am "in network" for these policies only. A portion of charges are generally but not always reimbursed by insurance policies. Please note that some insurance companies require authorization for services prior to the initial session. Therefore, it is important for you to contact your insurance company to verify your benefits, determine any deductible and/or co-payment amounts that may apply and to obtain any required initial authorization for services. AMB, LLC will bill most insurance companies as a courtesy to you.

A minimum 24-business hours notice is required to change or cancel an appointment. If you do not cancel within that allotted time or miss your appointment you will be responsible for the full cost of the appointment. There will be a $50 charge on returned checks. These charges cannot be filed to insurance companies and therefore are your full responsibility. Payment must be received prior to scheduling another appointment.

Payment will be charged to your card on file within two weeks of your appointment for the portion of your bill not covered by insurance. If the insurance claim indicates a different co-pay, co-insurance or deductible than was charged, the difference will be either collected, kept as a credit on your account, or reimbursed to your card. Any charges not paid by your insurance company are your full responsibility. Telephone Therapy Sessions are NOT reimbursable by insurance. There will be a charge for contact that goes beyond 10 minutes between sessions.

I authorize Angela Bach, LPC to release to my mental health plan any information which it deems necessary to ensure prompt payment of all charges for services provided. I also assign the payment of all insurance in-network benefits directly to Angela Bach, LPC for any charges incurred in connection with services provided.

I have read and fully understand the above and accept treatment under these terms.

_____ _____

Signature Date

AMB, LLC
3111 Northside Ave, Ste. 101
Henrico, VA23228

Authorization for Recurring Credit Card Charges

In the interest of utilizing your appointment time to the fullest, I ask that you authorize charges to your credit or debit card for your therapy sessions. This will eliminate time spent during your appointment for monetary transactions. The charge will be made under the name **AMB, LLC**. You agree that no prior notification is necessary unless the amount billed each time exceeds **$300.00,** in which case you will receive notification in advance.

All billing information and questions should go to my Billing Manager, Wilson:
Email: wilsonaw1@protonmail.com
Phone: 804-263-7512

I authorize AMB, LLC (Angela Bach, LPC) to charge the credit/debit card provided for professional services and associated charges as agreed below. These charges may include:

- Co-pay and/or co-insurance for session
- Self-pay for session or payment for session not covered due to deductible
- Charge for cancellation without 24 hours' notice (see financial agreement)
- Other charges (see financial agreement)

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify this practice in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date.

Signature of Authorized Credit Card User:

_____
Printed Name

_____ Date:_____
Signature