Abigail Cobey, PsyD PLLC
2312 Mt Vernon Ave, #207
Alexandria, VA 22301
703-350-5908
DrAbby@protonmail.com

Date _____/_____/_____

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status: □ Never Married □ Domestic Partnership/Civil Union □ Married
□ Separated □ Divorced □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)
_____
(City) (State) (Zip)

Home Phone: ( ) _____ May we leave a message? □ Yes □ No

Cell/Other Phone: ( )_____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.
Emergency Contact Name: _____ Relationship to you? _____
Telephone Number _____

Referred by (if any): _____
May we contact them to thank them (Please provide contact information if yes)_____

EMPLOYMENT INFORMATION

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation: □ Full Time □ Part-time □ Unemployed
□ On Disability □ Minor/not employed

Employer Name _____

Employer Address _____

Job Title: _____

If Student: □ Full-time □ Part-time School/College _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. Have you previously received any type of mental health services (psychotherapy, psychiatric? services, etc.)?
□ No □ Yes Name of Therapist(s): _____

Have you ever been prescribed psychiatric medication? □ Yes □ No

Please list and provide dates: _____

_____

2. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____
_____

3. How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

4. How many times per week do you generally exercise? _____
What types of exercise do you participate in? _____

5. Please list any difficulties you experience with your appetite or eating patterns:

_____

6. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long? _____

7. Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? _____
11. Are you currently taking any prescription medication? □ Yes □ No

Please list: _____

What would you like to accomplish out of your time in therapy?

_____

_____

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OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

Confidentiality

In general, all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission. All aspects of your treatment are confidential, and I will need your written permission if you wish me to discuss your treatment with anyone else, including your insurance company. There are exceptions when disclosure is required.

WHEN DISCLOSURE IS REQUIRED: If there is reasonable suspicion of a child, elderly, or disabled adult being abused or neglected, I am required by law to make a report to the appropriate agency. I am also required by law to disclose information when a client presents a danger to self or to others. This may include seeking hospitalization for the client, contacting the police, notifying the potential victim, or contacting family members or others who can help provide protection. I will make every effort to fully discuss this with you before taking any action.

If there is an emergency during therapy and I am concerned about your well-being, I may disclose your health information by contacting the appropriate agencies and/or your emergency contact identified on the intake sheet. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony and/or formal mental health record if he or she determines that the issues demand it. I may occasionally find it helpful to engage in professional consultation with another professional regarding some aspect of a client's treatment. I consult regularly with other professionals about my clients. During consultation, I make every effort to avoid revealing any identifying information about my client. The consultant is also legally bound to keep the information confidential.
While this written summary of exceptions to confidentiality should prove helpful in informing you about potential issues, it is important that we discuss any questions or concerns you have. I will be happy to discuss these issues with you, but if you need formal legal advice please consult an attorney.

Psychotherapy

THE INITIAL CONSULTATION: The initial consultation (intake session) will last approximately 50 minutes but can extend to additional sessions. Typically, during the first session, we will discuss your reasons for seeking treatment and basic background information about you. Policies, fees, and scheduling will also be discussed in this meeting. To the extent possible, I will offer you some first impressions of what our work will include. You should evaluate this information along with your own opinions to determine whether you feel comfortable working with me. Therapy involves a noteworthy commitment of time, money, and energy. You should be very thoughtful about the therapist you select. If you have questions or doubts about participating in therapy at the present

time or specifically with me as your therapist, please talk to me about your concerns. I will be more than happy to help you set up a meeting with another mental health professional for a second opinion.

Psychotherapy can have benefits and risks. Therapy often involves discussing unpleasant aspects of your life. You may experience considerable discomfort and strong feelings of anger, sadness, worry, depression, anxiety, guilt, anger, loneliness, helplessness, and trouble sleeping. On the other hand, psychotherapy may help you change your unhealthy or maladaptive thoughts and behaviors. You may benefit from participating in therapy by minimizing your overall distress, learning more effective problem-solving strategies, improving interpersonal relationships, and resolving the specific concerns that led you to seek therapy. Therapy requires your effort and active involvement, honesty, and openness to change unhealthy thoughts, feelings, and/or behaviors. I will ask for your feedback on your therapy and progress during sessions. Attempting to resolve issues that brought you to therapy may also result in changes that were not originally intended. Sometimes a decision that is positive for one family member is viewed negatively by another family member.
Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

I do not provide custody evaluation recommendations, medication recommendations, or legal advice, as these activities fall outside of my scope of practice.

THERAPY SESSIONS: Frequency of therapy sessions will be determined by the severity of your presenting symptoms, your treatment goals, and agreed upon treatment plan. Therapy sessions are generally scheduled once a week and may be reduced in frequency as you progress in treatment. A given hour is considered blocked for a particular client; this hour is comprised of 45 to 50 minutes of psychotherapy and 10 to 15 minutes of administrative procedures (e.g., note-taking, phone calls, insurance claim submissions). Therapy sessions may be longer in duration depending on the services provided (for instance, trauma-focused therapy sessions are generally 60-90 minutes).

Fees
PSYCHOTHERAPY: Fees for a 50 minute intake session for psychotherapy is $250. Fees for follow-up psychotherapy sessions are $250 per 50 minute session. If you require a therapy session that is a different length of time than the standard 50-minute appointment, the session fee will be prorated at $250 per hour and will be discussed with you prior to or at the beginning of the appointment.

OTHER PROFESSIONAL SERVICES: In addition to weekly appointments, I charge the same hourly rate for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services may include report writing, telephone conversations lasting longer than a few minutes, consulting with other professionals (with your permission), preparation of records or treatment summaries, and the time spent performing any other service you may request of me. Typically, the charge for a letter is $50 due at time of request and the charge for a clinical report is $200 due at time of request. Photocopying of records is $35. Fees may increase periodically.

Cancellation Policy, Late Arrivals, & Inclement Weather
CANCELLATION POLICY: Once an appointment hour is scheduled you will be expected to pay for it unless you provide **48 hours advance notice** of cancellation. **Note that this fee is the out-of-pocket cost of the session and not your copay amount. Insurance companies will not reimburse for missed appointments.** This includes initial consultations, diagnostic interviews,

psychotherapy sessions, and any other session requiring a one hour block of time.

LATENESS: If you arrive late for a scheduled appointment, only the remainder of the 45 to 50 minute session will be available. If I run late with a prior appointment for some reason, you will still receive the full 45 to 50 minutes. It is the office policy, that if you arrive 15 minutes late to your scheduled appointment, without notice, it will be considered a no-show and you will be responsible for the missed appointment fee.

INCLEMENT WEATHER AND CLOSURES: If there is inclement weather and/or if local schools are closed due to weather conditions, I will do my best to contact you via phone or email if I will not be in the office and may need to reschedule the appointment.

Telemedicine

There are some instances when psychotherapy sessions are conducted using telemedicine. Telemedicine services as defined by the state of Virginia pertains to the delivery of health care using electronic technology or media, including interactive audio and video, to diagnose and treat a patient. Telemedicine services does not include audio-only telephone, email messages, and faxes.

There are some situations and client presentations that are not appropriate for the utilization of telemedicine services as a component of, or in lieu of, in-person psychotherapy sessions. Some examples of instances when I will not conduct psychotherapy using telemedicine are when the client presents as a safety risk to themselves or others, acute crises, and severe psychological disturbances, such as schizophrenia, dissociation, bipolar disorder, or some personality disorders as it potentially limits my ability to provide the necessary standard of care. I am responsible for making the determination when telemedicine is not appropriate for psychotherapy sessions, and in doing so, must adhere to applicable laws and standards of care. If at any point I determine telemedicine is no longer effective helping you achieve your therapeutic goals, I am obligated to discuss it with you and, if appropriate, to require in-person sessions or to terminate treatment. Clients are expected to provide me with their current address and phone number, as well as a name, address, and phone number for an emergency contact person at the start of each psychotherapy session via telemedicine. According to Virginia law, I am only able to provide telemedicine services to clients physically located in the state of Virginia. I do not provide initial consultations and psychological evaluations using telemedicine services.

There is a risk of exposure of your personal health information with any electronic or technology-based communication. While I take measures to protect your information when using telemedicine services, such as using HIPAA compliant programs, password protecting program accounts, and password protecting computer and mobile screens, I cannot prevent or predict unauthorized access and I cannot be held responsible if there is a breach in the system. There is also the possibility that a session is interrupted due to a failure in the technology. I will do everything possible to restore the connection with you if your appointment is interrupted. This is, however, out of my control and I cannot be held responsible for any technology failure. If feasible, I will attempt to reschedule the appointment with you if a technology failure results in you missing more than half of the allotted appointment time. Telemedicine appointments are submitted to insurance for reimbursement using the same guidelines noted in the “Insurance” section below.

Insurance

Most health insurance plans provide for some outpatient mental health benefits. I am out-of-network for insurance providers. Depending on your coverage, you may receive full or partial reimbursement according to guidelines they have established for out-of-network providers. I will

fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, **you (not the insurance company) are responsible for full payment of the fees.** It is very important that you find out exactly what mental health services your insurance policy covers; Abigail Cobey PsyD PLLC does not determine coverage for you. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administration.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I must provide additional clinical information, such as treatment plans or summaries, or copies of the entire record (in rare cases) in order to process claims. This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with the information. I will provide you with a copy of any report I submit, if you request it. It is important to remember that you always have the right to pay for services yourself to avoid problems described above.

Billing and Payments

PAYMENTS: Payment is due at the time of service, unless we agree otherwise. Cash, check, bank transfer or credit cards are acceptable forms of payment. Payment schedules for other professional services will be agreed to when they are requested. A credit card is required to be kept on file to hold all scheduled appointment times. Missed sessions cancelled with less than 48 hours notice will be charged to the credit card on file.

CREDIT CARD AUTHORIZATION: Your signature authorizes Abigail Cobey PsyD PLLC to charge your credit card for late cancellations, missed appointments, and outstanding balances (over 60 days):

Payment method: MASTERCARD VISA AMERICAN EXPRESS DISCOVER

Credit Card Number _____

Print name as it appears on credit card _____

Zip code_____ Security code_____Expiration date _____/_____

Email address for receipts _____

Authorization signature _____ Date_____

By signing this agreement, you are confirming that you understand that it is your responsibility for full payment of our fees. Further you understand that we may submit your claims to your insurance company(ies), if applicable, for direct payment to Abigail Cobey PsyD PLLC and that if your insurance company does not cover 100% of your bills for services provided that it is your responsibility for full payment of our fees, not your insurance company's. Further, you confirm that you understand that it is your responsibility to:

- pay, at the time services are rendered, the agreed upon session fee, co-pay, co-insurance, deductible, or any other fees relating to services rendered that are denied or not fully covered by your insurance company(ies);

- provide current mailing address and phone numbers, as well as notification when there are any changes to this information.
- confirm with your insurance company that I am a participating provider under your specific insurance plan;
- provide appropriate and current insurance information and updates to ensure efficient billing and payment;
- obtain all necessary referrals or authorizations required prior to treatment

ASSIGNMENT OF BENEFITS: By signing this agreement, you authorize payment of all medical insurance benefits, which are payable under the terms of your insurance policy to be paid directly to Abigail Cobey PsyD PLLC for services rendered. You further authorize the release of any information needed for the purposes of treatment, payment and health care operations, including, but not limited to the processing of these insurance claims. A copy of this authorization may be used in place of the original. **You understand that you are financially responsible for charges not paid by your insurance company.**

DELINQUENT ACCOUNTS AND COLLECTIONS: You are responsible for payment of your therapy and testing fees, regardless of whether or not they are covered by your insurance carrier. **Outstanding balances of more than 60 days will be charged to the credit card on file.** If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency, and this could affect your credit. You agree to the costs of any action necessary to collect your portion of the fee due, including court and attorney fees that might accrue. You will receive appropriate notice of efforts to obtain this debt. There will be a $30 charge for the return of a check from the bank.

Contacting Me & Emergencies For non-urgent matters or for scheduling issues, please contact me by telephone, text or by email. Because this is a limited private practice, I am often not immediately available by telephone. When I am unavailable, please leave a message on my voicemail. Please note that email and text are not a secure, confidential form of communication and should not be used for discussion of clinical issues or for urgent communications. I monitor my voicemail and email regularly during the day on weekdays. I do not monitor my voicemail and email on weekends and holidays. I will make every effort to return your call or email within 24 hours, with the exception of weekends and holidays. If I will be unavailable for an extended time, such as for a scheduled vacation, I will provide you with the name of a colleague to contact if necessary

EMERGENCIES: In the event of a psychiatric emergency, and you are unable to reach me, please call a local Mental Health Hotline or CALL 911 or go to the nearest Emergency Room of your nearest hospital and ask to be evaluated by the psychologist or psychiatrist on call. Mental Health Hotline numbers include 703-573-5679 (Fairfax County), 703-746-3401 (City of Alexandria), 703-228-5160 (Arlington County) 202-673-9300 (Washington, DC), and 1-800-273-8255 (National Suicide Prevention Lifeline). Please do not use email for an emergency.

E–MAILS, CELL PHONES, TEXTS, COMPUTERS, AND FAXES: It is very important to be aware that computers, unencrypted emails, and e-fax communications can be rather easily accessed by unauthorized people and, hence, can compromise the privacy and confidentiality of such communications. Emails and e-faxes in particular are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all emails and e-faxes that go through them. While I take measures to protect your information when communicating via email and e-fax, such as using HIPAA compliant services and password

protecting e-mail accounts and computers, I cannot predict or prevent unauthorized access. It is always a possibility that e-faxes and emails are sent erroneously to the wrong address and computers. Please notify me if you decide to avoid or limit in any way the use of email, cell phone calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted emails, e-faxes, or phone messages, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and I will honor your desire to communicate on such matters. Please do not use emails, voice mails, or faxes for emergencies. I do not communicate with clients via text message except for scheduling.

Forensic and Litigative Services
It is the stated philosophy of this practice that I do not participate in lawsuits of any type on a plaintiff's behalf, unless compelled to do so by subpoena or court order. Client's should be aware that disclosures of information obtained during psychological treatment can result in negative consequences in legal matters. If you or the opposing attorney are considering requesting a disclosure of records or my testimony, I will do my best to discuss with you the risks and benefits of doing so.

RELATED FEES: If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation, deposition, telephone time, transportation costs, court appearance, report writing, consultation and supervision, even if I am called to testify by another party. Because of the complexity of legal involvement, any court appearance or telephone contact with the court during a court case regarding the client or the client's family members in a civil or criminal matter will be charged at $2500 per day, paid two weeks in advance and non-refundable. Travel time will be billed at an hourly rate of $250 per hour, plus mileage portal to portal. Depositions will be charged at $250 per hour plus travel time, wait time, and transportation costs portal to portal. In the events that records or other materials are subpoenaed, a charge of 50 cents per page will be made for copying and file preparation.

Professional Records
The laws and standards of my profession require that I keep treatment records. Please note that clinically relevant information from emails, voicemails, and faxes are part of the clinical records. Unless otherwise agreed to be necessary, I will retain clinical records only as long as is mandated by Virginia state law. If you have concerns regarding your treatment records, please discuss them with me. As a client, you have the right to review your records at any time, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful in any way. In such a case, I will provide the records to an appropriate and legitimate mental health professional of your choice. Alternatively, I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted by and/or upsetting to untrained readers. If you wish to see your records, I recommend you review them in my presence so that we can discuss the contents. Clients will be charged a fee for any professional time spent responding to information requests.

Ending Therapy
My goal is to provide a quality service in the shortest amount of time that is necessary for you to derive benefit from the therapy. As stated above, after the first couple of meetings, I will assess if I can be of benefit to you. I do not work with clients who, in my opinion, I cannot help. In such a case, if appropriate, I will give you referrals that you can contact. If at any point during psychotherapy I either assesses that I am not effective in helping you reach your therapeutic goals or perceive you as non-compliant or non-responsive, and if you are available and/or it is possible and appropriate

to do, I will discuss with you the termination of treatment and conduct pre-termination counseling. In such a case, if appropriate and/or necessary, I will give you a couple of referrals that may be of help to you. You have the right to withdraw from treatment for any reason at any time. I ask that you agree to have a final session after you notify me of your voluntary termination of treatment so that I may responsibly review and evaluate your reasons and make recommendations related to the termination of treatment.

Severability
If any of the provisions of the Agreement shall be held to be invalid or unenforceable, all other provisions shall nevertheless continue in full force and effect. The Agreement shall be interpreted in accordance with and controlled by the laws of the State of Virginia in effect at the time of the execution of this Agreement.

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT:
_____ (Initial) I HAVE REVIEWED AND BEEN PROVIDED A COPY OF THE HIPAA NOTICE OF PRIVACY PRACTICES. I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS ABOUT THESE POLICIES, AND I UNDERSTAND THAT I MAY ASK QUESTIONS ABOUT THEM AT ANY TIME IN THE FUTURE. I CONSENT TO ACCEPT THESE POLICIES AS A CONDITION OF RECEIVING MENTAL HEALTH SERVICES.

INFORMED CONSENT TO TREATMENT:
I HAVE READ, UNDERSTOOD, AND HAD OPPORTUNITY TO QUESTION, AND I AGREE TO THE ABOVE CONDITIONS AND POLICIES. I AGREE AND CONSENT TO PARTICIPATE IN BEHAVIORAL HEALTH CARE SERVICES OFFERED AND PROVIDED AT ABIGAIL COBEY PSYD PLLC. I ALSO PERMIT THE USE OF A COPY OF THIS SIGNED AUTHORIZATION IN PLACE OF THE ORIGINAL.

Signature of Client _____

Print Name of Client _____

Date Signed _____