**McLean Psychiatric Services LLC**
1307 Dolley Madison Blvd, Suite #3C
McLean, VA 22101
Phone: (703) 336-2406  Fax: (703) 646-7584

## Office Policies

Appointments and Payment: I understand that all services are provided by appointment only. I understand that McLean Psychiatric Services LLC does not participate in commercial insurance plans and payment is due at the time of service. Upon my request, Dr. Kim can provide a superbill receipt to me which I can use to file an out-of-network claim to my insurance company to obtain reimbursement for Dr. Kim's services.

**I attest that I DO NOT have Medicare or Medicaid and I will inform Dr. Kim if I obtain either Medicare or Medicaid:**

Appointment times held for me are not available for other patients. If I no-show to or do not cancel within 24 hours of my appointment, I understand that I will be charged Dr. Kim's FULL FEE for the missed appointment.

If I repeatedly no-show, cancel my appointments, or am non-compliant, then I understand that I may risk being discharged from the practice. I understand that in order to remain an active patient at the practice and receive appropriate monitoring of my treatment, I need to make and attend scheduled appointments.

Confidentiality: I acknowledge that I have received a copy of this practice's privacy policy. I understand that the practice respects the privacy of my medical information in accordance with federal and state law. I understand the major exceptions to patient confidentiality, as outlined in the HIPAA privacy practices document, which include but are not limited to cases where a patient may be at risk to harming themselves, or in cases of child or elder abuse.

Prescriptions: I understand that McLean Psychiatric Services and electronic medical record system may get data regarding my medication history from pharmacies and data regarding controlled substance prescriptions that may be held by the Virginia Prescription Monitoring Program.

Refills are generally provided during appointments. If refills are needed between appointments, medications will be sent to the pharmacy within 2 business days of my request to allow for enough supplies until the next appointment. Lost controlled substance prescriptions will not be replaced. I understand that I should call the office directly to request refills and Dr. Kim does not do refill requests faxed by pharmacies.

Forms: I understand that forms and letters (e.g. for disability, school/work) brought to Dr. Kim will be charged according to the time involved per Dr. Kim's average hourly rate and will be given an estimate of this fee prior to being charged. Dr. Kim does not provide any forensic or court-related documentation.

Communication: Dr. Kim has an electronic medical record system that allows patients to send messages and documents securely. It is recommended that you use this system. However, if I wish to communicate with Dr. Kim via email or text, then I understand that should limit the disclosure of personal health information or for urgent matters.

**I wish to communicate with Dr. Kim via: Text:** ☐ **Email:** ☐ **OR Neither:** ☐

I understand that I can call the office at 703-336- 2406 to schedule appointments or discuss administrative or clinical matters. Dr. Kim or his staff generally return calls within 1 business day. If I am experiencing an emergency, or cannot wait for a return phone call, I should go directly to the emergency room or call 911.

**I have read the above policies and my signature below indicates my consent to all of the policies above.**

**Patient's (or Parent/Guardian's) Signature:**

**Patient's (or Parent/Guardian's) Signature Date:**

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## Notice of HIPAA Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. If you have any questions, please call (703) 336-2406.

How we may use and disclose your health information: Except for the purposes below, we will use and disclose your health information only with your written permission. You may revoke this permission at any time by written notice.

Treatment: We may use and disclose your health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your health information to doctors, nurses, technicians, personnel or other mental health professionals, including people outside our office, who need the information to provide you with treatment.

Payment: We may use and disclose your health information for any billing purposes.

Health Care Operations: We may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with other health care entities that have operations pertaining to you.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services: We may use and disclose your health information to contact you and remind you of your appointments, to tell you about treatment alternatives, or health-related benefits and services that you could use.

Individuals Involved in Your Care or Payment for Your Care: When appropriate, we may disclose your health information with a person involved in your medical care, or who helps pay for your care (such as a family member or a close friend). 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 or location.

Research: We may use and disclose your health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we do so, the project needs to go through a special approval process. Even without special approval, we may permit researchers to look at records to help identify patients who may be included in their research, as long as they do not remove or copy any of your health information.

As Required by Law: We will disclose your health information when required to do so by law, for example, in cases of suspected child or elder abuse or neglect.

To Avert a Serious Threat to Health or Safety: We may use and disclose your health information when necessary to avert a serious threat to the health and safety of you, another person, or the public. Disclosures will be made to someone or an agency reasonably able to prevent or lessen the threat.

Business Associates: We may disclose your health information to our business associates that perform functions on our behalf or provide us with services if necessary, i.e. billing or answering services. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose then what appears in their agreement with us.

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Military and Veterans: If you are a member of the armed forces, we may release your health information as required by military command authorities. If you are a member of a foreign military we may release your health information to the foreign military command authority.

Worker's Compensation: We may release your health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose your health information for public health activities to prevent or control disease, injury, or disability. We may use your health information in reporting births or deaths, suspected child or elder abuse or neglect, medication reactions or product malfunctions or injuries, and product recall notifications. We may use your health information to notify someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may disclose your health information to a health oversight agency for activities authorized by law. These may include audits, investigations, inspections, and licensure. These activities are necessary for monitoring the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order. We may disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. When possible, we will make efforts to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release your health information to law enforcement officials for purposes, which include but are not limited to: (1) a court order, subpoena, warrant, summons or similar process; (2) a request for information needed to identify or locate a person of interest, such as a suspect, fugitive, material witness, or missing person; (3) a request for information about the victim of a crime; (4) a request for information about a death that may be the result of criminal conduct; (5) a request for information relevant to criminal conduct on our premises; and (6) a request for information needed in an emergency to report a circumstances relating to a crime.

Coroners, Medical Examiners, and Funeral Directors: We may release your health information to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence and other national security activities authorized by law.

Inmates or Individuals in Custody: If you are an inmate of a correctional institution or in custody, we may disclose your information (1) for the institution to provide you with health care; (2) to protect your health and safety or that of others; and (3) for the safety and security of the institution.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy: You have the right to inspect and copy your medical and billing records by written request. We may deny your request to inspect and copy your records in certain circumstances. We will notify you of the reason for denial and you will be provided with your options as defined in the HIPAA Privacy Rule.

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Right to Amend: You have the right to request an amendment to your records by written request. We may deny your request for an amendment and will notify you of the reason for denial and you will be provided with your options as defined in the HIPAA Privacy Rule.

Right to an Accounting of Disclosures: You have a right to request an accounting of disclosures we make of your medical information by written request.

Right to Request Restrictions: You have the right to request restrictions or limitations on the disclosure of your health information used for treatment, payment, or health care operations. You may also request to limit disclosures to someone involved in your care or in payment for your care (such as a spouse) by written request. We are not required to agree with these requests, but we will try to comply.

Right to Request Confidential Communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. Your written request must specify how or where you wish to be contacted and be addressed. It is important to note that we reserve 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. We will accommodate reasonable requests.

CHANGES TO THIS NOTICE

We may change this notice and make it effective for medical information we already have about you as well as new information. You have a right to request a paper copy of the current notice.

**I attest that I was provided the NOTICE OF PRIVACY POLICIES of McLean Psychiatric Services LLC and my signature below indicates my consent to all of the policies above.**

**Signature of Patient / Parent / Guardian:**

**Date of Signature:**

# Adolescent Intake Questionnaire

## Patient Information Form

1. Patient's First Name: Middle Name: Last Name: Date of Birth:

Gender:
○ Male ○ Female

Name of parent(s) and phone numbers:

Street Address: Apt./Unit #: City: State: Zip Code:

Home Phone: Patient's Phone:

2. Emergency Contact Name: Phone No: Relationship:

3. **Medical Problems:**

4. **Current Medications and Dosages:**

| | Medications: | Dosages: | Frequency: | Reason for Use: |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |

5. **Allergies**

| | Allergies: |
|---|---|
| 1 | |
| 2 | |
| 3 | |

6. Pharmacy Name: Phone:

Primary Care Doctor: Phone:

Therapist: Phone:

7. What concerns bring you to the practice?

8. How were you referred to us?

## Past Psychiatric History

9.

| | Dates of Treatment: |
|---|---|
| 1 | |
| 2 | |
| 3 | |

10.

| | Previous Psychiatrist/Therapist: |
|---|---|
| 1 | |
| 2 | |
| 3 | |

11.

| | Hospitalizations: | Date: |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |

12.

| | Date of Suicide Attempts: |
|---|---|
| 1 | |
| 2 | |
| 3 | |

13. Patient substance abuse history (alcohol, drugs):

14. Family History of Psychiatric Illness, Substance Abuse, Suicides:

15. Family History of Medical Illness:

16. Patient's Siblings:

| | Name: | Age: |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |

17. Educational Level:

18. Any other information that you would like Dr. Kim to know to help you: