Brian W. Towers LMFT,

CENTER FOR FAMILY COUNSELING

Welcome Letter

Welcome to the Center for Family Counseling. Enclosed in the packet you will find a General Information Form (one for each person attending counseling), a Billing and Treatment Agreement, and directions to the office. Please review and complete this information and bring it with you to your first session.

Whether you have attended counseling before or if this is your first time, you will find my style to be relaxed and conversational. However, this does not mean that therapy will not be challenging at times. Often we desire changes in our lives or relationships but discover that change can be difficult to achieve and maintain. In therapy we will work together to establish goals and create a “roadmap” to achieve your desired goals.

I use various methods and techniques during therapy that are primarily grounded in systems and cognitive-behavioral theories. These theories recognize the importance of families, their interactions, and your understanding of the events in your life. However, it is important to understand that the effort made by the families, couples, or individuals attending therapy will have an important impact on the overall success of the therapeutic process.

I am sometimes away on vacation, seminars, or training and will make every effort to inform you of these absences in advance. I can be reached via voicemail at (540) 361-1556 ext. 3 or by e-mail at brian@centerforfamilycounseling.com.

I look forward to working with you to help achieve the desired changes in your life.

Best regards,

Brian W. Towers, LMFT
License: 0717001213

307 Lafayette Blvd.
Ste 202
Fredericksburg, VA 22401

(540) 361-1556 ext. 703 Main
(540) 840-4278 Direct
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GENERAL INFORMATION FORM

Primary Patient Name: *(Last, First, M.I.):*	☐ M ☐ F	**DOB:** / /
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Main Patient Contact #: ( ) -	**Email:**	
Spouse/Parents Name: *(Last, First, M.I.):*	**Court Ordered?** ☐ **Y** ☐ **N**	
Secondary Contact #: ( ) -	**Email:**	
Mailing Address:	**City:**	**State:** **Zip:**
Additional Contacts: *(Last, First, M.I.):*	**Referred by:**	
Preferred contact preference:	Permission to send 24hr reminder notice? ☐ Y ☐ N	

INSURANCE

PLEASE COMPLETE ALL INSURANCE INFORMATION FOR ELECTRONIC SUBMISSION

Name of Insurance Company:	**Insurance Claims Mailing Address:**	
Primary Insured	**Full Name:**	
	Insurance ID or DOD #(Tricare):	**Group:**
	Relationship to Patient: ☐ Spouse ☐ Parent ☐ Legal Guardian	**DOB:** / /
		Effective Date: / /

Is this Medicare or Medicaid policy?	☐ **Yes**	☐ **No**
Do you have secondary insurance?	☐ **Yes**	☐ **No**
If yes, Insurance name and policy #:		
Annual Deductible: $ **Amount paid to date:**	$	
Do you agree to paying co-pay if in network or full payment if not in network at time of service	☐ **Yes**	☐ **No**

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FAMILY/LIVING COMPAINIONS		
List any children or family members currently residing with		
Name	Age	Relationship to you

HEALTH HABITS AND PERSONAL SAFETY						
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

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MENTAL HEALTH		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No
What would you like to accomplish short term & long term?		
Have you been hospitalized for mental health issues?	☐ Yes	☐ No
If yes, most recent date and facility name:		

CURRENT SYMPTOMS OR CONCERNS		
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.		
☐ Depression	☐ Sleep Issues	☐ Recent changes in:
☐ Anxiety	☐ Self-Harm	☐ Weight Changes
☐ Racing Thoughts	☐ Homicidal Thoughts	☐ Energy level
☐ Suicidal Thoughts	☐ Substance Abuse	☐ Ability to sleep
☐ Abuse/Trauma	☐ Pain	☐ Medication Changes:
☐ PTSD	☐ Overwhelmed	

COURT CASES ONLY		
Are you currently involved in a court matter pertaining to the therapeutic services being received?	☐ Yes	☐ No
Current Law Firm or Lawyer _____ Contact # ( ) -		
Do you expect to have me appear as an expert witness regarding your case?	☐ Yes	☐ No
Last Court Date ___/___/___ Pending or Future Court Date: ___/___/____		
Is there a GAL (Guardian at Litume) assigned to your case?	☐ Yes	☐ No
Current GAL _____ Contact # ( ) -		
Are you willing to sign a release of information regarding information pertaining to your case with the attorney on file?	☐ Yes	☐ No
Date of Release ___/____/_____ Release on file?	☐ Yes	☐ No
I understand if this is a court case, I will be required to sign an additional court agreement?	☐ Yes	☐ No

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Billing and Treatment Agreement

(To be filled out by the person responsible for treatment and billing)

I understand that therapy sessions are 50 minutes in duration, and that the Center for Family Counseling charges **$110 per session**. I also understand that a $25 fee will be charged for missed appointments or cancellations made less than 24 hours in advance of my appointment. If a second appointment is missed (no notice given), I understand the full rate will be charged. I also understand the same applies for a third appointment within 24 month and potential for termination. Payment, to include any co-pay or deductible is expected at each visit unless prior arrangements have been made. In the event a collection agency is retained to collect outstanding balance on my account, I agree that I will be responsible for any and all collection fees and court costs.

Initial_____

I understand that if **Mr. Towers does not participate in my insurance plan,** I am personally responsible for the agreed-upon fees for treatment, which may not be reimbursable through my insurance company. If I choose to seek out-of-network reimbursement from my insurance company, I understand that It is my responsibility to contact my insurance to obtain carrier's specific policies. If Mr. Towers is not an in-network provider for my insurance company, I am aware I am entitled to obtain a Superbill to submit to my insurance company for direct reimbursement. I understand out of network insurance can be electronically submitted on my behalf at my request with any and all reimbursements sent directly to me from my insurance carrier.

Initial_____

I understand that confidentiality means that what is discussed within our therapy session will not be revealed without my **written and express** permission. However, I understand that therapists in the Commonwealth of Virginia are mandated reporters in the following cases:

- If I am a danger to myself or others
- If there is evidence of child abuse, elder abuse, or anyone else who is otherwise mentally incapacitated

I further understand that in certain cases that the Commonwealth of Virginia or its agents can subpoena private health records to be submitted to the courts.

Initial_____

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I understand that I have the right to ask any questions about my treatment and may end my treatment at any time. However, I agree to make every effort to discuss my concerns about my progress or treatment before terminating therapy. I further understand that information in my treatment file is considered private health information and is subject to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I understand that I can request a copy of the act to review in the office or that I can download information on the Internet from http://www.hhs.gov/ocr/hipaa/ if I have questions about my private health information.

Initial_____

If I am consenting to the treatment of a minor, I understand that the therapist must tell me if my child is in danger, but to facilitate trust and a good, working therapeutic relationship, the therapist will give my child(ren) the same confidentiality afforded to others. The therapist will work with my child to share information that would be important to my child's healing or welfare. However, if I desire more than generalized information, I understand that I may need to seek out another therapist for my child.

If for minor child(ren), please list names, gender, and ages below:

Childs Name	Gender	Age	Initials
_____	_____	___	_____
_____	_____	___	_____

I have read and agreed with the above and agree to enter into therapy or have my child(ren) enter into therapy with Brian W. Towers LMFT LLC at Center for Family Counseling.

Signed: _____ Date: _____

Printed Name: _____
(Adult, parent, or legal guardian)

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Payment Arrangements

(To be filled out by the person responsible for payment)

Please indicate in the space below which method you would **typically** like to make payment for therapeutic services:

☐ Cash (please bring exact change, if possible)
☐ Check (please make out to **Brian W. Towers, LMFT LLC**)
☐ Credit Card (please complete the section below) If you choose to keep a credit card on file this information is uploaded in our system and we will shred the paper copy completed.

Brian W. Towers LMFT LLC with the Center for Family Counseling

Credit / Debit Card Authorization Form

This will authorize the Brian W. Towers LMFT LLC with the Center for Family Counseling, hereinafter called "CFC," to initiate credit entries and adjustments for any credit entries in error, if necessary, to the credit or debit card below for the amount listed below. This authorization will remain in effect until either services are terminated with CFC or until CFC receives written notice requesting a change.

This activity will authorize the credit card company indicated below to credit and or debit the same credit or debit card account.

BILLING INFORMATION		
VISA ○	Member Name (Print):	Expiration Date: ___ ___ / ___ ___
MasterCard ○	Card Number: __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __	
CVV Code:	Member Street Name:	Member Zip Code:
Signature & Date:		

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Directions to the Center for Family Counseling

307 Lafayette Blvd., Suite 202 Fredericksburg, VA 22401

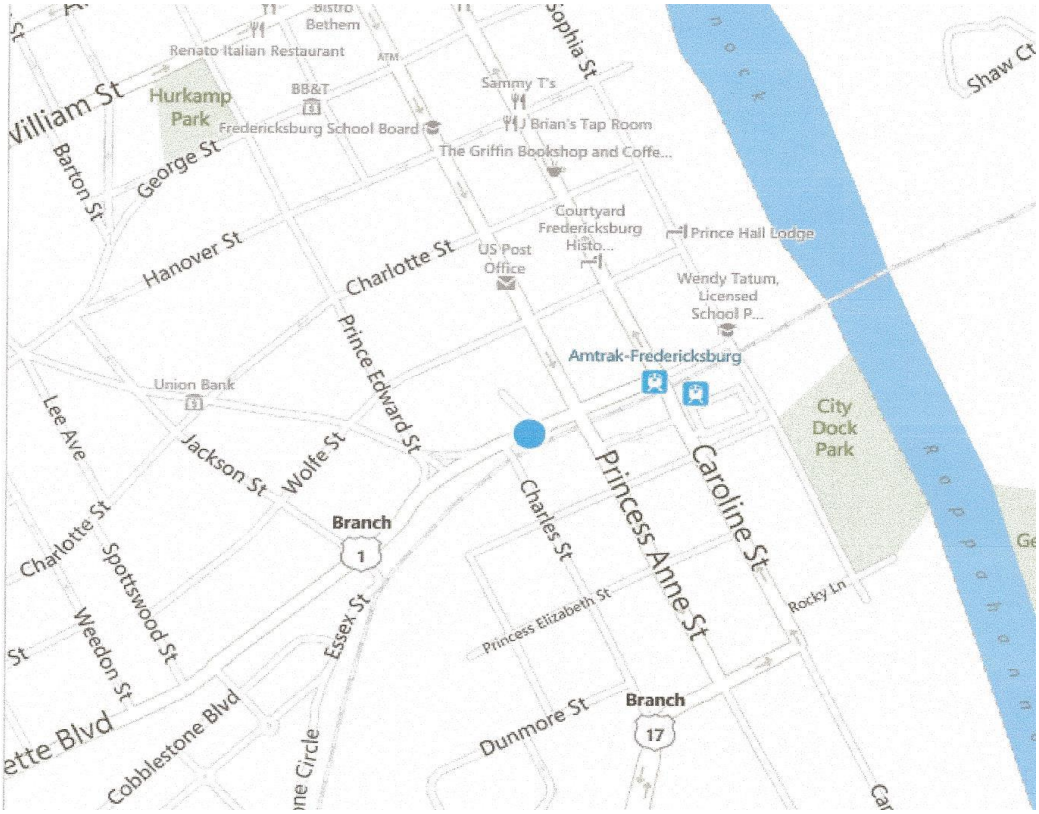
From Route 3:

- Eastbound Route 3 – turn left on William Street; Westbound Route 3 – turn right on William Street
- Make last right onto Lafayette Blvd/US-1-BR
- 307 Lafayette Boulevard is on the right.
- The Center for Family Counseling can be found in suite 202

From Route 1/Rt. 3:

- From VA-Rt. 3/Blue & Grey Pkwy
- Take US-1/Lafayette Blvd.
- Approximately 1.1 miles 307 Lafayette Blvd. is on the left
- The Center for Family Counseling can be found on the Second Floor

Limited parking can be found by the building. Street parking can be found all along Wolfe Street and Princess Anne Street. There is a parking garage at Wolfe Street and Caroline Street (pay).



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