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CHILDREN'S MEDICAL ASSOCIATES
OF NORTHERN VIRGINIA, P.C.

Partnership Pledge

Thank you for choosing the Mental Health Program at Children's Medical Associates of Northern Virginia, P.C. Participating in care within our Mental Health Service Line involves your entire family and our team. Your child's success is important to us and is greatly dependent on everyone's commitment to respectful interactions, as well as consistent attendance, and family participation.

With your collaboration, your child's CMA Mental Health Team will define a treatment plan that will include the kind of treatment and the frequency of visits. Effective communication is a critical part of this process and depends on respectful interactions and a safe environment. All children we see benefit from seeing adults model for them how to use respectful language and tone.

In order to maximize the benefits of therapy, it is very important that all scheduled appointments be attended. The consistency of attending therapy sessions assures that your child will obtain maximum treatment benefit, and assist in meeting your goals. A missed or late appointment disrupts therapy schedules that impact both you and other patients who are waiting for care.

The following guidelines help us provide safe, quality care for your child.

By reading and signing this form you agree to our family attendance and communication expectations.

Attendance

- Arrive on time to scheduled appointments
- Parent attendance at first appointment is mandatory
- I understand that if my child attends therapy unaccompanied then a guardian needs to be available during the time of the appointment in case of an emergency.
- Attend therapy sessions as scheduled
- Cancellations ***must be made 24 hours in advance***. I agree to call to cancel my appointments at least 24 hours in advance. If I do not call to cancel 24-hours in advance and do not attend therapy, this will be considered a "no-show".
- ***I understand that three no shows or cancellations are grounds for discharge from therapy. I understand that there will be a $50 no show fee for each no show.*** A letter will be mailed to you informing you of discharge from the program and a community resource list for future care.
- I understand that my referring provider will be notified of my missed appointments and the resulting discharge from therapy.
- I understand that if I arrive fifteen minutes late, my therapy session may either be cancelled or shortened.
- If I am out of care for 90 days or more alterative resources may be provided and a new referral may be needed for future care.
- I agree to provide up to date insurance information.
- A sick child, sibling or parent should not attend therapy. For cancellations due to illness, please contact our office as soon as possible.
- I agree to notify the therapist at least two weeks in advance of vacations or an extended leave of absence during my child's scheduled treatment sessions.

Communication

- My family and I commit to courteous and respectful behaviors with our team members, including our admin team as well as clinicians. I understand that CMA cannot continue treatment for families who cannot show respectful language and behavior, including swearing, threatening, or

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bullying language or behaviors. For these families, information about alternate treatment options will be offered.

CMA commits that our team will

- Communicate and interact in safe, timely respectful manner.
- Reschedule as soon as possible if your therapist needs to cancel or re-schedule an appointment
- Maximize your child's success through evidence-based treatment
- Send a text, email, or call to remind you of your visit
- Provide information about alternate community resources for families not able to participate fully and respectfully.

_____ _____

Caregiver signature Date

Updated: 1/6/2021

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6303 Little River Turnpike, #300, Alexandria, Virginia 22312 (703) 914-8989 Fax (703) 914-5494
10615 Braddock Road, #200, Fairfax, Virginia 22032 (703) 691-4700 Fax (703) 691-4791
www.cmanva.com

Mental Health Services

Consent for Treatment

I hereby request and consent to mental health services provided by Children's Medical Associates of Northern Virginia, PC (CMA) and authorize CMA to treat myself or minors in my legal custody, including stepchildren, in ways they determine to be therapeutically necessary.

Obligation of Payment

I direct and assign payment from my insurance company or other healthcare provider of benefits to CMA for services rendered. **I understand that my insurance policy is a contract between my insurance company and me, and that I am responsible to CMA for any charges not covered by my insurance, including co-payments, deductibles, and fees for non-covered services. Every effort will be made by CMA to call ahead for benefits and the result of such call communicated to you prior to your visit but there is no guarantee of payment. I understand that I will be responsible for payment of the visit if my insurance company does not cover the charge for the service.** If all charges are not paid when due to CMA then the account will be turned over to a collection agency. Date:_____Initials:_____

Communication Preference

For mental health services only, I am providing my email and consent to the use of unsecured email to send me communications that may include protected health information. I understand by choosing not to provide my email, my mental health service will not be affected. This is a voluntary decision and may be revoked by me at any time.

E-Mail:_____

All other consent for communication, phone calls and text messages such as appointment reminders will be governed by the patient responsibility form initially signed and on file with CMA.

Acknowledgments/Certification

I, the Parent/Legal Guardian/Patient, acknowledge and certify the following:

I have read and agree to the terms of the treatment and payment acknowledgment and consent, that I have had all my questions answered, and have had any necessary communication assistance. I understand the contents of this form and that I am the patient or the parent/legal guardian and have the authority to request this treatment. Furthermore, I permit a copy of this document to be used in place of the original. I certify that all statements are true and correct.

Patient Name: (Please Print)_____ Date of Birth: _____

Signature of patient/legal guardian:_____ Date:_____

Relationship to Patient:_____

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Mental Health Service Line Patient Questionnaire

Thank you for taking the time to provide this very important information, which we will review with you at your child's visit.

Child's name:_____Preferred Name:_____Today's date:_____

Form completed by:_____Relationship:_____

Child's age:_____Child's DOB:_____Sex:_____Gender:_____

Referring physician:_____

Current Concerns

Please briefly share up to 3 of the most important concerns/stressors and when it first occurred.

1._____

2._____

3._____

School/Daycare History

Name of current school or childcare: _____ Grade (if applicable): _____

How is your child's performance in school?: Comments: _____

Does your child receive any accommodations or supports: Yes [ ] No [ ] Comments: _____

Previous testing at school (psychological, psychosocial, IEP, gifted): Yes [ ] No [ ] Comments: _____

Does your child have/has your child ever had a : [ ] IEP [ ] 504 [ ] Reading support [ ] Other

Current or previous homebound instruction? O No O Yes If yes, explain? _____

Has your child ever repeated any grades? O No O Yes If yes, explain? _____

Has your child skipped any grades? O No O Yes If yes, explain? _____

Social History

Do you have any concerns about your child's ability to make/keep friends? Yes [ ] No [ ]

If yes, please explain _____

Has your child ever

Witnessed something scary (violence in the home or community, natural disaster, frightening or invasive medical procedure or other event)? Yes [ ] No [ ]

Any concerns related to alcohol/drug use? Yes [ ] No [ ]

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Has your child ever been Emotional/Physically/Sexually abused? Yes [ ] No [ ]

Child protection services involovement? Yes [ ] No [ ]

Are there firearms in the home? Yes [ ] No [ ]

Has your child ever witnessed domestic violence? Yes [ ] No [ ]

Any Custory/Court Concerns? Yes [ ] No [ ]

Additional Services/Testing Has your child had any of the following (now or in the past)? (Please bring any results to appointment)

Physical therapy [ ] Occupational therapy [ ] Speech therapy [ ]

Outpatient Mental health Services:_____

Psychological or cognitive Evaluation/Testing:_____

Partial HospitalizationIntensive outpatient/Inpatient Hospitalizations: _____

Genetic Testing: _____

Who lives in the home?

Name Relationship Age Occupation

1._____

2._____

3._____

4. _____

5. _____

Do the parents live together O Yes O No, how much time does the child spend in each home?

Are there any pending custody concerns or discussions O No O Yes, please explain _____

Current court/legal case involvement: O No O Yes If yes, please explain: _____

Previous or current involvement with police O No O Yes If yes, please explain: _____

Gender Identification

O Male O Female O Female to male (transgender male) O Male to Female (transgender female) O Genderqueer O Nonbinary

O Other _____

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Family Psychiatric History:

Concerns	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Deceased								
- Deceased Cause								
ADHD								
Alcohol Use Disorder								
Anxiety/Panic								
Autism Spectrum Disorder								
Bipolar Disorder								
Depression								
Learning Disability								
Intellectual Disability								
OCD								
Substance use disorder								
Schizophrenia/Psychosis/Hallucinations								
Tics/Tourette's								
Other (including PTSD,seizures, behavior or anger problems, nerve problems)								

Current Medications

List all current prescription and non-prescription medications (name and dose):

1. _____
2. _____
3. _____

Past Psychiatric Medication History:

Medication Name/Strength	Dose	Began medication	Ended medication	How did the medication affect your child?

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