Psychiatric Intake Form

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name_____Date_____

Date of Birth _____ Primary Care Physician_____

Do you give permission for ongoing regular updates to be provided to your primary care physician? _____

Current Therapist/Counselor_____ Therapist's Phone_____

What is/are the presenting problem(s) for which you are seeking help?

1._____
2._____
3._____

What are your treatment goals?

_____
_____
_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbance
( ) Loss of interest
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido
( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Increased libido
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) _____
( ) _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.
If **YES**, please answer the following. If **NO**, please skip to the next section.
Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____
Do you have access to guns? If yes, please explain. _____

Past Medical History:

Allergies_____
Current Weight _____ Height _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____
_____
_____
_____
_____
_____
_____
_____

Current over-the-counter medications or supplements:

_____
_____

Current medical problems:

_____
_____

Past medical problems, nonpsychiatric hospitalization, or surgeries:

_____
_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when _____ . Was the EKG ( ) normal ( ) abnormal or ( ) unknown?

For women only: Date of last menstrual period _____ Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No. Are you planning to get pregnant in the near future? ( ) Yes ( ) No
Birth control method _____
How many times have you been pregnant? _____ How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( ) No
Date and place of last physical exam: _____

You **Family** **Which Family Member?**

Ashby Gap Psychiatric Center

Patient Name

Intake Form

Thyroid Disease ----------	( )	( )	_____
Anemia----------	( )	( )	_____
Liver Disease ----------	( )	( )	_____
Chronic Fatigue ----------	( )	( )	_____
Kidney Disease ----------	( )	( )	_____
Diabetes ----------	( )	( )	_____
Asthma/respiratory problems ------	( )	( )	_____
Stomach or intestinal problems ---	( )	( )	_____
Cancer (type) ----------	( )	( )	_____
Fibromyalgia ----------	( )	( )	_____
Heart Disease ----------	( )	( )	_____
Epilepsy or seizures ----------	( )	( )	_____
Chronic Pain ----------	( )	( )	_____
High Cholesterol ----------	( )	( )	_____
High blood pressure----------	( )	( )	_____
Head trauma ----------	( )	( )	_____
Liver problems ----------	( )	( )	_____
Other ----------	( )	( )	_____

Personal and Family Medical History:

Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain:

_____

_

_____

_

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

_

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Reason	Dates Treated	By Whom

_____

_____

_____

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.

Reason	Date Hospitalized	Where

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Dates Dosage Response/Side-Effects

Antidepressants

Prozac (fluoxetine)

_____

Zoloft (sertraline)

_____

Luvox (fluvoxamine)

_____

Paxil (paroxetine)

_____

Celexa (citalopram) _____

Lexapro (escitalopram) _____

Effexor (venlafaxine)

_____ Cymbalta

(duloxetine) _____

Wellbutrin (bupropion) _____

Remeron (mirtazapine) _____

Serzone (nefazodone) _____

Anafranil (clomipramine) _____

Pamelor (nortrptyline) _____

Tofranil (imipramine) _____

Elavil (amitriptyline) _____

Other _____

Mood Stabilizers

Tegretol

(carbamazepine)_____

Lithium_____

_

Depakote (valproate) _____ _____

Lamictal (lamotrigine)

_____

Tegretol (carbamazepine) _____

Topamax (topiramate) _____

Other _____

Antipsychotics/Mood Stabilizers Dates Dosage Response/Side-Effects

Seroquel (quetiapine)

_____ Zyprexa

(olanzepine) _____

Geodon (ziprasidone)

Abilify (aripiprazole) _____

Clozaril (clozapine) _____

Haldol (haloperidol) _____

Prolixin (fluphenazine) _____

Risperdal (risperidone) _____

Other _____

Sedative/Hypnotics

Ambien (zolpidem) _____

Sonata (zaleplon) _____

Rozerem (ramelteon) _____

Restoril (temazepam) _____

Desyrel (trazodone) _____

Other _____

ADHD medications

Adderall (amphetamine) _____

Concerta (methylphenidate) _____

Ritalin (methylphenidate) _____

Strattera (atomoxetine) _____

Other _____

Antianxiety medications

Xanax (alprazolam) _____

Ativan (lorazepam) _____

Klonopin (clonazepam) _____

Valium (diazepam) _____

Tranxene (clorazepate) _____

Buspar (buspirone) _____

Other _____

Name of Current Pharmacy & Address _____

Phone # of Pharmacy _____

Your Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No

How many days a week do you get exercise? _____

How much time each day do you exercise? _____

What kind of exercise do you do? _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Post-traumatic stress	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Alcohol abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Other substance abuse	( ) Yes ( ) No
Suicide	( ) Yes ( ) No	Violence	( ) Yes ( ) No

If yes, who had each problem? _____

_____

_ Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No If yes, who was treated, what medications did they take, and how effective was the treatment?

_____

_____

—

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances?

_____ If yes, where were you treated and when? _____

_____

_ How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones?

_____ Have you ever abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long?

_____

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	( )	( )	
Cocaine	( )	( )	
Stimulants (pills)	( )	( )	
Heroin	( )	( )	
LSD or Hallucinogens	( )	( )	
Marijuana	( )	( )	
Pain killers (not as prescribed)	( )	( )	
Methadone	( )	( )	
Tranquilizer/sleeping pills	( )	( )	
Alcohol	( )	( )	
Ecstasy	( )	( )	
Other	( )	( )	

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

How you ever smoked cigarettes? ( ) Yes ( ) No

Currently? ( ) Yes ( ) No How many packs per day on average? _____ How many years? _____

In the past? ( ) Yes ( ) No How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No What kind? _____ How often per day on average? _____ How many years? _____

Family Background and Childhood History:

Were you adopted? ( ) Yes ( ) No Where did you grow up?

_____

List your siblings and their ages:

_____

_____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced?

_____

If your parents divorced, who did you live with?

_____

Describe your father and your relationship with him:

_____

_____

Describe your mother and your relationship with her:

_____

_____

_ How old were you when you left home?

_____ Has anyone in your immediate family died? _____

Who and when?

_____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.

Please describe when, where and by whom: _____

_____

Educational History:

Highest Grade Completed? _____ Where? _____

Did you attend college? _____ Where? _____Major? _____

What is your highest educational level or degree attained? _____

Occupational History:

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position? _____

What is/was your occupation? _____

Where do you work? _____

Have you ever served in the military? _____ If so, what branch and when? _____

Honorable discharge ( ) Yes ( ) No Other type discharge _____

Relationship History and Current Family:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed

How long? _____

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____

Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation?

( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual

( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other:

_____

_

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____

How long? _____

Do you have children? ( ) Yes ( ) No If yes, list ages and gender: _____

_____

_

Describe your relationship with your children:

_____

List everyone who currently lives with you:

_____

_____

_

Legal History:

Have you ever been arrested? _____

Do you have any pending legal problems? _____

Spiritual Life:

Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No

If yes, what is the level of your involvement? _____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Is there anything else that you would like us to know?

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Signature_____Date_____

Guardian Signature (if under age 18) _____ Date

_____

Emergency Contact _____ Telephone # _____

For Office Use Only:

Reviewed by _____Date _____

Reviewed by _____Date _____

Donna de Villier, DNP, MN, RN, RPT
540-247-2143

Ashby Gap Psychiatric Center
119 The Plains Rd, Suite 300
PO Box 915
Middleburg VA 20118

Mark P. de Villier, MSW, LPC
843-209-2067

Patient Information Sheet

Date_____

Patient: Last Name_____ First Name_____ M_____

Address_____ City_____

St_____ Zip_____

Home Phone_____ Mobile Phone _____

E-Mail Address _____

Emergency Contact _____ Emergency Phone Number_____

Employer/School_____

Date of Birth_____ Age_____

SSN_____ Sex _____ Race _____ Marital Status _____

Name of Spouse_____

Name of Parent/Guardian _____

Name of Family Physician_____

Physician's Phone Number_____

Current Medications _____

Allergies_____

Referral _____

Insurer Name: _____

Date of Birth of Insurance Policy Holder _____

Phone Number of Insured: _____ Address: _____

Relationship to Patient: _____ SS#: _____

Primary Insurance_____

Phone: _____ Address: _____

Policy Number _____ Group Number_____

Secondary Insurance _____ Phone _____

Policy Number _____

Group Number _____

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Patient Rights

As a patient of Ashby Gap Psychiatric Center seeking elective treatment, you are entitled to the following rights:

- To receive services regardless of race, sex, creed or color
- To considerate and respectful care.
- To know your records are protected which prohibits unauthorized disclosure of information.
- To receive privacy whenever it is indicated
- To individual treatment based upon your needs and goals.
- To know the rationale of all services provided to you.
- To know the identity and professional status of the individual providing services to you
- To know that the staff operates within a professional environment as Professional practitioners.
- To review your record upon request and to receive current information concerning your diagnosis treatment and prognosis. *Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right*
- To request amendments to your clinical file
- To receive a history of all disclosures of your protected health information. You will be required to pay .55/page.
- To restrict the use and disclosure of your protected health information for the purpose of treatment, payment and operations. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly what information you wish disclosed.
- To expect reasonable safety and comfort as far as the center's practices are concern.
- To be given information relative to transfer, discontinuing of services and continuity of care
- To refuse treatment at any time.
- To register a complaint with the Secretary of Health and Human Services if you believe your rights as stated above have been violated.

I have read and I understand the above Patient Rights.

_____ _____ _____

Patient Signature Parent/ Guardian's Signature Date

As noted above, psychotherapy notes are afforded special protection under HIPAA. Ashby Gap Psychiatric Center does not release psychotherapy notes. We will be happy to provide you with a "designated recorded set" which will consist of: Results of Clinical Testing, Treatment Plans, Symptoms, Prognosis, Modalities and Frequencies of treatment, Functional status, Progress to date, Diagnoses and Medication prescription and monitoring.

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Professional Disclosure Statement and Consent to Treatment

Contact Information: Dr. Donna de Villier is located at the above stated address. This is also the mailing address. Hours of operation are arranged between the practitioner and the patient Monday –Friday. Saturday appointment may be made with prior arrangements. Patients are seen by appointment and scheduled through Dr. Donna de Villier's website www.ddevillier.com or by phone 540-247-2143. The website, email and voicemail are secure and confidential.

Personal Qualification:

Dr. Donna de Villier, DNP, MN, RN, RPTS is a Psychiatric Mental Health Advanced Practice Nurse. She is a Registered Nurse, received her BSN from the Medical University of South Carolina, 1980, her Masters in Nursing, MN, University of South Carolina, 1989 and her Doctorate of Nursing Practice, DNP, Brandman University, 2014. She is a Registered Play Therapist, RPT, Association of Play Therapy and Registered Play Therapist Supervisor, RPT-S, Association of Play Therapy. Dr. de Villier operates within a professional environment. Psychiatric services are offered to adults, children and adolescents for improving the emotional health in individual, couples, family with treatment focus using cognitive behavioral and play therapy.

Mark P. de Villier, MSW, LPC is the primary counselor in this practice. His credentials are:

VA Licensed Professional Counselor

Mr. de Villier received his Master's Degree in Social Work from the University of South Carolina with emphasis in micro and macro social work and his undergraduate degree in Psychology from the College of Charleston. Mark P. de Villier, MSW, LPC operates within a professional environment as an independent practitioner. Services that are offered are for improving the emotional health in individual, couples, family and group.

I have read and understand the above.

Name: _____ Date of Birth: _____

By signing this consent form, I expressly acknowledge that my child is or I am being voluntarily admitted to Ashby Gap Psychiatric Center. I also express that I have custody of my child/children and may request services. I understand that the services of Ashby Gap Psychiatric Center are administered as an outpatient private practice and the services will be with a licensed professional. The services may consist of individual, family, and couples therapy approaches. I understand an Individual Treatment Plan will be developed through a collaborative process between the patient and Ashby Gap Psychiatric Center which could include any or all of these modalities.

I have carefully read this consent form and I have had an opportunity to ask questions pertaining to the above.

_____	_____	_____
Patient	Parent/ Legal Guardian	Date
_____	_____	_____
Patient Signature	Parent/ Guardian's Signature	Date

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Informed Consent

Your signature verifies you have been given copies of documents informing you of Patient Rights, Professional Disclosure, Consent to Treatment, Ethics, Informed Consent, Confidentiality, Fee Agreement and HIPAA and that you read and understand these forms.
Your signature also grants consent for treatment to you or your child.

You need to know that:
Treatment may open unexpected emotionally sensitive areas and isn't always successful.
Dr. Donna de Villier is not a physician but a Psychiatric Mental Health Advanced Practice Nurse.
Dr. Donna de Villier may need to consult with your physician, attorney or other health care providers, and will ask for a signed Release of Information form before consultation is made.
Dr. Donna de Villier is not available 24 hours a day or seven days a week.
Dr. Donna de Villier is licensed through the State Board of Nursing for the Commonwealth of Virginia: Department of Health Professions located at 9960 Mayland Drive, Suite 300, Richmond, VA, 23233-1463. Phone number (804) 367- 4515 and the website is www.dhp.virginia.gov/nursing.

You also need to know that:
Treatment isn't always successful and may open unexpected emotionally sensitive areas.
Mr. de Villier is not a physician
Mr. de Villier may need to consult your physician, attorney or other health care providers, but will inform you of this
Mr. de Villier is not available 24 hours a day or seven days a week
Mr. de Villier is licensed through the Commonwealth of Virginia Board of Counseling. This Board is located at 9960 Mayland Drive, Suite 300, Henrico VA 23233-1463. Their mailing address is the same.

Confidentiality: The information you share in therapy with Ashby Gap Psychiatric Center staff is generally considered confidential by Virginia state law and federal regulations. Your clinical file can be subpoenaed in Virginia through court orders (signed by a judge) but is considered privileged in the federal court system. Ashby Gap Psychiatric staff are mandated by state and federal regulations – through duties to warn -- to breach confidentiality if they are aware: 1) you being a harm to yourself or another, 2) if a child has been abused or is being abused, 3) if a vulnerable adult is being abused or neglected and 4) if you intend to break or have broken a law against another.
Any information other than the above will require a Release of Information form to be completed.

I have read and understand the above.

Name: _____ Date of Birth: _____

_____	_____	_____
Patient Signature	Parent/ Guardian's Signature	Date

Donna de Villier, DNP, MN, RN, RPT
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Ethics

Dr. Donna de Villier follows the Code of Ethics of the following organizations:
Virginia Board of Nursing
The Association of Play Therapy
Mr. de Villier follows the Code of Ethics of the following organizations:
The Commonwealth of Virginia Board of Counseling.
National Association of Social Workers

Any type of sexual behavior between therapist and patient is unethical. It is never appropriate and will not be condoned.

I have read and understand the above.

Name: _____ Date of Birth: _____

_____ _____
Patient Parent Legal Guardian

_____
Date

Additional family members involved with therapy after reading, reviewing and understanding the above, please sign.

_____ _____
Patient Patient

_____ _____
Patient Patient

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Mark P. de Villier, MSW, LPC
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Professional Disclosure

Dr. Donna de Villier is a psychiatric advanced practice nurse specializing in working with adults, adolescents and children providing individual, couples and family therapy and specializes in cognitive behavioral and play therapy and maintains a private practice in Middleburg, VA.

With over 25 years experience as a psychiatric advanced practice nurse, and as a graduate of Brandman University as a Doctorate of Nursing Practice she specialized in cognitive behavioral therapy. Dr. de Villier has been licensed by the Association of Play Therapy as a Registered Play Therapist-Supervisor to provide play therapy and supervise therapists in becoming play therapists. She is currently a private practitioner working with a broad spectrum of patients. Among her areas of expertise are assessment, diagnosis, functional assessments, behavioral plan development and collaborating with the public school system to get your child's special needs met within the educational system.

In addition to being a prominent relationship therapist, Dr. Donna de Villier has presented at national conferences and to general audiences speaking on the topics of play therapy and play therapy training and supervision.

Dr. Donna de Villier is an interactive, solution-focused therapist. Her therapeutic approach is to provide support and practical feedback to help patients effectively address personal life challenges. She integrates complementary methodologies and techniques to offer a highly personalized approach tailored to each patient. With compassion and understanding, she works with each individual to help them build on their strengths and attain the personal growth they are committed to accomplishing.

Education

- Registered Nurse, BSN, Medical University of South Carolina, 1980
- Masters in Nursing, MN, University of South Carolina, 1989
- Doctorate of Nursing Practice, DNP, Brandman University, 2014
- Registered Play Therapist, RPT, Association of Play Therapy
- Registered Play Therapist Supervisor, RPT-S, Association of Play Therapy

License, Certifications & Awards

- Licensed through the State Board of Nursing for the Commonwealth of Virginia: Department of Health Professions located at 9960 Mayland Drive, Suite 300, Richmond, VA, 23233-1463. Phone number (804) 367-4515 and the website is www.dhp.virginia.gov/nursing
- Registered Play Therapist- Supervisor licensed through the Association for Play Therapy
- Member of Sigma Theta Tau, International Honor Society of Nursing
- Awarded 2014 Best Research Poster Award at the International Society of Psychiatric-Mental Health Nursing

Professional Organizations

- International Society of Psychiatric- Mental Health Nurses
- Advanced Practice Nurse Practitioners
- Association of Play Therapy

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Mark P. de Villier, MSW, LPC
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Mark P. de Villier, MSW, LPC

Began his career with the Medical University of South Carolina working within the Department of Psychiatry on the Adolescent Inpatient Unit. He took advantage of the teaching environment to study with some of the leading clinicians treating adolescents and their families. He was asked in 1980 to lead a struggling residential program as the clinical and administrative director. While doing this he was also involved with assisting in developing a family oriented Intensive Outpatient Treatment program for an area Alcohol and Drug Commission. This program evolved to a model of care using the Multiple Family Group Therapy modality. Mark later worked with a Private Psychiatric Hospital in Atlanta, GA but returned to South Carolina when he had the opportunity to assist in developing an innovative campus of care model of service which assisted in making intensive psychiatric service more affordable to families and community agencies. Over a 15 year period Mark and his associates expanded the program to a level where they employed 600 professionals and provided care for approximately 300 children a day on four campuses. Mark retired in 1999 only to be recruited to assist other psychiatric services. This eventually led to Mark starting Atwater Counseling Center which included outpatient and residential services. In 2009 Mark and his family moved to Virginia to allow his wife to pursue her educational goals. He worked as a therapist for an area residential treatment center and eventually moved back to private practice. In 2015, Mark and his wife decided to open Ashby Gap Psychiatric Center due to the high need for quality mental health services in the Commonwealth of Virginia.

Mark has an emphasis on working with adolescents and their families, specializing in adolescents with oppositional behaviors, anxiety, ADHD and depression. He has extensive experience working with families and multi-family therapy groups. He provides counseling for adults struggling with Relationship Issues, Anxiety, Affective Disorders, Anger Management, and Father - Son issues. Mark's approach to care is a Cognitive Behavioral approach with focus on the communication of feelings between individuals and their family systems. Mark's approach to counseling involves assisting the individual in addressing their feelings, thinking and behaviors within their systems of functioning. He encourages patients to become aware of the communication process and practice foresight, insight and hindsight relative to the interactions with others.

Mark has provided clinical supervision for LPC Candidates in South Carolina and Virginia. Over the near 35 years in the Mental Health and Alcohol and Drug field, Mark has worked in both clinical and administrative positions, was the founder of Atwater Counseling Center, assisted in the development of New Hope Treatment Centers and worked with Alcohol and Drug Commissions in South Carolina. He worked with Grafton Integrated Health Network as a therapist and clinical supervisor for LPC candidates.

He has been a trainer for Professional Counselors and Social Worker in South Carolina and a consultant to residential treatment centers. He has developed Employee Assistance Programs, worked with industry to enhance team work, improve internal communication and focus on positivity.

Mr. de Villier received his Master of Social Work from the University of South Carolina, Columbia SC with an emphasis in clinical and administrative studies. He has a Bachelor of Science in Psychology from the College of Charleston, Charleston, SC. He is a member of the National Association of Social Workers (NASW) and is licensed as a Professional Counselor.

Donna de Villier, DNP, MN, RN, RPT
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Mark P. de Villier, MSW, LPC
843-209-2067

Psychiatric Counseling Services

Mark de Villier, specializes in working with Developmental Issues of Adolescents which involve relationships with parents and authority figures, gender and sexual identity issues, peer groups/friends and career path decisions. He works with Oppositional adolescents and their families. He works with individuals struggling with anxiety, depression, Anger Management and communication within relationships.

He provides Individual, Couples and Family therapies, works with parenting issues, Father-Sons relationships.

He does provide supervision for License Professional Counselor candidates.

Education

Masters in Social Work with emphasis in Micro and Macro Studies, University of South Carolina, Columbia, SC

Bachelor of Science in Psychology, College of Charleston, SC

License

Professional Counselor, Commonwealth of Virginia

Professional Organization

National Association of Social Workers

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843-209-2067

Fee Agreement

Ashby Gap Psychiatric Center is a private outpatient practice providing services to children, adolescents, adults and families experiencing difficulties as an individual and/or system. The collection of fees for the psychiatric services to the patients is necessary for Ashby Gap Psychiatric Center to provide quality mental health services. It is customary to pay all co-pays and for services not covered by insurance at the time they are rendered. Dr. Donna de Villier is currently on Aetna and Cigna Insurance Panels. Mark P. de Villier, MSW, LPC is on Anthem, United Healthcare, Cigna and Aetna Insurance Panels. If your insurance pays for out of network services, Ashby Gap Psychiatric Center is willing to bill your insurance carrier after verification of payment for services; however, any outstanding balance is expected to be paid upon the rendering of the service(s).

Responsibility for Payment: I agree to pay the following fee for service. For Dr. Donna de Villier: The charges for services are as follows: Initial Assessments are billed at $225.00. $150.00 dollars per 50 minute session for Individual Therapy, Family Therapy and Couples Sessions. For Mark de Villier: Assessments are $150 and Individual, Family and Couples Therapy are $135. Scheduled appointments missed/ or not cancelled 24 hours prior to the scheduled appointment may be billed for the full amount of the session. Time related to Court Appearances, dealing with attorneys, dispositions and professional testimony is billed at $200 an hour. (see Policy on Court and Legal Proceedings) Checks may be made out to Ashby Gap Psychiatric Center, Dr. Donna de Villier or Mark P. de Villier. Cash, credit cards and ATM Debit cards are accepted. Credit card and/or ATM payments can be paid online in the website: www.ddevillier.com Returned checks are subject to a $25 charge. Accounts over 60 days may be turned over to a collection agency for collection.

My signature indicates that I have read and understand this fee agreement and agree to abide by the terms stated above. I accept full responsibility for charges for myself and /or my child.

_____ _____

Patient Parent Legal Guardian

_____ _____ _____

Patient Signature Parent/ Guardian's Signature Date

Donna de Villier, DNP, MN, RN, RPT
540-247-2143

Ashby Gap Psychiatric Center
119 The Plains Rd, Suite 300
PO Box 915
Middleburg VA 20118

Mark P. de Villier, MSW, LPC
843-209-2067

Assignment and Instruction for Direct Payment

Patient Name: _____

Employer: _____

Claim/Group: _____

SS#: _____

ID#: _____

I hereby instruct and direct that _____ Insurance Company to pay by check made out and mailed to:
Ashby Gap Psychiatric Center, 119 The Plains Rd, PO Box 915, Middleburg VA, 20118
A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to my insurance company and/or adjuster involved in this case.
Dated this _____ day of _____ 20_____.

_____
Signature of Policyholder

_____
Witness

_____
Signature of Claimant, if other than Policy holder

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Notice of Privacy Practice

On August 8, 1996, the US Congress passed Public Law 104-191, commonly known as the Health Insurance Portability and Accountability Act (HIPAA). The purpose of HIPAA is to 1) promote the use of standards in healthcare for administrative and financial transactions and 2) provide for the confidentiality and security of protected health information. Ashby Gap Psychiatric Center is considered a covered entity under HIPAA regulations and as a result, we will only distribute our patients' protected health information under the regulations set forth by HIPAA.

As a patient you have the right to see your clinical file upon request. Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right.
As a patient, you have the right to receive a copy of your clinical file as a "designated recorded set." Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right.
As a patient, you have the right to request amendments to your clinical file.
As a patient, you have the right to receive a history of all disclosures of your protected health information.
As a patient, you have the right to restrict the use and disclosure of your protected health information for the purpose of treatment, payment and operations. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly what information you wish to disclose.
As a patient, you have the right to register a complaint with the Secretary of Health and Human Services if you believe your rights have been violated. In that Psychotherapy notes are afforded special protection, Ashby Gap Psychiatric Center will be happy to provide a designated record set which consist of: Session Start & Stop Time, Results of Clinical Testing, Treatment Plans, Symptoms, Prognosis, Modalities and Frequencies of treatment, sessions, Functional status, Progress to date, Diagnoses Medication prescription and monitoring.

I have read and understand the above.

Name: _____ Date of Birth: _____

_____	_____	_____
Patient Signature	Parent/ Guardian's Signature	Date

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Policy on Medication Management Follow Up Appointments

It is very important you follow your practitioner's treatment guidelines. At each appointment, your provider will indicate a time frame for your next visit. It is your responsibility to ensure you follow up with your appointment schedule within the time frame indicated and you keep these appointments. Please note you medication provider cannot refill medications without performing the appropriate follow up evaluation.

Some appointment times fill very quickly. We strongly recommend you schedule your next appointment before you leave the office. If this is not possible, please do your best to schedule follow up appointments shortly thereafter. This may assist in meeting your time need and ensure you do not run out of your medication as this may be dangerous to abruptly stop your medication. Delays in scheduling follow up appointments may result in significantly limiting your appointment time options.

I have read, understand and will abide by the above policy.

Patient - Parent/Guardian's Name _____

Signature _____ Date _____