



**Dr. Naoji A. Watson**  
**5901 Kingstowne Village Pkwy, Suite 300**  
**Alexandria, VA 22315**

Consent for Treatment and Recipient Rights

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_ the undersigned, hereby attest that I have voluntarily entered into treatment, or given my consent for the minor or person under my legal guardianship mentioned above, with Dr. Naoji A. Watson, Licensed Clinical Psychologist. Further, I consent to have treatment provided by Dr. Naoji A. Watson, or intern/extern/resident in collaboration with his supervisor, Dr. Watson. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. Dr. Watson encourages that this decision be discussed with him before termination of treatment to help facilitate a more appropriate plan for discharge.

**Non-voluntary Discharge from Treatment:** A patient may be terminated from treatment with Dr. Watson non-voluntarily if: (A) the patient exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or (B) the patient refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The patient will be notified of the non-voluntary discharge by Dr. Watson via letter. The patient may appeal this decision with the Dr. Watson or request to reapply for services at a later date.

**Patient Notice of Confidentiality:** The confidentiality of patient records maintained by Kingstowne Internal Medicine (Loudon Medical Group-LMG) and Dr. Naoji A. Watson is protected by federal and/or state law and regulations. Generally, Kingstowne Internal Medicine and Dr. Watson may not say to a person outside of the practice that a patient attends treatment or disclose any information identifying a patient as an alcohol or drug abuse unless: (1) the patient consents in writing, (2) the disclosure is allowed by a court order, or (3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of federal and/or stated law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or state law and regulations do not protect any information about a crime committed by a patient either at Kingstowne Internal Medicine, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under federal and/or state law to appropriate state or local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is Dr. Watson's duty to warn any potential victim when a significant threat of harm has been made. In the event of a patient's death, the spouse or parents of a deceased patient have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related patient records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor patients have the right to access the patient's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the patient, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Patient data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above-stated policies and agreements with Dr. Naoji A. Watson and Kingstowne Internal Medicine.

\_\_\_\_\_  
Signature of Patient/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

(In a case where a patient is under 18 years of age, a legally responsible adult acting on his/her behalf).



## *Financial Policy*

Dr. Naoji A. Watson is committed to providing caring and professional mental health care to all of his patients. As part of the delivery of mental health services, he has established a financial policy that provides payment policies and options to all of his patients. Dr. Watson's financial policy is designed to clarify the payment policies.

The Person Responsible for Payment of Account is required to sign the form policies and procedures, which explains Dr. Watson's fees and collection policies. Your insurance policy, if any, is a contract between you and the insurance company; Dr. Watson is not part of the contract with you and your insurance company.

As a service to you, Dr. Watson will bill insurance companies and other third-party payers but cannot guarantee such benefits or the amounts covered and is not responsible for the collection of such payments. In some cases insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. Dr. Watson charges his patients the usual and customary rates for the service area. Patients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The Person Responsible for Payment will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 120 days are subject to collections. A 1% per month interest rate is charged for accounts over 60 days.

**Insurance deductibles and co-payments are due at the time of service.** Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that were prior to the first session with Dr. Watson), this amount will be collected by Dr. Watson until the deductible payment is verified to Dr. Watson by the insurance company or third-party provider.

All insurance benefits will be assigned to Dr. Watson (by insurance company or third-party provider) unless the Person Responsible for Payment of Accounts pays the entire balance each session.

**Patients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved credit plan, charge card, or payment at the time of service.**

Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate noted in the Payment Contract for Services.

Payment methods include check, cash, or credit card. Patients using charge cards may either use their card at each session or sign a document allowing Dr. Watson to automatically submit charges to the charge card after each session.

Questions regarding the financial policies can be answered by Dr. Naoji A. Watson.

I have read, understand, and agree with the provisions of the Financial Policy.

Person responsible for account: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature: \_\_\_\_\_



## No-Show and Cancellation Agreement

In an effort to provide excellent client service to all of our patients, and to provide the best possible therapeutic environment, it is Dr. Watson's policy to require a fee for no-show appointments and cancellations made less than 24 hours in advance of the scheduled appointment. \*

The fee of \$75 will be charged to the following credit card:

\_\_\_\_\_ Visa \_\_\_\_\_ Mastercard \_\_\_\_\_ Other

Credit Card # \_\_\_\_\_

Expiration Date: \_\_\_\_\_ CCV (Credit Card Verification) \_\_\_\_\_

Name as it appears on Card: \_\_\_\_\_

I \_\_\_\_\_, understand and agree that if I do not show up for my scheduled appointment or if I cancel my scheduled appointment with less than 24 hour notice, the above named credit card will be charged in the amount of \$75.00.

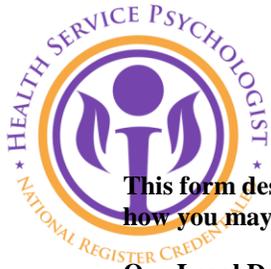
Signature \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name \_\_\_\_\_

Address: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

\*Exceptions for emergencies are determined by Dr. Watson and cancellations made 24 hours prior to your time on Monday appointments must occur on Friday as weekend days do not count.



## Privacy of Information Policies

**This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.**

### **Our Legal Duties**

State and Federal laws require that Dr. Watson keep your medical records private. Such laws required that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. Dr. Watson is required to abide by these policies until replaced or revised. He has the right to revise his privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by law as private information. Dr. Watson respects the privacy of information you provide him and he abides by ethical and legal requirements of confidentiality and privacy of records.

### **Use of Information**

Information about you may be used by Dr. Watson for diagnosis, treatment planning, treatment, and continuity of care. Dr. Watson may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a Patient cannot be shared with another party without the written consent of the Patient or the Patient's legal guardian or personal representative. It is Dr. Watson's policy not to release information about a Patient without a signed release of information except in certain emergency situations or exceptions in which Patient information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

### **Duty to Warn and Protect**

When a patient discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the patient discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the Patient.

### **Public Safety**

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws. Other Authorizations Required by Law, including: legal proceedings and law enforcement; Workers' Compensation; protected health information related to Inmates; Military, National Security and Intelligence Activities; for the Protection of the President; certain approved research purposes; organ donation; for use by coroners, medical examiners and funeral directors; or any other reason such a disclosure would be required by law.

### **Abuse**

If a Patient states or suggest that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a patient is the victim of abuse,



neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

### **Prenatal Exposure to Controlled Substances**

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

### **In the Event of a Patient's Death**

In the event of a Patient's death, the spouse or parents of a deceased Patient have a right to access their child's or spouse's records.

### **Professional Misconduct**

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professionals actions, related records may be released in order to substantiate disciplinary concerns.

### **Judicial or Administrative Proceedings**

Health care professionals are required to release records of Patients when a court order has been placed.

### **Minors/Guardianship**

Parents or legal guardians of non-emancipated minor Patients have the right to access the Patient's records.

### **Other Provisions**

Medical Records include both the written record and/or electronic records.

When a payment for services are the responsibility of the Patient, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g. diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the Patient's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the Patient. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about Patients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the Patient, or any identifying information, is not disclosed. Clinical information about the Patient is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the clinic or mental health professional must telephone the Patient for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify Dr. Watson in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when Dr. Watson phones you at home or work, he does not say the name of the clinic or the nature of the call, but rather his name only. If this information is not provided to us (below), Dr. Watson will adhere to the following procedure when making phone calls: First Dr. Watson will ask to speak to the Patient (or guardian) without identifying his name. If the person answering the phone asks for more identifying information Dr. Watson will say that it is a personal call. Dr. Watson will not identify his name (to protect confidentiality). If Dr. Watson reaches an answering machine or voicemail he will follow the same guidelines.



### **Disclosures for which Patient Authorization is Required**

The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity) (ii) uses and disclosures of protected health information (PHI) for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice. If Dr. Watson intends to send fundraising communications to an individual, the individual will be informed the intent and the individual has the right to opt out of such fundraising communications with each solicitation. Dr. Watson is required to notify the patient of any breach of his or her unsecured PHI.

### **Your Rights**

You have the right to request a review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows: You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. Dr. Watson will provide a copy or a summary of your health information, usually within 30 days of your request. Dr. Watson may charge a reasonable, cost-based fee.

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than Dr. Watson's address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if Dr. Watson does not agree with these restrictions, he may not be bound to abide by them.

You have the right to choose someone to act for you if you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. Dr. Watson will make sure the person has this authority and can act for you before he takes any action.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to Dr. Watson in writing.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although Dr. Watson might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

If you desire a copy of this notice you may obtain it by requesting a copy at the front desk or accessing it on our website.

### **Complaints**

If you have any complaints or questions regarding these procedures, please contact Dr. Naoji Watson, Licensed Clinical Psychologist at (571) 208-2613.

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I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Name of Patient or Parent/Guardian signing the form: \_\_\_\_\_

Signature of Patient or Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Patient (if not signing form): \_\_\_\_\_ DOB: \_\_\_\_\_