NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all records of your care generated by a provider of Psychological Health-Roanoke.

Our Responsibilities

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe examples of the way we use and disclose health information:

For Treatment:

We may use health information about you to provide treatment or services and continuity of care with other healthcare providers.

For Payment:

We may use and disclose health information about your treatment and services to bill and collect payment from you, or a third party payer. We may also tell your health plan about treatment you are going to receive to determine whether your plan will pay.

For Health Care Operations:

- To remind you that you have an appointment for medical care
- To tell you about health-related benefits or services

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

Future Communications:

We may communicate to you via newsletters, mail outs or other means regarding treatment options and health related information.

Law Enforcement/Legal Proceedings:

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Psychological Health- Roanoke you have the **RIGHT TO**:

Inspect and Copy:

You have the right to inspect and obtain a copy of the health information used to make decisions about your care. We may deny your request to inspect and copy in certain circumstances. If you are denied access you may request that the denial be reviewed. Another licensed health care professional chosen by Psychological Health-Roanoke will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Please turn over

Amend:
If you feel that your health information is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Psychological Health-Roanoke. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures:
You have the right to request an accounting of disclosures. This pertains to disclosures we make of your health information for purposes other than treatment where an authorization was not required.

Request Restrictions:
You have the right to request a restriction or limitation on the health information we use or disclose about you. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. **We are not required to agree to your request**. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment.

Request Confidential Communications:
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. Psychological Health-Roanoke will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services and related correspondence. 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.

A Paper Copy of This Notice:
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE
We reserve the right to change this notice at any time.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with Psychological Health-Roanoke. You may also file a complaint with the Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that provided to you.

Psychological Health-Roanoke-PATIENT REGISTRATION

Date: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____

Patient: _____
First Middle Last

Address _____
Street and PO Box

_____
City State Zip Code

Age ___Gender _____ Birth Date _____ Social Security # _____

Patient Employer Name: _____
Employer Address _____
_____

Spouse _____ DOB: _____ Social Security #_____
Employer Name/Address _____
Occupation: _____ Employer Phone _____

Do you have Medical Insurance? **If yes, Please provide a copy to the receptionist at time of check-in.**
Subscriber Info for Insurance provided: Name_____Relation:_____
DOB_____SSN_____Employer_____
If No, then payment is due in full date of service.

****

REQUIRED INFORMATION:

In case of emergency, who should be notified? _____
Phone: _____*Relation to patient:*_____

****

I authorize treatment deemed necessary by the health care providers of Psychological Health- Roanoke.

I authorize Psychological Health-Roanoke to release to my health plan any and all information which it deems necessary regarding my care and treatment to insure prompt payment of all charges for services provided. I hereby assign the payment of all insurance benefits to Psychological Health- Roanoke for any and all charges incurred in connection with services provided to me. I also consent to a copy of this authorization and assignment being used in place of the original.

I understand fully that I remain responsible to pay Psychological Health-Roanoke for all charges not paid by either my insurance companies and/or employer, subject to the rules of any federal or state health insurance program such as Medicare or Medicaid, or to other contractual provisions that may limit a patient's responsibility to pay for medical costs and services. **Payment shall be due within thirty days of receipt of a statement.**

A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service.

I understand fully that I remain responsible to pay Psychological Health-Roanoke for all charges not paid by either my insurance companies and/or employer, subject to the rules of any federal or state health insurance program such as Medicare or Medicaid, or to other contractual provisions that may limit a patient's responsibility to pay for medical costs and services. Payment shall be due within thirty days of receipt of a statement.

In consideration of the services rendered and to be rendered pursuant to my request for medical services from Psychological Health- Roanoke, I hereby waive any right to a jury trial should Psychological Health-Roanoke have to file suit to collect my account.

METHODS OF PAYMENT:

Our office accepts the following payment methods:

Cash, Personal Check and Credit Cards.

For returned checks we assess a $50.00 NSF charge, and report to the local Commonwealth attorney's office checks that are not paid within 2 weeks of being returned to our office.

If fees are not paid, the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, patient agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees.

The parties agree that all claims, disputes and other matters of action shall be brought within and decided in the Commonwealth of Virginia.

You agree, in order for us to service our account or to collect any amounts you may owe, that we may contact you by telephone at any telephone number associated with you account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lender/Creditor may contact me/us as described above.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THIS INFORMATION.

_____ _____

Patient Signature Date

Psychological Health- Roanoke
Informed Consent for Treatment

Confidentiality

Clinicians and staff in Psychological Health-Roanoke value the patient-therapist and patient-physician relationships and strive to keep all information confidential. We only release information to others with your written permission.

Here are some important exceptions to this confidentiality of which we want you to be aware. These include:

- Suspected child abuse or neglect
- Suspected abuse or neglect of an elderly or incapacitated adult
- Patient is thought to be an immediate threat to self or others
- Court-ordered releases with regard to legal actions
- Misconduct by a health care provider
- Workers Compensation
- If you are licensed or certified by a health regulatory board or hold a multistate license, and your condition places you or the public at risk
- For third party payers and their agents for purposes of reimbursement
- For crime investigation if it occurs on our premises

Other Matters Related to Confidentiality

- It may occasionally be helpful or necessary to consult about a patient with another professional. In these consultations, the physician/therapist makes every effort to avoid revealing the identity of the patient. The consultant is, of course, also legally bound to maintain confidentiality.
- If insurance reimbursement is requested, we are required to provide the insurer relevant information such as diagnosis and/or treatment plan.
- If the patient is under eighteen years of age, please be aware that while the specific content of therapy is confidential, parents have a right to receive general information on the progress of the treatment and have legal access to the record.

I understand that my therapist will discuss my diagnosis as well as the method of treatment. The nature of the treatment has been described to me as well as possible side effects and alternative forms of treatment. I understand I may withdraw from treatment at any time, but if I decide to do this, I will discuss my plan with this physician/therapist before acting on it.

The physician/therapist has further discussed with me scheduling policies, fees to be charged, and matters relating to insurance, and if applicable, preauthorization and utilization review issues.

If you need to change an appointment, please give us a minimum 24 hours notice. We reserve the right to assess service charge to patients who break or fail to attend their appointment commitments with us and who fail to give us at least 24 hours notice of their intention to do so. Follow-up appointments will only be made when any outstanding co-payment balance is paid.

I have read the above; fully understand the diagnosis, the nature of treatment, the alternatives to this treatment, the fees, and the limits of confidentiality and give consent for treatment.

I acknowledge that I have been given the Psychological Health-Roanoke Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: _____

Patient: _____ Date: _____

Provider: _____ Date: _____

PATIENT'S RIGHTS AND RESPONSIBILITIES

Statement of Patient Rights

*Patients have the right to be treated with dignity and respect.
*Patients have the right to fair treatment regardless of race, religion, gender, ethnicity, age, disability or source of payment.
*Patients have the right to have their treatment and other information kept private.
*Only in life-threatening situations or if required by law, can records be released without a signed consent from patients.
*Patients have the right to information from staff/providers in language they can understand.
*Patients have the right to an easy to understand explanation of their condition and treatment.
*Patients have the right to know all about their treatment choices regardless of cost coverage.
*Patients have the right to get information about services offered by their providers and patient role in the treatment process.
*Patients have the right to request professional information about their provider.
*Patients have the right to know the clinical guidelines used in providing and/or managing their care.
*Patients have the right to provide suggestions on office policies and procedures.
*Patients have the right to complain and to know about their complaint, grievance and appeals process.
*Patients have the right to know State and Federal laws governing their rights and responsibilities.
*Patients have the right to participate in the formation of their plan of care.

Statement of Patient Responsibilities

*Patients are responsible for providing their medical provider with information needed to deliver quality care.
*Patients are responsible for informing their provider when/if their treatment plan is no longer effective.
*Patients are responsible to follow their treatment plans and to inform their provider of any changes to the treatment plan made by other providers including any changes in their medications.
*Patients are responsible for reviewing their care and treatment plans continuously and reporting effectiveness or ineffectiveness of the care plan to their provider.
*Patients are responsible for treating those giving them care with dignity and respect.
*Patients should not be involved in any conscious behavior that could endanger the safety of their provider, office staff or other patients.
*Patients are responsible for keeping their appointments, arriving on time and notifying the office of any cancellation at least 24 hours prior to the appointment.
*Patients are responsible for addressing questions about their care to their provider and ensure understanding of their care and their role in the treatment process.
*Patients are responsible for notifying their provider of any concerns regarding payment or insurance coverage.

I understand my rights and responsibilities as stated above.

_____

Patient Signature ***Date***

Psychological Health Roanoke
Financial Policies

Name _____

Failed Appointment and Late Cancellation Policy

WE ASK THAT YOU GIVE 24 HOURS NOTICE IF YOU INTEND TO CANCEL AN APPOINTMENT.

Appointments cancelled with less than 24 hours notice and appointments not kept will result in a mandatory $25 scheduling charge unless there is illness or an emergency. Your therapist may also bill you for your missed or cancelled appointment. Your insurance will not pay for missed or cancelled appointments. Please discuss this policy with your therapist.

Co-Payment Policy

Insurance companies **require** us to collect applicable co-payments at **every** visit. If a co-payment is missed, it is to be paid at your next visit. **Failure to pay two consecutive co-payments will result in your not being able to schedule future appointments until paid.**

Collection Policy

Please note that all accounts 90 days in arrears are subject to be submitted to a collection agency. The amount will include the balance owed plus all collection agency fees.

I understand the Policies described above.

_____ _____

Signature Date

Psychological Health Roanoke PC

Patient Name_____

Date _____ DOB _____

Release for Coordination With Primary Care Physician:

For the purpose of coordinating care, my behavioral healthcare practitioner may wish to release pertinent information about my current treatment to my primary care physician. I hereby authorize the use or disclosure of my individually identifiable health information. This release shall be valid until 365 days after my last date of treatment or until the time I revoke this release, which can be done at any time. **Name of Primary Care Physician**

_____

☐ **I do not have a Primary Care Physician.**

(Check One) I do ☐ I do NOT ☐ give permission to the practitioner named above to exchange information about my current treatment with my primary care physician.

SIGNATURE IS REQUIRED

Patient (Guardian) Signature_____ Date _____

Signature of Witness _____ Date _____

Below this line is to be completed by Psychological Health Roanoke Clinician

To:_____

_____

_____

Dear Dr. _____:

In an effort to coordinate care, I want to inform you that your patient (named above) was seen by me on _____ for treatment of _____.

Current recommendations for the type and setting of treatment include:

( ) Individual Psychotherapy
( ) Family Psychotherapy
( ) Group Psychotherapy
( ) Evaluation
( ) Intensive Outpatient Program
( ) Partial Hospitalization Program
( ) Inpatient Unit

Comments:_____

_____

If you need any further information, please contact me at 540-772-5140 or fax at 540-772-5157.

Sincerely,
Clinician: _____

Psychological Health Roanoke PC

Patient Name_____

Date _____ DOB _____

Release for Coordination With Psychiatrist:

For the purpose of coordinating care, my behavioral healthcare practitioner may wish to release pertinent information about my current treatment to my psychiatrist. I hereby authorize the use or disclosure of my individually identifiable health information. This release shall be valid until 365 days after my last date of treatment or until the time I revoke this release, which can be done at any time.

Name of Psychiatrist

_____

☐ **I do not have a psychiatrist.**

(Check One) I do ☐ I do NOT ☐ give permission to the practitioner named above to exchange information about my current treatment with my Psychiatrist.

SIGNATURE IS REQUIRED

Patient (Guardian) Signature_____ Date _____

Signature of Witness _____ Date _____

Below this line is to be completed by Psychological Health Roanoke Clinician

To:_____

_____

_____

Dear Dr. _____:

In an effort to coordinate care, I want to inform you that your patient (named above) was seen by me on _____ for treatment of _____.

Current recommendations for the type and setting of treatment include:

( ) Individual Psychotherapy
( ) Family Psychotherapy
( ) Group Psychotherapy
( ) Evaluation
( ) Intensive Outpatient Program
( ) Partial Hospitalization Program
( ) Inpatient Unit

Comments:_____

_____If you need any further information, please contact me at 540-772-5140 or fax at 540-772-5157.

Sincerely,

Clinician: _____

Patient Health Questionnaire-9

(PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please circle your answer)	Not At All	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have you let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work. Take care of things at home, or get along with other people? (Please circle your answer)

Not difficult At All	Somewhat Difficult	Very Difficult	Extremely Difficult

NAME_____ DATE:_____

THE MOOD DISORDER QUESTIONNAIRE

If you are currently suffering from depression or have had problems with depression in the past- please answer the following questions.

1.	**Was there ever a time when you did not feel like yourself and...**	**YES**	**NO**
	...you felt so good, upbeat and energetic that others felt you were not acting like yourself ?		
	...were acting so hyperactive that you got into trouble?		
	...you were so irritable that you shouted at people or started fights or arguments?		
	...you felt much more self-confident than usual?		
	...you got much less sleep than normal and found you didn't really miss it?		
	...you were much more talkative or spoke faster than usual?		
	...thoughts raced through your head or you couldn't slow your mind down?		
	...you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
	...you had much more energy than usual?		
	...you were much more active or did many more things than usual?		
	...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
	...you were much more interested in sex than usual?		
	...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
	...spending money got you or your family into trouble?		
2.	**If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please circle one response only.***	**YES**	**NO**
3.	**How much of a problem did any of these cause you-like being unable to work; having family, money, or legal troubles; getting into arguments or fights? *Please circle one response only.***	**No Problem** **Moderate Problem**	**Minor Problem** **Serious Problem**

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the **last** 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	_____			

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Psychological Health Roanoke

Electronic Communications/Social Media Policy

Psychological Health Roanoke is required to follow standard HIPAA regulations. To assure your right to have your privacy protected, we ask you to join us in adhering to the following standards. Your therapist will review and/or discuss any questions you may have related to this policy. Thank you for taking time to review this information and sign accordingly.

We offer the following secure communication services:

- Telephone contact is available during business hours with our reception staff.
- We have the capability to encrypt outgoing email messages to secure your privacy rights. When receiving an encrypted message, you will be prompted to set up a password which you should retain for future communications. Please be aware that emails and texts are considered part of the clinical record and will be recorded in your chart.
- We publish an informative mental health blog on our website, www.psychhealthroanoke.com. You are welcome to visit our blog posts.

The following are NOT secure and/or confidential forms of communication:

- Mobile phone or texting
- Unencrypted email
- Social Media sites such as Facebook, Linked In, Twitter, Instagram, etc. Clinicians are NOT permitted to accept friend requests from current or former clients. Adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.
- You may email us at scheduling@psychhealthroanoke.com for quick, administrative issues such as changing appointment times.

Please Initial One Below and Sign:

_____ I choose to use encrypted email to ensure the maximum degree of confidentiality.

_____ I am accepting the risk of non-secure or encrypted email, mobile phones and texting. I understand the risks to confidentiality and am aware these are not secure forms of electronic communication.

I have read and understand the above policy. I understand that there are risks to confidentiality if I were to choose to avoid encrypted email or other electronic communication methods.

_____ _____

Please print patient's name Provider

_____ _____

Signature Date

Psychological Health Roanoke

Informed Consent for Telehealth

This informed consent for telehealth contains important information focusing on therapy by using the phone or the Internet. Please read this carefully and let me know if you have any questions. This signed document represents an agreement between us.

Benefits and risks of telehealth

Telehealth provides psychotherapy services remotely using telecommunications technologies, such as videoconferencing or telephone. One of the benefits of telehealth is that the client and clinician can engage in services without being in the same physical location. This may be helpful in situations in which the client and clinician are not able to meet in person. Both the clinician and the client must be located in Virginia during the scheduled session. Telehealth, however, requires technical competence on both our parts to be helpful. Although there are benefits to telehealth, there are some differences between in- person psychotherapy and telehealth, as well as some risks.

For example:

- Risks to confidentiality- Because telehealth sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for your session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.
- Issues related to technology- There are many ways that technology issues might impact telehealth. For example, technology may stop working during a session, other people might be able to get access to our private conference station, or store data could be accessed by unauthorized people or companies.
- Crisis management and intervention- Usually, I will not engage in telehealth clients who are currently in a crisis is ration requiring high levels of support and intervention. Before engaging in telehealth, we will develop an emergency response plan to address potential crisis situations that may arise during our telehealth work.

Electronic communications

We will decide together which type of telehealth service to use. You may have to have certain computer or cell phone systems to use telehealth services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telehealth.

For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made other arrangements. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email

or text. Therefore, I will not discuss any clinical information by email or text preferred that you do not either. Also, I do not regularly check my email or texts, nor do I respond immediately, so these methods **should not** be used if there is an emergency.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel you cannot wait for me to return your call, contact your family physician, psychiatrist, or the nearest emergency room. If I will be unavailable for an extended time, feel free to call our office. To reach a receptionist, call 540 –772–5140.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telehealth. However, the nature of electronic communication technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and backup systems when possible to help keep your information private, but there is a risk that are like trying to communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications. For example, only use secure networks for telehealth sessions and have passwords to protect the device you use for telehealth. The extent of confidentiality and the exceptions to confidentiality that was described in the psychological health Roanoke informed consent document still applies in telehealth. Please let me know if you have any questions about exceptions confidentiality.

Appropriateness of telehealth

From time to time we may schedule in-person sessions to check in with one another. I will let you know if I decide that telehealth is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting telehealth than in traditional in person therapy. To address some of these difficulties, we will create an emergency plan before engaging telehealth services. I will ask you to identify an emergency contact person who is near your location and whom I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911 or go to your nearest emergency room. Carilion Clinic has the Connect program (540-981-8181 or 800-284-8898) for psychiatric emergencies. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, please disconnect the session and I will wait 2 minutes and then re-contact you via telehealth platform on which we agreed to conduct

therapy. If you do not receive a call back within 2 minutes, then call me on the phone number I have provided you. If there is a technological failure and we are unable to resume the connection, you will only be charged prorated amount of actual session time.

Fees

The same fee rates will apply for telehealth as apply for in person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payer, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of session. Please contact your insurance company prior to our engaging in telehealth sessions in order to determine whether the sessions will be covered. Our financial office can provide assistance with this.

Records

The telehealth sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in person sessions in accordance with our policies.

Informed consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

_____ _____

Client Print Name Date

_____

Client Signature

_____ _____

Therapist Date

Psychological Health-Roanoke
Colonnade One Corporate Center
2840 Electric Road, Suite 200A
Roanoke, Virginia 24018
Phone (540) 772-5140 Fax (540) 772- 5158

AUTHORIZATION TO RELEASE PROFESSIONAL INFORMATION

Patient Name: _____

Date of Birth: _____ Phone #: _____

Information to be exchanged between: **Psychological Health- Roanoke**

And:

Name/Agency _____
Street Address _____
City, State, Zip Code _____
Phone & Fax Numbers _____

Purpose of Release:

Continuity of Care Communication Legal Representation
Other: _____

Information to be released:

Psychological Test Results Educational Evaluations
Written Treatment Information Recommendations PLEASE DO NOT FAX OVER
Verbal Treatment Information Any & All Information 10 PAGES, USE MAIL INSTEAD
Other: _____

I understand that information to be released may include information regarding drug abuse, alcohol abuse, psychological or psychiatric impairments. If information pertaining to drug and alcohol abuse or treatment of the same has been disclosed, it has been done so from records protected by Federal Confidentiality Rules (45 CRF Part 2). Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I certify this authorization is made voluntarily, I understand that the information to be released is protected under state and federal laws and cannot be re-disclosed without my further written consent unless provided for by state and federal law. A copy may be accepted in lieu of the original.

I understand I may revoke this authorization at any time, except to the extent that action has already been taken.

Please check one of the following options below:

____**This consent will expire at the end of one year from the date below.**
____**This consent will automatically renew each year unless notification is received to revoke.**

Date: _____ Signature of Patient: _____

Date: _____ Signature of Parent/Guardian: _____

Date: _____ Signature of Witness: _____

PSYCHOLOGICAL HEALTH ROANOKE

Specialty Psychological Pain Evaluation

You have been referred by your pain doctor for a specialty evaluation:

Implantable pain management device [ ] Pain medication management [ ]

This evaluation includes a psychological interview and extensive psychological testing, in which you will be asked to provide information about yourself. The psychological testing allows for a more complete and thorough evaluation than is possible with a psychological interview alone. The psychological testing provides a second source of information so that the report to your doctor is more complete and thorough than would be possible with a single psychological interview on a single day.

The purpose of the evaluation will be discussed with you by the psychologist at the start of the interview. If the evaluation is in relation to an Implantable pain management device, the psychologist will discuss the risks and benefits with you.

Following completion of the evaluation a report will be sent to your doctor to assist in making decisions about your medical care. There may also be recommendations for psychological treatment. You will be notified when the report is completed and will be offered the opportunity to return for a 2nd meeting with the psychologist to discuss the results. While this is optional for most patients, there are some for whom follow up is strongly recommended.

This type of evaluation is commonly done at the request of medical doctors and is considered to be usual, customary and reasonable.

This type of evaluation is required by some insurance companies and many pain doctors. This type of evaluation is approved by most insurance carriers. In the event these services are not covered by your insurance carrier, we will attempt to make individual arrangements with you.

There are separate charges for psychological interview and psychological testing, similar to the situation where you would be charged a fee for a medical doctor visit and for medical testing.

Name_____

Date_____

Witness_____

Date_____

Name _____ Date_____

MISCI

IN THE PAST 7 DAYS

1. I have been able to think clearly without extra effort
2. My mind has been as sharp as usual
3. I have been able to remember things as easily as usual without extra effort
4. I have been able to learn new things easily like telephone numbers or instructions
5. My ability to concentrate has been good
6. I have been able to pay attention and keep track of what I was doing without extra effort

NOT AT ALL	A LITTLE BIT	SOME WHAT	QUITE A BIT	VERY MUCH

IN THE PAST 7 DAYS

7. I have had trouble shifting back and forth between different activities that require thinking
8. I had trouble planning out the steps of a task
9. I have had to work harder than usual to express myself clearly
10. I have had trouble finding the right word(s) to express myself

NEVER	RARELY	SOME TIMES	OFTEN	VERY OFTEN

Name _____ Date _____

Spiritual Meaning Scale (SMS)

Directions: Please rate the extent to which you agree/disagree with each statement listed below according to the following scale

1	2	3	4	5
I totally disagree	I partially disagree	I'm in between	I partially agree	I totally agree

_____1. There is no particular reason why I exist.

_____2. We are each meant to make our own special contribution to the world.

_____3. I was meant to actualize my potential.

_____4. Life is inherently meaningful.

_____5. I will never have a spiritual bond with anyone.

_____6. When I look deep within my heart, I see a life I am compelled to pursue.

_____7. My life is meaningful.

_____8. In performing certain tasks, I can feel something higher or transcendent working through me.

_____9. Our flawed and often horrific behavior indicates that there is little or no meaning inherent in our existence.

_____10. I find meaning even in my mistakes and sins.

_____11. I see a special purpose for myself in this world.

_____12. There are certain activities, jobs, or services to which I feel called.

_____13. There is no reason or meaning underlying human existence.

_____14. Something purposeful is at the heart of this world.

_____15. We are all participating in something larger and greater than any of us.

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

SF-36 QUESTIONNAIRE

Name:_____ **Ref. Dr:**_____ **Date:** _____

ID#: _____ **Age:** _____ **Gender: M / F**

Please answer the 36 questions of the **Health Survey** completely, honestly, and without interruptions.

GENERAL HEALTH:
In general, would you say your health is:
◯ Excellent ◯Very Good ◯Good ◯Fair ◯Poor

Compared to one year ago, how would you rate your health in general now?
◯ Much better now than one year ago
◯Somewhat better now than one year ago
◯About the same
◯Somewhat worse now than one year ago
◯Much worse than one year ago

LIMITATIONS OF ACTIVITIES:
The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.
◯Yes, Limited a lot ◯Yes, Limited a Little ◯No, Not Limited at all

Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
◯Yes, Limited a Lot ◯Yes, Limited a Little ◯No, Not Limited at all

Lifting or carrying groceries
◯Yes, Limited a Lot ◯Yes, Limited a Little ◯No, Not Limited at all

Climbing several flights of stairs
◯Yes, Limited a Lot ◯Yes, Limited a Little ◯No, Not Limited at all

Climbing one flight of stairs
◯Yes, Limited a Lot ◯Yes, Limited a Little ◯No, Not Limited at all

Bending, kneeling, or stooping
◯Yes, Limited a Lot ◯Yes, Limited a Little ◯No, Not Limited at all

Walking more than a mile
◯Yes, Limited a Lot ◯Yes, Limited a Little ◯No, Not Limited at all

Walking several blocks
◯Yes, Limited a Lot ◯Yes, Limited a Little ◯No, Not Limited at all

Walking one block
◯Yes, Limited a Lot ◯Yes, Limited a Little ◯No, Not Limited at all

Bathing or dressing yourself

◯Yes, Limited a Lot ◯Yes, Limited a Little ◯No, Not Limited at all

PHYSICAL HEALTH PROBLEMS:

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

Cut down the amount of time you spent on work or other activities

◯Yes ◯No

Accomplished less than you would like

◯Yes ◯No

Were limited in the kind of work or other activities

◯Yes ◯No

Had difficulty performing the work or other activities (for example, it took extra effort)

◯Yes ◯No

EMOTIONAL HEALTH PROBLEMS:

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

Cut down the amount of time you spent on work or other activities

◯Yes ◯No

Accomplished less than you would like

◯Yes ◯No

Didn't do work or other activities as carefully as usual

◯Yes ◯No

SOCIAL ACTIVITIES:

Emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

◯Not at all ◯Slightly ◯Moderately ◯Severe ◯Very Severe

PAIN:

How much bodily pain have you had during the past 4 weeks?

◯None ◯Very Mild ◯Mild ◯Moderate ◯Severe ◯Very Severe

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

◯Not at all ◯A little bit ◯Moderately ◯Quite a bit ◯Extremely

ENERGY AND EMOTIONS:
These questions are about how you feel and how things have been with you during the last 4 weeks. For each question, please give the answer that comes closest to the way you have been feeling.

Did you feel full of pep?
- ◯ All of the time
- ◯ Most of the time
- ◯ A good Bit of the Time
- ◯ Some of the time
- ◯ A little bit of the time
- ◯ None of the Time

Have you been a very nervous person?
- ◯ All of the time
- ◯ Most of the time
- ◯ A good Bit of the Time
- ◯ Some of the time
- ◯ A little bit of the time
- ◯ None of the Time

Have you felt so down in the dumps that nothing could cheer you up?
- ◯ All of the time
- ◯ Most of the time
- ◯ A good Bit of the Time
- ◯ Some of the time
- ◯ A little bit of the time
- ◯ None of the Time

Have you felt calm and peaceful?
- ◯ All of the time
- ◯ Most of the time
- ◯ A good Bit of the Time
- ◯ Some of the time
- ◯ A little bit of the time
- ◯ None of the Time

Did you have a lot of energy?
- ◯ All of the time
- ◯ Most of the time
- ◯ A good Bit of the Time
- ◯ Some of the time
- ◯ A little bit of the time
- ◯ None of the Time

Have you felt downhearted and blue?

- ◯ All of the time
- ◯ Most of the time
- ◯ A good Bit of the Time
- ◯ Some of the time
- ◯ A little bit of the time
- ◯ None of the Time

Did you feel worn out?

- ◯ All of the time
- ◯ Most of the time
- ◯ A good Bit of the Time
- ◯ Some of the time
- ◯ A little bit of the time
- ◯ None of the Time

Have you been a happy person?

- ◯ All of the time
- ◯ Most of the time
- ◯ A good Bit of the Time
- ◯ Some of the time
- ◯ A little bit of the time
- ◯ None of the Time

Did you feel tired?

- ◯ All of the time
- ◯ Most of the time
- ◯ A good Bit of the Time
- ◯ Some of the time
- ◯ A little bit of the time
- ◯ None of the Time

SOCIAL ACTIVITIES:

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

- ◯ All of the time
- ◯ Most of the time
- ◯ Some of the time
- ◯ A little bit of the time
- ◯ None of the Time

GENERAL HEALTH:
How true or false is each of the following statements for you?

I seem to get sick a little easier than other people
◯Definitely true ◯Mostly true ◯Don't know ◯Mostly false ◯Definitely false

I am as healthy as anybody I know
◯Definitely true ◯Mostly true ◯Don't know ◯Mostly false ◯Definitely false

I expect my health to get worse
◯Definitely true ◯Mostly true ◯Don't know ◯Mostly false ◯Definitely false

My health is excellent
◯Definitely true ◯Mostly true ◯Don't know ◯Mostly false ◯Definitely false

Duke–UNC Functional Social Support Questionnaire (FSSQ)

Here is a list of some things that other people do for us or give us that may be helpful or supportive. Please read each statement carefully and place an 'X' in the column that is closest to your situation. Give only 1 answer per row.

	5	4	3	2	1
	As much as I would like	Almost as much as I would like	Some, but would like more	Less than I would like	Much less than I would like
1. I have people who care what happens to me.					
2. I get love and affection.					
3. I get chances to talk to someone about problems at work or with my housework.					
4. I get chances to talk to someone I trust about my personal or family problems.					
5. I get chances to talk about money matters.					
6. I get invitations to go out and do things with other people.					
7. I get useful advice about important things in life.					
8. I get help when I am sick in bed.					

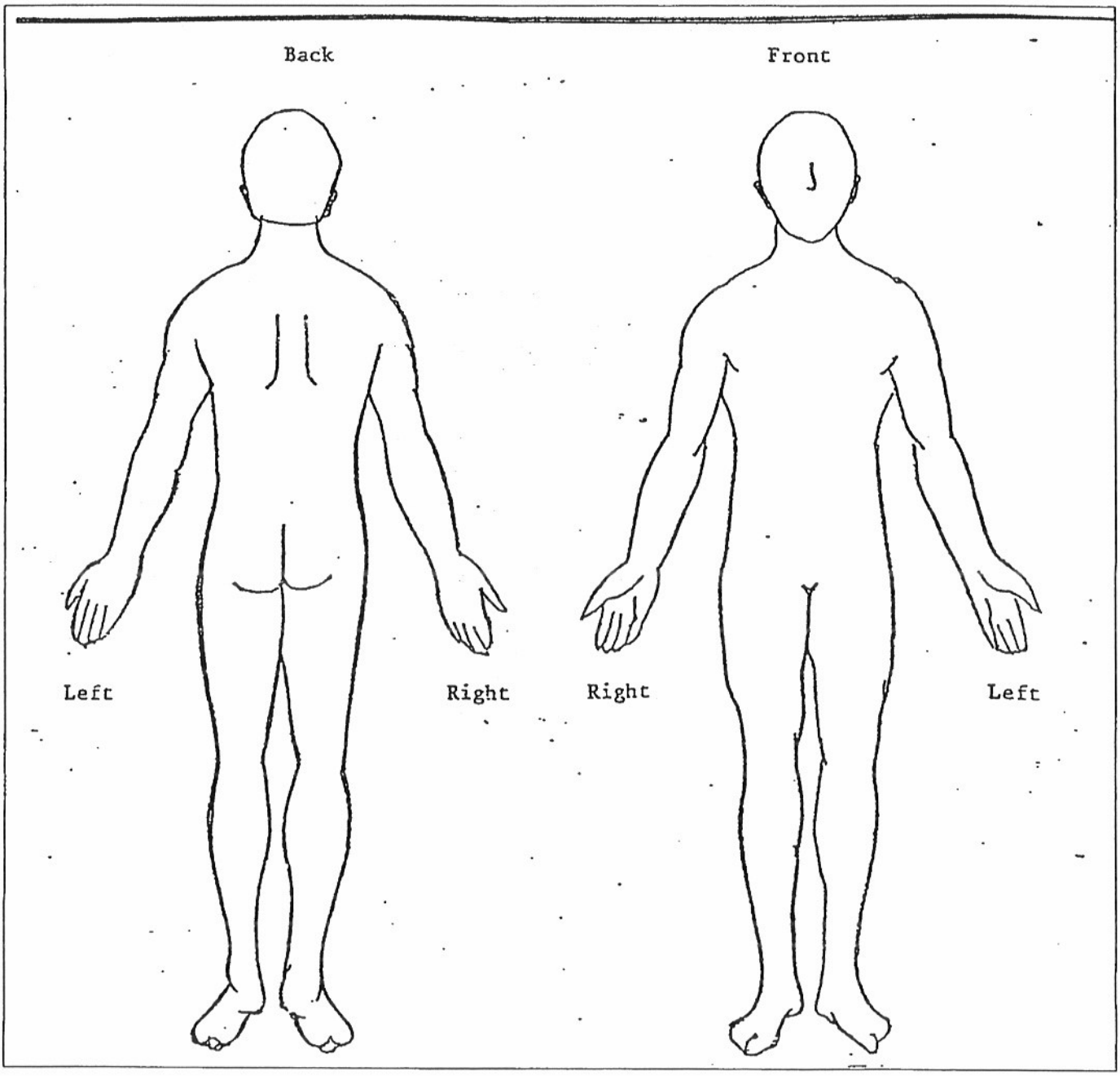
Source: adultmeducation.com

Patient Pain Drawing

Name:_____ Date:_____

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw in you face.

Aching	Numbness	Pins and Needles	Burning	Stabbing	Other
^ ^ ^	= = =	o o o	x x x	/ / /	o o o



McGill Pain Questionnaire

There are many words to describe pain. Some of these are grouped below. Check any words that describe the pain that you have right now. (You do not have to check words in every group).

1.	2.	3.	4.
Flickering	Jumping	Pricking	Sharp
Quivering	Flashing	Boring	Cutting
Pulsing	Shooting	Drilling	Lacerating
Throbbing		Stabbing	
Beating			
Pounding			

5.	6.	7.	8.
Pinching	Tugging	Hot	Tingling
Pressing	Pulling	Burning	Itchy
Gnawing	Wrenching	Scalding	Smarting
Cramping		Searing	Stinging
Crushing			

9.	10.	11.	12.
Dull	Tender	Tiring	Sickening
Sore	Taut	Exhausting	Suffocating
Hurting	Rasping		
Aching	Splitting		
Heavy			

13.	14.	15.	16.
Fearful	Punishing	Wretching	Annoying
Frightful	Grueling	Blinding	Troublesome
Terrifying	Cruel		Miserable
	Vicious		Intense
	Killing		Unbearable

17.	18.	19.	20.
Spreading	Tight	Cool	Nagging
Radiating	Numb	Cold	Nauseating
Penetrating	Drawing	Freezing	Agonizing
Piercing	Squeezing		Dreadful
	Tearing		Torturing

Name: _____ **Date:** _____

Psychological Health Roanoke$_{PC}$

HXQ

Zen Zone Digital

HEALTH OUTCOME EXPECTATION QUESTIONNAIRE

PAIN RATING - PAIN PROCEDURE

A. Place a slash (/) along the line below to indicate your pain NOW.

NO PAIN |_____| WORST PAIN IMAGINABLE

B. Place a slash (/) along the line below to indicate your pain as you EXPECT it to be 3 MONTHS AFTER THE PAIN PROCEDURE.

NO PAIN |_____| WORST PAIN IMAGINABLE

C. Place a slash (/) along the line below to indicate your pain as you EXPECT it to be 6 MONTHS AFTER THE PAIN PROCEDURE.

NO PAIN |_____| WORST PAIN IMAGINABLE

D. Place a slash (/) along the line below to indicate your pain as you EXPECT it to be ONE YEAR AFTER THE PAIN PROCEDURE.

NO PAIN |_____| WORST PAIN IMAGINABLE

NAME_____ DATE_____