

Psychological Health-Roanoke-PATIENT REGISTRATION

Date: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Patient: _____

First

Middle

Last

Address _____

Street and/or 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: Name _____ Relation _____ DOB _____

SSN _____ Employer _____

Name Of Insurance _____ ID # _____

Group # _____ Pre-authorization Phone# _____

***** IF NO INSURANCE, 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 ensure 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.**

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 may result in your not being able to schedule future appointments until paid.

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.

Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. You are responsible for being aware of your insurance benefit coverage.

I understand that my health insurance company may deny payment for the services identified above. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

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.

We ask that you give 24 hours' notice if you intend to cancel an appointment. Appointments cancelled with less than 24 hours' notice and missed appointments will result in a mandatory \$25 fee unless there is illness or an emergency. Your therapist may also bill you an additional fee. Your insurance will not pay for missed or cancelled appointments. Please discuss this policy with your therapist.

METHODS OF PAYMENT:

Our office accepts the following payment methods: Cash, Personal Check, and Credit/Debit 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, you understand that our office reports all accounts 90 days in arrears to an outside collection agency. If your account is turned over for collections, the amount due will include the balance owed plus all collection agency and attorney's fees. You agree to pay these fees should your account be turned over to collections.

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 for us to service your account or to collect any amounts you may owe and that we may contact you by telephone at any number associated with your account. 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 THE ABOVE INFORMATION. *****

Patient Signature: _____ Date: _____

Please initial below:

_____ **I have read and understand the HIPAA privacy policy. I understand I may request a paper copy of this policy at any time.**

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 regarding 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 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 clinician 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 clinician before acting on it.

The clinician has further discussed with me scheduling policies, fees to be charged, and matters relating to insurance, and if applicable, pre-authorization and utilization review issues.

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.

Patient Signature: _____ **Date:** _____

Clinician Signature: _____ **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

NAME: _____ DATE: _____

Patient Health Questionnaire-9 (PHQ-9)

Over the last <u>2 weeks</u> , 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 everyday
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
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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...	<u>YES</u>	<u>NO</u>
	...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? <i>Please circle one response only.</i>	<u>YES</u>	<u>NO</u>
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? <i>Please circle one response only.</i>	<u>No Problem</u> <u>Moderate Problem</u>	<u>Minor Problem</u> <u>Serious Problem</u>

NAME: _____ DATE: _____

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

Please circle your response:

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
PATIENT HISTORY FORM

PLEASE HELP US UNDERSTAND MORE ABOUT YOU BY THOROUGHLY COMPLETING THIS QUESTIONNAIRE.

DATE: _____

AGE: _____

NAME: _____

WHO REFERRED YOU TO OUR DEPARTMENT? _____

BRIEFLY STATE WHAT BROUGHT YOU HERE, AND HOW IT DEVELOPED:

ON THE SCALE BELOW, ESTIMATE THE SEVERITY OF YOUR SYMPTOMS (CHECK ONE):

MILDLY
UPSETTING

MODERATELY
SEVERE

SEVERE

EXTREMELY
SEVERE

INCAPACITATING

WHOM HAVE YOU CONSULTED ABOUT THE ABOVE AND WHAT HAVE YOU TRIED?
(PLEASE INCLUDE NAME(S) OF PREVIOUS COUNSELORS)

EDUCATIONAL BACKGROUND

HIGHEST EDUCATIONAL DEGREE OR VOCATIONAL PROGRAM: _____

SCHOOL ATTENDED: _____ YEAR COMPLETED: _____ GPA: _____

MEDICAL/LIFESTYLE INFORMATION

HEIGHT? _____ WEIGHT? _____ WHEN WAS YOUR LAST EXAM? _____

DOCTOR'S NAME: _____

PLEASE LIST ANY SURGICAL OPERATIONS OR MAJOR HEALTH PROBLEMS:

MEDICAL INFORMATION

PLEASE LIST ANY SIGNIFICANT ACCIDENTS: _____

HAVE YOU EVER RECEIVED A HEAD INJURY? _____ IF SO, WHEN? _____

HAVE YOU EVER HAD A SEIZURE? _____ IF SO, WHEN? _____

PLEASE LIST ALL MEDICATIONS YOU CURRENTLY TAKE (INCLUDE DOSAGE AND SIDE EFFECTS):

HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC TREATMENT OR SUBSTANCE ABUSE? _____

IF YES, CHECK THE HOSPITALS WHERE YOU HAVE RECEIVED INPATIENT PSYCHIATRIC TREATMENT AND/OR SUBSTANCE ABUSE:

- | | |
|--|---|
| <input type="checkbox"/> ROANOKE MEMORIAL HOSPITAL | <input type="checkbox"/> ST ALBANS PSYCHIATRIC HOSPITAL |
| <input type="checkbox"/> CATAWBA HOSPITAL | <input type="checkbox"/> LEWIS GALE MEDICAL CENTER |
| <input type="checkbox"/> MT. REGIS | <input type="checkbox"/> VIRGINIA BAPTIST HOSPITAL |
| <input type="checkbox"/> UNIVERSITY OF VIRGINIA | <input type="checkbox"/> LIFE CENTER OF GALAX |
| <input type="checkbox"/> OTHER : _____ | |

WHAT ARE YOUR EXERCISE HABITS? _____

WHAT DO YOU DO FOR RELAXATION OR FUN?

DO YOU USE ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

ALCOHOL ____ IF YES: HOW MUCH? _____ HOW OFTEN? _____

CIGARETTES ____ IF YES: HOW MUCH? _____ HOW OFTEN? _____

STREET DRUGS* ____ IF YES: HOW MUCH? _____ HOW OFTEN? _____

(*STREET DRUGS INCLUDE BUT ARE NOT LIMITED TO MARIJUANA, COCAINE, LSD, ECSTASY, ETC.)

FAMILY INFORMATION

RELATIONSHIP STATUS: (CHECK ALL THAT APPLY)

SINGLE ENGAGED WIDOW(ER) MARRIED SEPARATED DIVORCED

GAY LESBIAN BI-SEXUAL TRANSGENDER

YOUR CHILDREN (INCLUDE AGES): _____

PLEASE LIST ALL CURRENT MEMBERS OF YOUR HOUSEHOLD: _____

FAMILY OF ORIGIN:

BIRTHPLACE: _____ **RAISED:** _____
 State/City/Country State/City/Country

FATHER LIVING DECEASED – CAUSE OF DEATH: _____

MOTHER LIVING DECEASED – CAUSE OF DEATH: _____

BROTHER(S) AND SISTER(S): (INCLUDE AGES): _____

HAVE ANY FAMILY MEMBERS BEEN TREATED FOR EMOTIONAL PROBLEMS? _____

IF YES, LIST WHO AND THEIR DIAGNOSIS: _____

STRESS CHECKLIST (ADULTS)

PLEASE CHECK ALL THAT APPLY OVER THE PAST YEAR:

- | | |
|---|---|
| <input type="checkbox"/> DEATH OF SPOUSE | <input type="checkbox"/> DIVORCE |
| <input type="checkbox"/> MARITAL SEPARATION | <input type="checkbox"/> JAIL TERM |
| <input type="checkbox"/> PERSONAL INJURY OR ILLNESS | <input type="checkbox"/> MARRIAGE |
| <input type="checkbox"/> DEATH OF CLOSE FAMILY MEMBER | <input type="checkbox"/> FIRED AT WORK |
| <input type="checkbox"/> CHANGE IN HEALTH OF FAMILY MEMBER | <input type="checkbox"/> RETIREMENT |
| <input type="checkbox"/> MARITAL RECONCILIATION | <input type="checkbox"/> SEX DIFFICULTIES |
| <input type="checkbox"/> PREGNANCY AND/OR ABORTION | <input type="checkbox"/> GAIN NEW FAMILY MEMBER |
| <input type="checkbox"/> BUSINESS ADJUSTMENT | <input type="checkbox"/> DEATH OF CLOSE FRIEND |
| <input type="checkbox"/> CHANGE IN FINANCIAL STATE | <input type="checkbox"/> CHANGE IN SCHOOL |
| <input type="checkbox"/> CHANGE IN RESIDENCE | <input type="checkbox"/> TROUBLE WITH BOSS |
| <input type="checkbox"/> CHANGE TO DIFFERENT LINE OF WORK | <input type="checkbox"/> BEGIN OR END OF SCHOOL |
| <input type="checkbox"/> CHANGE IN RESPONSIBILITIES AT WORK | <input type="checkbox"/> CHANGE IN RECREATION |
| <input type="checkbox"/> CHANGE IN WORK HOURS/CONDITIONS | <input type="checkbox"/> SPOUSE BEGAN OR STOPPED WORK |
| <input type="checkbox"/> FORECLOSURE MORTGAGE/LOAN | <input type="checkbox"/> CHANGE IN LIVING CONDITIONS |
| <input type="checkbox"/> CHANGE IN NUMBER OF SPOUSE ARGUMENTS | <input type="checkbox"/> CHANGE IN CHURCH ACTIVITY |
| <input type="checkbox"/> SON/DAUGHTER LEAVING HOME | <input type="checkbox"/> TROUBLE WITH IN-LAWS |
| <input type="checkbox"/> INVOLVEMENT IN EXTRAMARITAL AFFAIR | <input type="checkbox"/> REVISION OF PERSONAL HABITS |
| <input type="checkbox"/> OUTSTANDING PERSONAL ACHIEVEMENT | <input type="checkbox"/> CHANGE IN SOCIAL ACTIVITIES |
| <input type="checkbox"/> CHANGE IN SLEEPING HABITS | <input type="checkbox"/> CHANGE IN EATING HABITS |
| <input type="checkbox"/> CHANGE IN NUMBER OF FAMILY GET TOGETHERS | <input type="checkbox"/> MINOR VIOLATIONS OF THE LAW |

STRESS CHECKLIST FOR ADOLESCENTS

(PLEASE CHECK ALL THAT APPLY)

- | | |
|---|---|
| <input type="checkbox"/> PARENT PASSED AWAY | <input type="checkbox"/> PARENTS DIVORCED |
| <input type="checkbox"/> PARENT TRAVEL AS PART OF JOB | <input type="checkbox"/> PARENTS SEPARATED |
| <input type="checkbox"/> CLOSE FAMILY MEMBER DIED | <input type="checkbox"/> PERSONAL ILLNESS /INJURY |
| <input type="checkbox"/> PARENT REMARRIED | <input type="checkbox"/> PARENT FIRED FROM JOB |
| <input type="checkbox"/> PARENTS RECONCILED | <input type="checkbox"/> MOTHER GOES TO WORK |
| <input type="checkbox"/> CHANGE IN HEALTH OF FAMILY MEMBER | <input type="checkbox"/> MOTHER BECAME PREGNANT |
| <input type="checkbox"/> SCHOOL DIFFICULTIES | <input type="checkbox"/> SCHOOL ADJUSTMENT |
| <input type="checkbox"/> BIRTH OF SIBLING | <input type="checkbox"/> STARTED A NEW ACTIVITY |
| <input type="checkbox"/> CHANGE IN FAMILY'S FINANCIAL CONDITION | <input type="checkbox"/> INJURY/ILLNESS OF CLOSE FRIEND |
| <input type="checkbox"/> CHANGE IN NUMBER OF FIGHTS WITH SIBLINGS | <input type="checkbox"/> THREATENED BY VIOLENCE AT SCHOOL |
| <input type="checkbox"/> THEFT OF PERSONAL POSSESSION | <input type="checkbox"/> CHANGE IN RESPONSIBILITIES |
| <input type="checkbox"/> OLDER BROTHER/SISTER LEFT HOME | <input type="checkbox"/> TROUBLE WITH GRANDPARENTS |
| <input type="checkbox"/> OUTSTANDING PERSONAL ACHIEVEMENT | <input type="checkbox"/> MOVED TO ANOTHER CITY |
| <input type="checkbox"/> MOVE TO ANOTHER PART OF TOWN | <input type="checkbox"/> RECEIVED OR LOST PET |
| <input type="checkbox"/> CHANGE IN PERSONAL HABITS | <input type="checkbox"/> TROUBLE WITH TEACHER |
| <input type="checkbox"/> MOVE TO A NEW HOUSE | <input type="checkbox"/> CHANGE IN NEW SCHOOL |
| <input type="checkbox"/> CHANGES IN SLEEP | <input type="checkbox"/> VACATION WITH FAMILY |
| <input type="checkbox"/> CHANGE OF FRIENDS | <input type="checkbox"/> CHANGE IN EATING HABITS |
| <input type="checkbox"/> CHANGE IN NUMBER OF FAMILY GET TOGETHERS | <input type="checkbox"/> CHANGES IN AMOUNT OF TV VIEWING |
| <input type="checkbox"/> PUNISHED FOR NOT TELLING THE TRUTH | |

Place a checkmark before all that apply to you:

- Current use of alcohol**
- Current use of drugs (other than prescribed)**
- Inappropriate use of prescription medications**
- Alcohol use is or has been a problem**
- Drug use is or has been a problem**
- Instances of poor judgment related to substance use**
- Others have been concerned about my drinking**
- Others have been concerned about my drug use**
- Instances of inappropriate drinking and driving**
- Instances of mixing drugs and alcohol**
- Use of alcohol or drugs as a method of coping**
- Use of alcohol or drugs to feel more comfortable socially**
- "Self-medicating" with alcohol or drugs**
- Past treatment for substance use**
- History of efforts to control or cut down alcohol or drug use**
- History of legal problems related to alcohol or drug use**
- Family members with a history of excessive alcohol use**
- Some problems with gambling**
- Some problems with compulsive sexual behavior**
- Spending too much time on the computer and/or gaming**
- Overspending**
- Overworking**
- Tobacco Addiction (Cigarettes, Cigars, Smokeless, Vaping)**
- Other Excessive Behaviors**

Psychological Health Roanoke: Telehealth/Electronic Communications/Social Media Policy

Psychological Health Roanoke follows standard HIPAA regulations. To ensure your right to have your privacy protected, we ask you join us in adhering to the following standards. Your therapist will review and/or discuss any questions you may have related to this policy.

Secure communication services we offer:	These are NOT secure/ confidential forms of communication:
Telephone contact – available during business hours with our reception staff.	Texting
Encrypted email – You will be prompted to set up a password which you should retain for future communications. Emails and texts with your therapist are considered part of the clinical record and will be recorded in your chart.	Unencrypted email

Clinicians are NOT permitted to accept friend requests from current or former clients on any social media sites.

Telehealth Services:

Telehealth services allow the client and clinician to engage in services without being in the same physical location. **Both the clinician and the client must be in Virginia during the scheduled session, unless otherwise agreed upon ahead of time.** There is potential for other people overhearing sessions if you are not in a private place during the session. Therefore, you should participate in therapy only while in a room or area where other people are not present. Your therapist will take reasonable steps to ensure your privacy on their end.

If an emergency/crisis were to arise during the therapy session, we will contact your emergency contact you listed on your initial paperwork to assist in addressing the situation. If the session is interrupted for any emergency reason, 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. If the session is interrupted for any non-emergency reason, we will call you back.

There is no guarantee your insurance will cover telehealth services. Please contact your insurance company prior to engaging in telehealth sessions to determine if the sessions will be covered. Our financial office can help with this.

The telehealth sessions shall not be recorded in any way unless agreed to in writing by mutual consent. This agreement is intended as a supplement to the informed consent that your therapist and you agreed to at the outset of your clinical work together and does not amend any of the terms of that agreement.

This signed document represents an agreement between your therapist and you. Your signature below indicates agreement with its terms and conditions.

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

Therapist's name

Signature of patient/parent/guardian

Date

If you would like to have your email communication encrypted, please initial here: _____

Psychological Health-Roanoke
Colonnade One Corporate Center
2840 Electric Road, Suite 200
Roanoke, Virginia 24018

Phone (540) 772-5140 Fax (540) 772- 5158

For medical records, call 540-562-8766 or email (sstanley@psychhealthroanoke.com)

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 Number: _____ Fax Number: _____

PCP Psychiatrist Other: _____

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 CFR 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.

This consent will automatically renew each year unless notification to revoke is received in writing. I understand I may revoke this authorization at any time, except to the extent that action has already been taken.

Date: _____ Signature of Patient/Parent/Guardian: _____

Date: _____ Signature of Witness: _____