Advantage Employee Assistance Program
Intake Information

1. Client's Name: _____

   Relationship to Employee: _____

   Employee's Name: _____

   Employer: _____Job Title: _____

   Length of Employment: _____ Full Time ( ) Part Time ( ) Retired ( )

2. Is this the first time you are using the EAP benefit? Yes ( ) No ( )
   If no, when was your last visit here _____.

<u>COMPLETE THE FOLLOWING ONLY IF YOU ARE THE EMPLOYEE</u>

3. Were you referred to EAP by your Supervisor? Yes ( ) No ( ) NA ( )

4. If yes, name of Supervisor: _____

   Phone: _____

5. Have you received disciplinary action/probation/suspension?
   Yes ( ) No ( ) N/A ( )

6. During the past 30 days: Number of job accidents: _____

   - Number of sick days used: _____
   - Number of times tardy or left early (unplanned): _____

Explain:

_____

_____

_____

Client Rights and Responsibilities

The Advantage Employee Assistance Program (EAP) is provided without cost to you to assist in clarification of personal problems and identification of appropriate resources or services in the community for resolution of the problems you discuss with the EAP personnel. The EAP will monitor that service to ensure that your needs are being met. It is your responsibility to pay for services provided by any outside resources. Consult your group insurance office if you have any questions on your insurance coverage.

CONFIDENTIALITY- The EAP will not reveal information that you disclose to EAP personnel to anyone outside the EAP except in the following circumstances: (1) you consent in writing; (2) the law requires disclosure (generally, the law does not require information to be released unless life or safety is seriously threatened); (3) the EAP discerns a threat to security of the company or to national security; and/or (4) insurance verification/claims certification is required.

EMPLOYER/SUPERVISOR REFERRALS- The EAP will not advise your employer/supervisor of your participation in the EAP unless you are referred by your employer/supervisor because of a work performance problem. Should that be the case, the EAP counselor will request that you sign a release of information form and then confidentially advise your employer/supervisor that you are coming to the EAP and are, or are not, in compliance with a plan to work on the problem.

VOLUNTARY PARTICIPATION- Participation in the EAP is solely at your discretion. In the event you have been offered EAP services, refusal to accept or utilize the EAP is not, in itself, a cause for disciplinary action. However, such refusal or failure to accept help may be taken into consideration when evaluating subsequent unsatisfactory performance or behavior. Furthermore, you are also advised that participation in the EAP does not constitute a waiver of your employer's right to take disciplinary measures in the event of unsatisfactory performance or behavior prior to, during or subsequent to your participation in the EAP.

FINANCIAL RESPONSIBILITY- Services provided by the EAP counselor are free. However, if the EAP counselor refers you to an outside resource, payment will be your responsibility. The provisions of your medical insurance govern any possible reimbursement for outside services.

I hereby certify that to the best of my knowledge, I have not been terminated from employment with my employer.

I have read this statement and understand the content.

_____ _____

Signature Date

_____ _____

Witness Date

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 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 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**

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 youwere 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**

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? **Please circle your response:**	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

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:

( ) ROANOKE MEMORIAL HOSPITAL
( ) CATAWBA HOSPITAL
( ) MT. REGIS
( ) UNIVERSITY OF VIRGINIA
( ) OTHER :_____

( ) ST ALBANS PSYCHIATRIC HOSPITAL
( ) LEWIS GALE MEDICAL CENTER
( ) VIRGINIA BAPTIST HOSPITAL
( ) LIFE CENTER OF GALAX

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*:

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

STRESS CHECKLIST FOR ADOLESCENTS

(PLEASE CHECK ALL THAT APPLY)

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

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 PC

Date: _____

Patient name: _____ DOB: _____

Release for Coordination with Primary Care Physician:

To coordinate care, my behavioral healthcare practitioner may wish to release pertinent information about my current treatment to my psychiatrist. I hereby authorize the use of 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.

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

Check one: ☐ I do ☐ I do not give permission to the Primary Care Physician named below to exchange information about my current treatment with my therapist.

Name of Primary Care Physician: _____

Name of Practice or Location _____

SIGNATURE IS REQUIRED

Patient (Guardian) Signature _____ Date: _____

Witness Signature: _____ Date: _____

Below this line to be completed by Psychological Health Roanoke Clinician

To: _____

Name of Practice or Location _____

Dear Dr. _____

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 further information, please contact me at 540-772-5140 or fax to 540-772-5157.

Clinician Signature: _____ Date: _____

Psychological Health ★ Roanoke PC

Date: _____

Patient name: _____ DOB: _____

Release for Coordination with Psychiatrist:

To coordinate care, my behavioral healthcare practitioner may wish to release pertinent information about my current treatment to my psychiatrist. I hereby authorize the use of 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.

☐ **I do not have a psychiatrist.**

Check one: ☐ I do ☐ I do not give permission to the psychiatrist named below to exchange information about my current treatment with my therapist.

Name of Psychiatrist: _____

Name of Practice or Location _____

SIGNATURE IS REQUIRED

Patient (Guardian) Signature _____ Date: _____

Witness Signature: _____ Date: _____

Below this line to be completed by Psychological Health Roanoke Clinician

To: _____

Name of Practice or Location _____

Dear Dr. _____

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 ___ Evaluation ___ Inpatient unit

___ Family psychotherapy ___ Intensive outpatient program

___ Group psychotherapy ___ Partial hospitalization program

Comments: _____

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

Clinician Signature: _____ Date: _____