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-MINOR REGISTRATION

Date:_____ Home Phone: _____
Cell Phone: _____
Email:_____

Patient:_____
First Middle Last
Address_____
Street and PO Box

_____
City State Zip Code

Age____Gender____Birth Date_____Social Security # _____
Responsible Party_____DOB:_____
Social Security #_____Relation to patient:_____
Employer/Address_____
Occupation:_____Employer Phone _____

If custody is shared both responsible parties need to be listed:

Responsible Party_____DOB:_____
Home Address (if different from above):_____
Home #:_____Cell#:_____(if different than above)
Social Security #_____Relation to patient: _____
Employer:_____
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. *****

Parent/Guardian 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***

PSYCHOLOGICAL HEALTH ROANOKE, PC
2840 Electric Road, Suite 200
Roanoke, VA 24018
Tel: 540-772-5140 Fax: 540-772-5157

PARENT/GUARDIAN CONTRACT

_____ _____
Client's Name Date of Birth

I/We have requested that Psychological Health Roanoke provide evaluation and treatment for my child, named above.

I/We have read the Office Policy Statement and the handout on Confidentiality and agree to adhere to the policies explained in these handouts.

I agree that to protect the confidential nature of my child's psychotherapy I will not call the treating therapist as a witness in any custody, visitation, support or other subsequent court proceedings. I have been advised that evaluations pertaining to custody issues should be done by neutral evaluators who assess all parties involved and that the child's therapist precludes acting as custody evaluator.

I understand that the charge will be $135 for the initial session and $101 for subsequent 45 minute sessions. This may differ as determined by your insurance company. Psychological Testing is billed at $143 per hour including time for scoring and interpretation. There will be a charge of $101 per hour for other professional services not covered by insurance. This includes report writing, telephone conversations lasting longer than 10 minutes, consultations and any other service you request. I understand that payment is due when the services are rendered. I have been informed that if for any reason there is an outstanding balance over 90 days, PHR will take action to collect this balance and I will be responsible for any additional collection fees and costs. By my signature below I attest that I will be responsible for these charges.

If at any time I/we decide that therapy is not benefitting my/our son/daughter, I/we agree to notify Psychological Health Roanoke in writing that the therapy is to be terminated. I/We agree to assume financial responsibility for all charges incurred. I/We also agree to discuss termination of therapy and termination of my/our financial responsibility for it with my/our son/daughter so that he/she will understand the reason(s) for these decisions.

_____ _____
Date Relationship & Signature of Parent/Guardian

If parents have joint legal custody, both parents need to sign permissions for their child to be seen here. A copy of this contract and the applicable handouts can be provided for the other parent.

Non-Subpoena Contract for Clients in Couple, Family, or Child/Parent Therapy

ALL PARTIES ACKNOWLEDGE THAT THE GOAL OF PSYCHOTHERAPY IS THE AMELIORATION OF PSYCHOLOGICAL DISTRESS AND INTERPERSONAL CONFLICT, AND THAT THE PROCESS OF PSYCHOTHERAPY DEPENDS ON TRUST AND OPENNESS DURING THE THERAPY SESSIONS.

It is understood that no party shall attempt to subpoena PHR or the treating therapist's records for a deposition or court hearing of any kind for any reason.

Therefore, it is understood by all parties that if they request services from PHR, they are expected not to use information given to during the therapy process for their own legal purposes or against any of the other parties in a court or judicial setting of any kind.

Further, any testimony that interested parties may request will be met with "I respectfully choose not to answer on the basis of therapist-client privileged communication," pursuant to:

> **Virginia State Law Sec. 8.01-399. Communications between physicians and patients (Supreme Court Rule 2:505).**
>
> **A. Except at the request or with the consent of the patient, or as provided in this section, no duly licensed practitioner of any branch of the healing arts shall be permitted to testify in any civil action, respecting any information that he may have acquired in attending, examining or treating the patient in a professional capacity.**

Any action to be taken to uphold this agreement and the integrity of the client/therapist relationship will result in all applicable fees and expenses. These fees and expenses include, but are not limited, to legal fees, fees for PHR staff time, phone calls, face to face meetings, and time away from the office. Any additional applicable fees and expenses incurred by any PRH staff member will also be assessed and charged.

Signed and Dated _____

Signed and Dated_____

Signed and Dated_____

Signed and Dated_____

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: 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: _____

Patient #_____

Psychological Health-Roanoke
Child History Form

Child's Name _____ Date of Birth _____ Age _____

Address _____Gender ____ Race _____

Street

_____

City State Zip Code County

Parent (s) or Guardian (s) _____

Cell Phone: Mother _____ Father_____

Work Phone: Mother _____ Father_____

Message # for reminder calls, cancellations, appointments, etc. _____

Who referred you here? Name & Relationship to Child

_____

Has the child been seen at Psychological Health-Roanoke before? _____ If yes, when? _____

Responsible party/parties for account information/billing: _____

Signature of person completing this form- _____

Relationship to child _____ Date _____

I. FAMILY HISTORY

Father's Name _____ Date of Birth _____

First Middle Last

Occupation _____ Employer _____

Highest Grade Completed _____ Other vocational training _____

Mother's Name _____ Date of Birth _____

First Middle Last

Occupation _____ Employer _____

Highest Grade Completed _____ Other vocational training _____

Marital status of parents _____ Marriage date _____

Date divorced, if applicable _____ Death of parent, if applicable _____

How long has the family lived at the current address? _____

Where else has the family lived during the child's life?

_____

_____

_____

List all persons living in the home:

Name	Age	Relationship to Child

II. PARENTAL CONCERNS

What are your main concerns with your child?

_____

_____

_____

What, if anything, have you been told by doctors, teachers, and/or others about your concerns with your child?

_____

_____

_____

What do you expect or hope to have happen because of an evaluation with this office?

_____

_____

What steps have you taken to resolve the current problem?

_____

_____

III. PREGNANCY HISTORY

Did the mother:	Yes	No	What Month	Complications/Medications
Drink alcoholic beverages (Indicate how much)	___	___	_____	_____
Smoke (Indicate how much)	___	___	_____	_____
Take medications or drugs (Other than vitamins/iron)	___	___	_____	_____
Have other illnesses or medical problems	___	___	_____	_____

IV. BIRTH INFORMATION

Length of pregnancy _____ Length of labor _____ Was labor induced? _____

Birth was: Normal _____ Cesarean _____ Breech _____ Twins or more _____

Were forceps used (yes or no)?_____ Did mother have complications (yes or no)? _____

If yes, please specify: _____

_____

Birth weight _____ How long did baby stay in the hospital after birth? _____

Did baby need medical assistance to start breathing (yes/no)? _____

Other complications (yes or no)? _____ If yes, please specify:_____

_____

V. CHILD'S GROWTH AND DEVELOPMENT

1. Motor Skills: (Write "N/At" where appropriate)

At what age did your child:

Smile _____ Roll over _____ Sit without support _____ Crawl _____

Pull to standing _____ Walk alone _____ Pedal a tricycle _____

What concerns, if any, do you have about your child's motor development?

_____

_____

2. Language and Hearing:

Do you feel your child hears:

Well _____ Poorly _____ Not at all _____ Inconsistently _____ Uncertain _____

Does your child communicate mostly by:

Gestures _____ Words _____ Crying _____Phrases _____ Sentences _____

Has your child ever had PE tubes? _____ At what ages? _____

What age did your child: Make single sounds _____ Use words _____ Combine words to make sentences _____

Did your child begin to use words and then stop? ____ At what age? ____

What concerns do you have about your child's speech, language, or hearing?

_____

_____

3. Feeding: (Write "N/A" where appropriate)

Was your child: bottle fed? _____ breast fed? _____

For his/her age, is your child: Average ____ Underweight ___ Overweight _____

Has you child had any problems with:

Feeding ___ Chewing ___ Teeth ___ Swallowing ___

What eating problems or unusual food habits does your child have, if any?

_____

_____

4. Personal/Social: (Write "not yet" where applicable)

At what age did your child do the following:

give up the bottle _____ feed him/herself _____ drink from a cup _____ dress him/herself _____

At what age was he/she: bladder trained _____ bowel trained _____

VI. MEDICAL HISTORY

Has your child ever been seriously ill? ___ If yes, with what_____

_____

Has your child ever been hospitalized or had surgery? _____ If yes, why? _____

_____

When: _____ Where (Name and address of hospital: _____

_____

List all medications your child currently takes, amounts and reason for taking (use another piece of paper if needed):

Name of Medicine	Dosage	Reason Taken

Check any of the following which pertain to your child, indicating age and complications.

Medical Issue	**Age**	**Complications (yes or no – if yes, what?)**
__ Meningitis	___	_____
__ Fainting spells	___	_____
__ Visual problems	___	_____
__ Developmental delay	___	_____
__ Measles	___	_____
__ Seizures	___	_____
__ Headaches	___	_____
__ Ear infections	___	_____
__ High fever	___	_____
__ Other (Please specify below)	___	_____

_____

VII. FAMILY HISTORY

Complete the following table for all the mother's pregnancies in chronological order, including any miscarriages or stillbirths. (Please use another page if additional space is needed).

Name	Date of Birth	Birth Weight	Length of Pregnancy	Length of Labor	Problems at Birth	Any emotional, physical, behavioral, or educational problems?

Please note below if <u>any of the child's relatives</u> have had any of the following conditions (For example, brother, aunt, cousin, grandparent).

Type of Condition	**Relationship to Child**	**Type of Condition**	**Relationship to Child**
Convulsions	_____	Cerebral Palsy	_____
Hearing Loss	_____	Mental Illness	_____
Mental Retardations	_____	Speech Problems	_____
School Difficulties	_____	Muscular Weakness	_____
Visual Impairment	_____	Physical Deformities	_____
Alcoholism	_____	Emotional Problems	_____
Overactivity, attention problems	_____	Drug Addiction	_____
		Other	_____

Describe any of the above _____

_____

What stressors have impacted your family recently? (i.e. deaths in family, marital conflicts, death of pet, etc.)

_____

_____

VIII. BEHAVIOR

What problems are you experiencing with your child's behavior?

_____

_____

_____

Who else (i.e. school, sitter) is having problems with your child's behavior? _____

_____

IX. SCHOOL HISTORY

If your child has been to school, please complete the following, beginning with nursery/day care and ending with current placement. (If more room is needed, please use an additional sheet of paper).

School	Address	Grade or Class Placement	Dates of Attendance

Have you requested testing from the school? Yes/No – if yes, what? _____

Is any testing scheduled? Yes/No - If yes, when? _____

X. PLEASE LIST THE NAMES AND ADDRESSES OF OTHER PROFESSIONALS WHO HAVE WORKED WITH YOU AND YOUR FAMILY.

Type of Professional	Name	Complete Address
Pediatrician		
Mental Health Professional		
Specialist (specify what)		

FOR CLINICIAN USE ONLY:

DX: _____

_____

_____

GOALS:

1. _____

2. _____

3. _____

4. _____

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: _____