

New Patient Information Sheet
(PLEASE PRINT)

PATIENT INFORMATION:

Patient's Name _____
Last Name _____ First Name _____ Middle Initial _____

Responsible Party (if a minor) _____

Mailing Address (Street and/or PO Box) _____ Apt # _____

City _____ State _____ Zip Code _____

Phone: Home _____ Cell _____ Work _____

Email Address: _____ Yes, I would like to receive periodic informative emails from this office.

Sex: ___ Male ___ Female Date of Birth _____ Age _____ Social Security Number _____
___ Single ___ Married (How long? _____) ___ Divorced ___ Widowed ___ Separated

Please list children and their ages: (if applicable)

Patient Employer _____
Address _____ City _____ State _____ Zip _____
Occupation _____

How or from whom did you hear of us? (Name: _____)

Doctor Church/Pastor Yellow Pages Current/Former Patient Internet Other _____

In Case of Emergency, Please Contact: _____ Phone _____

PARENT/SPOUSE INFORMATION:

Spouse/Parent _____ Date of Birth _____
Employer _____ Work Phone _____
Occupation _____ Social Security Number _____

INSURANCE INFORMATION:

Primary Insurance Company _____ Phone Number _____
Subscriber's Identification Number _____ Group Number _____
Subscriber's Name _____ Relationship to Patient _____
Subscriber's Social Security Number _____ Date of Birth _____

RELEASE OF INFORMATION: I authorize Shawn D. Hughes PhD, LPC, to obtain/release/exchange information with my Primary Care Physician (PCP), other healthcare practitioners, or as requested by my insurance company for the purpose of service coordination and continuity of care.

Primary Care Physician's/Other practitioner's name _____
Address _____

Phone _____ Fax _____

Check here if you do not authorize this release of information.

(Signature of Patient or Responsible Party) (Date)

For Office Use Only:
Chart# _____
 ABT Medisoft
Initials _____

Shawn D. Hughes, PhD, LPC

Communication Between You and my Office

Occasionally it will be necessary for me to contact you regarding matters about counseling. This permission form will help me know when and how to contact you in ways which are comfortable for you.

By giving permission for me to contact you in one or more of the ways listed below, you are agreeing for me to leave messages and information. I will always try to be discrete in any messages I leave, but I cannot guarantee confidentiality once the message is left.

Which is your **preferred contact phone number**? (circle one) Home Work Cell

Home

Yes No May I contact you at your home telephone number? # _____

Work

Yes No May I contact you at your work telephone number? # _____

Cell Phone

Yes No May I contact you at your cell telephone number? # _____

Courtesy Appointment Reminders IMPORTANT:

Would you like to be reminded of your appointment via e-mail, text messaging or both? Yes _____ No _____

E-Mail Yes No *If you choose this option, E-mail reminders are sent (2) two business days before your scheduled appointment.*

E-Mail Address: _____

Text Messaging Yes No Cell Phone Carrier _____ Cell Phone () _____

Choose how often you would like a text message: **(You cannot respond back to a text message)**

- | | |
|--------------------------------|--|
| <input type="radio"/> 48 hours | <input type="radio"/> 48 & 24 hours |
| <input type="radio"/> 24 hours | <input type="radio"/> 48 & 2 hours |
| <input type="radio"/> 2 hours | <input type="radio"/> 48, 24 & 2 hours |

NOTE: If you need to make/change/cancel an appointment, have patient account or insurance questions, please CALL 540-353-0101.

Client Name: _____ Date: _____

Client or Guardian Signature: _____

SHAWN D. HUGHES, PHD, LPC

Patient Health Questionnaire (PHQ)

SHAWN D. HUGHES, PhD, LPC

All information is kept confidential in adherence with current HIPAA regulations.

Name: _____ Date: _____

People commonly have some problems in the following categories. Please indicate how you are affected by each by circling the appropriate number beside the item. **Please circle only ONE number for EVERY item.**

Not a Problem 0	A Slight Problem 1	A Moderate Problem 2	A Serious Problem 3	A Severe Problem 4							
1. Feeling sad, depressed or unhappy	0	1	2	3	4	1. Euphoria (feeling high)	0	1	2	3	4
2. Feeling discouraged or hopeless	0	1	2	3	4	2. Sudden changes in mood for no apparent reason	0	1	2	3	4
3. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3	4	3. Decreased need for sleep (such as feeling rested after only 3 hours of sleep)	0	1	2	3	4
4. Little interest or pleasure from things I usually enjoy	0	1	2	3	4	4. More talkative than usual	0	1	2	3	4
5. Feeling guilty, worthless, helpless	0	1	2	3	4	5. Racing thoughts	0	1	2	3	4
6. Crying spells	0	1	2	3	4	6. Acting impulsive (such as buying sprees, drinking more, sexual activity, etc.)	0	1	2	3	4
7. Restless, irritable or agitated	0	1	2	3	4	7. Excessive irritability or agitation	0	1	2	3	4
8. Feeling tired or having little energy	0	1	2	3	4	8. Angry outbursts	0	1	2	3	4
9. Trouble falling or staying asleep, or sleeping too much	0	1	2	3	4	9. Property destruction	0	1	2	3	4
10. Poor appetite or overeating	0	1	2	3	4						
11. Trouble making decisions	0	1	2	3	4	1. Making careless mistakes at school, work or other activities	0	1	2	3	4
12. Difficulty with concentration	0	1	2	3	4	2. Difficulty sustaining attention during tasks	0	1	2	3	4
13. Less interest in sex	0	1	2	3	4	3. Difficulty following through or finishing things	0	1	2	3	4
14. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3	4	4. Difficulty in organizing tasks or activities	0	1	2	3	4
						5. Easily distracted	0	1	2	3	4
1. Anxious/nervous/worried	0	1	2	3	4	6. Losing things or forgetful	0	1	2	3	4
2. Stressed/overwhelmed	0	1	2	3	4	7. Hyperactivity (can't sit still)	0	1	2	3	4
3. Intense fear, panic/discomfort	0	1	2	3	4	8. Poor impulse control	0	1	2	3	4
4. Panic or fear with physical symptoms (such as pounding heart, sweating, shaking, nausea, dizzy, fear of losing control, etc.)	0	1	2	3	4						
5. Anxiety about being in certain situations (such as being in a crowd, traveling, standing in line, etc.)	0	1	2	3	4	1. Hearing things	0	1	2	3	4
6. Anxiety or fear related to being in social situations or having to perform (such as public speaking, test taking, etc.)	0	1	2	3	4	2. Seeing things	0	1	2	3	4
7. Fear, anxiety, or avoiding specific situations (such as flying, heights, animals, etc.)	0	1	2	3	4	3. Experiencing confusion	0	1	2	3	4
8. Worrying about health problems	0	1	2	3	4	4. Memory lapses/forgetting	0	1	2	3	4
						5. Feeling of unreality or being outside of self	0	1	2	3	4
						6. "Missing time"	0	1	2	3	4
						7. Suspiciousness (questioning other people's motives)	0	1	2	3	4
1. Having unwanted thoughts over and over again	0	1	2	3	4						
2. Repeating specific acts over and over (such as hand washing, checking, etc.) or mental acts (such as counting, repeating words)	0	1	2	3	4						

I have been experiencing these problems for:
 < 1 Mo 1-6 Mos 7-12 Mos > 1 Yr

Check any of the following that have caused concern or difficulties during the last 6 months:

- | | | |
|---|--|---|
| <input type="checkbox"/> Taking care of personal grooming needs | <input type="checkbox"/> Preparing meals for family/self | <input type="checkbox"/> Getting along with spouse/partner |
| <input type="checkbox"/> Taking care of children or others | <input type="checkbox"/> Meeting financial obligations | <input type="checkbox"/> Getting along with children |
| <input type="checkbox"/> Enjoyment of hobbies | <input type="checkbox"/> Meeting "home" responsibilities | <input type="checkbox"/> Getting along with co-workers & others |
| <input type="checkbox"/> Enjoyment of work | <input type="checkbox"/> Meeting "work" responsibilities | |

Current Life Stressors

- | | |
|---|--|
| <input type="checkbox"/> Relationship issues (arguments, separation, divorce) | <input type="checkbox"/> Health issues (illness or injury) |
| <input type="checkbox"/> Financial (owe money, loss of job, unemployment) | <input type="checkbox"/> Abuse (physical, mental, emotional, sexual) |
| <input type="checkbox"/> Legal difficulties (law suit, traffic, criminal charges) | <input type="checkbox"/> Substance abuse (alcohol/drugs/food) |

If you checked off any of the above 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?

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

Briefly describe why you are seeking help at this time: _____

Please check below if you have had any of the following medical conditions:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> PMS | <input type="checkbox"/> Surgery: _____ |
| <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Head injury/concussion | <input type="checkbox"/> Asthma | _____ |
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other Respiratory Problems | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Angina | <input type="checkbox"/> Menstrual Problems: _____ | |
| <input type="checkbox"/> Colitis/Crohn's | <input type="checkbox"/> High blood pressure | | |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Urinary retention | <input type="checkbox"/> Pregnancy: _____ times | |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Migraines | <input type="checkbox"/> Miscarriage: _____ times | |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Chronic headaches | <input type="checkbox"/> Hysterectomy | |

Please list all current medications: (Use the back of this form if necessary)

Medication	Strength	Frequency	Date started	Prescribed by

Please list all PREVIOUS psychotropic medications you have EVER taken.

Medication	Strength	Frequency	Date started	Prescribed by

Medication Allergies: No Yes (Describe: _____)

Please list all previous counseling/psychiatric treatment including any psychiatric hospitalizations.

Dates	Reason	Counselor's/Doctor's Name

Yes No Has any family member ever had a problem with drugs and/or alcohol? If so, who and what? _____

Yes No Has any member of your family ever had any history of depression, anxiety, or other mental problems? Any history of suicide? _____

Yes No Never 1. Do you have thoughts about suicide now?

Yes No Never 2. Have you ever thought about suicide?

Yes No Never 3. Have you ever attempted suicide?

Yes No Never 4. Do you have access to guns/weapons?

Yes No Never 1. Are you thinking about hurting someone now?

Yes No Never 2. Have you ever thought about hurting someone else?

Yes No Never 3. Have you ever hurt someone else?

Please answer the following questions:

Do you drink alcoholic beverages? Yes No Never (Skip to next section)

If yes, how many alcoholic drinks do you have in the average: day _____, week _____, month _____, year _____

If yes to the above, please answer the following:

- Yes No Have you ever sought help for alcohol or drug use (including AA or NA meetings)?
- Yes No In the past year, have you ever drunk alcohol or used drugs more than you meant to? Or have you spent more time drinking or using than you intended to?
- Yes No Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?
- Yes No Have you felt you wanted or needed to **cut down** on your drinking or drug use in the last year?
- Yes No Has anyone ever objected to your drinking or drug use?
- Yes No Have you ever found yourself preoccupied with wanting to use alcohol or drugs?
- Yes No Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?
- Yes No Has your drinking or drug use ever caused legal problems (DUI's, traffic accidents, violence, etc.)?

Check if you have taken any of the following drugs: Yes No Never (Skip to next section)

- Marijuana/Pot Cocaine/crack Inhalants
- Amphetamines/speed Barbiturates/sedatives/downers Designer drugs, Ecstasy
- Heroin/opiates Intravenous drug use Tranquilizers (Xanax, Valium, etc.)
- PCP/Angel Dust Pain medicine LSD/hallucinogens

Yes No Have you ever taken prescribed medication inappropriately?

Sleep Difficulties (Check all that apply):

- None Nightmares
- Falling asleep Wets bed
- Falling back to sleep Walks in sleep
- Tired upon waking Snores
- Early morning awakening Stops breathing during sleep
- Bad dreams Falls asleep when emotional

Usually, the time that I ...

Go to bed: _____ A.M. _____ P.M.
Wake up: _____ A.M. _____ P.M.

Smoking:

None
Packs per day: 1 2 3 Other
Age began: _____

Caffeine (cups per day):

Coffee: 1 2 3 4 More
Tea: 1 2 3 4 More
Soda/other: 1 2 3 4 More

Are you sensitive to caffeine? Yes No

Please answer the following questions:

- Yes No Is there any history of violence, verbal or sexual abuse in your family?
- Yes No Have you ever been physically abused?
- Yes No Have you ever been sexually abused?
- Yes No Have you ever experienced or witnessed a traumatic event (accidents, crime, major medical illness)?

If yes to any of the questions above, please elaborate with your counselor.

I certify that all information above is true and accurate.

Signature of Client, Parent or Guardian

Date

**ASSIGNMENT OF BENEFITS
AND
RELEASE OF INFORMATION**

I authorize the release of any medical information necessary to process counseling services. I also authorize payment of medical benefits directly to Dr. Hughes for services indicated on the insurance claim form. I understand I am financially responsible to Dr. Shawn Hughes for all charges not covered by insurance. I also agree that if services performed are non-covered benefits or not authorized by insurance and I consent to such services, I am financially responsible for these charges.

If a referral is required by my insurance company for services provided, it is my responsibility to obtain this document. It is also my responsibility to provide my insurance company with documentation they request from me. I authorize the use of this signature on all my insurance claim submissions. In addition, if this is a covered eap benefit provided by my employer, I understand that I am responsible for providing an authorization number at the first session; otherwise, I will be responsible for these charges.

Responsible Party Signature

Date

CONSENT TO TREAT

By signing below, I acknowledge that I give my consent for counseling and treatment for myself or for my child.

Client/Parent/Legal Guardian

Date

I have read, understood, and received a copy of the HIPAA regulations of this office. I have read, understood, and received a copy of the informed consent from the counselor- Shawn Hughes, PhD, LPC. I have also had the opportunity to ask any question that I may have prior to the beginning of counseling.

Client/Parent/Legal Guardian

Date

Informed Consent for: Email, Payment, Cell Phone Use

Information contained in email or communicated through cell phone use may be privileged and confidential. There is some risk that protected health information contained in such communication may be disclosed to, or intercepted by, unauthorized third parties. Please be aware that email communication can be intercepted in transmission or misdirected. Your use of email or cell phone use to communicate protected health information to the counselor indicates that you acknowledge and accept the possible risks associated with such communication. By providing consent, you recognize that email and cell phone use is not a secure form of communication. The counselor will use the minimum necessary amount of protected health information to respond to your query. Please consider communicating any sensitive information by scheduling an appointment. This office encourages you to limit emails or texting to the scheduling or cancelling of appointments **only** (within the appropriate time frame). The counselor will respond to emails but will not respond to instant messages or text messages other than confirming or canceling appointments.

By signing below, I acknowledge the risks above and give my consent to communicate with my counselor through email. I also authorize texting **only** to confirm scheduled appointments or cancellations.

Client

Parent/Guardian:

By signing below, I acknowledge the risks of cell phone communication, and authorize my counselor and this office/staff to communicate to me via cell phone.

Client

Parent/Guardian:

By signing below, I understand that credit card/debit payments are conducted through Paypal or ABT. I authorize this office to bill me through Paypal/ABT by using the email address provided. This office will not provide identifying information other than the amount of the service, your name, email address and Paypal account name for this office. This office will be happy to provide you a statement of services and dates upon request.

Responsible Party or Client Signature:

Email:

Email Address:

AUTHORIZATION TO RELEASE PROFESSIONAL INFORMATION

I authorize Shawn D. Hughes, PhD, LPC to obtain information from, release information to and/or exchange information with:

Release information to: Shawn D. Hughes, PhD
4346 Starkey Road, Suite 1
Roanoke, VA 24018
Phone: (540) 353-0101
Fax: (540) 204-4376

In regard to: (Name) _____ for the purpose of communication of relevant information regarding therapy/counseling.

Material To Be Released: Records, treatment recommendations, assessment information, and any content pertinent to counseling & treatment of client.

I understand my records are protected under Federal and State regulations and that the information to be released by my signature may contain information pertaining to medical, psychiatric, substance abuse, and/or confidential HIV/AIDS related information. (See 42 U.S.C.290dd-3 and 42 U.S.C. 2900ee-3 for Federal Laws and 42 DFR Part 2 for Federal regulations.)

Client's Signature: _____

Signature of Parent, Guardian or Authorized Representative:

Date: _____

Expiration Date: _____

Witness: _____

Date: _____

Shawn D. Hughes, PhD, LPC
4346 Starkey Road, Suite 1
Roanoke, VA 24018
Phone: (540) 353-0101

Location: Roanoke, VA

HIPAA NOTICE OF PRIVACY PRACTICES

(Effective Date: April 14, 2003)

This privacy notice is provided on behalf of: Shawn D. Hughes, PhD, LPC

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law. We are required by HIPAA to provide you with this notice. This notice describes our privacy practices, legal duties and your rights concerning your Protected Information. We must follow the privacy practices described in this notice while it is in effect. This notice takes effect April 14, 2003. It will remain in effect unless and until we publish and issued a new notice.

OUR PLEDGE TO YOUR PRIVACY

We are responsible for the information that we collect about you and your privacy is important to us. We are committed to protecting the confidential nature of your medical information to the fullest extent of the law. These are designed to protect your information. We understand how important it is to protect your privacy. We will continue to make this a priority.

OUR LEGAL DUTIES

We are required by law to make sure that your Protected Information that identifies you is kept private. We are to give you this notice of your legal duties and privacy practices with respect to medical information about you and follow the terms of this notice that is currently in effect.

The HIPAA Privacy Regulations generally do not preempt state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a state, or other federal laws, rather than the HIPAA Privacy Regulation, might impose a privacy standard that we are required to follow. Where such laws are in place, we will follow more stringent state privacy laws that relate to use and disclosure of Protected Information about mental health, substance abuse, chemical dependency, etc.

DISCLOSURE AND USES OF PROTECTED INFORMATION

The following categories describe different ways that we use and disclose your Protected Information for purposes of treatment, payment and health care operations:

***For Treatment.** We may disclose your Protected Information to people outside this facility who may be involved in your treatment such as doctors, nurses, technicians, medical students or other personnel who are involved in taking care of you. We may also disclose your Protected Information to people who may be involved in your medical care such as family members, clergy or others we use to provide services that are part of your care.

***For Payment.** We may use and disclosed your Protected Information so that the treatment and services you receive at this facility may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover treatment.

***For Health Care Operations.** We may use and disclose your Protected Information for health care operations. These uses and disclosures are necessary to run this facility and make sure that all of our patients receive quality care. For example, we may use your Protected Information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of the facility's patients to decide what additional services the facility should offer, what services are not needed and whether certain treatments are effective. We may also disclose information to other health care personnel for review and learning purposes. We may also combine the medical information we have with medical information from other health care providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care without learning who the specific patients are.

OTHER USES AND DISCLOSURES OF YOUR PROTECTED INFORMATION

We must disclose your Protected Information to you with some exceptions. This will be described in the Individual Rights sections of this notice. You may give us written authorization or release of information to use or disclose your Protected Information to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosure permitted by your authorization while it was in effect. Without your written authorization, we may not use or disclose your Protected Information for any reason except as described in this notice.

The following is a description of other possible ways we may (and are permitted by law) to use and/or discuss your Protected Information without your specific authorization:

***Family and Friends.** If you are unavailable to agree, we may disclose your Protected Information to a family member, friend or other person when the situation indicates that disclosure would be in your best interest. This includes a medical emergency or disaster relief. If you are available and agree, we may disclose your Protected Information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

***Research, Death or Organ Donation.** We may use or disclose your Protected Information for research purposes in limited circumstances specified in the HIPAA privacy regulation. We may disclose the Protected Information of a deceased person to a coroner, medical examiner, funeral director or organ procurement organization for certain purposes.

***Public Health and Safety.** We may disclose some of your Protected Information permitted by state law to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may disclose your Protected Information to a government agency that oversees the health care system or government programs or its contractors, and to public health authorities for public health purposes. We may disclose your Protected Information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

***Required by Law.** We may use or disclose your Protected Information when we are required to do so by law. For example, we must disclose your Protected Information to the U.S. Department of Health and Human Services upon request in order to determine if we are in compliance with federal privacy laws. We may disclose your Protected information to comply with worker's compensation or similar laws.

***Legal Process and Proceedings.** We may disclose your Protected Information in response to a court or administrative order, subpoena, discovery request, or other lawful process. These disclosures are subject to certain administrative requirements imposed by the HIPAA privacy regulation and permitted by state law.

***Law Enforcement.** We may disclose limited information to a law enforcement official concerning the Protected Information of a suspect, fugitive, material witness, crime victim or missing person subject to certain administrative requirements approved by the HIPAA privacy regulation and permitted by state law. We may disclose the Protected Information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances specified by the HIPAA privacy regulation. We may also disclose Protected Information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

INDIVIDUAL RIGHTS

***Right to Inspect and Copy.** You have the right to inspect and copy your Protected Information that may be used to make decisions about your care. Usually this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, submit your request in writing to: **Shawn D. Hughes, PhD, LPC, 3433 Brambleton Avenue, Suite 120-B, Roanoke, VA 24018**. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy. If you are denied access to medical information, you may request that the denial be reviewed.

***Right to Amend.** If you feel that your Protected Information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by our office. We are required by law to keep records for six (6) years. We may deny your request for an amendment if it is not made in writing or does not include a reason to support the request. In addition, we may deny the request to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for **Shawn D. Hughes, PhD, LPC**.
- Is not part of the information which you would be permitted to inspect or copy;
- Is accurate and complete

***Accounting of Disclosures.** You have the right to request and receive an accounting of disclosures of your Protected Information made by us. We are not required under the HIPAA regulation to provide you with an accounting of certain types of disclosures. The most significant types include:

- Any disclosures made prior to April 12, 2003
- Disclosures for treatment, payment of health care operations activities
- Disclosures to you or pursuant to your release of authorization
- Disclosures to persons involved in your care
- Disclosures for disaster relief, national security or intelligence purposes

To request an accounting of disclosures, you must send a written request to our office. The first list your request within a 12 month period will be free. For additional lists, we may charge you for the costs involved and you may choose to withdraw or modify your request at that time.

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

***Confidential Communications.** You may believe that you will be in danger if we communicate Protected Information to you or to your address of record. If so, you have the right to request that we communicate with you about your Protected Information at an alternative location or by alternative means. We will make reasonable efforts to accommodate your request if you specify an alternate address.

CONTACTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

You may also submit a written complaint to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be penalized for filing a complaint.

Signature below is acknowledgement that you have received our Notice of Privacy Practices:

Signature: _____ Print Name: _____

Date: _____ Witness: _____

The client wanted a copy of this privacy practice (Circle one) YES NO
This signed HIPAA will remain in the patient's file; a copy may be given upon request.

**Shawn D. Hughes, PhD, LPC, LPSC
4346 Starkey Road, Suite 1
Roanoke, VA 24018 (540) 353-0101**

APPOINTMENTS

Counselor hours are by appointment only. Evening and weekend appointments are available. Please be sure to consult with the counselor when you leave to confirm your appointments. If you cannot keep an appointment, call and leave a voice mail message immediately. Please give a 24-hour notice so that this time may be given to another client. However, if you do not cancel or show up for a scheduled appointment, you will be charged for the reserved time.

TELEPHONE CALLS

Your counselor is happy to answer your questions, and you are encouraged to write down your concerns and bring them with you to your next office visit. If your concerns require a telephone call, please leave a message and the counselor will return your call. On weekends or holidays, you may also leave a confidential message on voice mail. This office does not provide a 24-hour crisis or emergency intervention service. In case of an emergency, you may go to your local Emergency Room, call Respond at 776-1100, or call CONNECT at 981-8181 to reach a crisis counselor.

FEES, PAYMENTS AND INSURANCE

Every effort is made to keep down the cost of your medical care. Therefore, please pay for your treatment at the time of your visit. If you have insurance coverage that is accepted, please make your co-pay and unmet deductible fees at the time of your office visit. If at any time during your treatment you are having financial difficulties and cannot make regular monthly payments on your account, you may contact this office to set up financial arrangements. Most plans include co-insurance, a deductible, and other expenses, which must be paid by the client. If you have insurance, please bring your insurance card with you. Insurance will automatically be filed for you if you have provided the necessary information. However, you are responsible for all fees regardless of coverage. If you ever have a change in insurance coverage or benefits, please notify this office immediately.

Court Testimony: Counselor participation in court related issues is strongly discouraged. If you believe that court testimony will be needed by a counselor, please notify the counselor during the first session, so that an appropriate referral may be made. If the counselor becomes required to attend court, please be aware that fees will be charged according to the outline provided below.

Dr. Shawn Hughes is a Licensed Professional Counselor (LPC), a Licensed Professional School Counselor, a Nationally Certified Counselor, and a Registered Respiratory Therapist. She holds a Doctorate (PhD) and Masters Degree in Counseling from Virginia Tech. Shawn works with children, adolescents, and adults dealing with a wide range of emotional and behavioral concerns.

Professional Fees and Rates

- Make checks payable to Dr. Shawn Hughes. I accept cash, money orders, and personal checks and credit cards. Paypal can be used for credit or debit cards with signed consent. This office also utilizes ABT for credit card payments and billing.
- **A collections fee of 35%** will be charged to any account turned over to a collection agency after 90 days.

Dr. Hughes/Clinical Services

Initial Assessment and Diagnosis

Clinical Therapy Session

Phone Conference Session

Fee for Service

\$125 (60 minute session)

\$115 (45 minute session)

\$100 (45 minute session)

No Show or Same Day Cancellation:

\$45

Appearance in Court

\$1000

(\$300 charge occurs even if appearance in court does not require testifying)

Records and Document Reviews

\$25 per hour

Copy and Deliver Records

\$1 per page

Written Correspondence

\$25 per 15min, based on time

Confidentiality

What is Confidentiality?

You should understand that all identifying information about your case is kept confidential. Counselors are ethically bound by professional confidentiality - we cannot and will not release your records or other information about you without your advance written consent, except as allowed by law. Exceptions to this rule are very limited and are described below. Please also consult the [privacy policy](#) you received at your first appointment for more detailed information.

Confidentiality of Counseling

To help protect our clients' privacy and confidentiality, state and federal privacy guidelines are followed. We do not automatically respond to inquiries or requests for information about my clients, whether written, by telephone, or personal. Except for information used for the purposes of treatment, payment, and operations, you must sign an *Authorization for the Release of Information Form* before we will share any information about you with anyone outside my clinic. If we believe it is in your best interests not to disclose, then we will advise you to withhold the requested information. Of course, the final decision will always be yours to make. All records, and any other materials that identify you are also kept confidential.

Exceptions to Confidentiality

You should know that there are specific situations in which we are allowed by law to reveal information obtained during counseling to other persons or agencies without your permission. These situations are:

- For the purposes of treatment, payment, and operations.
- If you inform me that you intend to hurt yourself, we are required to contact either a family member, a friend or other support person, or an authority that can assist in providing safety for you while you are a danger to yourself.
- If you threaten bodily harm to someone else, we are required to tell the intended victim and/or inform law enforcement (police).
- If a court of law issues a subpoena regarding your case or your records, we are required by law to provide the information specifically described in the subpoena. Before responding to the subpoena, we will inform you so you may object to the court if you wish. Also, we will do whatever is possible to minimize information released, but I am obligated by law to comply with a subpoena.
- If you reveal information relative to child abuse and neglect, or abuse of a vulnerable adult, we have a responsibility to notify the appropriate authorities of such allegations.
- If you are coming to therapy because of a court order, the results of your counseling may be required to be revealed to the court.

Understanding the Counseling Process

It is important for you to understand what counseling is all about and what you may expect during therapy. Please read this material carefully and ask me to explain anything that is unclear to you.

What is Counseling?

Counseling and therapy, are two words for the same process: using proven methods of emotional health enhancement to assist people experiencing life problems of various kinds in learning to feel better and to behave better.

What Type of Therapy Will Be Used?

We will use only research-proven methods and techniques that have been shown to consistently produce desirable results with most people. You will receive effective therapy aimed at your specific needs and concerns. This way, you reach your goals faster. Our counseling methods are intended to be personally enriching and to help you solve real-life concerns. As your counselor, we ask that you have a true desire to work and to make positive changes in your life.

The Risks of Therapy

Research has shown that competent therapy provided by trained and licensed professionals is helpful to most people. At the same time, therapy is not guaranteed to result in a successful outcome every time for everyone. It is important that you understand this before you invest time and money in counseling. The greatest risk in counseling is that it may not by itself resolve your problem or concern. You should also understand that unexpected emotional strain, stress, and life changes may happen during therapy. In addition, other people in your life may not react to changes you make during therapy in the way you would like for them to respond.

Finally, your progress in therapy depends mainly on two things: you should work only with a trained and licensed counselor, and you should come to therapy with a sincere desire and motivation to work with me to achieve your goals. We will check with you regularly to determine if progress is being made. If little or no improvement occurs over a significant period of time, we will recommend that you consider referral to another counselor.