Main Office: Floyd, VA

FLOYD COUNSELING & CARE MANAGEMENT
RHODA HURST, PHD, LCSW
202 N. Locust Street
P. O. Box 573
Floyd, VA 24091
(877) 895-8674 Toll-Free

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

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 Rhoda Hurst, PhD, LCSW. 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.

For Office Use Only:

Chart#

_____

❒ ABT ❒ Medisoft

_____
(Signature of Patient or Responsible Party) **(Date)**

Revised 10/09

Rhoda Hurst PhD, LCSW

Communication Between You and our Office

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

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

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

Home

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

Work

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

Cell Phone

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

Courtesy Appointment Reminders **IMPORTANT:** (*We are no longer making phone call reminders*)

Would you like us to remind you 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)**

- ○ 48 hours
- ○ 24 hours
- ○ 2 hours
- ○ 48 & 24 hours
- ○ 48 & 2 hours
- ○ 48, 24 & 2 hours

NOTE: If you need to make/change/cancel an appointment, have patient account or insurance questions, please CALL our office at 540-772-8043 or toll-free 877-895-8674.

Client Name: _____ Date: _____

Client or Guardian Signature: _____

Patient Health Questionnaire (PHQ)

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

RHODA HURST, PHD, LCSW
Floyd Counseling & Care Management

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
2. Feeling discouraged or hopeless	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
4. Little interest or pleasure from things I usually enjoy	0 1 2 3 4
5. Feeling guilty, worthless, helpless	0 1 2 3 4
6. Crying spells	0 1 2 3 4
7. Restless, irritable or agitated	0 1 2 3 4
8. Feeling tired of having little energy	0 1 2 3 4
9. Trouble falling or staying asleep, or sleeping too much	0 1 2 3 4
10. Poor appetite or overeating	0 1 2 3 4
11. Trouble making decisions	0 1 2 3 4
12. Difficulty with concentration	0 1 2 3 4
13. Less interest in sex	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

1. Anxious/nervous/worried	0 1 2 3 4
2. Stressed/overwhelmed	0 1 2 3 4
3. Intense fear, panic/discomfort	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
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
7. Fear, anxiety, or avoiding specific situations (such as flying, heights, animals, etc.	0 1 2 3 4
8. Worrying about health problems	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

1. Euphoria (feeling high)	0 1 2 3 4
2. Sudden changes in mood for no apparent reason	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. More talkative than usual	0 1 2 3 4
5. Racing thoughts	0 1 2 3 4
6. Acting impulsive (such as buying sprees, drinking more, sexual activity, etc.)	0 1 2 3 4
7. Excessive irritability or agitation	0 1 2 3 4

1. Making careless mistakes at school, work or other activities	0 1 2 3 4
2. Difficulty sustaining attention during tasks	0 1 2 3 4
3. Difficulty following through or finishing things	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
6. Losing things or forgetful	0 1 2 3 4
7. Hyperactivity (can't sit still)	0 1 2 3 4
8. Poor impulse control	0 1 2 3 4

1. Hearing things	0 1 2 3 4
2. Seeing things	0 1 2 3 4
3. Experiencing confusion	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
8. Withdrawn from others socially	

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:

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

Current Life Stressors

❑ Relationship issues (arguments, separation, divorce)
❑ Financial (owe money, loss of job, unemployment)
❑ Legal difficulties (law suit, traffic, criminal charges)
❑ Health issues (illness or injury)
❑ Abuse (physical, mental, emotional, sexual)
❑ 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:

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

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**

Rhoda E. Hurst, PhD, LCSW
202 N. Locust Street
P. O. Box 573
Floyd, VA 24091

Appointments (540)772-8043 or
Toll Free (877) 895-8674
Voice Mail (540) 267-4748
Fax (540) 745-2432

Floyd Counseling & Care Management
INFORMED CONSENT

Welcome to my practice. I am pleased to have the opportunity to serve you and hope that this handout will provide helpful information in making an informed decision concerning my services. **Please ask questions at any time.**

Hours of Operation: The office staff answers telephone calls from 8:30 a.m. until 5:30 p.m. Monday through Thursday and from 8:30 a.m. until 2:00 p.m. on Friday. At all other times calls are forwarded to a voice mail system. I do not answer phone calls while in session. I am available for appointments Monday through Friday. Evening appointments are available also.

****Background & Training:** I completed a PhD. in Human Development and a graduate certificate in Gerontology at VA Tech in 1993. I earned a Masters of Social Work at Virginia Commonwealth University in 1982. For more than twenty five years, I have worked with people experiencing a wide array of problems. In all service settings—hospital, outpatient, court services, home and community, I have been impressed with people's innate ability to grow and to heal. I am experienced in working with children, adolescents, and adults in individual, couples, family and group counseling. I specialize in these areas: depression and mood disorders, anxiety, adjustment difficulties, and health challenges. I also deal with family issues across the life span, from marriage to parenting young children and adolescents, to late life role changes brought on by caregiving and/or loss.

****Philosophy:** I accept in my practice only clients whom I believe have the capacity to resolve their own problems with my assistance. The foundation of the healing process is the therapeutic relationship which is based on trust, respect, honesty, confidentiality and effort. As people learn more about their strengths and weaknesses, they usually become more accepting of themselves and others and feel more empowered to accomplish their goals. As the client, you are responsible for setting the goals you want to accomplish and can terminate counseling at any time. My responsibility is to help you accomplish these goals in the shortest time possible. If counseling is successful, you should feel better about yourself and be able to face life's challenges in the future without my support or intervention. I cannot guarantee results.

I ask that you be as honest and as open as possible in discussing your concerns. If you are unclear about anything regarding your therapy, please ask questions. Psychotherapy can be very helpful for some individuals but it is not without some risks. These risks may include the experience of intense and unwanted feelings, such as sadness, anger, fear, guilt or anxiety. It is important to remember that these feelings may be natural and normal and are an important part of the therapy process. Other risks might include: recalling unpleasant life events, facing unpleasant thoughts and beliefs or possible alteration of an individual's relationships. I will make every effort to minimize potential risks and hazards which are not helpful to the therapeutic process. Often in therapy, major life decisions are made, including: decisions involving families or friends, changes in relationships, or changes in your jobs or careers. These decisions are a legitimate outcome of therapy as a result of an individual's calling into question some of their beliefs and values, recognizing their strengths, increasing their self-acceptance, alleviating symptoms and problems or learning more helpful coping skills.

**I use research-based "best practices therapy methods" including, but not limited to, Cognitive-Behavioral Therapy (CBT), Solution-Focused Brief Therapy, Person Centered Therapy, Strategic or System based approaches, assessments, and bibliotherapy. These methods sometimes utilize psycho-education methods with homework assignments.

Fees, Payments and Insurance: I make every effort to keep down the cost of your medical care. Therefore I require that you pay for your treatment at the time of your visit. The cost of therapy is $125.00 for the initial session and $115.00 for each following session. Payment may be made by cash, check or credit/debit card. If you have insurance coverage I ask that you 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 the required payments on your account, you may contact the Office Manager to set up financial arrangements. Most plans include co-payments/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. I will automatically file your insurance for you if you have provided us with the necessary information. **However, I cannot fully guarantee your coverage or your benefits. In the event that your insurance company does not pay for services rendered, you will ultimately be responsible for payment.** If you have a change in insurance coverage or benefits, please notify the business office immediately.

Returned Checks: If you pay for any service provided with a check and that transaction is returned to us from your bank as non-payable, there will be a charge of $35.00. After a non-payment incident, checks may no longer be accepted and you will be required to pay all outstanding balances on a **cash only basis**.

Cancellations: I see clients by appointment only, and each appointment constitutes a significant portion of my day, it is common practice to charge a fee for missed appointments. A charge of $25.00 will be made when less than 24-hour advance notice is given for a cancelled appointment. A charge of $45.00 will be made if you do not show up for an appointment or call in response to your absence. These charges are not reimbursable by insurance carriers. I would appreciate you notifying me at 1-877-895-8674 if you will not be attending a session with as much notice as possible-preferably 48 hours or more. Please leave a voice mail for the receptionist of your cancellation.

****Messages:** As we work together, you will notice that I do not accept phone calls while with you. During those times and at other times during the day or evening, my calls are answered via voice mail. Messages are checked frequently during the day, and I will attempt to call you back as soon as possible. Usually, I can get back with you within 24 hours. If you need to speak with me directly during regular office hours, please leave your name and phone number on my voice mail at 540-267-4748. On evenings, weekends, and holidays, the messages will be received and acted upon during the next working day.

Complaints: If at any time you are dissatisfied with my services, please let me know or contact our Office Manager or Clinical Director, David Mortellero. If he/she is not able to resolve your concerns you may report your complaints to the Virginia Department of Health Professions at 1-800-533-1560. I am required to follow a Code of Ethics. If you would like to see a copy of the Code it can be found on-line at the Association of Social Workers at www.naswdc.org

Counseling and Financial Records: Counseling and financial records are maintained on each client for a period of seven years. Records are stored in boxed paper files in a secure central location. The records are my property but may be reviewed by a client with 30 days notice.

Noncompliance: I may cancel or terminate services for noncompliance with the plan of care, failure to keep or cancel appointments, violent behavior, a threat of violence or involvement in criminal behavior.

Exceptions to Confidentiality: Under certain circumstances certain information may or must be revealed or released to others. The following are examples of exceptions that may apply:

- If I am subpoenaed and ordered to testify in a court of law and my objections are overruled. This happens in very few instances and typically occurs in legal proceedings involving child custody, law suits in which services you received are considered to be evidence in a court of law, or charges involving certain types of criminal behavior.

- If you request that I communicate with someone, you will normally be asked to sign a "Release of Information" and to specify what can be communicated and for how long the release will remain in effect.

- If I believe that abuse or harm has been done to a child or to an elderly person. This would involve situations where I find it is necessary to report this information to proper authorities.

- If I believe that you are dangerous to yourself, or another person, and it is necessary to take steps to protect you or the safety of others. I can only release that information that is necessary to protect or insure your health and safety or the health and safety of others.

- If during a medical emergency I need to reveal information that is necessary to protect or insure your health and safety. I can only release that information necessary to protect or insure you health and safety.

- If you are a minor, or a minor that is not emancipated, I may be required to advise or involve your parents or guardian in your treatment. There are circumstances in which I am not required to notify the parents of a minor.

- If I must take action to collect a debt incurred for services, your name and the amount of your debt may be revealed to a collection agent.

If you have any questions, concerns, or confusion regarding your rights to confidentiality, or any potential exception, please discuss this with me.

Consultation: In keeping with generally accepted standards of practice, I may confidentially consult with other mental health professionals regarding the management of treatment. The purpose of the consultation is to assure quality care. Every effort is made to protect the identity of the clients.

Emergencies: My office is not set up to routinely provide crisis intervention services. In case of an emergency and/or my office is closed, you may go to your local Emergency Room, call ACCESS at (540) 961-8400 or call CONNECT at (540) 981-8181 to reach a crises counselor.

Affiliation Relationships: Floyd Counseling & Care Management and I, Rhoda Hurst, are independent contractors affiliated with Associates in Brief Therapy, Inc.. Employees and independent contractors of Associates in Brief Therapy, Inc. are each wholly responsible for his/her own acts and omissions.

Copying Fees for Medical Records: I attempt to honor your request of medical records as quickly as possible. I make every effort to respond within 30 days. The charge for copying and mailing medical records is as follows:

- Handling and processing fee $10.00 per request
- Photocopying (pages 1 – 25) $ .50 per page
- Photocopying (pages over 25) $ .25 per page

This charge is billed to the organization/individual requesting the records as outlined in your authorization and **payment is due in advance of the records being released**. However, you will ultimately be responsible for any unpaid fees should that party not make payment.

Permission to Treat a Minor Child: Please note that I require written permission before I can treat any client under the age of 18:

- When parents are married, the signature of one parent is sufficient to provide treatment.
- If the parents are divorced, I require the signature of the parent having legal custody of the child.
- If the parents have joint legal custody, I may require the signature of both parents
- If the parents are separated, I may also require the signature of both parents to provide treatment.

Phone authorizations are not accepted. Parents must sign the "Informed Consent/Permission to Treat Form" in person or have it notarized with seal and signature if signed off premises. I will not provide treatment for any child who does not have the proper signed consent form(s) on file. The office staff is directed to reschedule your appointment if the form(s) is not completed.

Requests for Letters: I take a great deal of time corresponding with requested individuals on the behalf of their client. There is a charge for letters written by me at the request of the client. If a legal letter is needed, a fee starting at $100.00 will be charged. The charge will vary and is based on the clinical and clerical time required to complete the letter. Insurance benefits will not cover this charge; therefore, you will be fully responsible for this cost. Payment must be received before a letter can be delivered.

Request for Forms: In most instances I will complete health or treatment forms on your behalf. However, please be aware that there may be a charge of $15.00 for forms to be completed by me at the request of the client. In the event that the form is lengthy or complex, I may request that you schedule an appointment and complete the form as part of your session. Insurance benefits will not cover this charge; therefore, you will be fully responsible for this cost. Payment must be received before a form can be delivered.

Telephone Consultations: There is usually no charge for a brief phone conversation with me. If you require a more lengthy discussion, a receptionist will schedule a time with me by phone. Please ask me to explain my rate for phone consultations. Insurance benefits will not cover this charge; therefore, you will be fully responsible for this cost. **I ask that you pay by credit card prior to the consult.**

Court Appearances: I am occasionally needed to testify in court or provide a deposition as an expert witness for a client regarding a legal matter. If you think you may be involved in a legal dispute or may require my testimony, please inform me as quickly as possible. If a judge or another party subpoenas me or your medical records, I am legally required to comply. If you or your attorney subpoenas me to appear in court on your or your dependent's behalf, **you will be charged a fee of $300.00. Full payment is expected to be paid prior to the scheduled court date**. If the time required in court is in excess of three (3) hours (including travel time) you will be charged an additional $100.00 per hour. You will be billed for the balance due. You will be charged for my presence in court, regardless if I testify or not. If court is cancelled our office needs at least a 24 hours notice in order for you to receive reimbursement of your initial $300.00 fee. Insurance will not reimburse for these fees.

Payment of Outstanding Balances: Each month I mail billing statements for each account with outstanding balances due. **You are responsible for paying the total amount due upon receipt of the statement.**

- If I do not receive payment in full for balances due within 30 days of billing, this may result in the suspension of services.
- Outstanding balances exceeding 90 days past due will result in collection procedure. In the event that your account is forwarded to an external collection agency, all collection fees will be added to your account. In addition, finance charges of 1.5% will be added each month to accounts which are 90 days past due or a $5.00 finance charge, whichever is greater. In order to service your account if sent to collections, you may be contacted via phone or any telephone number associated with your account including wireless phone numbers, text messages (which could result in charges to you) or email.

Damages to Facility: My office is structured in order to provide a comfortable and professional setting for you. It is my policy to hold my clients or their parents financially responsible for any damages imposed upon the building or its contents. Clients or parents will be billed in full for any cost of repairing or replacing anything which is damaged.

Emergencies at the Facility: In case of a medical emergency at our facility, I will contact the nearest and most appropriate medical facility to provide care.

I hope this brief introduction answers some of your questions. Please feel free to ask any additional questions you may have. Again, I welcome you to our work together and trust that it will be mutually beneficial.

Rhoda E. Hurst, PhD, LCSW
Floyd Counseling & Care Management

Permission for treatment is hereby authorized to Rhoda E. Hurst, PhD, LCSW, to render treatment to _____ whose relationship to me is (circle one) self, child, spouse, guardian or other _____ .

_____ _____
Signature of Client, Parent or Guardian Date

_____ _____
Signature of Witness or Counselor Date

I have received a copy of this Consent Form.

_____ _____
Signature of Client, Parent or Guardian Date

Rhoda Hurst, PhD, LCSW
202 N. Locust Street
Floyd, VA 24091

FLOYD COUNSELING & CARE MANAGEMENT

Locations: Floyd, VA
P. O. Box 573
Floyd, VA 24091

(540) 772-8043 or Toll-Free (877) 895-8674

HIPAA NOTICE OF PRIVACY PRACTICES

(Effective Date: April 14, 2003)

This privacy notice is provided on behalf of: Floyd Counseling & Care Management

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: ***Floyd Counseling & Care Management , P.O. Box 573, Floyd, VA 24091. 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 ***Floyd Counseling & Care Management.***
- 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.