Alfred Hughes Ph.D., P.C
Licensed Psychologist (GA 2750)
485 Huntington Rd., Suite 201, Athens, GA 30606
Office 706-546-8440 Fax 706-369-0390

Authorization to Use or Disclose Protected Heath Information (PHI)

Section 1. Who is the Patient?

Last Name	First Name	Middle Intial
Subscriber Number from ID Card		
Insurance Company Name		
Date of Birth (mm/dd/yyy)		
Phone Number (s)		
Street Address		
City	**State**	**Zip**

I hereby authorize the use or disclosure of protected heath information about the individual named above. I am:

__ the individual named above (complete section 8 below to the sign this form)
__ a personal representative because the patient is a minor, incapacitated, or deceased (complete section 9 below)

Section 2. Who Will Be Disclosing Information About the Individual?

The following person(s) or entity may use or disclose the information:

Name (a person, a class of persons like "doctors who treated me in August 2003," or an organization)
Phone Number
Street Address
City, State, Zip

Section 3. Who Will Be Receiving Information About the Individual?

This information may be disclosed to:

Name (a person, a class of persons like "family members residing with me", or an organization
Phone Number
Street Address
City, State, Zip

Section 4. What Information About the Individual Will Be Disclosed?

Please specify the type of behavorial health and/or substance abuse service information to be disclosed, including any relevant dates.

____

Section 5. What is the Purpose of this Disclosure?

Please give the reason the information is being requested or disclosed.

____

Section 6. What is the Expiration Date or Event?

This authorization must expire within 1 year, on either a specific date or upon a specific event. Please choose either

- the following expiration date (no more than 1 year from today: ______________
- the following specific event (needs to happen within 1 year): ______________

Section 7. Important Rights and Other Required Statements You Should Know

- You can revoke this authorization at any time by writing to: Dr. Alfred Hughes, 485 Huntington Road, Suite 201, Athens, GA 30606. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- The information disclosed bases on this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- You do not need to sign this form in order to obtain enrollment, eligibility, payment or treatment for services.
- This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask us for a copy at any time by writing to the same address as above.
- If you have any questions about anything on this form, or how to fill it out, we can help.

Section 8. Signature of the Individual

Signature: ________________________________ Date: ________________________

Section 9. Signature of Personal Representative (if applicable)

Signature: ________________________________ Date: ________________________

Please describe your relationship to the individual and /or your legal authority to act on behalf of this individual in making decisions related to healthcare. You may be asked to provide us with relevant legal document giving you this authority.

Relationship to the individual (required): ____

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Informed Consent for Treatment

Patients Name:____

Date:____________________________

I, ___________________________________ (name of patient), agree and consent to participate in behavioral health care services offered and provided at the hand of/by Dr. Alfred Hughes. I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to perform within: (1) scope of the provider's license, certification, and training; or (2) the scope of license, certification and training of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of eighteen (18) or unable to consent to treatment, I attest that I have legal custody of the above named individual and am authorized to initiate and consent treatment and/or legally authorized to initiate and consent treatment on behalf of this individual.

Signature:____

Date: ____

Relationship to Patient (if applicable):

____

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Initial Evaluation

Demographic Information
(Please complete all questions on this form)

Date: ____________________

Patients Name: ____

Address: ____

____

Phone (home): ____________________ **Phone (work):**______________________

Date of Birth: ____________________ **Social Security #:** ___________________

Email____________________________

Guardianship (for children and adults when applicable): ______________________________

Marital Status (check one):
___ Never married ___ Divorced
___ Married ___Separated
___ Widowed ___Cohabiting

Race (optional):
___White ___Native American
___African-American ___Asian
___Hispanic ___Other

Gender: ___Male ___Female ___Transgender Male ___Transgender Female

Age: _____

Family Members:

Name Age Sex Relationship

____

____

____

____

____

Employer: ________________________ **Occupation**: ____________________________

School (for children, and adults when applicable): ________________________________

____

Referral Source: ____

Insurance Information:

Insurance Company/HMO: ___________________________ Phone: _______________

Member ID #: ___________________________Managed Care Company: _____________

Subscriber Name: _______________________ Group Number: ________________

Employer: ____

Claims Address: _________________________________ Phone: __________________

Emergency Information:

Name of Emergency Contact: _______________________ Phone: ___________________

Relationship to Patient: ____

Advance Directives:

I have an Advance Directive/Instruction for Mental Health Treatment: ___Yes ____No

I request that payment of authorized third party benefits be made on my behalf to Dr. Alfred Hughes for any services rendered by him or his assistants. I understand my signature also authorizes release of any information contained in my records to any relevant insurer, or its assignees, necessary to pay a particular claim.

By my signature, I acknowledge that I am ultimately responsible for payment of all fees in the event that payment is not received by a third party for any reason. These fees include any/all services performed by Dr. Hughes, including any/all forensic (court) appearances, court preparation, and travel. In some cases, a third party may be contacted for confidential collections.

A minimum for 24 hours of cancellation of your appointment is required. I understand that payment is due at the time services are delivered. I understand that psychological testing reports will not be released until payment for the evaluation is made in full. I understand that I will be charged full psychotherapy or psychological testing fees and I agree to pay those fees in the event that I or my child fails to show up for an appointment or cancellation of an appointment with less than twenty four hours notice.

____________________________________ ______________________________

Signature of Patient or Responsible Party Date

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Authorization to Disclose Protected Health Information

Communication between your behavioral health provider(s) and other relevant parties (i.e., primary care physician, school personnel) is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows your behavioral health provider to share valuable information with other parties. No information will be released without your signed authorization. Once completed and signed, please give this form to your behavioral health provider.

Section 1: The Patient

Full Patient Name: ________________
Date of Birth: (MM/DD/YYYY) ________________
Phone Number: ________________
Insurance Company ________________
Member/Subscriber Number from ID Card: ________________

I hereby authorize the disclosure of protected health information about the individual named above.
I am __ the individual named above
__ a personal representative because the patient is a minor, incapacitated, or deceased

Section 2: The following represents authorization for the release of information between Dr. Alfred Hughes Ph.D., P.C. and those parties identified by the patient (or legal guardian) in the list below. This consent allows for Dr. Hughes to provide information to individuals and/or agencies listed, and for Dr. Hughes to receive information from these individuals and/or agencies.

Name of Authorization 1:____________________ Phone number:____________________
Name of Authorization 2:____________________ Phone number:____________________
Name of Authorization 3:____________________ Phone number:____________________

Authorization for Primary Care Physician:

Name of Primary Care Physician:________________ Phone number:____________________
Name of any other Physicians:________________ Phone number:____________________

Section 4: What Information About the Individual Will Be Disclosed?

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis, and medication(s) if necessary.

Section 5: The Purpose of the Disclosure

To release (and receive) behavioral health evaluation/intervention information with the authorized party to ensure quality and coordination of care.

Section 6: The Expiration Date of Event

This authorization shall expire 1 year from the date of signature below unless revoked prior to that date.

Section 7: Important Rights and Other Required Statements You Should Know

- You can revoke this authorization at any time by writing to the behavioral health provider named above. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- The information disclosed based on this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services.
- This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting your behavioral health provider named above.

Section 8: Signature of Personal Representative (Signature of Guardian – if applicable)

Signature: ______________________________ Date: ____________________

Relationship to the individual: ____

Section 9: Signature of the Individual (If Patient is an adult and his/her own legal guardian)

Signature: ______________________________ Date: ____________________