

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

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

FINANCIAL POLICY

ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED
AN ACCOUNT 60 DAYS OLD WILL BE CONSIDERED DELINQUENT AND IS SUBJECT
TO BEING TURNED OVER TO AN OUTSIDE AGENCY FOR COLLECTION

The current rates for services provided by this office are listed below. We welcome frank discussions of services and fees *prior* to treatment in order to avoid misunderstandings.

Dr. Alfred Hughes

Psychotherapy: \$140 per 45-min session

Psychological Evaluations: \$160 per hour

Court Consultations: \$220 per hour

(depositions, expert witness, court appearances, travel)

Missed Appointments: \$50 per session

Late Cancellations: \$50 per session

(cancellations must be called in at least 24 hours in advance)

*Payment for court related services must be paid in full before any court appearances and before any testing results will be shared with court.

I understand the above stated fees and policy.

Signature of Client (or parent/guardian of minor)

Date

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: _____

Patient's Date of Birth: _____

I hereby request and authorize: **Alfred Hughes, Ph.D., P.C.**
485 Huntington Rd, Suite 201
Athens, GA 30606
Phone: (706) 546-8440 Fax: (706) 546-8456

To obtain from and release to:

1. _____
2. _____
3. _____

The following types of information from my records and/or specific portions thereof:

_____ All records

_____ Exclusions

for the purposes of: _____

All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released without my consent. I understand this authorization includes release of all medical records including Human Immunodeficiency Virus records, Psychiatric, Drug/Alcohol Abuse records Venereal Disease and any other statutory protected disease records. This authorization and consent will remain in effect until I revoke this authorization and consent. I understand that I may revoke this authorization and consent at any time except to the extent that action has been previously taken in reliance herof.

Signature of Patient or Legal Guardian: _____

Date: _____

**CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES;
CONFIDENTIALITY STATEMENT;
& PAYMENT AGREEMENT**

Minor Client Form-Child's Name: _____

I, _____, understand that counseling or psychotherapy or psychological testing has potential risks as well as potential benefits. I understand that the risks may include, for example, uncomfortable levels of unpleasant emotions and that individuals receiving therapy may feel worse, emotionally, before they begin to feel better.

I understand that all information disclosed to my child in therapy or during psychological testing is maintained in strict confidence and that documents pertaining to my child's treatment will not be released to other parties except when mandated by law. I understand that if the therapist has reason to believe that a child or elderly person has been abused or neglected, the therapist is legally required to file a report with the appropriate authorities. I understand that if my child expresses serious intent to physically harm him/herself or another person, then a report to appropriate individuals will be required. I further understand that there may be other conditions (such as a court order) that may place limits on the therapist's legal ability to maintain my child's confidentiality. I further understand that all testing and therapy sessions may be videotaped, and the videotape recordings will be maintained to the same degree of confidentiality detailed above, as well as being subject to the same conditions under which confidentiality cannot be maintained as mandated by law.

It is my expectation that I will be made aware of my child's progress in non-specific terms, but that I will not be informed of specific details of what is discussed in therapy. However, I do expect that the therapist will inform me of any serious health or safety issues of which my child may be at risk, with the understanding that this determination will be made by the therapist.

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

GENERAL INFORMATION

- All individual psychotherapy sessions will be 45 minutes in length unless prior arrangements have been made.
- If you fail to show-up for an appointment and/or you cancel less than 24 hours in advance, then all future will be canceled. At this time you may call and schedule one appointment at a time. The second violation of this policy can result in removal from schedule and a referral to another mental health provider.

I understand that Dr. Alfred Hughes, is a clinical psychologist in independent practice.

I also acknowledge that I have read and understand the HIPPA Georgia Notice Form.

My signature below indicates that I have read, been advised of, and understand the above information and that I give consent for my child to receive psychological services under these conditions.

Signature of Parent or Legal Guardian: _____ Date: _____

AUTHORIZATION TO REALEASE INFORAMTION
FOR
COURT TESTIMONY

I, _____, hereby authorize Alfred Hughes, Ph.D., P.C. to provide expert testimony regarding (*circle one*) me/my child's (*name*) _____ (*date of birth*) _____ case in a court of law, including all depositions, other trial or hearing related situation, or any court or litigation administrative needs. I grant Dr. Hughes permission to disclose any and all information regarding my evaluation or treatment with no exceptions, including but not limited to psychological testing results, information regarding therapy, and psychological testing raw data. In doing so, I waive all rights to confidentiality.

I understand the need for and the implications of this disclosure of information and this authorization is being made voluntarily on my part. I understand that I may revoke this release in writing at any time except the extent that action based on this consent has already been taken.

Date Signature of Client

OR

Date Signature of Parent/Legal Guardian

Alfred Hughes, Ph.D., P.C.

GEORGIA NOTICE FORM

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
 - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
 - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposed outside of treatment, payment, or health care operations, I will obtain authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes that I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.
- *Adult and Domestic Abuse* – If I have reasonable cause to believe that as disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by

accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.

- *Health Oversight Activities* – If I am the subject of and inquire by the Georgia Board of Psychological Examiners, I may be required to disclose protected health information regarding you in proceedings before the Board.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.
- *Worker's Compensation* – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. Upon your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. Upon your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you at the mailing address you provided.

V. Questions and Complaints

- If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me.
- If you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to me.
- You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.
- You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.
- I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mailing it to you at the address you provided.