LOUISIANA NOTICE FORM

Notice of 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 social worker.
  - *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 [office, clinic, practice group, etc.], such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], 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 purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes 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, and the 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 cause to believe that a child's physical or mental health or welfare is endangered as a result of abuse or neglect or that abuse or neglect was a contributing factor in a child's death, I must report this belief to Louisiana Department of Social Services.

- **Adult and Domestic Abuse** – If I have cause to believe that an adult's physical or mental health or welfare has been or may be further adversely affected by abuse, neglect, or exploitation, I must report this belief to the appropriate authorities as required by law. Please note that the term "adult", for the purposes of this section, means any person sixty years of age or older, any disabled person eighteen years of age or older, or an emancipated minor.

- **Health Oversight Activities –** The Louisiana State Board of Social Work Examiners may subpoena records from me relevant to its disciplinary proceedings and investigations.

- **Judicial and Administrative Proceedings** – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without your written authorization, or a court order. In the event of your death, your legally-appointed representative will be given access if a suit is brought on behalf of the estate. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I will inform you in advance if this is the case.

- **Serious Threat to Health or Safety** – If you communicate to me a threat of physical violence, which I deem to be significant, against a clearly identified victim or victims, coupled with the apparent intent and ability to carry out such threat, I must take reasonable precautions to provide protection from the violent behavior. These precautions include communicating the threat to the potential victim(s) and notifying law enforcement.

  Worker's Compensation – If you file a worker's compensation claim and I have treated you relevant to that claim, I must disclose any requested medical information and records relative to your injury to your employer, to a licensed and approved vocational rehabilitation counselor assigned to your claim, another health care provider examining you, or the worker's compensation insurer.

IV. Patient's Rights and Social Worker'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 at 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 Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *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. On 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. On 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, even if you have agreed to receive the notice electronically.

Social Worker'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 by mail of these changes.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact **Louisiana State Board of Social Work Examiners, 18550 Highland Road Suite B, Baton Rouge, LA 70809, (225) 756-3470** or visit **www.labswe.org**.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on July 14, 2011.

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 mail.

Karen L. Collier, LCSW
10641 Hillary Court, Suite 1
Baton Rouge, LA 70810
(225) 387-3325

Receipt of Notice of Privacy Practices

This is to certify that the HIPAA Notice of Privacy Practices has been made available to me regarding me as a patient or regarding my child, for whom I am a legal guardian.

____
Signature of Patient or Authorized Party

____
Date

____
Witness

CONSENT FOR TREATMENT

I, ____, hereby consent to diagnosis and treatment of my minor child,____ by **Karen L. Collier, LCSW.** In entering into this agreement, I understand that all mental health care, diagnosis and treatment is provided by the licensed professional person named above and not by Psychological Evaluation & Treatment Services.

I accept responsibility for payment of all usual and customary professional fees charged, **or** insurance deductibles and copayments set by my insurance carrier, managed care company, or other third party administrator, **and** that I am responsible for any expenses incurred that are not covered by such other entities (i.e. un-authorized procedure, telephone communications to third parties or yourself, reports or other written communications, etc.). I understand that payment is due at the time services are rendered, unless other arrangements have been made in advance.

I understand further that all communications shall be held in professional confidence except for those circumstances provided by law or when I have given permission in writing for release of information on my behalf to a third party. Examples (**not a complete list**) of legal exceptions to the patient's privilege of confidentiality include the following:

* When you have filed a lawsuit placing your mental status at issue;
* When you have signed an agreement with some other person or company, such as your insurer, authorizing release of information;
* When your condition poses a danger to yourself or someone else;
* When evidence of abuse is revealed.

Cancellation of sessions, and re-scheduling of sessions, must be done at least 24 hours in advance. ***If you do not cancel/reschedule at least 24 hours in advance, you will be billed for that session. If you are going through an insurance company, you should know that they will not pay this cancellation fee; it will be an out-of-pocket expense for you.***

____________________________ ____
Date Signature

____
Witness

Karen L. Collier, LCSW

Adolescent Client Information

****Please fill out entire form to the best of your ability****

Patient Name ____ Today's Date _____________________

Birthdate ___________________ Age ________ Height _______________ Weight _______________

Home/Mailing Address ____

____ Phone (____)________________

SSN# ______-_____-________ Email ____

School ____ Present or Highest Grade _______

Parents ____ Marital Status _____________________

Mother's Address (if different) ____

Home Phone (____)________________ SSN# ______-_____-________ Birthdate _________________

Employer/Occupation __________________________________ Work Phone (____)________________

Father's Address (if different) ____

Home Phone (____)________________ SSN# ______-_____-________ Birthdate _________________

Employer/Occupation __________________________________ Work Phone (____)________________

Brothers/Sisters (names and ages) ____

____

Circle All That Apply:

Pregnancy: normal threatened miscarriage mother sick; comment____________________

Delivery: normal premature complicated C-section; comment______________________

Infant: normal irritable handicapped sickly; comment________________________

Development: normal delayed; comment____

PLEASE FILL OUT THE FOLLOWING COMPLETELY:

Problem/Symptoms ____

____

Previous Evaluation/Treatment (where, when, who) ____

____

Medications ____

____

Referred by ____

Primary Care Physician ____

Karen L. Collier, LCSW
10641 Hillary Court, Suite 1
Baton Rouge, LA 70810
(225) 387-3325

Authorization for Release of Confidential Information

I, ____________________________________, give my consent for the release of confidential information concerning:

my son/daughter ____

Information to be released is limited to:

all findings ____

Disclosure of this information is for the purpose of:

evaluation and treatment ____

Information shall be interchanged between:

Karen L. Collier, LCSW ____

____

and:

Your insurance provider ____

____

This consent may be revoked in writing at any time, but such revocation shall not be retroactive.

This consent shall expire not later than one year after treatment ends.

____________________ ______________________________

Date Signature

____

Witness

CHILD/ADOLESCENT SYMPTOM CHECKLIST

In order to assist your clinician in the assessment process, please check any of the following symptoms that your child has experienced within the last month.

School Difficulties:

______ Reading problems
______ Writing problems
______ Arithmetic problems
______ Clumsy, awkward
______ Won’t obey at school
______ Problem speaking
______Won’t go to school
______Won’t try in school
______ Poor work habits
______ Difficulty following directions
______ Doesn’t care
______ Runs away from school
______ Slow learner
______ Tries hard but fails
______ Fights at school
______ Plays sick when not
______ Daydreams (“In another world”)
______ Fidgety, hyperactive, can’t sit still
______ Talks out of turn
______ Disturbs others when working

Everyday Situations:

______ Shy
______ Keeps to self
______ Doesn’t make friends
______ Cries too much
______ Hurts self
______ Jealousy
______ Worries too much
______ Complains too much
______ Poor loser
______ No confidence
______ Depressed/Unhappy
______ Asks for too much help
______ Won’t take help
______ Won’t sit still
______ Forgets things learned
______ Won’t keep at one thing
______ Feelings hurt too easily
______ Unable to express feelings
______ Overactive
______ Nervous
______ Runs away from home
______ Fights
______ Hurts others
______ Lies
______ Steals
______ Sets fires
______ Temper fits
______ Bad language
______ Says strange things
______ Does strange things
______ Bed-wetting
______ Clothes-wetting
______ Soiling (stool in pants)
______ Too neat
______ Works too hard
______ Thumb-sucking
______ Many bad dreams
______ No friends
______ Friends younger mostly
______ Friends older mostly
______ Bossy
______ Tattles, tells on others
______ Keeps bad company
______ Poor grooming
______ Motor coordination problems
______ Fears of ______________________

Date:________________________