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 myself 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 comunications 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. *Answering service available 7 days a week, 24 hours a day. I*f you do not cancel/reschedule at least *24 hours* in advance, you will be charged $80. 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

Client Information

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

Patient Name _____ **Today's Date** _____

Birthdate _____ **Age** _____ **Height** _____ **Weight** _____

Mailing Address _____

City _____ **State** _____ **Zip code** _____

Home Phone (____)_____ **Cell** (____)_____ **SSN#** _____-_____-_____

Email Address _____

Employer/Occupation _____ **Work Phone** (____)_____

Highest Grade Completed or Degree _____ **School** _____

Marital Status Single _____ / Married _____ (Date _____) / Widowed _____ (Date _____)
Separated _____ (Date_____) / Divorced _____ (Date _____)

Spouse Name _____ **Birthdate** _____ **Age** _____

Address (if different) _____

Telephone (___)_____ **SSN#** _____-____-_____ **Cell Phone** (____)_____

Employer/Occupation _____ **Work Phone** (___)_____

Children (names and ages) _____

_____

Parents _____ **Marital Status** _____

Address _____

_____ **Telephone** (___)_____

Brothers/Sisters (names and ages) _____

_____

Chief Complaint _____

_____

_____

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

_____

Medications (Current/Past) _____

_____

Referred by _____

ADULT SYMPTOM CHECKLIST

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

_____ Irritability
_____ Sleep problems
_____ Worry a lot
_____ Tense
_____ Nightmares
_____ Poor appetite
_____Excessive appetite
_____Binge eating
_____Weight loss
_____ Crying
_____ Poor concentration
_____ Low energy
_____ Energy loss
_____ Hopelessness
_____ Fearfulness
_____ Lying
_____ Shyness
_____ Vomiting after eating
_____ Laxative use to control weight
_____ Trouble expressing feelings
_____ Trouble managing anger
_____ Physical violence

_____ Frequent sadness
_____ Recent loss
_____ Parenting problems
_____ Marital problems
_____ Sexual problems
_____ Family problems
_____ Work or school problems
_____ Hearing voices
_____ Do things over and over
_____ Trouble making decisions
_____ Drug usage
_____ Drink too much
_____ Family members drink
_____ Overspending
_____ Gambling
_____ Jealousy
_____ Hurts self
_____ Trouble with law
_____ Memory problems
_____ Feel someone is out to get you
_____ Feel taken advantage of
_____ Fears of _____

Name:_____ Date:_____

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

Authorization for Release of Confidential Information

Part I

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

myself_____

Information to be released is limited to:

all findings_____

Disclosure of this information is for the purpose of:

evaluation or treatment_____

Information shall be exchanged between:

Karen L. Collier, LCSW_____

And the following person(s): (Ex: parent/guardian, spouse, primary care physician, etc.)

_____

_____

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

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

Authorization for Release of Confidential Information
Part II

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

___myself_____

Information to be released is limited to:

___my findings_____

Disclosure of this information is for the purpose of:

___evaluation or 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

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

Insurance Filing Requirements

Our current office policy requires payment at the time of service. We will file with all in-network managed care companies if indicated below. If you do not wish for us to file with your in-network insurance company, we will not backdate services if you later decide you want us to file. However, we will start filing your claims starting on the date you sign a new 'Insurance Filing Requirements' form allowing us to do so. If you have out-of-network insurance, we will not file for you but you are allowed to file on your own. Please note that insurance companies have limitations on which diagnoses and services are covered, and this information may be used in determining future insurance eligibility. **This means you are responsible for any payments not covered under your insurance policy.** Refer to your policy for these details.

- ☐ I do want this office to file with my in-network insurance company at this time
- ☐ I do not want this office to file with my in-network insurance company at this time
- ☐ I do not have health insurance at this time

_____
Signature of Authorized Party

_____
Date

_____
Witness

Revised 9/4/12

Please sign, date, and sign.

Do not fill out the rest.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY STATE	8. RESERVED FOR NUCC USE	CITY STATE
ZIP CODE TELEPHONE (Include Area Code) ( )		ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $
29. AMOUNT PAID $	30. Rsvd for NUCC Use		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.