NOLA Art Therapy and Counseling, LLC

▪ 1000 Veterans Memorial Blvd, Suite 310, Metairie, LA 70005 ▪ phone: 504-220-1483 ▪ fax: 888-248-7189
▪elizabeth@nolaarttherapy.com▪

Client Name: _____

ADMISSION AGREEMENT

CONSENT TO TREATMENT

I acknowledge that I have received a satisfactory explanation and understand the information about my therapy including problems, goals, and methods of treatment. I do hereby consent to take part in treatment with the above therapist. I understand that assessment, development of a treatment plan with this therapist, and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. No guarantees have been made to me about the outcomes of this care. How long therapy lasts tends to vary depending on the issues and goals each client has. I understand that my therapist will recommend a number of sessions. I acknowledge that I have the right to stop treatment at any time.

CONFIDENTIALITY

Clients are entrusted to the care of the staff and are given the assurance that all information is held in strict confidence. Any information about a patient's condition, care or treatment must not be discussed with anyone, either at or away from the office, except with the patient's written consent. What we discuss in treatment is confidential.

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental health professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

If, in the professional judgment of the mental health provider, information contained in the record would be harmful to the client, that information may be withheld from him/her and/or the legal guardian/ caretaker except under court order.

If records are requested, clients or legal guardians/ caretakers shall contact the office to set an appointment to review the records. Original records cannot be removed from the office. Copies can be made if necessary, but there is a fee for a medical records request.

I understand and agree to the limits of confidentiality and understand their meanings and ramifications.

Client/ Guardian Signature:_____ Date:_____

Additional Guardian Signature (if applicable):_____ Date:_____

*Please have all legal guardians sign this consent to treatment form.

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CLIENT REGISTRATION FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. If you answer no at the beginning of a section, please write N/A in the fields under that question and then complete the next section.

CLIENT INFORMATION

Name:

_____
(Last) (First) (Middle)

Birth Date: _____ /_____ /_____ Age: _____ Sex: ☐ Male ☐ Female Gender:_____

SSN:_____ Ethnicity:_____

Marital Status: ☐ Single/ Never Married ☐Domestic Partnership ☐Married ☐ Separated ☐Divorced ☐Widowed

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Please explain visitation schedule with other caretakers and list their addresses: _____

***** Please attach a copy of the custody agreement if applicable*****

Home Phone: (___)___-_____ Cell/Other Phone: (___)___-_____
May we leave a message on the voicemail/ answering machine or with anyone who answers the phone? ☐Yes ☐No

E-mail: _____ May we email you? ☐Yes ☐No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Name of parent/legal guardian (if under 18 years):_____
(Last) (First) (Middle Initial)

Custodial status (circle): Independent adult, biological mother, biological father, joint biological parent, gov't/judicial
Other (explain):_____

Address of parent/legal guardian_____
(Street and Number)

(City) (State) (Zip)

Are there any other caretakers involved? ☐Yes ☐No

Address of additional parent/legal guardian: _____
(Street and Number)

_____
(City) (State) (Zip)

Please explain visitation with other caretakers: _____
_____
_____

Please explain relationship with other caretakers: _____
_____
_____

****Please attach a copy of the custody agreement if applicable. All legal guardians must consent to treatment.****

Referred by (if any): _____

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CURRENT MENTAL HEALTH SERVICES

Are you currently receiving mental services (psychotherapy, psychiatric services, etc.)? ☐ Yes ☐No
If yes, please sign a consent form so we can coordinate care.
If yes, current diagnoses:_____
Current therapists/practitioners: _____
Please explain service dates, type:_____
Is the client having a positive experience in treatment? ☐Yes ☐No
Explain: _____
_____
Is the client compliant with treatment recommendations and/or medication? ☐Yes ☐No
Explain:_____
_____

Please describe and explain your global preferences/hopes for treatment, preferred level of care, duration of care, plan for discharge below.

_____
_____

PREVIOUS MENTAL HEALTH SERVICES

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?☐ Yes ☐No
Have you previously received any prior outpatient mental health treatment?☐ Yes ☐No
Have you previously received any prior residential mental health treatment?☐ Yes ☐No
Have you previously received treatment at a psychiatric hospital?☐ Yes ☐No
If yes, Previous diagnoses:_____
Previous therapists/practitioners: _____
Explain service dates, type: _____
Did client have a positive experience in previous treatment? ☐Yes ☐No
Explain: _____
_____
Was client compliant with treatment recommendations and/or medication? ☐Yes ☐No
Explain:_____
_____

MEDICAL HISTORY

Does client report taking any medications for any reason? ☐**Yes** ☐**No**
Please list **current** medications using for any reason:

Name of Medication	Dosage	Administration	Condition	Start Date

Please list **previous psychiatric** medications:

Name of Medication	Dosage	Administration	Condition	Start Date

Any Allergies or Special Precautions: ☐Yes ☐No
If yes, list allergies and /or special precautions: _____

PRESENTING PROBLEM

Chief Complaint (major symptoms, difficulties, and/or issues as they related to behavioral health): _____
_____

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Symptoms (mental, emotional, and/or behavior problems):_____

Date of Onset, frequency, duration, and progression of symptoms:_____

Additional information about symptoms: _____

Please explain any past or current stressors:_____

Does client **currently** have thoughts, plans, intent, or behaviors indicative of suicide:
☐Yes ☐No If yes, explain: _____

In the **past**, has client had thoughts, plans, intent, or behaviors indicative of suicide:
☐Yes ☐No If yes, explain: _____

Does client **currently** have thoughts, plans, intent, or behaviors indicative of homicide:
☐Yes ☐No If yes, explain: _____

In the **past** has client had thoughts, plans, intent, or behaviors indicative of homicide:
☐Yes ☐No If yes, explain: _____

Are there any guns, knives, weapons, medications, or others means to harm self or others at the home?
☐Yes ☐No If yes, explain safety plan with those items (locked in a safe, etc.): _____

Risk to harm self (circle all that apply): Prior suicide attempt, stated plan/ intent, access to means (weapons, pills, etc.), recent loss, presence of behavioral cues (isolation, giving away possessions, rapid mood swings), family history of suicide, terminal illness, substance abuse, marked lack of support, psychosis, suicide of friend/family/ acquaintance, none
Other:_____
Explain: _____

Risk to harm others (circle all that apply): Prior acts of violence, destruction of property, arrests for violence, access to means (weapons), substance use, physically abused as child, was physically abusive as a child, harms animals, fire setting, angry mood/agitation, Prior hospitalization for danger to others, psychosis/command hallucinations, none
Other:_____
Explain: _____

Client Safety

Client safety risk (circle all that apply): Feels unsafe in current living environment, Feels currently being harmed/hurt/abused/threatened by someone, Engages in dangerous sexual behavior, Past involvement with child or adult protective services, Relapse/decompensation triggers, none
Other:_____
Explain: _____

EDUCTATION

School: _____
Current grade: _____
Number of schools attended: _____
History of (if yes, explain in the space provided):
a. Academic problems: ☐Yes ☐No

Describe: _____
_____

b. Academic strengths: ☐Yes ☐No
Describe: _____
_____

b. Behavior problems: ☐Yes ☐No
Describe behavior problems and if child has been suspended or expelled: _____
_____

d. Special education placement: ☐Yes ☐No
If yes, explain (504, IEP, accommodations):_____
_____

Additional information on education: _____
_____

EMPLOYMENT

☐ Not currently employed ☐ Employed ☐ Full Time Student
Employer:_____ Job description/occupation:_____
Describe any job related stress:_____

Employer Phone Number: (___)___-_____
May we leave a message on the voicemail/ answering machine or with anyone who answers the phone? ☐Yes ☐No

FINANCIAL

Is the client experiencing any financial concerns? ☐Yes ☐No
If yes, explain:_____
_____

TRANSPORTATION

Is the client experiencing any issues with transportation? ☐Yes ☐No
If yes, explain:_____
_____

SOCIAL

Is client able to form and maintain relationships? ☐Yes ☐No

Preferred social activities or Describe any leisure activities or hobbies: _____
_____
Romantic Partner: ☐Yes ☐No
If yes, for how long? _____
Current problems with intimate relationships? ☐Yes ☐No
On a scale of 1-10, how would you rate your relationship? _____
Sexually active: ☐Yes ☐No
Please describe your romantic relationships: _____
_____
Gang involvement or criminal activity: ☐Yes ☐No
If yes, explain:_____

LEGAL HISTORY

Current legal status:
☐ Arrest charges pending ☐ Probation ☐ Restitution ☐ Previous Arrests ☐ OJJ
☐ Detention ☐Family Court / Status Offenses / FINS / TASC ☐ DCFS
If yes, explain (include dates, charges, convictions, terms of probation, next court date and probation officer)
_____
_____

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Past legal status:
☐ Arrest charges pending ☐ Probation ☐ Restitution ☐ Previous Arrests ☐ OJJ
☐ Detention ☐Family Court / Status Offenses / FINS / TASC ☐ DCFS
If yes, explain below and include dates, charges, convictions, terms of probation, next court date and probation officer.

_____
_____

DEVELOPMENTAL/BIRTH HISTORY

☐ Information not available.
☐ All early development issues are reported within normal limits. Proceed to Infant Temperament Section.
☐ There are some development issues worth noting. Please complete all items below that you answer "yes" to and include age of onset.

Were there complications with the pregnancy? ☐Yes ☐No
Discuss complications, prenatal care, and planned / unplanned pregnancy: _____
_____
_____
Were there any delays in meeting developmental milestones? ☐Yes ☐No
If yes, explain: _____
_____
Were there any issues with infant temperament (difficult to comfort, quiet, aloof, irritable, overactive, feeding issues)?
☐Yes ☐No
If yes, explain: _____
_____

GENERAL MEDICAL HISTORY

Overall general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Information not available

Neurological issues: ☐Yes ☐No
Chronic Pain: ☐Yes ☐No
Explain any general medical information:_____
_____

Please explain additional significant Medical History (diagnosis, hospitalizations, surgery, labs, status of condition):_____
_____
_____
_____

An Advance Directive is a legal document that provides instructions for medical care and will only go into effect if you cannot communicate your own wishes. To complete the forms at the office, there must be a witness present who knows you, but is not related to you by blood, marriage or adoption nor the person who you would appoint to make mental health treatment decisions for you if you would like to create one with us at the office. We are not able to be witnesses on the document since we are providing services to you. We can provide you with the document to complete on your own if desired.

If you are 18 years of age or older, would you like to create an advance directive?
☐ Yes, but on my own (please provide the form) ☐Yes, and I will bring a witness with me to the office
☐No ☐N/A, client is a minor

ADDICTION HISTORY

Does client have a history of substance abuse? ☐Yes ☐No
If yes, explain: _____
_____
Other Addictions: ☐Yes ☐No
If yes, explain: _____
_____

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Please check any/all that apply in the past 12 months
☐ Alcohol Use ☐ Illegal drug use ☐ Injection drug use ☐Tobacco product use ☐ Prescription drug abuse
☐ non- prescription (OTC) abuse ☐ Alcohol and/or drug overdose ☐ Alcohol and/or drug withdrawal
☐Problems caused by gambling ☐ Trouble stopping any substance ☐ vaping ☐ Other_____

Please explain any additional addiction information (other addictions, etc.) : _____
_____
For the last 30 days, please explain substance use. Include Type), Age of 1st use, Years of use in lifetime, How often in the past 30 days, Amount used, Route of administration (oral, nasal, smoking, non-IV injection, IV): _____
_____
_____
_____

Does client currently live with anyone with substance abuse issues? ☐Yes ☐No
If yes, explain: _____

Substance abuse treatment:
☐ outpatient ☐ intensive outpatient ☐ residential/inpatient ☐ detox
☐ Other(describe)_____
Please explain substance abuse treatment history:: _____
_____

FAMILY HISTORY

Are there family issues which need to be addressed in treatment? ☐Yes ☐No
If yes, explain: _____
_____
Positive relationship with parents?
☐Yes ☐No
If no, explain: _____
_____
Positive relationship with siblings?
☐Yes ☐No
If no, explain: _____
_____
Number of persons, other than client, currently living in the home (If you live alone, please make note of that):

Household Members

Name	Age	Relationship

Form of discipline used in home?_____

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Current Support Systems:
Describe client's current support systems (family, friends, Mentor, etc)? _____
_____
List Abilities and Strengths:
_____
_____
List Needs and Weaknesses:
_____
_____
Please list any preferences or needs for treatment (religious, spiritual, ethnic, etc)): _____
_____

Past Significant Events (Check any of the following that occurred during childhood):

- ☐ Significant medical condition of parent / caregiver
- ☐ Medical condition of child or family member
- ☐ Post-partum adjustment problems of mother
- ☐ Mental illness of caregiver/ family member
- ☐ Substance abuse of caregiver / family member
- ☐ Attempted/ completed suicide of family member
- ☐ Separation/ divorce of caretaker
- ☐ Criminal behavior
- ☐ Abuse
- ☐ Neglect
- ☐ Other:_____
- ☐ Adoption
- ☐ Abandonment by significant adult caregiver
- ☐ Death of parent / caregiver
- ☐ Mental retardation of parent / caregiver
- ☐ Incarceration of parent / caregiver
- ☐ Developmental disabilities of caretaker
- ☐ Poverty
- ☐ Domestic Violence
- ☐ Violence
- ☐ Trauma
- ☐ None

If yes to any, please explain:_____
_____
_____
_____
_____

Has client ever lived in any of the following settings? ☐Yes ☐ No If yes, check below to all that apply.

- ☐ Relative's home
- ☐ Group home
- ☐ Emergency shelter
- ☐ Detention facility
- ☐ Hospital
- ☐ Foster family
- ☐ Therapeutic foster care
- ☐ Correctional facility
- ☐ Homeless shelter
- ☐ Other_____
- ☐ Orphanage
- ☐ Halfway house
- ☐ Residential substance abuse facility
- ☐ Residential treatment center

If yes to any, please explain:_____
_____
_____

How many times has client's residence changed in the last two years? _____

Where does the client currently live?

- ☐ Relative's home
- ☐ Group home
- ☐ Emergency shelter
- ☐ Detention facility
- ☐ Foster family
- ☐ Therapeutic foster care
- ☐ Correctional facility
- ☐ Homeless shelter
- ☐ Orphanage
- ☐ Halfway house
- ☐ Residential substance abuse facility
- ☐ Residential treatment center

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☐ My own home ☐ Out of home placement ☐ Unhoused

☐ Hotel/motel ☐ Rent with roommates ☐ Rent alone

☐ Hospital ☐ Other_____

Please describe and give any information about the client's current residence:_____
_____

TRAUMA HISTORY

Check any/all traumas that apply.

☐ Experienced trauma personally ☐ Witnessed trauma ☐ Abuse

☐ Neglect ☐ Sexual assault ☐ Physical assault

☐ Other:_____ ☐ None

If yes to any, please explain:_____
_____
_____
_____
_____

FAMILY MEDICAL HISTORY

Please explain family history related to Psychiatric/ Mental Health (Abuse, Neglect, Anxiety, Depression, Domestic Violence, Eating Disorders, Obesity, Obsessive Compulsive Behavior, Schizophrenia, Suicide Attempts, Personality Disorders, Developmental Disorders), Alcohol/Substance Abuse, and Physical Illness.

	Biological Parents	Step Parents	Extended Family
Psychiatric/ Mental Health			
Drugs/Alcohol			
Physical Illness			

Client/ Guardian Signature:_____

Date:_____

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Authorization to Disclose Information to Primary Care Physician

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR Part 2 and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. If not previously revoked, this consent will terminate upon completion of the specific purpose as stated below.

I, _____, Date of Birth _____
(client's name)

hereby authorize NOLA Art Therapy and Counseling. *(please check one)*

_____ To release any and all applicable information to my Primary Care Physician.

_____ NOT to release information to my Primary Care Physician.

_____ I do not have a Primary Care Physician

for the specific purpose of coordinated treatment.

_____ _____
Client/ Guardian Signature Date

Primary Care Physician's Name, Address & Phone:

_____

_____

_____

_____

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Authorization for Electronic Communication

As a convenience to me, I authorize NOLA Art Therapy and Counseling, LLC to communicate with me regarding my treatment via the electronic communications of email, text, and/or the patient portal to transmit my protected health information electronically as described below.

I understand there are risks inherent in the electronic transmission of information by email or text message:

● Such communication does not provide a completely secure means of communication.

● Any protected health information transmitted via electronic communications pursuant to this authorization may not be encrypted.

● Electronic transmission of information cannot be guaranteed to be secure or error-free.

● Data may be vulnerable to access by unauthorized third parties.

As such, NOLA Art Therapy and Counseling, LLC shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by NOLA Art Therapy and Counseling, LLC to me.

Your treatment does not depend on consent. You have the right to terminate or amend this agreement at any time. The use of more secure communication methods, such as messaging through your TherapyAppointment Patient Portal or a phone call are alternatives ways to communicate with NOLA Art Therapy and Counseling, LLC.

I understand that NOLA Art Therapy and Counseling, LLC may transmit my protected health information electronically as described above unless and until I revoke or amend this authorization by submitting notice to NOLA Art Therapy and Counseling, LLC in writing. This authorization does not allow for electronic transmission of my protected health information to third parties, and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

Placing my name in the field below acknowledges my authorization of electronic communication via text, email, and/or the patient portal.

_____ _____

Client/ Guardian Signature Date

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Billing, Payment, and Insurance Information & In Case of Emergency Contact and Consent

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all of my insurance submissions.
2. I authorize the release of information to my insurance company and Therapy Appointment for billing purposes.
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.
6. It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by your insurance. The day and time serviced is provided.
7. Be advised that a notice of unpaid balances will be mailed to the address on this form.
8. There will be a $50.00 service charge for all returned checks.
9. In event that your account goes to collections, there will be a 20% collection fee added to your balance.
10. There is a 24-hour cancellation policy, which requires that you cancel your appointment 24-hours in advance between the hours of 8 a.m. - 5 p.m. Monday – Friday to avoid being charged a missed appointment fee.

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the therapist. I understand that I am financially responsible for any balance. I also authorize NOLA Art Therapy and Counseling or insurance company to release any information required to process my claims. I understand that my diagnosis will be provided to my insurer. I understand that my insurance company may request additional clinical information regarding my treatment in order to authorize sessions and/or payment. I authorize NATC to provide such information as necessary. I authorize NATC to contact the in case of emergency person listed above as needed to assist in a crisis situation.

_____ _____

Client/Guardian signature *Date*

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Insurance Form

Client Information					
Client's Name:			DOB:		
Member ID #:			Sex:	M	F
Group #:			SSN:		
Address:					
Phone:			Other Phone:		
Email address:					
Is this client covered by insurance?	Yes	No			
Primary Insurance Company					
Primary Insurance Company Name:			Co- payment:		
Insurance Phone:					
Insured					
Insured's Name:			DOB:		
Member ID #:			Sex:	M	F
Group #:			SSN:		
Address:					
Phone:			Other Phone:		
Email address:					
Occupation:			Employer:		
Employer Address:					
Employer Phone:			Insured's Relation to client:		
Secondary Insurance Company					
Secondary Insurance (if applicable):			Co- payment:		
Insurance Phone:					
Insured					
Insured's Name:			DOB:		
Member ID #:			Sex:	M	F
Group #:			SSN:		
Address:					
Phone:			Other Phone:		
Email address:					
Occupation:			Employer:		
Employer Address					
Employer Phone:			Insured's Relation to Client:		

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Cancellation Policy and Credit Card Form

This form is mandatory in order to receive services at NATC.

If you do not show up for your scheduled therapy appointment, and you have not notified us at least 24 hours in advance, you will be required to pay a cancellation fee. Insurance will not cover the cost of missed appointments. The fee will be the lesser of the insurance company's contracted rate for the session or $95.

Client Name: _____

I, _____ am authorizing NOLA Art Therapy and Counseling to charge my credit card in the event I fail to show up for my scheduled appointment and do not notify NATC staff of my inability to attend a scheduled appointment at least 24 business hours in advance. I agree to pay the above-mentioned cancellation fee for any session cancelled without 24 business hours in advance. I will not dispute the charges for the sessions I have received or that I have not cancelled less than 24 business hours in advance. I further authorize NATC staff to disclose information about my attendance/ cancellation to my credit card company if I dispute a charge. In addition, I authorize this card to be used to pay balance on any outstanding balance should my insurance lapse or have a deductible.

Card Type: _____ Visa_____Mastercard_____Discover_____American express

Full Name on Card: _____

16 Digit Card Number: _____ Exp Date:_____

Verification/ Security Code:_____(3 digit code on back by the signature line)

Billing Zip Code:_____Email address:_____

Phone number:_____

Client/ Guardian Signature:_____
Date:_____

*Please note: This form will be securely stored in your clinical file and may be updated upon request at any time. Your credit card will not be charged unless the following conditions apply: no show for a scheduled appointment, cancellation less than 24 business hours in advance, or an outstanding unpaid balance for services received at NATC.

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Health Insurance Portability and Accountability Act (HIPAA)
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed. It also describes how you can access this information.

Please read carefully.

Privacy Notice Introduction. This notice tells you about the ways health information is used. It describes your rights and our obligations regarding the use and disclosure of heath information. Over time your therapist may change this notice. If changed, your therapist is required to inform you of our new privacy policy by making a revised notice available to you.

Your therapists reserve the right to change this notice and make the new provisions effective for all Protected Health Information that we maintain.

General Privacy Information. When you contract to be under the care of a therapist, a record is usually kept. These records contain demographic information (such as name, address, telephone number, Social Security Number, birth date, and health insurance information). The records may also contain other information including how you say you feel, what health problems you have, treatments you may have received, observations by health care providers, diagnosis and plan of care. **This is known as Protected Health Information, or PHI**, and is used for a number of purposes explained in detail in this document.

Your PHI may be used and/or disclosed by your therapist for the purpose of providing health care services, to pay or obtain payment for your health care treatment, to inform you about other health-related options, to comply with the law.

Treatment. Your therapist will use and disclose your protected health information to provide, coordinate, or manage your care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fulfill a prescription or to a subcontracted provider who is also providing services for you. Your therapist may also disclose protected health information to physicians who may be treating you or consulting with the treating therapist with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

Payment. Your PHI will be used and disclosed, as needed, to obtain payment for the services provided by your therapist. This may include certain communications to your health insurer to get approval for the treatment that are recommended by your therapist. For example, if a certain level of service is recommended, we may need to disclose information to your health insurer to get prior approval for the level of service. We may also disclose protected health information to your insurance company to determine whether you are eligible for benefits or whether a particular service is covered. In order to get payment for your services, we may also need to disclose your protected health information to your insurance company to demonstrate the medical necessity of the services or to demonstrate that required documentation exists. Your therapist may also disclose patient information to another provider involved in your care for the other provider's payment activities.

Operations. Your therapist may use or disclose your PHI, as necessary, for to support the health care operations of the therapist's practice. Health care operations include but are not limited to:

- Quality assessment and improvement activates
- Employee review activities
- Training programs including those in which students, trainees, or practitioners in healthcare learn under supervision
- Accreditation, certification, licensing or credentialing actives
- Review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs.

In certain situations, we may also disclose consumer information to another provider or health plan for their health care operations

Other Uses and Disclosures. As part of treatment, payment and healthcare operations, your therapist may also use or disclose your protected health information for the following purposes:

- To remind you of an appointment including messages left on answering machines
- To inform you of potential treatment alternatives or options
- To inform you of heath-related benefits or services that may be of interest to you.

Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or opportunity to Object: The HIPAA Privacy Rule also allows your therapist to use or disclose your PHI without your permission or authorization for a number of reasons including the following:

When Legally Required. Your therapist will disclose your PHI when required to do so by any Federal, State or local law.

When there are Risks to Public Health. We may disclose your PHI for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law
- To report vital events such as birth or death as permitted or required by law
- To conduct public health surveillance, investigations and interventions as permitted by law
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law
- To report to employer information about an individual who is a member of the workforce as legally permitted or required.

To Report Abuse, Neglect Or Domestic Violence. Your therapist may notify government authorities if we believe that a consumer is the victim of abuse, neglect or domestic violence. This disclosure will be made only when specifically required or authorized by law or when the client agrees to the disclosure.

To Conduct Health Oversight Activities. Your therapist may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. Your therapist will not disclose your health information if you are the subject of an investigation and your health information are not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings. Your therapist may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a signed authorization (in a format approved by the Louisiana Court Administrator).

For Law Enforcement Purposes. Your therapist may disclose your PHI to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person
- Under certain limited circumstances, when you are the victim of a crime
- To a law enforcement official if the therapist has a suspicion that your death was the result of criminal conduct
- In an emergency in order to report a crime.

To Coroners, Funeral Directors, and for Organ Donation. Your therapist may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. Your therapist may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

For Research Purposes. Your therapist may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board or privacy board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

In the Event of A Serious Threat To Health Or Safety. Your therapist may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, the Federal regulations authorize your therapist to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

For Worker's Compensation. Your therapist may release your health information to comply with worker's compensation laws or similar programs.

Uses and Disclosures That You Authorize: Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

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Your Rights: You have the following rights under HIPAA regarding your health information: You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation or used in a civil, criminal, or administrative action or preceding and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means that you may ask your therapist to not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state that specific restrictions requested and to whom you want the restriction to apply.

Your therapist is not required to agree to a restriction that you request. If the therapist believes it is in your best interest to permit use and disclose of your PHI. Your PHI will not be restricted you then have the right to use another health care professional.

You have the right to have your therapist amend your PHI. If your request for amendment is denied, you have the right to file a statement of disagreement. Your therapist may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Request for amendments must be directed to the Privacy Officer. In this written request you must also provide a reason to support the requested amendments.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

Complaints. You may complain to your therapist if you believe your privacy rights have been violated.

Your signature below is acknowledgement that you have received this notice of Privacy Practices.

Client/ Guardian Name: _____Signature: _____Date: _____

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Legal Policy and Fee Schedule

Court appearance is by subpoena only. The subpoena must be accompanied by either a consent form from the client/client's guardian or a court order.

Clients are discouraged from having the therapist subpoenaed. Though the client, client's guardian or the client's attorney is responsible for the court fees, it does not mean that the therapist's testimony will be solely in the client's favor. Once you are a client, the therapist is only able to be a fact witness in any legal case. A therapist is not able to serve both a clinical role and a forensic role. The therapist will only be able to testify to the facts of the case. NOLA Art Therapy and Counseling does not offer expert witness testimony. If you need an expert witness to give an expert opinion, please ask the court to appoint an unbiased, objective, forensic evaluator, or the attorney can retain a forensic expert to evaluate legal issues and make recommendations to the court in the best interests of the parties involved.

Please also consider that if the therapist must appear in court, it could be damaging to the therapeutic relationship between the client and the therapist.

As a fact witness, I do require compensation for my time, as is usual and customary when professionals are requested to testify in court.

Due to a subpoena to appear in court, I am required to cancel my clients for a substantial block of time. I am requesting to be paid in advance for all preparation time, all time required out of my office, including travel time, as I will not be available to see clients during those times.

I thank you in advance for understanding that I simply cannot afford to provide this professional service pro bono.

Should you and your attorney still desire my presence in court, my fee structure for court is as follows:

- All preparatory time (e.g., reviewing the file, court preparation with attorney, communication related to scheduling and preparation) is charged at $300/ hour
- Court time, for all time required out of the office (i.e., including drive time) and/or scheduled out that I otherwise would not be able to see clients is charged at $300/ hour.
- I cannot be available "on-call," as being called to come to court at the last minute is too disruptive to my practice. It is not fair to my clients that otherwise would be scheduled that day.
- I have a 4-hour minimum that will be required to be paid 3 business days in advance.
- If the court date is canceled without 2 business days' notice, I must still be paid the 4-hour minimum.
- All costs incurred by the therapist due to the timing of the court date must be paid (canceled vacations, childcare, etc).
- If services are needed with 48 hours' notice, there is an additional $275 charge.
- If the case is reset within 72 hours, there is an additional $275 charge.
- Additional fees may be determined on a case by case basis (cost of court documents, shipping, written summaries, etc).

Once a subpoena is received, the therapist will contact your attorney about the above fee schedule. By signing this form, you give your consent for the therapist to use verbal and written communication to contact your attorney and their office staff about the information above.

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I have read, understand, and agree to the above policies:

_____
Client Name

_____ _____
Client/Guardian Signature Date

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Custody/Access Dispute Contract

(Adapted from the Court Clinic in Ottawa, Canada)

_____

Client Name Date of Birth

The purpose of this contract is to obtain written agreement that the therapist will not be asked to participate in any litigation regarding the custody/access dispute. If the therapist is asked to participate in litigation, the therapist's neutral role with the family may be compromised. This is likely to seriously jeopardize any progress that may have been made in therapy. In order to prevent such deterioration of any therapy, it is crucial that I/we have every reassurance that there will be absolutely no involvement on my/our part in current or future litigation between the parents. This is best accomplished by both parents signing this statement:

We wish to enlist the services of NOLA Art Therapy and Counseling, LLC in the treatment of our family. We understand that such treatment will be compromised if information revealed therein is brought to the attention of the court in the course of a custody/access dispute. Accordingly, we mutually pledge that we will neither individually, nor jointly involve NOLA Art Therapy and Counseling, LLC in any litigation whatsoever. We will neither request nor require NOLA Art Therapy and Counseling, LLC to provide medical records or testimony in court. If the services of a mental health professional are desired for court purposes, the services of a person outside of NOLA Art Therapy and Counseling, LLC must be enlisted.

We have read the above, discussed these provisions with any attorney that we may be involved with at the present time and agree to proceed with therapy at NOLA Art Therapy and Counseling, LLC.

_____ _____

Client/Guardian Signature Date

_____ _____

Client/Guardian Signature Date

_____ _____

Witness/Therapist Date

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Additional Fees

Clinical needs should be addressed during your session. However, if additional time is required outside of your scheduled appointment, you will be billed the following:

Telephone calls after the first 10 minutes of free consultation:
$35 for each additional 15 minutes

Written correspondence (emails, letters, documents, etc):
$135/hour
The total cost will depend on the total time spent creating the written document.

Medical Record Request:
Paper and Electronic Records
Search Fee : $25.00
Pages 1 - 25 : $1.00 per page
Pages 26 - 350 : $0.50 per page
Pages 351+ : $0.25 per page
Cost of postage
Max Fee : $100.00 per request

I have read, understand, and agree to the above policies:

_____
Client Name

_____ _____
Client/Guardian Signature Date

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Symptoms Worksheet

Please discuss with minor client if needed and check all that apply.

Mood:
Describe general mood:
Mood symptoms:

- ☐ Excessive boredom
- ☐ Difficult to Concentration
- ☐ Decreased energy
- ☐ Weight loss
- ☐ Insomnia
- ☐ Grandiosity
- ☐ Thoughts of death
- ☐ Increased energy
- ☐ Decreased appetite
- ☐ Mood swings / emotional outbursts
- ☐ Impulsivity
- ☐ Decreased need for sleep
- ☐ Irritability
- ☐ Increased appetite
- ☐ Tearfulness
- ☐ Weight gain
- ☐ Hypersomnia
- ☐ Racing thoughts

Describe any symptoms: _____

Anxiety Symptoms:

- ☐ Excessive worries
- ☐ Avoidances
- ☐ Obsessions
- ☐ Flashbacks
- ☐ Excessive fears
- ☐ Extreme startle
- ☐ Compulsions

Describe any symptoms: _____

Psychosis Symptoms:

- ☐ Auditory Hallucinations
- ☐ Bizarre thinking
- ☐ Visual hallucinations
- ☐ Paranoia
- ☐ Delusions

Describe any symptoms: _____

Oppositional and Conduct Symptoms:

- ☐ Argues with adults
- ☐ Bullies others
- ☐ Blames others for mistakes
- ☐ Sets fires to cause damage
- ☐ Cruel to animals
- ☐ Often annoyed
- ☐ Spiteful and vindictive
- ☐ Ran away
- ☐ Often angry
- ☐ Initiate fights
- ☐ Steals significant items

Describe any symptoms: _____

Attention Deficit/ Hyperactivity Symptoms:
Symptoms at *home*:

- ☐ Fidgets
- ☐ Difficulty concentrating
- ☐ Difficulty taking turns
- ☐ Interrupts people
- ☐ Excessive energy
- ☐ Difficulty remembering due to poor attention

Describe any symptoms: _____

Symptoms at *school/work*:

- ☐ Fidgets
- ☐ Difficulty concentrating
- ☐ Difficulty taking turns
- ☐ Interrupts people
- ☐ Excessive energy
- ☐ Difficulty remembering due to poor attention

Describe any symptoms: _____

Eating disorders:
☐ Yes ☐ No
Describe any symptoms: _____

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Comprehensive Mental Health Treatment Plan

☐ **Initial Treatment Plan** ☐ **Updated Treatment Plan**		
Member Name:	**Date of Tx Plan:**	**DOB:**

Diagnosis history (ICD-10):	
Current Medication:	
Dose and Frequency:	
Start Date:	
Medication is appropriate to the dx:	**Circle: Yes/ No/ Unsure, will contact prescribing doctor**
Prescribing Doctor and contact information: (consent form if needed)	
Response to Medication and other concurrent treatment:	**Circle: Successful/ Unsuccessful** **Why:**
Problem Side Effects:	
Existing Problem	**Manifested By**
Strengths, Needs, Abilities, & Preferences	Strengths – Needs – Abilities – Preferences –
Long Term Goals:	_____ _____ _____ _____ _____ _____ _____ _____
The target date to reach the goal is ___ months from the date the treatment plan is signed.	
Short Term Goals/Objectives	_____ _____ _____ _____ _____ _____ _____ _____

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Comprehensive Mental Health Treatment Plan

Current Safety Risks	☐ None/Denied ☐ Thoughts of hurting or killing self ☐ Thoughts of hurting or killing someone else ☐ Reports feeling unsafe or reports of abuse ☐ Other:
Current Coping Skills	☐ Listen to Music ☐ Talk to a Friend or family member ☐ Deep Breathing ☐ Go for a Walk ☐ Exercise ☐ Read a Book ☐ Color ☐ Journal ☐ Take a Bath/Shower ☐ Punch a pillow ☐ Play video games ☐ Watch funny videos ☐ Clean something ☐ Draw ☐ Meditate/Yoga ☐ Dance ☐ Pace back and forth ☐ Other: _____
Parent/Guardian Communication Plan	Contact parent/guardian to update them on the treatment plan. Therapist will always contact the parent/guardian with any safety concerns.
Case Management Needs:	☐ None Identified ☐ PCP Referral ☐ Housing Referral ☐ Family Counseling ☐ Food Stamps ☐ Medication Management ☐ Substance Use Referral ☐ Other: _____
Services and informal supports:	Plan to coordinate services needed beyond scope of organization or program and to document date/time of coordination with other provider/services in chart. (Attach consents)

Participants	**Name, Title & Credentials**	**Signature**	**Date**
Client			
Guardian/Legal Representative/Care Giver			
Other			
Clinician			