# Disclosure Forms

**Client Psychotherapy Intake Form**

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (Middle Initial)

Name of parent/ guardian (if under 18 years):

{Last) (First) (Middle Initial)

Birth Date:

/ /

\_ Age:

\_ Gender: o Male □ Female

Marital Status:

o Never Married o Domestic Partnership o Married o Separated o Divorced o Widowed

Please list any children/age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:



(Street and Number)



(City, State)

Home Phone:(

May we leave a message? □ Yes o No

Cell/Other Phone: (

May we leave a message? □ Yes o No

(Zip)

E-mail: May we email you? o Yes □ No

\*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by): ­

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ Yes □ No

Previous therapist/practitioner ­

Are you currently taking any prescription medication? □ Yes □ No

Please list: Have you ever been prescribed psychiatric medication? □ Yes □ No

Please list and provide dates: - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

List diagnosis from previous therapists/practitioner (if any)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

|  | Please Circle | List Family Member |
| --- | --- | --- |
| Alcohol/Substance | yes/no |  |
| Abuse | yes/no |  |
| Anxiety | yes/no |  |
| Depression | yes/no |  |
| Domestic Violence | yes/no |  |
| Eating Disorders | yes/no |  |
| Obesity | yes/no |  |
| Obsessive/Compulsive Behavior | yes/no |  |
| Schizophrenia | yes/no |  |
| Suicide Attempts | yes/no |  |

What would you like to accomplish out of your time in therapy?





Additional Information:

Insurance Information:

Name of Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Id Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Disclosure Forms Limits of Confidentiality

Contents of all therapy sessions are confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

**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 care 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.

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



Client Signature (Client's Parent/Guardian if under 18)



Today's Date

# Disclosure Forms Cancellation Policy

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment. A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Thank you for your consideration regarding this important matter.



Client Signature (Client's Parent/Guardian if under 18)



Today's Date

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

(Page 1 of 2)

1. Client's name:



First Name Middle Name Last Name

1. Date of Birth: --- / /
2. Date authorization initiated: --- / /
3. Authorization initiated by: Name (client, provider, or other)
4. Information to be released:

Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

1. Purpose of Disclosure: The reason I am authorizing release is: My request

Other (describe):

1. Person(s) Authorized to Make the Disclosure:



1. Person(s) Authorized to Receive the Disclosure:



1. This Authorization will expire on \_ /\_ /\_ or upon the happening of the following event:



**Authorization and Signature:** I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re­ disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.



**Signature of the Patient**



**Signature of Personal Representative Relationship to Patient if Personal Representative**



**Date of signature**

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

(Page 2 of 2)

***The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").***

* 1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.
  2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.
  3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
  4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
  5. If this office initiated this authorization, you must receive a copy of the signed authorization.
  6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

***Client’s Bill of Rights and Responsibilities***

# These are your rights, and you can expect to…

* Be treated with respect;
* Communicate with your provider and understand your treatment;
* Have your questions answered;
* Choose your provider. You have a right to change;
* Identify your provider by name and credentials. You will also be told if someone is in training;  Understand how much your care cost;
* Make the final decision about your care. You may change your mind or refuse services before or during any recommended treatment or plan of care;
* Tell us now what you want us to do later about end of life decisions (called an Advance Directive);
* Have everything about your care treated as confidential: records, phone calls, and exams. We only report your information if it is permitted or required by law (like in cases of suspected abuse or public health disease reporting);
* Receive a copy of your medical records;
* Ask us about business relationships we might have that could influence your treatment or care;
* Know about our policies as they may relate to your care, your treatment, and your responsibilities;
* Ask us about resources that we have available to resolve disputes, grievances, and conflicts;
* Know that we never physically restrain our clients and;
* Be notified verbally and in writing if your services are restricted with Changing Perceptions Counseling because we haven’t been able to work out our issues. We will work with you to find a practice or provider that better suits your needs.

# These are your responsibilities: You should…

* Treat everyone with respect and courtesy at all times;
* Communicate with your provider and give us complete and truthful information about your health and living situation, medications, past and current treatment, and contact information of other providers;
* Ask questions. We will tell you about the risks, benefits, and estimated costs to you;
* Follow the treatment plan that you and your provider develop. Tell us right away if you decide to stop treatment or go against provider’s advise.
* Keep any scheduled appointments. If you must cancel, you are responsible for telling us at least

1. ours in advance or potentially be charged a fee of $100;

* Give us your complete information about your insurance coverage and financial situation to avoid cost to you if inaccurate,
* Tell us about your concerns. If you have a grievance, we can help you follow our grievance process;
* Ask us about additional treatment and follow-up services;
* Always behave appropriately when you are at our facility or via telehealth sessions;
* Know that our location is weapons-, drug-, smoke- and alcohol-free zones;
* The use of tobacco products (including, but not limited to, cigarettes, cigars, pipes, smokeless tobacco, and other nicotine products, including electronic cigarettes, vaping devices, or any other product packaged for smoking or the simulation of smoking) is prohibited throughout all indoor areas under the control of Changing Perceptions Counseling. Please don’t bring these products with you when you meet with our staff; and Know that if appear intoxicated or with diminished capacity due to illegal or legal drugs or alcohol use when seeking service, including those via telehealth, we will reschedule the visit.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the undersigned, acknowledge receipt of my Client Bill of Rights and Responsibilities and my signature below indicates I read them and understand them.

Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent - Telehealth Consultation**

1. I understand that Revive Again Therapeutic Services can engage in telehealth services with me to provide treatment.

2. I understand this is out of necessity and an abundance of caution and has originated due to the Coronavirus {Covid-19) pandemic. This will continue until such time that we are able to meet in person, or could continue, depending on the circumstance.

3. I understand that telehealth treatment has potential benefits including, but not limited to, easier access to care.

4. I understand that telehealth has been found to be effective in treating a wide range of disorders, and there are potential benefits including, but not limited to easier access to care. I understand; however, there is no guarantee that all treatment of all patients will be effective.

5. I understand that it is my obligation to notify Revive Again Therapeutic Services of my location at the beginning of each treatment session. If for some reason, I change locations during the session, it is my obligation to notify Revive Again Therapeutic Services of the change in location.

6. I understand that it is my obligation to notify Revive Again Therapeutic Services of any other persons in the location, either on or off camera and who can hear or see the session. I understand that I am responsible to ensure privacy at my location. I will notify my [insert discipline] at the outset of each session and am aware that confidential information may be discussed

7. I understand that it is my obligation to ensure that any virtual assistant artificial intelligence devices, including but not limited to Alexa or Echo, will be disabled or will not be in the location where information can be heard.

8. I agree that I will not record either through audio or video any of the session, unless I

notify my [insert discipline] and this is agreed upon.

9. I understand there are potential risks to using telehealth technology, including but not limited to, interruptions, unauthorized access, and technical difficulties. I understand some of these technological challenges include issues with software, hardware, and internet connection which may result in interruption.

10. I understand that DOXY.ME is not responsible for any technological problems of which my Therapist has no control over. I further understand that Revive Again Therapeutic Services does not guarantee that technology will be available or work as expected.

11. I understand that I am responsible for information security on my device, including but not limited to, computer, tablet, or phone, and in my own location.

12. I understand that Revive Again Therapeutic Services or I (or, if applicable, my guardian or conservator), can discontinue the telehealth consult/visit if it is determined by either me or the therapist that the videoconferencing connections or protections are not adequate for the situation.

13. I have had a conversation with Revive Again Therapeutic Services, during which time I have had the opportunity to ask questions concerning services via telehealth. My questions have been answered, and the risks, benefits, and any practical alternatives have been discussed with me.

14. Doxy.me is the technology service we will use to conduct telehealth videoconferencing appointments. ( Revive Again Therapeutic Sergices) has discussed the use of this platform. Prior to each session, I will receive a text or email link to enter the "waiting room" until the session begins. There are no passwords or log in required.

**By signing this document, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_I acknowledge**

1. doxy.me is NOT an emergency service. In the event of an emergency, I will use a phone to call 9-1-1and/or other appropriate emergency contact.

2. I recognize Revive Again Therapeutic Services Staff may need to notify emergency personnel in the event he/she feels there is a safety concern, including but not limited to, a risk to self/others or my [insert discipline] is concerned that immediate medical attention is needed.

3. Though Revive Again Therapeutic Services Staff and I may be in virtual contact through telehealth services, neither the Telehealth Service -doxy.me or ( Revive Again Therapeutic Services) provides any medical or emergency or urgent healthcare services or advice. I understand should medical services be required, I will contact my physician. If emergency services are needed,I understand I should call 9-1-1.

4. The doxy.me facilitates videoconferencing and this technology platform is not, itself a source of healthcare, medical advice, or care.

5. I understand that the same fee rates apply for telehealth as apply for in-person treatment. Some insurers are waiving co-pays during this time. It is my obligation to contact my insurer before engaging in telehealth to determine if there are applicable co­ pays or fees which I am responsible for. Insurance or other managed care providers may not cover telehealth sessions.I understand that if my insurance, HMO, third-party payor, or other managed care provider do not cover the telehealth sessions, I will be solely responsible for the entire fee of the session.

6. During these times of the impact of Coronavirus (Covid-19) Revive Again Therapeutic Services may not have access to all of my medical/treatment records. Revive Again Therapeutic Services has made reasonable efforts to obtain records, but I understand and agree this may not be reasonably possible.

7. To maintain confidentiality, I will not share my telehealth appointment link or information with anyone not authorized to attend the session.

8. I understand that either I or ( Ms. Carter) My Therapist, Doctors, and Nurse Practioner's can discontinue the telehealth services if those services do not appear to benefit me therapeutically or for other reasons which will be explained to me. I understand there may be no other treatment alternative available.

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Declaration of Practices and Procedures**

Miyokia Carter, ME.d., NCC,. LPC

Revive Again Therapeutic Services

18389 Petroleum Dr.

Baton Rouge LA 70809

Phone: 225-450-5944

**Qualifications:** I earned a Master of Education degree in School Counseling from Nicholls State University of Louisiana in 2016. I am a Licensed Professional Counselor (LPC) LPC# \_\_\_\_\_\_\_7296\_\_ and hold a license with the Louisiana LPC Board of Examiners, 11410 lake Sherwood Avenue North Suite A, Baton Rouge, Louisiana 70816, (225) 295-8444.

**Counseling Relationship:** I see counseling as a process in which you the client takes the time to discuss your thoughts, feelings, and experiences. This counseling process is a personal and challenging process of which you decide what the goals are. It is my job to reflect, provide feedback, and support any positive decisions that you decide to make. I encourage you to attend sessions consistently so you can get the proper help you need and all benefits of the counseling experience. The length of counseling depends on the person and the situation, and I will let you know when it is my professional opinion that a client no longer needs my services. Although counseling is an extremely personal experience, it is important to realize that the counselor and client relationship is a professional rather than a personal one. This means that our time together will be limited to the scheduled sessions. I believe that you will be best served if the relationship remains focused on *your* concerns.

**Areas of Focus**: My area of interest is working with young children, adolescents and teenagers and adults. My focus areas are trauma, mental health issues (that relate to those individuals including but not limited to depression, anxiety, relationship, and family of origin issues), and conduct disorder, helping individuals to cope with disabilities, life adjustments, conflict resolution, and stress management. The policies herin apply to both In-person services and Teletherapy Services. If my client’s issues are in an area that I do not feel qualified to treat, I will discuss this with them and attempt to refer them to a professional who is better qualified to with those specific areas. In addition to being licensed as a LPC in Louisiana, I hold a national certification as a National Certified Counselor (NCC# 1169716)

**Services Offered/Clients Served:** I provide Mental Health Counseling/Psychotherapy Services which includes education, prevention, assessment, diagnosis, and treatment of emotional, and mental disorders to individuals, groups, and families. I employ principles, methods, and procedures that are delivered in a nonjudgmental, compassionate, confidential, and safe space (in-person or teletherapy).

The client has the option of selecting In-person Services (services delivered in an office with both the counselor and the client present) or Teletherapy Services (services provided using interactive HIPAA secure technology-assisted media that enables the counselor and the client, separated by distance to interact via synchronous video and audio transmission) , unless it is determined that the client may not be within and across Louisiana. A client (s) may utilize either mode of delivery as they so choose unless it is determined that the client may not be diagnosed and or/treated via teletherapy. A client (s) who cannot be properly diagnosed and/or treated via teletherapy shall be restricted to In-person services, and/or properly terminated with appropriate referrals. Teletherapy requires verification of client’s identity and location at the start of each session.

**Fee and Office Procedures**

Clients are seen by appointment only. Appointments can be made via phone Monday-Thursday from 9:00am-5:00pm at 225-450-5944. After first session, appointments are typically set at the close of each session. In the event you may not be able to keep an appointment, please notify me 24 hours in advanced. To schedule or cancel an appointment, please contact me by phone at 225-450-5944. If you are greeted by voicemail, simply state your interest in counseling or reason for canceling or rescheduling your appointment. Be sure to leave your name and phone number. I will return your call as soon as possible. Failure to cancel within 24 hours can result in a cancellation fee of $75. If you do not show up for services and you do not call to cancel, you will be billed for the entire cost.

The fee for counseling services is **$110 per 45 minute sessions**. You are responsible for any fees not covered by insurance. These fees are due at the time of service. It is your responsibility to know the coverage of counseling services before your initial session and understand you will be held responsible for the determined amount. I will not contact insurance companies on your behalf unless it is a coding error or diagnosis code error on my behalf. Insurance claims will be submitted to insurance companies that I am in network with. For all out-of-network sessions you are responsible for full payment at time of service. You will be provided with a payment statement to file with your insurance company.

**Services Offered and Clients Served**: I approach counseling from a cognitive-behavioral perspective in that patterns of thoughts and actions are explored in order to better understand the clients’ problems and to develop solutions. Various other perspectives, approaches and strategies are used based on the client’s individual issues and needs as well.

**Code of Conduct**: As a LPC, I am required by law to adhere to the Code of Conduct for practice as a LPC that has been adopted by my licensing board, the Louisiana LPC Board of Examiners. A copy of the Code of Conduct is available to you upon request. Should you wish to file a disciplinary complaint regarding my practice as a LPC, you may contact the Louisiana LPC Board of Examiners.

**Confidentiality**: Material revealed in counseling will remain strictly confidential except for material shared with my supervisor/colleague to best serve your needs and under the following circumstances in accordance with state law:

1) The client signs a written release of information indicating informed consent of such release, 2) The client expresses intent to harm her/himself or someone else,

3) There is a reasonable suspicion of abuse/neglect against a minor child, elderly person (6) or older), or a dependent adult, or

4) A court order is received directing the disclosure of information. Any material obtained from a minor client may be shared with the client’s parent or guardian.

**Privileged Communication**: It is my policy to assert privileged communication on behalf of the client and the right to consult with the client if at all possible, except during an emergency, before mandated disclosure. I will endeavor to apprise clients of all mandated disclosures. I will endeavor to apprise clients of all mandated disclosures as conceivable.

**Emergency Situations**: When I am unavailable to answers calls after normal hours, you may leave a message on the answering machine, and I will return your call as soon as possible. In an emergency situation when an immediate response is necessary, you may call 911.

**Client Responsibilities**:I strive to make the counseling session a place where you feel safe. I see counseling as a collaborative process, meaning that you are a is a full partner in counseling. Your honesty and effort is essential to success. If as we work together and you have suggestions or concerns about your counseling, I expect you to share those with me so that we can make the necessary adjustments. If it develops that you would better be served by another mental health provider, I will help you with the referral process. If you are seeing another mental health professional, please inform me so that with your permission I may contact the other professional and develop a collaborative professional relationship.

**Physical Health:** Physical health can be an important factor in the emotional well-being of an individual. If you have not had a physical examination within the past year, it is recommended that you do so. Also, please provide me with a list of any medications that you are currently taking.

**Potential Counseling Risk**: The client should be aware that counseling poses potential risks. In the course of working together, additional problems may surface of which you were not initially aware. If this occurs, you should feel free to share these concerns with me.

I have read the Declaration of Practices and Procedures of Miyokia Carter, M.E.d, NCC., LPC and my signature below indicates my full informed consent to services provided by Miyokia Carter, NCC., LPC

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Miyokia Carter, M.E.d., NCC., LPC Date

Parent/Guardian Consent for Treatment of a Minor:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give my permission for Miyokia Carter, M.E.d, NCC., LPC to conduct therapy with my \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Relationship) (Name of minor)

Signature of Parent or Legal Guardian Date



