HILL PSYCHOLOGICAL SERVICES

1502 Stubbs Avenue, Monroe, LA 71201
Phone: 318. 323. 8700
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www.medpsychla.com

ADOLESCENT INTAKE FORM

Patient Information:

Patient Name: _____
Last, First, Middle

Preferred Name: _____ Date of Birth: _____ Age: _____

Address: _____

Best contact phone number: _____

Email address: _____

Primary Care Physician or Provider: _____

Phone #: _____ Fax #: _____

Preferred Pharmacy: _____

Phone #: _____ Fax #: _____

Parent/Guardian's Name: _____

Home phone: _____ Work phone: _____ Cell: _____

Parent's marital status (select one):

☐ Single, never married
☐ Married, living together
☐ Married, not living together
☐ Living with a partner
☐ Separated
☐ Divorced
☐ Remarried
☐ Widowed

If divorced, what are the custody arrangements? (Please bring copy of custody agreement for the chart)

_____

Please provide other parent's name, address and phone number.

Name: _____

Address: _____

Home/Cell #: _____ Work #: _____

Where was your child born and raised? Born: _____Raised: _____

Has your child moved a number of times? Yes ☐ No ☐

If yes, list their age at the time of move(s) and location(s):

Parents: (Include Step-mother & Step-father, if applicable). Include each parent's name, education, occupation, work hours/week, and quality of relationship with the child.

Name	Education	Occupation	Work hrs/wk	Relationship

List other children in the family and any household members who may be living in your home. Include names, ages, relation to the child, and quality of relationship.

Name	Age	Relation	Quality	Lives with child?

School History:

Did your child meet all developmental milestones on time? Yes ☐ No ☐

List the age at which your child met each developmental milestone listed below:

Rolling over: _____

Sitting without assistance: _____

Standing without assistance: _____

Walking: _____

1st word: _____

Potty trained: _____

Current grade: _____ Current School: _____

Teacher's name: _____

School address: _____

Phone #: _____ Fax #: _____

Summarize child's progress (e.g., academic, social), within each of these grade levels:

Preschool: _____

Kindergarten: _____

Grades 1-3: _____

Grades 4-5: _____

Grades 6-8: _____

Grades 9-12: _____

What are your child's academic strengths?

Academic weaknesses?

Has there been a change in your child's performance at school? Yes ☐ No ☐

If yes, describe:

Has your child received IQ or academic testing? Yes ☐ No ☐

If yes, what were the results?

Does or has your child participated in any of the following?

Yes ☐ No ☐ Resource (for which classes/how many hours?) _____

Yes ☐ No ☐ Accelerated or Honors programs, explain: _____

Yes ☐ No ☐ Individual Education Plan (IEP), explain: _____

Yes ☐ No ☐ Virtual Academy, explain: _____

Yes ☐ No ☐ School Study Team (SST)

Yes ☐ No ☐ Speech and language therapy

Yes ☐ No ☐ Learning disabilities class

Yes ☐ No ☐ Behavioral/emotional disorders class

Has your child had problems with any of the following?

Yes ☐ No ☐ Truancy, explain: _____

Yes ☐ No ☐ Fights, explain: _____

Yes ☐ No ☐ Absenteeism, explain: _____

Yes ☐ No ☐ Detention, explain: _____

Yes ☐ No ☐ Suspension, explain: _____

Yes ☐ No ☐ School refusal, explain: _____

Please bring copies of psychological, educational, speech, or occupational therapy evaluations, if applicable.

Areas of concern (check all that apply):

Personal/Social Adjustment:

- ☐ Unduly sad
- ☐ Overly anxious
- ☐ Overly aggressive
- ☐ Temper tantrums
- ☐ Withdrawn or shy
- ☐ Disturbing habits or mannerisms
- ☐ Strange or bizarre behavior
- ☐ Problems in peer relationships
- ☐ Drug or alcohol
- ☐ Problems with the law
- ☐ Harms self or others (suicidal or homicidal)
- ☐ Other (please specify): _____

School Adjustment:

- ☐ Academic problems
- ☐ Difficulty with peers
- ☐ Difficulty with authority
- ☐ Behavior problems
- ☐ Attendance probs./reluctance to go to school
- ☐ Learning disabilities
- ☐ Attention problems
- ☐ Aches and pains related to school
- ☐ Other (please specify): _____

Family Adjustment

- ☐ Parent-child problem
- ☐ Marital conflict or co-parenting problems
- ☐ Sibling conflict
- ☐ Recent family changes
- ☐ Neighborhood difficulties
- ☐ Mother experiencing difficulties
- ☐ Father experiencing difficulties
- ☐ Sibling experiencing difficulties
- ☐ Drug or alcohol problems in family
- ☐ Domestic violence
- ☐ Other, (please specify): _____

Physical/Development Factors

- ☐ Eating
- ☐ Sleeping
- ☐ Toileting
- ☐ Grooming
- ☐ Perceptual/visual functions
- ☐ Language or Speech
- ☐ Motor coordination problems
- ☐ History of trauma or loss
- ☐ Abuse
- ☐ Other (please specify): _____

Abuse History:
Has your child ever been the victim of abuse or neglect? Yes ☐ No ☐

If yes, what was the nature of the abuse? (Please check all that apply.)

- ☐ Physical
- ☐ Emotional
- ☐ Neglect
- ☐ Accidents
- ☐ Disasters
- ☐ Sexual
- ☐ Witnessing violence
- ☐ Other: _____

Are you struggling with your marital relationship or parenting? Yes ☐ No ☐
If yes, please describe:

Has your child ever been involved with the following, if yes, explain in the space provided:

Yes ☐ No ☐ Child protective services: _____

Yes ☐ No ☐ Children's Mental Health: _____

Yes ☐ No ☐ Probation/Juvenile Probation/Detention: _____

Yes ☐ No ☐ Boys and Girls Club: _____

Yes ☐ No ☐ Youth Services: _____

Yes ☐ No ☐ Head Start: _____

Yes ☐ No ☐ Early Intervention Services (ages 0-3): _____

Social History:

Do you have any concerns regarding your child/adolescent's friendships? Yes ☐ No ☐

On the following page, check all concerns you may have with your child/adolescent's friendships.

Social History (continued):

Check all of the applicable concerns you have with your child/adolescent's friendships.

- ☐ Too old
- ☐ Too young
- ☐ Fringe
- ☐ Too much time together
- ☐ Drug/alcohol use
- ☐ Violence
- ☐ Truant
- ☐ Gang
- ☐ Too many
- ☐ Too few
- ☐ Sexual Promiscuity
- ☐ Other (please specify): _____

Has your child had a recent change in friendships? Yes ☐ No ☐

If yes, what changes are concerning you?

Are you concerned that your child/adolescent is abusing (or has used) drugs (including over the counter medicines) or alcohol? Yes ☐ No ☐

If yes, describe:

Are you concerned about your child/adolescent's sexual activities? Yes ☐ No ☐

Is your child/adolescent sexually active? Yes ☐ No ☐

Does your adolescent have a job? Yes ☐ No ☐

Has your child/adolescent's behavior ever resulted in police, detention, or court involvement? Yes ☐ No ☐

If yes, explain:

Is there anything else you would like us to know about your child?

What are your child's favorite activities?

Is your child currently seeing a therapist? If so, please provide his/her name and contact number.

Has your child ever been treated by a psychiatrist/psychotherapist before? Yes ☐ No ☐
If yes, please list:

Previous History:

Has he/she ever been treated for any of the following? (check all that apply)

- ☐ Depression
- ☐ ADHD
- ☐ Bipolar (Manic/Depressive) Disorder
- ☐ Anxiety
- ☐ OCD
- ☐ Schizophrenia
- ☐ Panic Attacks
- ☐ PTSD
- ☐ Alcohol Problems (Including AA)
- ☐ Anorexia/Bullimia
- ☐ Binge-eating
- ☐ Substance Use/Dependance
- ☐ ECT Treatment
- ☐ Other (please specify): _____

Please list in chronological order all prior psychiatric hospitalizations (if any). Include the date, length of stay, name of the hospital and reason for admission.

Date Length Hospital Reason for admission

Has he/she attempted to harm/kill themselves? Yes ☐ No ☐

If yes, list the occurrences below. Include the approximate date of the attempt and the method used.

List ALL current medications below:

Include birth control pills, over the counter medication and herbal remedies (i.e. decongestants, St. John's Wort, etc.). Following this question, psychotropic medications are listed for your convenience.

Please review the following list of medications. If he/she has **EVER** taken or been prescribed any of these medications check them. Trade names and Generic names are included.

Selective Serotonin Reuptake Inhibitors (SSRIs)

- ☐ Luvox (Fluvoxamine)
- ☐ Lexapro (Escitalopram)
- ☐ Zoloft (Sertraline)
- ☐ Paxil (Paroxetine)
- ☐ Paxil CR (Paroxetine)
- ☐ Celexa (Citalopram)
- ☐ Prozac (Fluoxetine)

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

- ☐ Effexor (Venlafaxine)
- ☐ Effexor XR (Venlafaxine)
- ☐ Cymbalta (Duloxetine)
- ☐ Pristiq (Desvenlafaxin)

Other Antidepressants

- ☐ Desyrel (Trazadone)
- ☐ Viibryd (Vilazodone)
- ☐ Serzone (Nefazodine)
- ☐ Wellbutrin XL/SR (Bupropin XL/SR)
- ☐ Remeron (Mirtazapine)

Tricyclic Antidepressants

- ☐ Adapin (Doxepin)
- ☐ Elavil (Amitriptyline)
- ☐ Pamelor (Nortriptyline)
- ☐ Tofranil (Imipramine)
- ☐ Anafranil (Clomipramine)
- ☐ Ludiomil (Maprotiline)
- ☐ Sinequan (Doxepin)
- ☐ Vivactil (Protriptyline)
- ☐ Asendin (Amoxapine)
- ☐ Norpramin (Desipramine)
- ☐ Surmontil (Trimipramine)

Other Psychotropics (Have you taken any of these?)

- ☐ Abilify
- ☐ Buprenorphin
- ☐ Dexedrine
- ☐ Adderall XR
- ☐ Seroquel
- ☐ Librium
- ☐ Synthoid
- ☐ Vistaril
- ☐ Campral
- ☐ Mobane
- ☐ Symbyax
- ☐ Valproic Acid
- ☐ Focalin
- ☐ Atarax
- ☐ Methadone
- ☐ Prolixin
- ☐ Vyvanse
- ☐ Restoril
- ☐ Xanax
- ☐ Parnate
- ☐ Ambien
- ☐ Ritalin
- ☐ Emsam
- ☐ Provigil
- ☐ Mellaril Risperidal
- ☐ Hydroxyzine
- ☐ Metadate
- ☐ Daytrana
- ☐ Lunesta
- ☐ Meridia
- ☐ Saphris
- ☐ Loxitane
- ☐ Antabuse
- ☐ Haldol
- ☐ Niravam
- ☐ Phentermine
- ☐ Trilafon
- ☐ Ambien CR
- ☐ Klonopin
- ☐ Geodon
- ☐ Suboxone
- ☐ Sonata
- ☐ Tegretol
- ☐ Buspar
- ☐ Ativan
- ☐ Nardil
- ☐ Depakote
- ☐ Dalmane
- ☐ Invega
- ☐ Valium
- ☐ Strattera
- ☐ Stelazine
- ☐ Clozapine
- ☐ Adderall
- ☐ Lithium
- ☐ Orap
- ☐ Dexadrine
- ☐ Halcion Thorazine
- ☐ Tranxene
- ☐ Rozerem
- ☐ Lamictal
- ☐ Navane
- ☐ Zyprexa
- ☐ Naltrexone
- ☐ Concerta
- ☐ Cylert
- ☐ Topamax

Family History:

Has anyone in your family ever been treated for any of the conditions listed below (if a condition applies, please indicate relationship with the child and note if paternal or maternal)?

	Yes/No	Relationship with child	Maternal/Paternal
Depression			
Anxiety			
Panic Attacks			
Post-traumatic Stress			
Bipolar/Manic Depression			
Schizophrenia			
Alcohol problems			
Drug problems			
ADHD			
Suicide Attempts			
Psychiatric hospitalization			

Allergies (medication, food, seasonal, environmental, etc)? Yes ☐ No ☐

If yes, please name and describe your child's reaction:

Has your child ever experienced a head injury, loss of consciousness, or seizures? Yes ☐ No ☐
If yes, describe:

Does your child have any chronic medical problems? Yes ☐ No ☐
If yes, describe:

Does your child have a history of any serious injuries or medical hospitalizations? Yes ☐ No ☐
If yes, describe:

Does your child have chronic pain (frequent headaches, stomachaches, chest pain)? Yes ☐ No ☐
If yes, describe:

Have you recently worried that your child may have problems with any of the following? (Check all that apply)

- ☐ Heart
- ☐ Age of first menses
- ☐ Lungs
- ☐ Frequent infections
- ☐ Regular or irregular cycle
- ☐ Constipation/Diarrhea
- ☐ Endocrine (i.e. diabetes, thyroid)
- ☐ Dysregulation; excessive hair growth
- ☐ Neurological
- ☐ Kidneys/Bladder

Are immunizations up to date? Yes ☐ No ☐

Has your child ever had an EEG, MRI, CT Scan, etc? Yes ☐ No ☐

If yes, why was it done and were the results normal?

If yes, where were the tests performed and who ordered them?

To be filled out by adolescent, if applicable:

Do you want to participate in therapy? Yes ☐ No ☐

If no, what are your reservations?

If yes, what problems or goals would you like to address?

Are you currently, or have you ever considered committing suicide? Yes ☐ No ☐

If yes, when was the last time you experienced suicidal thoughts? ---

Have you ever considered killing someone else? Yes ☐ No ☐

If yes, when was the last time you thought about killing someone else? ---

Have you ever heard things other people did not hear or seen things that other people did not see? Yes ☐ No ☐
If yes, please describe:

Regarding alcohol, when was your last drink? ---

In the past 30 days, about how many of those days have you had at least one alcoholic drink? ---

What is the maximum number of drinks you have had in one day in the past month? --- drink(s)

Have you ever been arrested for or convicted of DUI, DWI, or Public Intoxication? Yes ☐ No ☐

Have you ever experienced seizures or other withdrawal symptoms? Yes ☐ No ☐

Please check all substances that you have used and specify age of 1st use and duration of use.

- ☐ Cocaine
- ☐ Amphetamine
- ☐ Speed
- ☐ Marijuana
- ☐ Diet Pills
- ☐ Hallucinogens
- ☐ LSD
- ☐ Mushrooms
- ☐ PCP
- ☐ Diuretics
- ☐ Tranquilizers
- ☐ Pain Pills
- ☐ Inhalants
- ☐ Sleeping Pills
- ☐ Laxatives
- ☐ Cigarettes
- ☐ Cigars
- ☐ Tobacco
- ☐ Ecstasy
- ☐ Other: ---
- ☐ IV Drug Use
- ☐ Heroin
- ☐ GHB
- ☐ Anabolic Steroids
- ☐ Caffeine (coffee, tea, cola)
- ☐ Benzodiazepines (Xanax, Valium, Ativan, Restoril, Librium)
- ☐ Mescaline
- ☐ Angel Dust

Other History:

Last menstrual period (if applicable) _____

Are you sexually active? Yes ☐ No ☐

If yes, what contraceptive method do you use?

Romantic Relationships: (Please list those that were significant)

Name: _____ Age when dated: _____ Your age when dating: _____

Quality of Relationship: _____

Name: _____ Age when dated: _____ Your age when dating: _____

Quality of Relationship: _____

Name: _____ Age when dated: _____ Your age when dating: _____

Quality of Relationship: _____

Name: _____ Age when dated: _____ Your age when dating: _____

Quality of Relationship: _____

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Hill Psychological Services Policy Form

Insurance Information:

Would you like this office to file your insurance? Yes ☐ No ☐
(If yes, a copy of your insurance card **MUST BE ATTACHED**.)

Primary Insurance: _____

Member's Name:_____ Date of Birth:_____

Insurance Card ID Number: _____

Social Security Number:_____ Relation to patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers:
Home: _____ Mobile: _____ Work: _____

Employer: _____

City: _____ State: _____ Zip: _____

Secondary Insurance: _____

Member's Name:_____ Date of Birth:_____

Insurance Card ID Number: _____

Social Security Number:_____ Relation to patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers:
Home: _____ Mobile: _____ Work: _____

Employer: _____

City: _____ State: _____ Zip: _____

CONSENT FOR INSURANCE AND PAYMENT AGREEMENT

All professional services rendered on behalf of my minor child are to be charged directly to me. I assume responsibility for all fees, regardless of insurance coverage or the status of any insurance claim(s). For office visits, the patient will pay for service at the time it is rendered.

I hereby authorize Hill Psychological Services to furnish information to my insurance carrier(s) concerning my minor child's medical history, illness(es), and treatment(s). I hereby authorize Hill Psychological Services to release all information necessary to secure payment(s) of insurance benefits. A photocopy of this assignment shall be considered as valid as the original. This assignment will remain in effect until revoked by me in writing. In the event my account is assigned to collection, I agree to pay all costs of collection, including reasonable attorney fees. I hereby authorize Hill Psychological Services to furnish information to the collection agency concerning my account in the event that I do not meet my financial obligations.

Client Signature: _____ Date: _____

CRISIS COUNSELING POLICY

I understand no providers with Hill Psychological Services provide 24-hour crisis counseling. Should I or my child experience an emergency necessitating immediate mental health attention, I will immediately call 911 or go/take my child to an emergency room for assistance. I understand the providers, due to their schedules, may not be readily accessible by phone or any message may take up to 48 hours to return. If the nature of my call can be addressed by the office administrator, I understand that person may be reached during office hours (8 AM - 12 PM; 1 PM - 5 PM Monday - Thursday and 8 AM - 12 PM on Friday). If I leave a message after 3 PM Monday - Thursday and 10 AM on Friday, I understand my message will not be returned until the following business day. I understand if I am more than 15 minutes late for my appointment, it may be cancelled/rescheduled and the card on file will be charged as outlined in the Office Policy.

Client Signature: _____ Date: _____

CANCELLATIONS AND MISSED APPOINTMENTS

CANCELLATIONS AND MISSED APPOINTMENTS

The client is expected to attend each scheduled session on time. A minimum of 24 hours' notice is required for rescheduling or canceling an appointment. If you should know before the required 24-hour notice that you will not be able to attend our session, call the office. If you call after hours, leave a voice message, which is time stamped.

WHEN THE NO SHOW/LATE CANCEL FEE IS WAIVED

The only exception to this cancellation policy is in the event of a serious or contagious illness or emergency. We offer one grace for these purposes every six months. Some examples of emergencies are car accidents, deaths in the family or extreme illness. Work issues do not constitute emergencies. This cancellation policy also applies even if missing the appointment was an unintentional act. In the event of prohibitive weather, we can conduct the session by video.

FEES FOR NO-SHOWS & LATE CANCELLATIONS

No-Show and Late Cancellation Fees: Anytime you fail to attend a scheduled appointment without giving appropriate prior notice of cancellation or any session that is missed by canceling less than 24 hours in advance, you will be charged $50.00 for the missed session. Patients arriving 10 minutes or later for a therapy session or 5 minutes or later for a medication management will be marked as a "No-Show," and will be charged the no-show fee.

By providing us with your credit card information or booking an appointment, you consent to this policy and consent to your card being charged as a result of a "No-Show" or "Late Cancellation." Multiple no-shows and/or repeated cancellations may result in the patient being removed from the schedule and being placed at the bottom of the waiting list.

No-Show and Late Cancellation Fees are not billed to insurance and must be paid prior to your next visit.

Client Signature: _____ Date: _____

Please fill out the following information. Failure to do so will result in incomplete paperwork.

Name on Credit Card: _____

Credit Card Number: _____ Expiration: _____

Security Code: _____ Zip Code: _____

NOTICE OF RECORDS RELEASE

If your child was referred to our office by another doctor, and you would like for his/her records to be released to them for their records, please be aware that the final report will be sent to that doctor.

If you have another doctor, attorney, officer of the court or someone else that you would like his/her final report sent to, you may add their names to the list below. Otherwise, his/her report will only be sent to their referring doctor.

I do not disclose client confidences or information to third parties without the client's written consent except under the following circumstances and/or when mandated by law:

- The client signs a written release of information indicating informed consent of such release. Verbal authorization will not be sufficient except in emergency situations.
- I am mandated by state law to report to the appropriate authorities suspected cases of child abuse/neglect, elder (65 or older) abuse/neglect, or dependent adult abuse/neglect.
- I am mandated by state law to report instances of danger to self or others to protect the client or other parties from a clear and imminent threat of serious physical harm.
- Certain types of litigation may lead to court-ordered release of information without your consent.
- Any material obtained from a minor client may be shared with the minor client's parent(s) or guardian(s).
- For supervision and training purposes, information may be shared with supervisors or therapists.
- Divorced parents of minor clients will be afforded equal access to the treatment record, unless otherwise prohibited by court order.
- When working with a child, sessions with parents that are held as part of the child's therapy that are considered part of the child's treatment are a part of the child's treatment record. The parents have no expectation of privacy regarding these sessions.

If you want his/her records sent to someone else in the future, you will have to sign a release form in order for those records to be released.

I give my permission to release my child's records to: _____

_____

_____

Signing below indicates that you are aware of this practice and are giving us permission to release to the people listed above.

Client Signature: _____ Date: _____

PRESCRIPTION POLICY

Medical Psychologists (MP) have a unique role in the practice of psychology because they are able to provide prescriptions for medications in addition to their other psychological services. However, with that privilege, there also are responsibilities, for both the Medical Psychologist and the patient. Some of those responsibilities are described.

Collaboration with your primary care/treating physician, in Louisiana, is required for a medical psychologist but also is considered good practice. In line with this, your physician will be contacted for his/her concurrence with your treatment. It is important for you to see your physician for medical follow-up on a yearly basis. The MP will be responsible for any prescriptions, but your physician will be aware of what is prescribed.

It is imperative to do appropriate follow-up after the prescribing of a psychotropic medication. Depending on the medication and the reason for the prescription, follow-up appointments will be needed at varying times. For example, if a medication is prescribed for attention or hyperactivity problems, it is very important to follow-up after a short time to determine whether the medication is working properly. If a medication is provided for depression or anxiety, it is important to be seen for follow-up after approximately a week. Therapy is recommended with depression or anxiety and the medication will likely work better if therapy is provided. During follow-up sessions, side effects and other needs, also, will be discussed.

After the initial follow-up and evaluation of response to treatment is completed and the patient is on a maintenance schedule, it is still necessary to be seen on a regular basis but not as frequently. On a maintenance schedule, the medication checks must occur no less than every 3 months and will typically last 15 minutes. Failure to attend the medication checks will result in this office being unable to continue providing medications and may necessitate a referral to another provider.

If problems or concerns develop during the initial treatment phase or while on a maintenance schedule, please call and make an appointment for a follow-up visit. It is the goal of this practice to provide the best treatment possible. To help with the provision of good treatment, please feel free to call and provide information about your response to medication or therapy if you believe it is important for that information to be provided.

Finally, to help with the provision of good treatment, please notify us a minimum of 5 days before your medication is needed. Many of our prescriptions can be e-faxed to your pharmacy, but some must be picked up in person or mailed to your residence. Please consider if your prescription is going to run out on the weekend and call the office before that time. NO medications can be sent to pharmacies outside of Louisiana.

I have read the above information and understand it.

Client Signature: _____ Date: _____

PROFESSIONAL DISCLOSURE STATEMENT

Qualifications: I hold a Doctorate Degree in Counseling Psychology from Louisiana Tech University and a postdoctoral Masters of Clinical Psychopharmacology. I am licensed by the Louisiana State Board of Examiners of Psychologists (8706 Jefferson Highway, Ste. B, Baton Rouge, LA 70809; (225)925-6511) as a Licensed Psychologist (#1322) and by the Louisiana State Board of Medical Examiners (630 Camp St, New Orleans, LA70130) as a Medical Psychologist (#324799). Additionally, I completed Master's degrees in Psychometrics and Counseling and Guidance from the University of Louisiana-Monroe and Louisiana Tech University, respectively.

Areas of Expertise: I am experienced in working with adults, children, couples, and families.

Code of Conduct: I am required by state law to adhere to the Louisiana Code of Ethics for Psychologists. A copy of this code is available upon request.

Fees and Scheduling: Scheduling is done by telephone and in person. Payment is expected at the time services are rendered. Intake sessions for court-related evaluations generally last 120 minutes and are billed at a rate of $250/hour. You will be charged based on the length of your session. Intake sessions for counseling generally last 60 minutes and are billed at a rate of $185. For children and adolescent clients, we will meet with the parents, without the child present, first to review policies and procedures and to gain a full psychosocial history. We will meet the child at a separate time. If Dr. Hill is subpoenaed for court, fees are $2000 for a half-day or $4000 for a full day. These fees cover Dr. Hill's time for court hearing and time preparing for the hearing. Payment is required 48 hours in advance and is non-refundable and non-transferrable. Preparation for court takes much time and energy prior to the hearing.

Initial: _____

Explanation of the types of Services Offered and Clients Served: I have been trained in a variety of treatment methods and therapeutic orientations. During the course of therapy, I may employ various techniques and therapeutic orientations. The techniques and orientations chosen will be determined by your stated goals, needs, and personality. I may need to gather information from other sources, depending upon the circumstances of the problem. If that occurs, I will need your permission to talk to these people.

Initial: _____

Client Responsibilities: You are expected to follow office procedures for scheduling and payment. Additionally, you are expected to participate in the services provided to the best of your ability. If referred for therapy then, therapy is a joint effort that involves your willingness to be honest and to provide information that will help me in understanding your situation. If you are currently receiving services from another mental health professional, please let me know. In some situations, I may request your permission to share information with other treatment professionals so that we may coordinate services. Assessments and evaluations may require you to provide records from schools, doctors, and other sources. If you are participating in an evaluation, you are expected to provide information and complete testing in a timely manner. Failure to do so will result in delays.

Initial: _____

Physical Health: Please describe any medical difficulties you are experiencing, supply a list of medications you are taking, and describe your past or present substance use. I may suggest that you see a medical doctor during the course of treatment. If you have not had a physical examination in the past year, I recommend that you do so.

Initial: _____

Emergency Situations: Our office is open between 8:00 a.m. and 5:00 p.m. Monday through Thursday and 8:00 a.m. and noon on Friday. If you have an emergency situation when our office is not open, you may seek assistance through a hospital emergency room, law enforcement, or contact one of the following:

- Brentwood Behavioral Health at 877-678-7500
- LSU Health (Shreveport) at 318-675-6045
- St. Patrick's Psychiatric Hospital at 318-327-4686
- St. Francis North Behavioral Health at 318-388-1946
- Glenwood Behavioral Health at 318-329-4525
- Liberty Behavioral Health at 318-281-2448
- E. A. Conway Acute Psychiatric Unit at 318-330-7521
- Emergency Dispatch (local) at 911

Initial: _____

Privileged Communication: I do not disclose client confidences or information to third parties without the client's written consent except under the following circumstances and/or when mandated by law:

- The client signs a written release of information indicating informed consent of such release. Verbal authorization will not be sufficient except in emergency situations.
- I am mandated by state law to report to the appropriate authorities suspected cases of child abuse/neglect, elder (65 or older) abuse/neglect, or dependent adult abuse/neglect.
- I am mandated by state law to report instances of danger to self or others to protect the client or other parties from a clear and imminent threat of serious physical harm.
- Certain types of litigation may lead to court-ordered release of information without your consent.
- Any material obtained from a minor client may be shared with the minor client's parent(s) or guardian(s).
- For supervision and training purposes, information may be shared with supervisors or therapists.
- Divorced parents of minor clients will be afforded equal access to the treatment record, unless otherwise prohibited by court order.
- When working with a child, sessions with parents that are held as part of the child's therapy that are considered part of the child's treatment are a part of the child's treatment record. The parents have no expectation of privacy regarding these sessions.

Initial: _____

Potential Risks and Benefits: Therapy often has positive and negative consequences attached to it. Be advised that sometimes people discover during therapy that parts of their lives, with which they were satisfied, are not as satisfactory. Also, people important to you may not like some of the changes you make. Assessment and evaluation, also, has positive and negative consequences. You may not always be pleased with findings or recommendations. You should be aware that studies suggest that counseling involving only one spouse can lead to the dissolution of the marriage instead of improving it.

Initial: _____

Roles and Responsibilities of the Clinician: Within the context of the treatment relationship, Dr. Hill may have contact with family members of the identified client. In those instances, Dr. Hill will not provide treatment, of any kind, to the family members. Instead, the family members serve as informants who support the client's progress. At times, it may be important to discuss ways the family can support the client. Information provided to Dr. Hill in those sessions is considered part of the identified client's treatment record. There is no expectation of confidentiality for the family member.

Initial: _____

Court involvement: Dr. Hill does not participate in custody litigation in the context of therapy. If Dr. Hill, or her records, are subpoenaed or requested for the purpose of litigation, Dr. Hill will terminate therapy and refer the client to another provider. Court involvement is harmful to the therapeutic relationship and limits the impact of therapy. Further, such disclosures violate confidentiality resulting in clients' inability to open during the treatment process.

Initial: _____

Please do not hesitate to discuss any questions you have now or that may arise regarding my qualifications, office policies, our professional relationship, or any other concerns.

INFORMED CONSENT

I have read this professional disclosure statement. I was given the opportunity to discuss anything I did not understand. I understand the information contained in this document. I agree to participate in the evaluation and/or therapy under the conditions described in this statement.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

SOCIAL MEDIA POLICY

I understand providers do not accept friend requests from current or former clients on any social media sites (i.e. Facebook, LinkedIn, etc.), as doing so compromises boundaries. I also understand providers do not follow current or former clients on any social media sites (i.e. Instagram, Twitter, etc.), as doing so could compromise my privacy and confidentiality. I further understand should current or former clients encounter providers outside of the therapeutic setting, providers will not initiate acknowledgement of clients as a matter of privacy and confidentiality.

Client Signature: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

This notice is required by federal law, and the information it contains is mandated by law. If you have any questions about how your Protected Health Information (PHI) is used or about this notice, please call Hill Psychological Services at (318) 323-8700.

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

Initial: _____

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).
We are legally required to protect the privacy of your PHI, which includes information that can used to identify you that we've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. We must provide you with this Notice about our privacy practices, and such Notice must explain how, when, and why we will "use" and "disclose" your PHI. A "use" of PHI occurs when we share, examine, utilize, apply, or analyze such information within our practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of our practice. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. We are legally required to follow the privacy practice described in this Notice.

However, we reserve the right to change the terms of this Notice and our privacy policies at any time. Before we make any important changes to our policies, we will promptly change this Notice and post a new copy of it as noted at the beginning of this document. You can also request a copy of this Notice from our office at any time.

Initial: _____

III. HOW WE MAY USE AND DISCLOSE YOUR PHI.
We will use and disclose your PHI for many different reasons. For some of these uses or disclosures, we will need your prior authorization; for others, however, we do not. Listed below are different categories of our uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Healthcare Operations Do Not Require Your Prior Written Consent. We can use and disclose your PHI without your consent for the following reasons:

1. For Treatment. We can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you're being treated by a psychiatrist, we can disclose your PHI to your psychiatrist in order to coordinate your care. However, it is our practice to only do so if you have directly authorized us in writing, unless a threat to your safety is involved.

Initial: _____

2. To obtain payment for treatment. We can use and disclose your PHI to bill and collect payment for the treatment and services provided by our office to you. For example, we might send your PHI to your insurance company or health plan to be paid for the health care services that we provide. We may also send it to business associates, such as billing companies, claims processing companies, and others that process health care claims. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other that as specified in our contract.

Initial: _____

3. For health care operations. We can disclose your PHI to operate our practice. For example, we may use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. We may also provide your PHI to our accountant, attorneys, consultants, and others to make sure we are complying with applicable laws.

Initial: _____

4. Other disclosures. We may also disclose your PHI to others without your consent in certain situations. For example, your consent is not required if you need emergency treatment, as long as we try to obtain your consent after treatment is rendered, or if we try to obtain your consent but you are unable to communicate with us (for example, if you are unconscious or in severe pain) and we think that you would consent to such treatment if you were able to do so.

Initial: _____

B. Certain uses and Disclosures Do Not Require Your Consent. We can use and disclose your PHI without your consent or authorization for the following reasons:

1. When disclosure is required by federal, state or local law; judicial or administrative proceedings; or law enforcement. For example, we may make a disclosure to applicable officials when a law requires us to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.

Initial: _____

2. For public health activities. For example, we may have to report information about you to the county coroner.

Initial: _____

3. For health oversight activities. For example, we may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

Initial: _____

For research purposes. In certain circumstances, we may provide PHI in order to conduct medical research.

4. To avoid harm. In order to avoid a serious threat to you or another person, we may disclose PHI to law enforcement personnel or persons able to prevent or lessen such harm.

Initial: _____

5. For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.

Initial: _____

6. For worker's compensation purposes. We may provide PHI in order to comply with worker's compensation laws.

Initial: _____

7. Appointment reminders and health related benefits or services. We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.

Initial: _____

8. Disclosures required by court order or subpoena. We may disclose your PHI as directed by court appointed authorities. Any order of the court overrides all other limits of disclosure.

Initial: _____

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations. We do have you sign a form for approved persons in regard to your medical care in our office.

Initial: _____

D. Other Uses and Disclosures Require Your Prior Written Authorization. There are specific disclosures that would require your authorization. These include disclosing your PHI for marketing purposes (marketing of services other than those of Family Counseling), sale of PHI to third parties, and fundraising purposes.

Initial: _____

In these or any other situation not described in sections III, A, B, and C above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop future uses and disclosures (to the extent that we have not taken any action in reliance on such authorization) or your PHI by our office.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI. You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment. You may not limit the uses and disclosures that we are legally required or allowed to make.

Initial: _____

B. Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Initial: _____

C. The Right to Choose How we Send PHI to You. You have the right to ask that we send information to you at an alternate address (for example, sending information to your work address rather than your home address)or by alternate means (for example, e-mail instead of regular mail) we must agree to your request so long as we can easily provide the PHI to you in the format you requested.

Initial: _____

D. The Right to See and Obtain Copies of Your PHI. In most cases, you have the right to view or obtain copies of your PHI, but you must make the request in writing. If we don't have your PHI, but we know who does, we will tell you how to obtain it. We will respond to you within 30 days of receiving your written request. **In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have our denial reviewed.** Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that. In our practice, we keep "treatment notes" which are a regular part of your PHI. We also utilize "psychotherapy notes," which are a separate sort of record and are generally not accessible to clients.

Initial: _____

E. Minors' and Parents' Rights to View and Obtain Copies of PHI. Patients under 18 years of age who are not emancipated, and the parents of such patients, should be aware that the law may allow parents to examine their treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes our policy to request an agreement from parents that they consent to give up their access to their child's treatment and his/her attendance at scheduled sessions. We will also provide parents with a summary of their child's records. If they agree, during treatment, we will provide them only with general information about the progress of the child's treatment when it is complete. Any other communication will require the child's authorization unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

Initial: _____

- Unless limited by court order, both parents are provided equal access to the records of juvenile patients. Those records will include treatment notes from meetings with individual parents that occurred in the context of treatment of a juvenile.

Initial: _____

- When parents participate in the treatment of their children, the child is the identified patient. No parent has any expectation of confidentiality from the other parent.

Initial: _____

F. The Right to Correct or Update your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request to correct or update your PHI. We may deny your request in writing if the PHI is correct and complete, is not created by our office, is not allowed to be disclosed, or is not part of my records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file a disagreement, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, notify you of the changes, and notify others who need to know about the change to your PHI.

Initial: _____

G. The Right to Obtain This Notice by E-Mail. You have the right to obtain a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

Initial: _____

H. The Right to Obtain Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Initial: _____

V. HOW TO COMPLAIN ABOUT PRIVACY PRACTICES. If you think that our office has violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. Any complaints or questions regarding the practice of psychology can be directed to The Louisiana State Board of Examiners of Psychologists, 8280 YMCA Plaza Drive-Building 8B, Baton Rouge, Louisiana 70810, (225)763-3935.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES. If you have any questions about this notice or any complaints about our privacy practices, please contact Dr. Candi L. Hill, Ph. D ., M.P. at (318)323-8700.

VII. EFFECTIVE DATE OF THIS NOTICE. The latest version was effective on August 24, 2022.

HIPAA NOTICE OF PRIVACY PRACTICES

I, _____, received a copy of Hill Psychological Services HIPAA notice of Privacy Practices. My signature signifies my acknowledgement that I received the document and was allowed to ask questions, so as to ensure my understanding of the related policies.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____