Notice of Privacy Practices (Brief Version)

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

My commitment to your privacy

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am also required by law to keep your information private. These laws are complicated, but I must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to the privacy officer (see the end of this form) about any questions or problems.

How I use and disclose your protected health information with your consent

I will use the information I collect about you mainly to provide you with **treatment**, to arrange **payment** for your services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice, I will ask you to sign a **consent form** to let me use and share your information in these ways. If you do not consent and sign this form, I cannot treat you. If I want to use or send, share, or release your information for other purposes, I will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. I will only share information with persons who are able to help prevent or reduce the threat.
2. When I are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires me to do so.
4. For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Discolosing your health information for purposes of billing and payment

I may use your information to bill you, your insurance, or others, so I can be paid for the treatments I provide to you. I may contact your insurance company to find out exactly what your insurance covers. I may have to tell them about your diagnoses, what treatments you have received, and the changes I expect in your conditions. I will need to tell them about when we met, your progress, and other similar things.

There are obligations and responsibilities when you choose to use your insurance to pay for services. Use of insurance to pay for services requires that this provider release confidential information/PHI in order to secure payment for services. If

this provider is an in-network provider with your insurance company, she is contractually obligated to provide your insurance company with whatever information they request from your medical records at this office. Your insurance company (as the payer of your services) reserves the right to review, audit, or request any information concerning your services and records at this office. Your insurance company may request information even after you are no longer actively receiving services at this office.

Your rights regarding your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. I will try my best to do as you ask.

2. You can ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends.

3. You have the right to look at the health information I have about you, such as your medical and billing records. You can get a copy of these records, but I may charge you for it. Contact our privacy officer to arrange how to see your records. See below.

4. If you believe that the information in your records is incorrect or missing something important, you can ask me to make additions to your records to correct the situation. You have to make this request in writing and send it to the privacy officer. You must also tell me the reasons you want to make the changes.

5. You have the right to a copy of this notice. If I change this notice, I will post the new version in our waiting area, and you can always get a copy of it from the privacy officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. I will be happy to discuss these situations with you now or as they arise. If you have any questions or problems about this notice or our health information privacy policies, please contact the privacy officer, who is Rachel R. Domingue and can be reached by phone at 337-534-4083.
The effective date of this notice is October 1, 2012.

Client Name: _____ DOB: _____ MR#_____

Rachel R. Domingue
Licensed Professional Counselor

Child/Adolescent Client Information Form

Person(s) completing this form: _____ Today's date: ____/____/_____

I have: ❑ sole custody ❑ legal custody only ❑ share joint legal AND physical custody with other parent

❑ I will provide a copy of legal custody papers to show who is able to consent for mental health services.

A. Identifying Information/Demographics

1. Child's full name: _____ Date of Birth: _____ Age: _____

Child's Social Security Number: _____ - _____ - _____ Home phone: _____

Address: _____

Biological Sex: ❑ Male ❑ Female

Gender identity: ❑ Male ❑ Female ❑ Transgender

Sexual orientation: ❑ Heterosexual ❑ Gay ❑ Lesbian ❑Bisexual ❑Unknown

Race (check all that apply): ❑ Caucasian/White ❑ African-American/Black ❑ Hispanic or Latino ❑ Asian

❑ American Indian or Alaskan Native ❑ Native Hawaiian or Other Pacific Islander ❑ Other: _____

Current religious affiliation: ❑ Catholic ❑ Baptist ❑ Pentecostal ❑ Methodist ❑ Lutheran ❑ Anglican

❑ Presbyterian ❑ Non-denominational Christian ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu Other: _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

Which (if any) church, synagogue, temple, or place of worship Is this child and their family involved with?

_____

What is the primary language that this child and their family speak? _____

Does this child or their parent/guardian need any translation or interpreter services? ❑ Yes ❑ No

2. Mother's name: _____ Birthdate: _____ Home ph#: _____

Address: _____

Currently employed?: ❑ Yes, as: _____ ❑ No Work phone: _____

3. Father's name: _____ Birthdate: _____Home phone: _____

Address: _____

Currently employed?: ❑ Yes, as: _____ ❑ No Work phone: _____

4. Child's parents are: ❑ Married ❑ Divorced ❑ Remarried ❑ Never married ❑ Other: _____

Client Name: _____ DOB: _____ MR#_____

5. Stepparent Information (If applicable)

Stepparent's name (1): _____ Birthdate: _____ Home ph#:_____

Married to: ❑ Mother on ____/____/_____ ❑ Father on ____/____/_____

Address: _____

Currently employed?: ❑ Yes, as: _____ ❑ No Work phone: _____

Has this step-parent adopted the child in question? ❑ Yes ❑ No

Are you consenting to release information about your child's treatment to this step-parent? ❑ Yes ❑ No

Will this step-parent be participating in counseling with your child? ❑ Yes ❑ No

Stepparent's name (2): _____ Birthdate: _____ Home ph#:_____

Married to: ❑ Mother on _____ ❑ Father on _____

Address: _____

Currently employed?: ❑ Yes, as: _____ ❑ No Work phone: _____

Has this step-parent adopted the child in question? ❑ Yes ❑ No

Are you consenting to release information about your child's treatment to this step-parent? ❑ Yes ❑ No

Will this step-parent be participating in counseling with your child? ❑ Yes ❑ No

6. Legal guardian/custodian's name (if not mother or father): _____

Relationship to child: _____ Birthdate: _____ Home phone: _____

Address: _____

Currently employed?: ❑ Yes, as: _____ ❑ No Work phone: _____

B. Household

1. Please list all people living in the household where the child currently resides.

Name	Relationship to Child	Date of Birth	Age	Gender (M or F)

For this child, is there a history of frequent moves? ❑ Yes ❑ No

If yes, please provide details: _____

_____

Please describe custody and visitation agreements for this child, if applicable.

_____

_____

Client Name: _____ DOB: _____ MR#_____

C. Developmental History

1. Pregnancy and delivery

Did mother receive prenatal care (routine appts. w/ OB/GYN, ultrasounds, lab work)? ❑ Yes ❑ No ❑ Unknown

Any medical conditions/illnesses that mother had while pregnant?: _____

_____

Did mother use alcohol, tobacco, or other substances while pregnant? ❑ Yes ❑ No ❑ Unknown

Was the child born premature? ❑ Yes ❑ No ❑ Unknown

Any complications with the pregnancy or birth of this child? (check all that apply)

☐ None ☐ Diabetes ☐ Premature Birth ☐ High Blood Pressure ☐ Cesarean Section
☐ Poor Nutrition ☐ Breech Birth ☐ Poor Emotional Health ☐ Toxemia ☐Jaundice
☐ Mother's Loss of Consciousness ☐ Special medical help at birth: _____

2. At what rate did child reach developmental milestones (sitting up, crawling, walking, talking)?

❑ On time, within normal range ❑ Delayed If delayed, please explain: _____

_____

3. Has this child ever been diagnosed with any speech/language disorder? ❑ Yes ❑ No If yes, check all that apply:

☐ Difficulty pronouncing certain sounds ☐ Stuttering ☐ Lisping ☐ Delayed speech ☐ Selective mutism

☐ Expressive language disorder ☐ Receptive language disorder

☐ Other: _____

4. Has this child ever been diagnosed with an intellectual disability? ❑ Yes ❑ No

Have you been diagnosed with a vision or hearing disability or impairment? ❑ Yes ❑ No
If yes, please provide details: _____

5. Has this child ever been diagnosed with any of the following developmental disorders?
☐ Autism spectrum disorder ☐ Cerebral palsy ☐ Fetal Alcohol Syndrome ☐ Muscular Dystrophy

☐ Tourette Syndrome ☐ Spina bifida ☐ Attention-Deficit/Hyperactivity Disorder (ADHD)

☐ Other: _____

6. Was this child adopted? ❑ Yes ❑ No
If yes, please provide child's age at adoption and any relevant details: _____

_____

_____

7. Has this child ever been placed in a residential placement, institutional placement, or foster care? ❑ Yes ❑ No
If yes, please provide details: _____

_____

_____

8. Social development
This child tends to play with children who are: ❑ same age ❑ younger ❑ older than him/her.

Difficulty making friends? ❑ Yes ❑ No Difficulty keeping friends? ❑ Yes ❑ No

D. Medical Health History

Name of Child's Primary Care Doctor/Pediatrician: _____ Ph#_____

Other Treating Provider (if applicable): _____ Ph#_____

For this child, list any major illnesses, hospitalizations, allergies/adverse reactions to medications, head injuries, significant accidents/injuries, surgeries, periods of loss of consciousness, convulsions/seizures..

_____

_____

Please list any and all medical conditions that this child has been diagnosed/treated for (e.g asthma, hypothyroidism, sleep apnea, acid reflux, diabetes, cardiovascular conditions, any chronic disease, any genetic conditions).

_____

_____

_____

_____

_____

List ALL medications (physical and psychiatric, as well as supplements, vitamins, etc) that this child is currently taking.

Name of medication	Dosage	Frequency (daily, as needed)

Is there any family history of physical health/medical conditions? ❑ Yes ❑ No
If yes, please provide details: _____

_____

Is this child engaging in any of the following risky behaviors: ❑ alcohol use ❑ drug/substance use ❑ tobacco use

❑ risky sexual behaviors (e.g. sexually active, multiple partners, unprotected sex)

Client Name: _____ DOB: _____ MR#_____

E. Behavioral Health History

1. Has this child ever been diagnosed with any of the following? ❑ Yes ❑ No
❑ ADD ❑ ADHD ❑ Asperger's ❑ Autism ❑ Oppositional Defiant disorder ❑ Conduct Disorder

❑ Depression ❑ Anxiety ❑ Bipolar Disorder ❑ Other: _____

2. Has this child ever received counseling services before? ❑ Yes ❑ No
If yes, please provide details (provider?, what for?, when? outcome?): _____

_____

3. Has this child ever taken medications for psychiatric or emotional problems? ❑ Yes ❑ No
If yes, please provide details (provider?, what for?, when? outcome?): _____

_____

_____

4. Has this child ever been hospitalized for psychiatric reasons? ❑ Yes ❑ No
If yes, please provide details (provider?, what for?, when? outcome?): _____

_____

_____

5. Has this child ever used drugs/tobacco/ alcohol? Or ever received drug/alcohol treatment before? ❑ Yes ❑ No
If yes, please provide details (what substance? how often? how much?)(provider?, what for?, when? outcome?):

_____

_____

_____

6. Is there any family history of mental health/psychiatric issues? ❑ Yes ❑ No
If yes, please provide details: _____

_____

F. Trauma/Abuse history:
PLEASE BE AWARE OF LIMITS OF CONFIDENTIALITY BEFORE COMPLETING THIS SECTION. DUE TO MANDATORY REPORTING LAWS, I AM REQUIRED TO REPORT SUSPICIONS OR KNOWLEDGE OF ABUSE OF CHILDREN, THE ELDERLY, AND VULNERABLE ADULTS. IF THIS IS A SENSITIVE TOPIC FOR YOU, YOU ARE WELCOME TO SKIP THIS SECTION AND ASK TO DISCUSS IT WITH ME WHILE IN A COUNSELING SESSION.

Has this child ever experienced any of the following:

❑ physical abuse ❑ verbal/emotional abuse ❑ sexual abuse

❑ neglect (e.g. lack of basic necessities, lack of supervision, abandonment)

❑ Witnessed domestic violence ❑ Witnessed a traumatic or violent death

❑ Other: _____

❑ This child does NOT have any history of trauma/abuse.

❑ This child Is NOT currently experiencing any trauma/abuse.

Has this child ever perpetrated abuse against someone else (physical, verbal/emotional, sexual)? ❑ Yes ❑ No

Client Name: _____ DOB: _____ MR#_____

G. Educational History

School child attends:_____ Grade: _____

At school, this child is in: ❑ regular classes ❑ resource ❑ 504 ❑ special education classes ❑ gifted/talented

Has this child ever been diagnosed with a learning disorder? ❑ Yes, _____ ❑ No

Does this child have an IEP? ❑Yes ❑No Does this child have a behavior plan at school? ❑ Yes ❑ No

Has this child ever repeated a grade? ❑ Yes ❑ No If yes, which grade? _____
For what reason? _____

Has this child ever skipped a grade? ❑ Yes ❑ No If yes, which grade? _____
For what reason? _____

Has this child had issues with behavior/discipline issues at school? ❑ Yes ❑ No
If yes, for what reason? _____

Name of current teacher:_____ School counselor:_____
May I call and discuss your child with the: current teacher? ❑ Yes ❑ No school counselor? ❑ Yes ❑ No

H. Legal Issues

1. Is this child required by a court, the police, or a probation/parole officer to have this appointment? ❑ Yes ❑ No

If yes, please explain: _____

_____

2. List all the contacts this child has had with the police, courts, and/or juvenile detention. Include all open charges and pending ones. Under "Jurisdiction," write in a letter: F = federal, S = state, Co = county, Ci = city.
Under "Sentence," write in the time and the type of sentence you served or have to serve (AR = accelerated or alternate resolution, CS = commu-nity service, F = fine, I = incarceration, Pr = probation, Pa = parole, O = other, R = restitution).

Date	Charge(s)	Jurisdiction (F,S,C,Ci)	Sentence (AR, I, Pr, Pa)	Probation officer's name	Attorney's name

❑ This child does NOT have any history of contact with the police, court, or juvenile detention.

3. Are there any custody issues involving this child that are being reviewed in the court/legal system right now?

_____

I. Strengths/Hobbies/Leisure Activities

❑ Educated ❑ Common Sense/Practical knowledge ❑ Artistic ❑ Creative ❑ Musical

❑ Verbal/Written Communication skills ❑ Insightful/Psychologically minded ❑ Athletic ❑ Humor

❑ Physically healthy ❑ Empathetic/Compassionate ❑ Assertive ❑ Confident ❑ Brave/Courageous

❑ Hard-working ❑ Self-disciplined/Self-control ❑ Honest ❑ Optimistic/Hopeful ❑ Forgiving

❑ Flexible/Open-minded ❑ Persistent ❑ Curious ❑ Patient ❑ Modest/Humble ❑ Imaginative

Client Name: _____ DOB: _____ MR#_____

❑ Adventurous/Willing to try new things ❑ Logical thinking/Analytical ❑ Love of learning ❑ Ambitious

❑ Motivated/Proactive/Self-starter ❑ Generous ❑ Helpful ❑ Resilient ❑ Cooperative/Good in groups

❑ Loyal/Dedicated ❑ Observant ❑ Organized/Orderly/Neat ❑ Trustworthy ❑ Planning ahead

❑ Problem-solving ❑ Faith/Spirituality ❑ Committed to fairness/justice ❑ Leadership

❑ Has hobbies/interests ❑ Has a good support network of family/friends ❑ Works

❑ Other: _____

J. Special skills or talents of child

List this child's hobbies, sports, recreational, musical, TV, etc. preferences: _____

_____

List this child's strengths (character/personality traits):_____

_____

What are this child's future career interests?_____

K. Current Needs for this child and his/her family:
Check all that apply:

❑ Transportation ❑ Food ❑ Housing ❑ Financial Assistance ❑ Employment ❑ Education/Career

❑ Translation or Interpreter services ❑ Other: _____

L. Community Resources that this child and their family are currently using:
Check all that apply:

❑ Medical Transportation ❑ Public transportation ❑ Housing assistance/Section 8

❑ WIC/SNAP (food stamps) ❑ Food pantry ❑ IEP/504/Resource/ESL services at school

❑ Childcare assistance ❑ Social Security benefits ❑ Supplemental Security Income benefits (SSI)

❑ Translation or Interpreter services ❑ Health Insurance assistance (Medicaid, Medicare, marketplace policy)

❑ Other: _____

M. Other

Is there anything else I should know that doesn't appear on this or other forms?

_____

_____

IMPORTANT NOTICE CONCERNING COUNSELING WITH MINOR CHILDREN

Even when a child is seen individually for counseling, the parents/guardians are considered a vital part of the process. Therefore, they will be included in adult only consultations/updates and will very likely participate in the child's counseling sessions throughout treatment. Although legally parents/guardians have the right to know information about their child's treatment, please allow the child some privacy; otherwise, the safe atmosphere necessary for the therapeutic process will be compromised. I will provide updates on the general themes and goals of therapy, but will avoid specifics. If I discover that your child is having thoughts of harming themselves or others OR are engaging in high-risk behaviors that are dangerous to his/her wellbeing, I will immediately notify the parent/guardian. You are your child's primary support and teacher, so your participation will only increase the likelihood that the treatment will be effective.

A parent/guardian is expected to be present in the waiting room during their child's entire counseling session.

Client Name: _____ DOB: _____ MR#_____

Child Checklist of Presenting Concerns

Person completing this form: _____ Relationship to child: _____

Please mark all of the items below that apply to this child, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- ❑ Argues, "talks back," smart-alecky, defiant
- ❑ Bullies/intimidates, teases, is bossy to others, picks on, provokes
- ❑ Cruel to animals
- ❑ Conflicts with parents over house rules, money, chores, homework, grades, choices in music/clothes/hair/friends
- ❑ Complains
- ❑ Cries easily, feelings are easily hurt
- ❑ Dawdles, procrastinates, wastes time
- ❑ Difficulties with parent's paramour/new marriage/new family
- ❑ Dependent, immature
- ❑ Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
- ❑ Distractible, inattentive, poor concentration, daydreams, slow to respond
- ❑ Drug or alcohol use
- ❑ Eating–poor manners, refuses, appetite increase or decrease, odd combinations, overeats
- ❑ Education/school issues (poor/failing grades, discipline/behavior, truancy, refusing to go, in danger of not completing high-school/dropping out)
- ❑ Extracurricular activities interfere with academics
- ❑ Fearful (specific phobias:_____)
- ❑ Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- ❑ Fire setting
- ❑ Frequent physical complaints; reports feeling sick often
- ❑ Immature, "clowns around," has only younger playmates
- ❑ Interrupts, talks out, yells
- ❑ Isolates, withdrawn
- ❑ Lacks organization, unprepared
- ❑ Lacks respect for authority
- ❑ Learning disability
- ❑ Legal difficulties–truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
- ❑ Lying
- ❑ Low frustration tolerance, irritability

- ❑ Moody
- ❑ Nervous, anxious, worries more than other children
- ❑ Nightmares
- ❑ Need for high degree of supervision at home over play/chores/schedule
- ❑ Obedient
- ❑ Obesity
- ❑ Overactive, restless, hyperactive, out-of-seat behaviors, restlessness, fidgety, noisiness
- ❑ Oppositional, resists, refuses, does not comply
- ❑ Pouts, sulks
- ❑ Recent move, new school, loss of friends
- ❑ Relationships with brothers/sisters or friends/peers are poor (e.g. competition, fights, teasing/provoking, assaults)
- ❑ Runs away
- ❑ Sad, unhappy
- ❑ Self-harming behaviors (e.g. biting or hitting self, head banging, scratching self, cutting)
- ❑ Speech difficulties
- ❑ Sexual – sexual preoccupation, public masturbation, inappropriate sexual behaviors
- ❑ Shy, timid
- ❑ Stubborn
- ❑ Suicide talk or attempt
- ❑ Swearing, blasphemes, foul language
- ❑ Temper tantrums, rages
- ❑ Teased, picked on, victimized, bullied
- ❑ Underactive, slow-moving or slow-responding, lethargic
- ❑ Work problems - not able to maintain grades while working, not handling job responsibilities/poor work performance
- ❑ Verbally abusive - insulting, name-calling, intolerant

Any other concerns:

_____

_____

*****Please look back over the concerns you have checked off, choose the one that you most want your child to be helped with, and circle it.*****