CLIENT INTAKE FORM

Acadian Counseling Center, LLC

Please answer the following questions to the best of your abilities. These questions are to help the therapist with the therapy process. This information is held to the same standards of confidentiality as our therapy. This questionnaire will take approximately 30 minutes to complete.

Name:____
(Last) (First) (Middle Initial)

Name of parent or guardian (if minor):____
(Last) (First) (Middle Initial)

Birth date: _____/_____/_____ Age:_______ Gender: Male Female

Marital status: Never married Partnered Married Separated Divorced Widowed

Number of children: _______ Ages:___________________________

Current address: ____
____

Home phone:_________________________ May we leave a message? Yes No
Cell/other: __________________________ May we leave a message? Yes No

Email:______________________________
NOTE: Emails sent to Acadian Counseling Center, LLC may not be encrypted.

In case of an emergency, please provide the name and contact information of a local friend or relative (not living at the same address). _______________________ ___________ ___________
Name of friend/relative Relationship Contact Number

Referred by:____

Primary Care Physician: ____

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? Yes No Reason for change:____

Have you had any mental health services in the past? Yes No Reason for change:_______________________

Are you currently taking any psychiatric prescription medication? Yes No
If yes, please list:____

Have you been prescribed psychiatric prescription medication in the past? Yes No
If yes, please list:____

General Health and Mental Health Information

How is your physical health at the present time? Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.): ____

Are you on any medication for physical/medical issues? Yes No
If yes, please list: ____

Are you aware of any drug or food allergies? Yes No
If yes, please explain any known adverse reactions: ____

Are you having any problems with your sleep habits? Yes No
If yes, circle those that apply:
Sleep too much Sleep too little Poor quality Disturbing dreams Other: ____

How many times per week do you exercise? ____ days ____ minutes/hours

Are there any changes or difficulties with your eating habits? Yes No

If yes, circle one: Eating less Eating more Bingeing Restricting

Have you experienced a weight change in the last two months? Yes No

Do you consume alcohol regularly? Yes No

In one month, how many times do you have four or more drinks in a 24-hour period? ____

Do you consume any form of nicotine? Yes No. If Yes, please specify what form, duration and frequency: ____

How often do you engage in recreational drug use? Daily Weekly Monthly Rarely Never

Have you felt depressed recently? Yes No If yes, for how long? ____

Have you had any suicidal thoughts recently? Yes No If yes, how often? ____

Have you ever had suicidal thoughts in your past? Yes No If yes, how long ago? ____
How often did you have these thoughts? Frequently Sometimes Rarely
Are you currently in a romantic relationship? Yes No
If yes, how long have you been in this relationship? ____
On a scale from 1-10 (10 being great), how would you rate the quality of your relationship? ____
In the last year, have you had any major life changes (e.g. new job, moving, illness, relationship change, etc.)?

____

____

Quick Check
Circle the issues below that apply to you.

Extreme depressed mood	Mood swings	Rapid speech	Extreme anxiety
Panic attacks	Phobias	Sleep disturbance	Hallucinations
Memory lapse	Alcohol/substance abuse	Body complaints	Eating disorder
Repetitive thoughts	Anxiety	Time loss	Repetitive behaviors
Homicidal thoughts	Suicide attempts	Trouble planning	Difficulty with relationships

Occupational Information
Are you currently employed? Yes No If yes, who is your employer? ____

What is your position?____________________ Are you happy in your current position? Yes No

Are you fulfilled in your current position? Yes No

Does your work make you stressed? Yes No If yes, what are your work-related stressors?____________________

____

Religious/Spiritual Information

Do you practice a religion? Yes No If yes, what is your faith? ______________________________

If no, do you consider yourself to be spiritual? Yes No

Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate the family member affected.

Depression	Yes No________________	Bipolar Disorder	Yes No____________________
Anxiety Disorders	Yes No________________	Learning Disability	Yes No____________________
Trauma History	Yes No________________	Domestic Violence	Yes No____________________
Obesity	Yes No________________	Eating Disorder	Yes No____________________
Schizophrenia	Yes No________________	Alcohol/Substance Abuse	Yes No____________________
Panic Attacks	Yes No________________	Obsessive Compulsive Behavior	Yes No________________

Other Information

List your strengths ____

____

List areas you feel you need to develop ____

____

What do you like most about yourself? ____

____

What are some ways you cope with life obstacles and stress?____________________________

____

What are your goals for therapy/what would you like to accomplish? ______________________

____

____

YOUR RIGHTS

The therapists and staff at Acadian Counseling Center, LLC want to assist you and provide the best possible service. As a client, you have the right to know what your rights are:

- You have the right to expect prompt, professional, and courteous service. In the event that you were to have a complaint or concern, please know that there is a protocol in place for responsive solutions.
- You have the right to be served without discrimination as to sex, race, creed, color, religion, or national origin. *If you require handicap accessible services, please know that accomodations can be made at the Lafayette Public Library – South Regional Branch, at 6101 Johnston Street. We are also willing to extend accomodations when deemed necessary.*
- You have the right to have the nature of any behavioral health problems (when applicable), the recommended treatment, the discharge planning procedure, and any specific risks of such treatment or discharge plan carefully explained to you.
- You have the right to assist in your treatment plan, which should be tailored to meet your specific needs.
- You have the right to confidentiality. Except as may be required by law, no information concerning you, your family, or your treatment may be given out without your consent in writing.
- You have the right to privacy. Your case will not be discussed by the staff in front of visitors or other clients.
- If you wish to use video cameras or tape recorders, you must notify your therapist.
- You have the right to be told if your counselor cannot provide the services that you need.
- You have the right to be informed of supportive community services and other care options.
- You have the right to refuse treatment or request a change in your treatment plan. Should you refuse recommended treatment at any time, you and family members or legal guardians (when applicable) have the right to be made aware of the risks associated with noncompliance.

CONSENT TO TREAT

Your signature below indicates that you have read your rights and do hereby consent to treatment.

Signature of Client or Guardian: ______________________________ Date: __________________________

Printed Name of Client or Guardian (if Minor) ____

If minor, please indicate relationship to minor : _______________________________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Acadian Counseling Center, LLC. I hereby assign all rights, title, and interests in the benefit payment due me with all claims, rights, and actions under Louisiana Revised Statue 22:657. I understand that I am financially responsible for any balance if insurance does not pay and is due at the time of service. I also authorize Ashley Fletcher, MS, LPC, NCC and Acadian Counseling Center, LLC or insurance company to release any information required to process my claims.

X____

CLIENT/GUARDIAN SIGNATURE DATE

Acadian Counseling Center, LLC

SOCIAL MEDIA POLICY

This document outlines our office policies related to use of Social Media. Please read it to understand how we conduct ourselves on the Internet as mental health professionals and how you can expect us to respond to various interactions that may occur between us on the Internet. If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when we need to update this policy. If we do so, we will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

1. FRIENDING

We do not accept friend or contact requests from current or former clients on any Social networking site (Facebook, LinkedIn, etc.). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

2. INTERACTING

Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook or Linkedin to contact us. These sites are not secure and we may not read these messages in a timely fashion. Do not use Wall postings, replies or other means of engaging with us in public online if we have an already established client/therapist relationship. Engaging with us this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact us between sessions, the best way to do so is by phone, at 337-504-4974. See the email section below for more information regarding email interactions.

3. BUSINESS REVIEW SITES

You may find out psychology/counseling practice on sites such as Yelp, Healthgrades, Yahoo, Local, Bing or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find our listing on any of these sites, please know that our listing is NOT a request for a testimonial, rating or endorsement from you as our client. The Louisiana Licensed Professional Counselors Board of Examiner, Administrative Ethic Code states under Title 46, 2107.2, that it is unethical for Licensed Professional Counselors to solicit testimonials " Counselors who use testimonials shall not solicit them from clients or other persons who, because of their particular circumstances, may be vulnerable to undue influence". Of course, you have a right to express yourself on any site you wish. But due to confidentiality, we cannot respond to any review on any of these sites whether it is positive or negative. We urge you to take your own privacy as seriously as we take our commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with us about your feelings about our work, there is a good possibility that we may never see it. If we are working together, we hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like. Confidentiality means that we cannot tell people that you are our client and our Ethics Code prohibits us from requesting testimonials. But you are more than welcome to tell anyone you wish that we're your therapist or how you feel about the treatment we provided to you in any forum of your choosing. If you do choose to write something on a business review site, we hope you will keep in mind that you may be sharing personally revealing information in a public forum. We urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection. If you feel we have done something harmful or unethical and you do not feel comfortable discussing it with me, you can always

contact the Licensed Professional Counselors Board of Examiners, which oversees licensing, and they will review the services we have provided.

4. **Email/ Electronic Communication/Electronic Devices**

It is very important to be aware that computers and unencrypted email and e-fax communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communications. Emails, text, and e-fax in particular, are vulnerable to such unauthorized access. The Center's computers, Fax Machine and other electronic devices authorized by the Center, such as your counselor's laptop, are secured and password protected. However email and e-fax may not be. It is always a possibility that these communications can be sent erroneously to the wrong address and computers. You should not communicate any information with the Center, including with your counselor that you would not want to be included on a postcard that is sent through the Post Office.

If you choose to communicate with us by email, be aware that all emails are retained in the logs of your and our Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails we receive from you and any responses that we send to you become a part of your legal record.

While encryption of emails is required by HIPAA, the 2013 HHS Omnibus rules states " if individuals are notified of the risks and still PREFER unencrypted email, **the individual has the right to receive protected health information in that way,** and covered entities are not responsible for unauthorized access of protected health information while in transmission to the individual based on the individual's request. Further, covered entities are not responsible for safeguarding information once delivered to the individual. "

5. CONCLUSION

Thank you for taking the time to review our Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to our attention so that we can discuss them.

SOCIAL MEDIA INFORMED CONSENT

This is to affirm that I have read the aforementioned Social Media policy and understand that as part of the informed consent procedure at Acadian Counseling Center, the benefits, limitations, and boundaries of the use of social media, particularly the use of unencrypted email as a means of communication, be fully disclosed and explained.

Please read each consent option prior to signing.

Option 1

_______I, (please print name)________________________________DO HEREBY **AUTHORIZE** THE USE OF UNENCRYPTED EMAIL AS A MEANS OF COMMUNICATION AND HEREBY WAIVE MY RIGHT TO CONFIDENTIALITY UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996. AND THAT ACADIAN COUNSELING CENTER AND/OR ITS EMPLOYEES **ARE NOT RESPONSIBLE** FOR UNAUTHORIZED ACCESS OF PROTECTED HEALTH INFORMATION WHILE IN TRANSMISSION.

CLIENT SIGNATURE____________________________DATE_______________

COUNSELOR SIGNATURE_______________________DATE_______________

(If minor) PARENT OR GUARDIAN SIGNATURE:_____________________________DATE:____________

Option 2

_______I, (PLEASE PRINT NAME) ________________________________HEREBY **DO NOT AUTHORIZE** THE USE OF UNENCRYPTED EMAIL AS A MEANS OF COMMUNICATION AND HEREBY REQUEST ALL COMMUNICATION, UNLESS THROUGH ENCRYPTED EMAIL, BE VIA TELEPHONE OR FACSIMILE.

CLIENT SIGNATURE____________________________DATE_______________

COUNSELOR SIGNATURE_______________________DATE_______________

(If minor) PARENT OR GUARDIAN SIGNATURE:_____________________________DATE:__________

24-Hour Cancellation Form

Acadian Counseling Center
850 Kaliste Saloom Road, Suite 219
Lafayette, La 70508

This form is mandatory in order to receive services at Acadian Counseling Center.

I, ______________________________, am authorizing Acadian Counseling Center to charge my credit card in the event I fail to show up for my scheduled appointment and do not notify Acadian Counseling Center staff of my inability to attend a scheduled appointment. I agree to pay $85.00 for any session cancelled without a 24-hour notice in advance. I will not dispute the charges for the sessions I have received or that I have not cancelled less than 24 hours in advance. I further authorize Acadian Counseling Center staff to disclose information about my attendance/cancellation to my credit card company if I dispute a charge. In addition, I authorize this card to be used to pay any outstanding balances should my insurance lapse or have a deductible. I understand that any outstanding charges on my account must be settled before my next schedule appointment.

Client Information:

Client Name:______________________________Date of Birth:____________________

Billing Information:

Please indicate the information associated with the debit card you wish to use._____ I prefer to use a credit card

Name____

Address______________________________________City________________State_______

Zip__________ Home Number____________________Mobile Number________________

SSN______________________________Email____

I authorize all service fees to be deducted from the card ending in _______________ (last four digits of the card).

Full Name(s)____

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. By authorizing use of this card, and signing this payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

____ _____________________________

Cardholder Signature Date

Debit or Credit Card Information: Please provide your payment information below. The card information you provide on this form will be destroyed once your information has been encrypted and stored.

Card (circle one): Visa Master Card Discover

Card Number: ____ Expiration Date: _____________

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

ACADIAN COUNSELING CENTER, LLC
850 KALISTE SALOOM ROAD, SUITE 219
LAFAYETTE, LA 70508

www.acadiancounselingcenter.com

Notice of Privacy Practices

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

ACADIAN COUNSELING CENTER, LLC
850 KALISTE SALOOM ROAD, SUITE 219
LAFAYETTE, LA 70508

www.acadiancounselingcenter.com

As a Licensed Professional Counselor licensed in this state and as a member of the State of Louisiana Licensed Professional Board of Examiners, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *State of Louisiana Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.
With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Ashley A. Fletcher, MS, LPOC, NCC at 337-504-4974.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated Officer, Ashley A. Fletcher, MS, LPOC, NCC at 337-504-4974 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257.
We will not retaliate against you for filing a complaint. The effective date of this Notice is September 2013.

ACADIAN COUNSELING CENTER, LLC
850 KALISTE SALOOM ROAD, SUITE 219
LAFAYETTE, LA 70508

www.acadiancounselingcenter.com

NOTICE OF PRIVACY PRACTICES CONSENT

This form is an agreement between you and Acadian Counseling Center, LLC. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here________________________________.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to let us use this information here and send to insurance companies and other practitioners when needed. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent Form.

IF YOU DO NOT SIGN THIS CONSENT FORM AGREEING TO WHAT IS IN OUR NOTICE OF PRIVACY PRACTICES WE CANNOT TREAT YOU.

In the future we may change how we use, and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our office or by calling us at 337-504-4974

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment, or administrative functions. You will have to tell us what you want in writing.

After you have signed this Consent Form, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information that we would not be able to change.

____ ____________

Signature of client or his/her personal representative Today's Date

____ ____________

Printed name of client or personal representative Today's Date

Date of NPP_________

Copy Consent Form given to the client/parent/personal representative__________

Print and sign this consent for your initial consultation session

SCREENING FORM FOR COUNSELING

NAME:______________________ AGE:______________

DATE:______________________

1.	I HAVE BEEN THINKING ABOUT SUICIDE	YES	NO
2.	I HAVE ATTEMPTED SUICIDE	YES	NO
3.	I AM THINKING ABOUT HARMINNG SOMEONE	YES	NO
4.	PEOPLE HAVE DESCRIBED ME AS VIOLENT	YES	NO
5.	I HAVE FLASHBACKS FROM A TERRIBLE EXPERIENCE	YES	NO
6.	I HAVE LOST INTEREST SINCE THE TIME SOMETHING TERRIBLE HAPPENED.	YES	NO
7.	I TAKE ADVANTAGE OF OTHER	YES	NO
8.	I HAVE BEEN ARRESTED	YES	NO
9.	I STRUGGLE WITH TRYING TO CONTROL MY DRINKING	YES	NO
10.	I MISUSE DRUGS	YES	NO
11.	I SEE OR HEAR THINGS THAT OTHERS CAN'T	YES	NO
12.	PEOPLE ARE OUT TO GET ME	YES	NO
13.	PEOPLE SAY THAT MY WORRYING INTERFERES WITH MY LIFE	YES	NO
14.	CHANGES IN MY ROUTINE CAUSE TOO MUCH STRESS	YES	NO
15.	MY THOUGHTS ARE OFTEN RACING	YES	NO
16.	MY MOOD IS OFTEN VERY HIGH OR VERY LOW	YES	NO
17.	I HAVE PURPOSEFULLY CUT ON MYSELF	YES	NO
18.	I OFTEN FEEL ABANDONED	YES	NO
19.	I FIND MYSELF CRYING FOR NO REASON	YES	NO
20.	THINGS ARE HOPELESS	YES	NO

FOR OFFICE USE ONLY

______SH	_____AS	______AN	_____DE
______AG	_____SA	______MA	
______TR	_____PE	______BO	