

# Family Therapy Clinic of Louisiana, LLC

## Intake Form (Adult)

Please note: information you provide here is protected as confidential information.

Name: \_\_\_\_\_

Last

First

Middle Initial

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender : \_\_\_\_ Marital Status: \_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

Home Phone: \_\_\_\_\_ OK to call? \_\_\_\_\_

Work Phone: \_\_\_\_\_ OK to call? \_\_\_\_\_

Cell Phone: \_\_\_\_\_ OK to call? \_\_\_\_\_

Email: \_\_\_\_\_ May we contact you? \_\_\_\_\_

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

Place of Employment/Occupation: \_\_\_\_\_

Are you allergic or do you have adverse reaction to any type of medication?

Yes: \_\_\_\_ No: \_\_\_\_ If Yes please explain: \_\_\_\_\_

Do you give Family Therapy Clinic of Louisiana LLC consent to release or request information from your primary care physician?

Yes: \_\_\_\_ No: \_\_\_\_ If Yes, name of physician: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

### Person Responsible for Payment - Policy Holder if Using Insurance

Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Client: \_\_\_\_\_ SSN#: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### Payment Policy

I understand and agree to the following:

1. Payment is due at the time of service.
2. I accept full responsibility for the complete payment of my account.
3. I authorize payment of benefits to Family Therapy Clinic of Louisiana, LLC for services described.
4. **Missed appointments/ or appointments cancelled without a 24-hour notice will result in a no exception \$35.00 fee.**  
(Exceptions will be considered ONLY for potentially hazardous travel conditions such as inclement weather.)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## General Health and Mental Health Information

1. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?  
If Yes, please list the previous therapist/practitioner: \_\_\_\_\_
  
2. Are you currently taking any prescription medication?  
If Yes, please list: \_\_\_\_\_
  
3. Have you ever been prescribed psychiatric medication?  
If Yes, please list and provide dates: \_\_\_\_\_  
\_\_\_\_\_
  
4. How would you rate your current physical health? (please circle)  

Poor	Unsatisfactory	Satisfactory	Good	Very Good
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 Please list any specific health problems you are currently experiencing:  
 \_\_\_\_\_  
 \_\_\_\_\_
  
5. How many times per week do you generally exercise? \_\_\_\_\_  
 What type of exercise do you participate in: \_\_\_\_\_
  
6. Please list any difficulties you experience with your appetite or eating patterns:  
 \_\_\_\_\_  
 \_\_\_\_\_
  
7. Are you currently experiencing overwhelming sadness, grief or depression? If Yes, for approximately how long? \_\_\_\_\_
  
8. Are you currently experiencing anxiety, panic attacks, or have any phobias? If Yes, when did you begin experiencing this? \_\_\_\_\_
  
9. Are you currently experiencing any chronic pain? If Yes please describe:  
 \_\_\_\_\_
  
10. Do you drink alcohol more than once a week? \_\_\_\_\_
  
11. How often do you engage recreational drug use?: \_\_\_\_\_
  
12. Are you currently in a romantic relationship? If so for how long?: \_\_\_\_\_
  
13. What significant life changes or stressful events have you experienced recently:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Family Mental Health History

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided. Please include any additional family mental health history in the space provided.

	List Family Member/s
Alcohol/Substance Abuse	_____
Anxiety	_____
Depression	_____
Domestic Violence	_____
Eating-Disorders	_____
Obesity	_____
Obsessive Compulsive Disorder	_____
Schizophrenia	_____
Suicide Attempts	_____
_____	_____
_____	_____
_____	_____

### Additional Information:

1. Are you currently employed? If Yes, what is your current employment situation?

\_\_\_\_\_

2. Do you enjoy your work? Is there anything stressful about your current work?

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

3. What do you consider to be some of your strengths?

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

4. What do you consider to be some of your weaknesses?

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

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

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

# Family Therapy Clinic of Louisiana, LLC

## Patient Bill of Rights

### Mental Health Bill Of Rights Project

A Joint Initiative of Mental Health Professional Organizations:  
Principles for the Provision of Mental Health and Substance Abuse Treatment Services

#### A Bill of Rights

Our commitment is to provide quality mental health and substance abuse services to all individuals without regard to race, color, religion, national origin, gender, age, sexual orientation, or disabilities.

#### Right to Know:

##### Benefits

Individuals have the right to be provided information from the purchasing entity (such as employer or union or public purchaser) and the insurance/third party payer describing the nature and extent of their mental health and substance abuse treatment benefits. This information should include details on procedures to obtain access to services, on utilization management procedures, and on appeal rights. The information should be presented clearly in writing with language that the individual can understand.

##### Professional Expertise

Individuals have the right to receive full information from the potential treating professional about that professional's knowledge, skills, preparation, experience, and credentials. Individuals have the right to be informed about the options available for treatment interventions and the effectiveness of the recommended treatment.

##### Contractual Limitations

Individuals have the right to be informed by the treating professional of any arrangements, restrictions, and/or covenants established between third party payer and the treating professional that could interfere with or influence treatment recommendations. Individuals have the right to be informed of the nature of information that may be disclosed for the purposes of paying benefits.

##### Appeals and Grievances

Individuals have the right to receive information about the methods they can use to submit complaints or grievances regarding provision of care by the treating professional to that profession's regulatory board and to the professional association. Individuals have the right to be provided information about the procedures they can use to appeal benefit utilization decisions to the third party payer systems, to the employer or purchasing entity, and to external regulatory entities.

##### Confidentiality

Individuals have the right to be guaranteed the protection of the confidentiality of their relationship with their mental health and substance abuse professional, except when laws or ethics dictate otherwise. Any disclosure to another party will be time limited and made with the full written, informed consent of the individuals. Individuals shall not be required to disclose confidential, privileged or other information other than: diagnosis, prognosis, type of treatment, time and length of treatment, and cost. Entities receiving information for the purposes of benefits determination, public agencies receiving information for health care planning, or any other organization with legitimate right to information will maintain clinical information in confidence with the same rigor and be subject to the same penalties for violation as is the direct provider of care.

Information technology will be used for transmission, storage, or data management only with methodologies that remove individual identifying information and assure the protection of the individual's privacy. Information should not be transferred, sold or otherwise utilized.

##### Choice

Individuals have the right to choose any duly licensed/certified professional for mental health and substance abuse services. Individuals have the right to receive full information regarding the education and training of professionals, treatment options (including risks and benefits), and cost implications to make an informed choice regarding the selection of care deemed appropriate by individual and professional.

**Determination of Treatment**

Recommendations regarding mental health and substance abuse treatment shall be made only by a duly licensed/certified professional in conjunction with the individual and his or her family as appropriate. Treatment decisions should not be made by third party payers. The individual has the right to make final decisions regarding treatment.

**Parity**

Individuals have the right to receive benefits for mental health and substance abuse treatment on the same basis as they do for any other illnesses, with the same provisions, co-payments, lifetime benefits, and catastrophic coverage in both insurance and self-funded/self-insured health plans.

**Discrimination**

Individuals who use mental health and substance abuse benefits shall not be penalized when seeking other health insurance or disability, life or any other insurance benefit.

**Benefit Usage**

The individual is entitled to the entire scope of the benefits within the benefit plan that will address his or her clinical needs.

**Benefit Design**

Whenever both federal and state law and/or regulations are applicable, the professional and all payers shall use whichever affords the individual the greatest level of protection and access.

**Treatment Review**

To assure that treatment review processes are fair and valid, individuals have the right to be guaranteed that any review of their mental health and substance abuse treatment shall involve a professional having the training, credentials and licensure required to provide the treatment in the jurisdiction in which it will be provided. The reviewer should have no financial interest in the decision and is subject to the section on confidentiality.

**Accountability**

Treating professionals may be held accountable and liable to individuals for any injury caused by gross incompetence or negligence on the part of the professional. The treating professional has the obligation to advocate for and document necessity of care and to advise the individual of options if payment authorization is denied.

Payers and other third parties may be held accountable and liable to individuals for any injury caused by gross incompetence or negligence or by their clinically unjustified decisions.

**Participating Groups:**

- American Association for Marriage and Family Therapy
- American Counseling Association
- American Family Therapy Academy
- American Nurses Association
- American Psychological Association
- American Psychiatric Association
- American Psychiatric Nurses Association
- National Association of Social Workers
- National Federation of Societies for Clinical Social Work

**Supporting Groups:**

- Mental Health America
- National Depressive and Manic-Depressive Association
- American Group Psychotherapy Association
- American Psychoanalytic Association
- National Association of Drug and Alcohol Abuse Counselors

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**Patient Signature**

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**Date**

# Family Therapy Clinic of Louisiana, LLC

## Notice of Privacy Practices

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

**Family Therapy Clinic, LLC** must maintain the privacy of your personal mental health information and give you this notice that describes our legal duties and privacy practices concerning your personal mental health information. In general, when we release your mental health information, we must release only the information we need to achieve the purpose of the use or disclosure. However, all of your personal mental health information will be available for release to you, to a provider regarding your treatment, or due to a legal requirement. We must follow the privacy practices described in this notice.

However, we reserve the right to change the privacy practices described in this notice, in accordance with the law. Changes to our privacy practices would apply to all mental health information we maintain. If we change our privacy practices, we will give you a revised copy of the privacy notice in written form either in person or by mail.

Once you have signed our consent form, we can use your mental health information for the following purposes:

**1. Treatment.** For example, a clinician may use the information in your mental health record to determine which treatment option best addresses your mental health needs. The treatment selected will be documented in your mental health records so that other mental health care professionals can make informed decisions about your care.

**2. Payment.** In order for an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the treatment provided to you. As a result, we will pass such mental health information onto an insurer in order to help receive payment for your mental health bills.

**3. Mental Health Care Operations.** We may need your diagnosis, treatment, and outcome information in order to improve the quality or cost of care we deliver. These quality and cost improvement activities may include evaluating the performance of your clinicians, mental health care staff, and other mental health care professionals, or examining the effectiveness of the treatment provided to you when compared to patients in similar situations. In addition, we may want to use your mental health information for appointment reminders. For example, we may look at your mental health record to determine the date and time of your next appointment with us, and then send you a reminder letter to help you remember the appointment. Or, we may look at your mental health information and decide that another treatment or a new service we offer may interest you. For example, we may contact a patient to notify them that we have a new research facility that offers new treatments. Furthermore, we may want to use information found in your mental health record, such as your name, address, phone number, and treatment dates, to contact you for fund-raising purposes. (FTC does not conduct fund-raising).

Please note that if you refuse to provide your consent to us, we may refuse to treat you.

Without your written consent or authorization, we can use your mental health information for the following purposes:

**1. As required or permitted by law.** Sometimes, we must report some of your mental health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence, or certain physical injuries, or to respond to a court order.

**2. For public mental health activities.** We may be required to report your mental health information to authorities to help prevent or control disease, injury, or disability. This may include using your mental health record to report certain diseases, injuries, birth or death information, information of concern to the Food and Drug Administration, or information related to child abuse or neglect. We may also have to report to your employer certain work-related illnesses and injuries so that your workplace can be monitored for safety.

- 3. For mental health oversight activities.** We may disclose your mental health information to authorities so they can monitor, investigate, inspect, discipline, or license those who work in the mental health care system or for government benefit programs.
- 4. For activities related to death.** We may disclose your mental health information to coroners, mental health examiners and funeral directors so they can carry out their duties related to your death, such as identifying the body, determining cause of death, or in the case of funeral directors, to carry out funeral preparation activities.
- 5. For organ, eye, or tissue donation.** We may disclose your mental health information to people involved with obtaining, storing, or transplanting organs, eyes, or tissue of cadavers for donation purposes.
- 6. For research.** Under certain circumstances, and only after a special approval process, we may use and disclose your mental health information to help conduct research. Such research might try to find out whether a certain treatment is effective in curing an illness.
- 7. To avoid a serious threat to mental health or safety.** As required by law and standards of ethical conduct, we may release your mental health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to your or the public's mental health or safety.
- 8. For military, national security, or incarceration law enforcement custody.** If you are involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your mental health information to the proper authorities so they may carry out their duties under law.
- 9. For workers' compensation.** We may disclose your mental health information to the appropriate persons in order to comply with the laws related to workers' compensation or other similar programs. These programs may provide benefits for work-related injuries or illness.
- 10. To those involved with your care or payment of your care.** If people such as family members, relatives, or close personal friends are helping care for you or helping you pay your mental health bills, we may release important mental health information about you to those people. The information released to these people may include your location within our facility, your general condition, or death. You have the right to object to such disclosure, unless you are unable to function or there is an emergency. In addition, we may release your mental health information to organizations authorized to handle disaster relief efforts so those who care for you can receive information about your location or mental health status. We may allow you to agree or disagree orally to such release, unless there is an emergency.

NOTE: Except for the situations listed above, we must obtain your specific written authorization for any other release of your mental health information. An authorization is different than consent. One primary difference is that unlike with consents, a provider must treat you even if you do not wish to sign an authorization form. If you sign an authorization form, you may withdraw your authorization at any time, as long as your withdrawal is in writing. If you wish to withdraw your authorization, please submit your written withdrawal to **Erich G. Duchmann, Ph.D.**

### **Your Mental Health Information Rights**

You have several rights with regard to your mental health information. If you wish to exercise any of the following rights, please contact **Erich G. Duchmann, Ph.D.** Specifically, you have the right to:

- 1. Inspect and copy your mental health information.** With a few exceptions, you have the right to inspect and obtain a copy of your mental health information. However, this right does not apply to psychotherapy notes or information gathered for judicial proceedings, for example. In addition, we may charge you a reasonable fee if you want a copy of your mental health information.
- 2. Request to correct your mental health information.** If you believe your mental health information is incorrect, you may ask us to correct the information. You may be asked to make such requests in writing and to give a reason as to why your mental health information should be changed. However, if we did not create the mental health information that you believe is incorrect, or if we disagree with you and believe your mental health information is correct, we may deny your request.

**3. Request restrictions on certain uses and disclosures.** You have the right to ask for restrictions on how your mental health information is used or to whom your information is disclosed, even if the restriction affects your treatment or our payment or mental health care operation activities. Or, you may want to limit the mental health information provided to family or friends involved in your care or payment of mental health bills. You may also want to limit the mental health information provided to authorities involved with disaster relief efforts. However, we are not required to agree in all circumstances to your requested restriction.

If you receive certain mental health devices, you may refuse to release your name, address, telephone number, social security number or other identifying information for purpose of tracking the mental health device.

**4. As applicable, receive confidential communication of mental health information.** You have the right to ask that we communicate your mental health information to you in different ways or places. For example, you may wish to receive information about your mental health status in a special, private room or through a written letter sent to a private address. We must accommodate reasonable requests.

**5. Receive a record of disclosures of your mental health information.** In some limited instances, you have the right to ask for a list of the disclosures of your mental health information we have made during the previous six years, but the request cannot include date before April 14, 2003. This list must include the date of each disclosure, who received the disclosed mental health information, a brief description of the mental health information disclosed, and why the disclosure was made. We must comply with your request for a list within 60 days, unless you agree to a 30-day extension, and we may not charge you for the list, unless you request such list more than once per year. In addition, we will not include in the list disclosures made to you, or for purposes of treatment, payment, mental health care operations, our directory, nation security, law enforcement/ corrections, and certain mental health oversight activities.

**6. Obtain a paper copy of this notice.** Upon your request, you may at any time receive a paper copy of this notice, even if you earlier agreed to receive this notice electronically.

**7. Complain.** If you believe your privacy rights have been violated, you may file a complaint with us and with the federal Department of Mental Health and Human Services. We will not retaliate against you for filing such a complaint. To file a complaint with either entity, please contact who will provide you with the necessary assistance and paperwork.

Again, if you have any questions or concerns regarding your privacy rights or the information in this notice, please contact **Erich G. Duchmann, Ph.D.** at **225-292-0155**.

This Notice of Mental Health Information Privacy is effective **April 14, 2003**.

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**Initial**