Louisiana Family counseling
Karen M. Kirk, LCSW-BACS
11420 US Hwy 1 #212
North Palm Beach, Florida 33408
(985) 871-8177

Intake Forms

Patient Information:

Full name: _____

Date of birth: _____

Sex:_____

SSN:_____

Marital status:_____

Spouse's name: _____

Children's names: _____

Mailing Address:_____

Physical Address:_____

Email Address:_____

Home Phone Number:_____

Cell Phone Number: _____

Employer Name: _____

Employer Phone Number: _____

Employer Address: _____

Emergency Contact Name/Telephone Number:
_____

Primary Care Physician Name/telephone
number:_____

Responsible Party:

Name: _____

Relationship to patient: _____

Date of Birth: _____

Mailing Address: _____

Telephone Number: _____

Please produce a copy of your driver's license prior to your first appointment.

Please note that at this time, we do not accept any insurance plans in Florida.

Privacy Practices:
I acknowledge that I have received a notice of privacy practices.

Signed: _____

Date of signature: _____

Louisiana Family Counseling
Informed Consent and Policies

Individual counseling:
Individual counseling sessions are $125.00 per session. Each session lasts approximately one hour. Initial sessions may take somewhat longer than a normal session. If you would like for us to bill your insurance, please ensure that you have appropriate coverage for counseling prior to your first appointment. At this time, we are only offering video or telephone counseling sessions.

Family Counseling:
Marriage and family counseling sessions are $200.00 for each session. At this time, we are only offering telephone or video counseling sessions.

Phone Counseling:
Phone sessions can be provided with advanced notice, and will be billed as if it was an individual counseling session.

Video Counseling:
Video counseling is active through a video counseling provider, and will be billed as if it was an individual counseling session or family counseling session.

Payment Policy:
We are only able to accept cash or checks. Please make checks payable to Louisiana Family Counseling. Receipts will be available upon request. You will be responsible for a fee of $50.00 if your check is returned by your bank.
Please notify us at least twenty-four hours in advance if you must cancel or re-schedule an appointment. If you miss an appointment, you will receive a bill for your missed appointment.

Court fees:
If I am required to attend court due to a subpoena, my fee associated with this is $500.00 per hour. One hour of court must be covered prior to the court date in order to secure my attendance to your court date.

Office staff:
Please note that we have support stuff to assist with billing purposes. The additional staff members have access only to your name, address, telephone number, insurance information, and billing information.

Confidentiality:
Issues discussed in therapy are important and generally legally protected as both confidential and privileged; however, there are some limits to this confidentiality. These situations include:
-suspected abuse or neglect of an adult or child
-when I believe you are in danger of harming yourself or someone else
-if you report that you intend to harm someone else
-if I am ordered by a court to release information as part of a legal investigation
-when otherwise required by law

Record Keeping:
A clinical chart is maintained, describing goals and progress, dates of and fees of your sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the confidentiality section above. You have the right to expect that your therapist has met the minimal qualifications of education, training, and experience required by state law. You also have the right to examine public records maintained by the board which contain your therapist's qualifications and credentials. You have the right to report a complaint about your therapist's practice to the appropriate state board, and also have access to your own records as allowed by the law.

Children of separation and/or divorce:
If there is a non-custodial parent with joint custody, please have the non-custodial parent sign our contract to provide permission for the child to participate in our therapy program.

Access to records of minors:
Records may be released upon request to any parent with joint custody status. Documents verifying custody status and a copy of your picture identification will both be required to be submitted to Louisiana Family Counseling in order for the records to be released. If you are requesting your child's records or information to be released to another party, an authorization to release protected health information form must be completed.

Your therapist:
Karen M. Kirk, LCSW-BACS is licensed by the State Board of Social Workers at the Florida Department of Health; License #17461. The Florida State Board of Social Workers can be reached at: (850) 488-0595.

Informed Consent for counseling:
By signing below, I acknowledge that I have read and understand the above statements and that my questions have been answered. I accept the terms of this agreement, and consent to participate in counseling services. I understand that I may withdraw from counseling at any time.

_____

Signature of client or legal guardian

_____

Date of signature

Consent for disclosure of identifying information to office staff:
By signing below, I acknowledge that I have read and understand that my identifying information might be shared with additional office staff in the future, such as my name, address, insurance information and any other relevant information needed for billing purposes and record keeping only. I understand that I may e contacted by additional support staff in order to coordinate appointments at Louisiana Family Counseling. I also understand that any other details of my case will remain confidential.

_____

Signature of client or legal guardian

_____

Date of signature

Child Intake Form

Name: _____

Age: _____

Email Address: _____

School: _____

What are your hobbies?_____

Do you get along with your family members?_____

Do your family members get along with each other?
_____

Are you having any problems getting to sleep or staying asleep?
_____

Have you had any recent appetite changes?_____

How do you feel overall? _____

What problems, if any, have you been having in school?

_____

_____

How would you describe your friendships?_____

Have you ever received any counseling before? If so, how did you feel about counseling?

_____

_____

What are some things that you would like to see change as a result of your counseling?

_____

Parent Intake Form

Parent's name(s):_____

Child's name:_____

Child's Date of Birth:_____

Address:_____

Home Phone: _____

Child's Email address:
_____

Mobile Phone:_____

Name of Child's School:_____

Name of child's medical doctor:_____

Name of child psychiatrist, if
any:_____

Medications your child is currently
taking:_____

Any known medical issues:
_____

Please describe your child's living situation.
_____

If the child's parents are separated and/or divorced, please describe the relationship as it relates to co-parenting issues. (i.e., please describe any conflict and the nature of the conflict).
_____

Please describe any custody information, if applicable, and attach any court documents which show the current custody status.

_____

_____

If a non-custodial parent with joint custody is active, have they been notified of your desire to seek therapy for your child? If so, are they supportive of your child's participation in counseling?

_____

_____

Separated parent's name and telephone number:
_____

*If separated from your child's other parent, please obtain a signature from him or her on the attached

permission page in order to participate in our psychotherapy program.
Please describe any concerns you are currently having regarding your child's emotions or behaviors at home or school. _____

Has your child ever experienced any trauma? If so, please describe the circumstances.

Please describe any family relational problems that are impacting your child's emotions.

Please describe your child's symptoms.

Does your child appear to have any off-task behaviors at home or school?

Has your child ever exhibited any violent or oppositional behaviors? If so, please describe.

Does your child have any juvenile court involvement at this time? If so, please explain:

What are some things your child enjoys?

What would you like to see as a result of your child's counseling?

Non-custodial parent Consent form

I, _____ acknowledge that I am aware that my child; _____is participating in psychotherapy at Louisiana Family Counseling. I hereby provide my consent for my child to participate in this counseling program. I acknowledge that I may contact my child's therapist at any time to inquire about my child's treatment plan or provide any feedback I feel that my child's therapist needs to be aware of about my child's needs.

_____

Signature of Parent

_____

Date of signature

Adult Client Intake Form

Name: _____

Address: _____

Email address:_____

Phone:_____

Are you currently under a medical doctor's care? _____

If yes, what is the name of your doctor? _____

Are you currently under the care of a psychiatrist? _____

If yes, what is the name of your psychiatrist? _____

Reason for doctor's care: _____

Are you currently taking any psychiatric medications? If so, what are they?
_____

If yes, please list them: _____

Have you ever been hospitalized for a physical illness? _____

If yes, please describe: _____

Have you ever been hospitalized for a mental illness? _____

If yes, what was the reason? _____

What, if any is your most recent mental health diagnosis? _____

Do you have any chronic medical issues? _____

Do you use any drugs or alcohol? _____

If you do use any drugs or alcohol, please explain how often and what type?_____

Do you have any pending legal charges or any current criminal or civil court involvement? If so, please explain: _____

Have you ever been in counseling before? _____

If yes, describe when and where. _____
What is your occupation? _____

Describe your relationship with your family of origin. _____

Are your married, single, divorced, widowed, or living with a domestic partner? _____

If you are married, how long have you been married? _____

If you have any children, what are their names and ages? _____

Is there any family history of substance abuse? _____

Is there any history of domestic violence that affected you or an immediate member of your family?
_____

If yes, please describe: _____

Were your parents divorced, and if they were, what age were you? _____

If raised by someone other than your birth parents, please describe: _____

Did you ever experience any trauma as a child? _____

If yes, what was the trauma? _____

If you are receiving treatment as a couple, what are your goals for therapy?
_____
_____
_____

Are you currently experiencing any feelings of depression or anxiety?
_____

If yes, describe the symptoms you are experiencing:
_____

Please state briefly what brings you into counseling. _____

Have you ever had any thoughts of harming yourself or anyone else? _____

Have you ever had any suicidal attempts? _____

Are you currently having any suicidal thoughts? _____

Please describe some things that can make you feel better. _____

Please describe some of the things that you would like to work on during the course of your treatment.
_____

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HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

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.

If you have any questions about this notice, please contact us.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with

us.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. 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 than as specified in our contract.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about

criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Louisiana Family Counseling, DBA for Tchefuncte Family Counseling, LLC. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

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

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Louisiana Family Counseling, DBA for Tchefuncte Family Counseling, LLC.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Louisiana Family Counseling, DBA for Tchefuncte Family Counseling, LLC.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Louisiana Family Counseling, DBA for Tchefuncte Family Counseling, LLC. 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 us “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.

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.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Tchefuncte Family Counseling, LLC DBA Louisiana Family Counseling. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Florida Board of Social Workers at the Florida Department of Health. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

You may contact our office at (985) 871-8177.

The Plans may change the terms of this Notice at any time. If the Plans change this Notice, the Plans may make the new Notice terms effective for all of your PHI that the Plans maintain, including any information the Plans created or received before we issued the new Notice. If the Plans change this Notice, the Plans will make it available to you.

Louisiana Family Counseling
Authorization for Release of
Protected Health Information

I, _____ hereby authorize Tchefuncte Family Counseling, LLC DBA Louisiana Family Counseling to release the following information which include records and/or treatment-related information about me or my child to the following:

Name of individual or entity: _____
Mailing Address: _____
Telephone Number: _____
Fax Number: _____
For the following purpose: _____

This authorization is in effect until _____

I understand that by signing this authorization, that I authorize the use or disclosure of my individually identifiable health information as described above for the following purposes listed.
I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
I understand that I have the right to receive a copy of this authorization.
I am signing this authorization voluntarily, and that my treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
I further understand that a person to whom records and information are disclosed persuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure in specifically required or permitted by law.

Signed: _____

Or signed by parent/legal guardian on behalf of: _____

Date of signature: _____