**Cenla Professional Counseling**
**REGISTRATION FORM**

**Today's Date:** _____ **PCP:** _____

## CLIENT INFORMATION

Client's Last Name: _____ First: _____ Middle: _____

☐Mr. ☐Mrs. ☐Miss ☐Ms. Former Name (if applicable): _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Is this your legal name? ☐Y ☐N If not, what is your legal name? _____

DOB: _____ Age: _____ Sex: _____ SSN: _____

Street Address: _____ Cell Ph#: _____ Hm Ph#: _____

P.O. Box: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____ Student: ☐Full-time ☐Part-time

Employer: _____ Employer's Ph#: _____

Chose clinic because/Referred to clinic by: _____

Other family members seen here: _____

## INSURANCE INFORMATON
**(Please give insurance card to receptionist)**

Person responsible for bill: _____ DOB: _____
Address (if different): _____ Home Ph#: _____
Is this person a patient here? ☐Y ☐N

**PRIMARY INSURANCE:** _____ ☐Private OR ☐Medicaid
Subscriber's Name: _____ Subscriber's SSN: _____ DOB: _____
Subscriber's Address: _____
Subscriber's ID or Policy #: _____ Group #: _____ Co-payment: _____
Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other: _____

**SECONDARY INSURANCE (if applicable):** _____ ☐Private OR ☐Medicaid
Subscriber's Name: _____ DOB: _____ Subscriber ID #: _____
Subscriber's Address: _____
Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other: _____

## IN CASE OF EMERGENCY

Name of local friend or relative: Relationship to patient: Phone #:

_____

**The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Cenla Professional Counseling or insurance company to release any information required to process my claims**.

Patient/ Guardian signature: _____ Date: _____

**Cenla Professional Counseling, LLC**
**4207 Parliament Drive, Suite B**
**Alexandria, Louisiana 71303**
**Office: (318) 787-6805**

## Personal Agreements

I understand that I may be asked to do **certain "homework exercises" such as reading, praying, changing behaviors, and otherwise acting in my own best interest.** I understand that I am entirely responsible for my own actions, and I will always make my own final decisions regarding counseling.

I further understand that much of the homework done will be to resolve issues and will depend on my honesty and willingness to do the things I need to do to move forward, even it is painful or difficult.

I understand that whatever I say in a session is strictly confidential and will not be released to anyone without my consent unless I am violating codes of abuse, harm to myself or others.

_____

Client Signature Date

As your therapist/counselor, you honor me by sharing your life and growth with me. I will not hide myself behind silence or position and will hold high regard for you as a person. I will bring the best that I know from my study and experience. I will bring you the highest of my insight, wisdom, and spiritual guidance. I will keep a holistic perspective in our work together, because I believe that the physical, spiritual, and soul (mind, will, emotions) all work together to form a wholly, healthy person.

You can expect truth from me even when you may not want to hear it. I will always have compassion and empathy for you in all that we do. I value you as a person in need of care. I will do my best to honor that.

***Suzanne Palmer, MA, NCC, LAC, LPC***

# Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Bother verbal and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

**Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the mental health professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Abuse of Children and Vulnerable Adults**

If a client states or suggests that he or she abusing a child (or vulnerable adult), has recently abused a child (or vulnerable adult), or a child (or a vulnerable adult) is in danger of abuse, then the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

**Prenatal Exposure to Controlled Substances**

Mental Healthcare professionals are required to report admitted prenatal exposure to controlled substance that are potentially harmful.

**Minor/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records

**Insurance providers** (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

*I agree to the above limits of confidentiality and understand their meanings and ramifications.*

_____ _____

Client Signature (Client's parent/guardian if under 18 years of age) Date

# Client Agreement

**PLEASE READ THE FOLLOWING CAREFULLY**
**AND INITIAL AFTER EACH STATEMENT**

- I understand that I am responsible for the fee payment at the beginning of each appointment. ___
- I agree to be responsible for the full payment of the fees for services rendered regardless of whether insurance reimbursement will be sought. ___
- Cenla Professional Counseling will honor contractual agreements made with those managed healthcare companies which stipulate reimbursement restrictions. ___
- I hereby consent to treatment by Suzanne Palmer, LPC, LAC, NCC, MA although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions. ___
- I understand that I have the right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop. ___
- I hereby authorize the release of necessary medical information for insurance reimbursement purposes. ___
- I authorize the payment of medical benefits to the provider of services.

_____ _____

Client Signature (Client's parent/guardian if under 18 years of age) Date

Cenla Professional Counseling, LLC.
4207 Parliament Drive, Suite B
Alexandria, LA 71303

# **Cancellation Policy**

If you miss an appointment or fail to cancel a scheduled appointment within 24 hours, we cannot use this time for another client, and you will be billed a **$50 missed appointment fee**.

Thank you in advance for your cooperation and consideration regarding this important matter.

**Private insurance and Medicaid cannot be billed for missed sessions.**

_____ _____

*Client Signature (parent/guardian if under 18 years of age)* *Date*

# CENLA Professional Counseling, LLC.
# 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.**

Cenla Professional Counseling, LLC. ("CPC") provides counseling services. Cenla Professional Counseling staff must collect information about you to provide these services. CPC knows that information we collect about you and your health is private. CPC is required to protect this information by Federal and State law. **We call this information "protected health information" (PHI).** This Notice of Privacy Practices tells you how CPC may use or disclose information about you. Not all situations will be described. We are required to give you a notice of our privacy practices for the information we collect and keep about you. **This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including HIPAA Privacy and Security Rules and our Code of Ethics.** CPC is required to follow the terms of the notice currently in effect. However, CPC may change its privacy practices and make that change effective for all PHI maintained by the Department. The effective date of this Notice of Privacy Practices is April 14, 2003.

## CPC May Use and Disclose Information without Your Authorization

**For Treatment.** CPC may use or disclose information to health care providers who are involved in your health care. For example, information may be shared to create and carry out a plan for your treatment.

**For Payment.** CPC may use or disclose information to get payment or to pay for the healthcare services you receive. For example, CPC may provide PHI to bill your health plan for services provided to you.

**For Health Care Operations.** CPC may use or disclose information in order to manage its programs and activities. For example, CPC may use PHI to review the quality of services you receive.

**Appointments and Other Health Information.** CPC may send you reminders for medical services, checkups, and eligibility renewal. CPC may send you information about health services that may be of interest to you.

**For Public Health Activities.** CPC is the public health agency that keeps and updates vital records such as births, deaths, and the tracking of some health issues and diseases.

**For Health Oversight Activities.** CPC may use or disclose information to inspect or investigate health care providers.

**As Required by Law and for Law Enforcement.** CPC will use and disclose information when required or permitted by Federal or State law or by a court order. If Federal or State law creates higher standards of privacy; CPC will follow the higher standard.

**For Abuse Reports and Investigations.** CPC is required by law to receive and investigate reports of abuse, neglect or exploitation.

**For Government Programs.** CPC may use and disclose information for public benefits under other government programs. For example, CPC may disclose information for the determination of Supplemental Security Income (SSI) benefits.

**To Avoid Harm.** CPC may disclose PHI to law enforcement agencies in order to avoid a serious threat to the health, welfare and safety of a person or the public.

**For Research.** CPC uses information for studies and to develop reports.

**Disclosures to Family, Friends, and Others.** CPC may disclose information to your family or other persons who are involved in your medical care. You have the right to object to the sharing of this information.

**Other Uses and Disclosures Require Your Written Authorization.** For other situations, CPC will ask for your written authorization before using or disclosing information. You may cancel this authorization at any time in writing. CPC cannot take back any uses or disclosures already made with your authorization.

**Other Laws Protect Your Protected Health Information.** Many CPC programs have other laws for the use and disclosure of information about you. For example, your written authorization may be needed for CPC to use or disclose your mental health or chemical dependency treatment records.

## Your Privacy Rights

**Right to See and Get Copies of Your Records.** In most cases, you have the right to look at or get copies of your records. You must make the request in writing. You may be charged a fee for the cost of copying your records.

**Right to Request to Correct, Amend, or Update Your Records.** You may ask CPC to change or add missing information to your records if you think there is a mistake. You must make the request in writing, and provide a reason for your request.

**Right to Get a List of Disclosures.** You have the right to ask CPC for a list of disclosures made after April 14, 2003. You must make the request in writing. This list will not include the times that information was disclosed for treatment, payment, or health care operations. The list will not include information provided directly to you or your family or information that was sent with your authorization.

**Right to Request Limits on Uses or Disclosures of Protected Health Information.** You have the right to ask CPC to limit how your information is used or disclosed. You must make the request in writing and tell CPC what information you want to limit and to whom you want the limits to apply. CPC is not required to agree to the limit. You can request in writing that the limit be terminated.

**Right to Revoke Permission.** If you are asked to sign an authorization to use or disclose information, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been shared.

**Right to Choose How We Communicate with You.** You have the right to ask that CPC share information with you in a certain way or in a certain place. For example, you can ask CPC to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain the reason for your request.

**Right to File a Complaint.** You have the right to file a complaint with CPC at the address listed below and with the Secretary of the United States Department of Health and Human Services if you do not agree about how CPC has used or disclosed information about you.

**Right to Get a Paper Copy of this Notice.** You have the right to ask for a paper copy of this notice at any time.

**Right to Receive Notice of Change to CPC Privacy Practices.** You have a right to receive notice of changes in CPC privacy practices that affect you on or after the effective date of the change.

**How to Review CPC Privacy Policies.** You may review CPC privacy policies in our office located at 4207 Parliament Drive, Suite B, Alexandria, LA 71303.

## How to Contact CPC to Review, Correct, or Limit Your Protected Health Information (PHI)

You may contact the CPC office which collects and maintains your protected health information or you may contact the CPC Privacy Officer at the address listed at the end of this notice to:

- Ask to look at or copy your records;
- Ask to limit how information about you is used or disclosed;
- Ask to cancel your authorization;
- Ask to correct or change your records; or
- Ask for a list of the times CPC disclosed information about you.

Your request to look at, copy, or change your records may be denied. If CPC denies your request, you will receive a letter that tells you why your request is being denied and how you can ask for a review of the denial. You will also receive information about how

to file a complaint with CPC or with the U.S. Department of Health and Human Services, Office for Civil Rights.

## How to File a Complaint or Report a Problem

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Office at 4207 Parliament Drive, Suite B, Alexandria, LA 71303 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.

# PATIENT HIPAA CONSENT FORM

## Please Review Carefully

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your ***Notice of Privacy Practices***, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions of how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Cenla Professional Counseling, LLC.
4207 Parliament Drive, Suite B
Alexandria, LA 71303

# DECLARATION OF PRACTICES AND PROCEDURES

Suzanne Palmer, MA, LPC, LAC, NCC

1.) I earned a Master's degree from Northwestern State University in 2008. I am licensed as an LPC # 4257 with the: ***LICENSED PROFESSIONAL COUNSELORS BOARD OF EXAMINERS, 8631 SUMMA AVENUE, BATON ROUGE, LOUISIANA 70809, TELEPHONE (225) 765-2515***

2.) **Counseling Relationship:** I see counseling as a process in which you, the client, and I, the counselor, having come to understand and trust one another, work as a team to explore and define present problem situations, develop future goals for an improved life and work in a systematic fashion toward realizing those goals.

3.) **Areas of Expertise:** I have a general practice, but specialize with marriage and families, substance abuse, anxiety, and depression. I hold a national certification as a ***National Certified Counselor (NCC) and a Licensed Addiction Counselor # 1316.***

4.) **Fee Scales:** The fee for my services is $100.00. Payment is due at time of service.

5.) **Services Offered and Clients Served:** I approach counseling from an eclectic perspective in that patterns of thoughts and actions are explored in order to better understand the clients' problems and to develop solutions. I work with a variety of formats, including individually, as couples and as families. I also conduct group therapy. I see clients age 14 and older and of all backgrounds.

6.) **Code of Conduct:** As a counselor, I am required by state law to adhere to the Code of Conduct for practice that has been adopted by my licensing Board. A copy of this Code of Conduct is available upon request.

7.) **Privileged Communications:** Material revealed in counseling will remain strictly confidential except for:

1) The client signs a written release of information indicating informed consent of such release.
2) The client expresses intent to harm him/herself or someone else.
3) There is a reasonable suspicion of abuse or neglect against a minor child, elderly person (60 or older), or a dependent adult.
4) A court order is receive directing the disclosure of information.

*It is my policy to assert privileged communication on behalf of the client and the right to consult with the client if at all possible, except during an emergency, before mandated disclosure. I will endeavor to apprise clients of all mandated disclosures as conceivable.*

*In the event of marriage or family counseling, material obtained from an adult client individually may be shared with the client spouse or other family members only with the client's permission. Any material obtained from a minor client may be shared with that client's parents or guardian.*

8.) **Emergency Situations:** If an emergency situation should arise, you may seek help through hospital emergency room facilities or by calling 911.

9.) **Client Responsibilities:** Your honesty and effort is essential to success. If as we work together you have suggestions or concerns about your counseling I expect you to share these with me so that we can make the necessary adjustments. If it develops that you would be better served by another mental health provider, I will help you with the referral process. If you are currently receiving services form another mental health professional, I expect you to inform me of this and grant me permissions to share information with this professional so that we may coordinate out services to you.

10.) **Physical Health:** Physical health can be an important factor in the emotional wellbeing of an individual. If you have not had a physical examination in the last year, it is recommended that you do so. Also, please provide me with a list of the medicines you are currently taking.

11.) **Potential Counseling Risk:** The client should be aware that counseling poses potential risks. In the course of working together additional problems may surface of which the client was not initially aware. If this occurs, the client should feel free to share these new concerns with me.

I have read and understand the above information.

Client Signature _____ Date _____

Counselor Signature _____ Date _____

*Signature of parent or guardian of minor being seen by counselor:*

I, _____ give permission for _____
*(Parent/ Guardian)* *(Counselor)*

to conduct counseling with my, _____, _____
*(Relationship)* *(Name of Minor)*

**COUNSELING INTAKE FORM**

Name: _____ Age: _____ Date: _____
Best Contact Phone Number(s): _____
Marital Status: _____ Months/Years:_____

Children: Name and Age (If child is deceased, please indicate name, age, year.)

_____
_____
_____

General Health: Excellent Good Average Fair Poor
Smoke: Y N Drink: Y N Drugs: Y N
*If yes for any of the three, what kind, how much, and how long?*_____
_____

Significant medical conditions: _____
_____
_____

Previous therapy, counseling, or interventions? Y N If *so, with who, when, and for what?* ____
_____

Have you ever engaged in self-injurious behavior such as cutting or intentional self-harm? Y N
*If yes, please explain.* _____
_____

Medications, purpose, dosage, time of day, any side effects?
1. _____
2. _____
3. _____
4. _____
5. _____

Life-style habits (ex. exercise, hobbies, fun activities) _____
_____
_____

**Family History**

Ethnicity_____
Father: Alive Deceased *If deceased, what year?* _____ *Your age?* _____
Describe your relationship: _____
_____

Mother: Alive Deceased *If deceased, what year?*_____*Your age?* _____
Describe your relationship: _____

_____

Parents divorced? Y N Your age? _____ Step-father? _____ Step mother? _____
Describe relationship _____

_____

Siblings:

| Name | Age | Name | Age |
|---|---|---|---|
| _____ | | _____ | |
| _____ | | _____ | |
| _____ | | _____ | |
| _____ | | _____ | |

Describe relationship(s) _____

_____

_____

In your family, was there any substance abuse, alcoholism, suicide, self-harm, or mental illness?
Physical, verbal, sexual, or emotional abuse? Y N *If yes, please describe.* _____

_____

_____

Any trauma? Y N *If yes, please describe.* _____

_____

_____

**Work/ Social/ Educational/ Legal History**

Current Occupation: _____ Like OR dislike

Military Service? You or significant other? _____

_____

Current Level of Education: _____

Describe your school experience (friends, bullying, teachers, grades, etc) _____

_____

_____

Have you ever had any legal problems, arrests, or convictions? Y N *If so, please describe.* __

_____

_____

**Spiritual History**

Religious upbringing _____ Present Affiliation _____

Is this an important part of your life? _____

Would you like for this to incorporated in to your sessions? Y N

**Present Situation**

What are your reasons for coming in for therapy? Briefly explain the nature of your situation(s). _

_____

_____

_____

_____

Are you experiencing any of the following symptoms?

Anxiety Panic Attacks Depression Unclear Sense of Self

Memory loss Low sense of self-esteem Change of Appetite

Weight gain/loss Flashbacks/nightmares Compulsive behaviors(OCD)

Sleep Disturbances Mood Swings Physical Pain Suicidal Thoughts

Obsessive Thinking

When did the symptom(s) begin? _____

What other people may be contributing to your symptoms or problems? _____

_____

How do you feel about yourself? _____

_____

How do you feel about counseling? _____

_____

Is there anything I haven't asked you that you feel is important for me to know? _____

_____

_____

_____

*Please feel free to use the back to provide further information*