NORTHLAKE MEDICAL
PSYCHOLOGY AND COUNSELING

Alicia Seicshnaydre MSN, APRN, PMHNP-BC
215 St. Ann Drive, Suite 2
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Phone (985) 951-2250
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Notice of Provider's Policies and Practices to Protect the Privacy of Your Health Information

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

I. Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for certain *treatment, payment, and health care operations* purposes without your *authorization*. In certain circumstances I can only do so when the person or business requesting your PHI gives me a written request that includes certain promises regarding protecting the confidentiality of your PHI.

To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment and Payment Operations"*
- *Treatment* is when I provide or another healthcare provider diagnoses or treats you. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist, regarding your treatment.
- *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- *Health Care Operations* is when I disclose your PHI to your health care service plan (for example your health insurer), or to your other health care providers contracting with your plan, for administering the plan, such as case management and care coordination.
- "*Use*" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.
- *"Authorization"* means written permission for specific uses or disclosures.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment and payment operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our

conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.
You may revoke or modify all such authorizations (of PHI or psychotherapy notes) at any time; however, the revocation or modification is not effective until I receive it.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** Whenever I, in my professional capacity, have knowledge of or observe a child I know or reasonably suspect has been the victim of child abuse or neglect, I must immediately report such to a police department or sheriff's department, county probation department, or county welfare department (Child Protective Services). Also, if I have knowledge of or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, I may report such to the above agencies.
- **Adult and Domestic Abuse:** If I, in my professional capacity, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if I am told by an elder or dependent adult that he or she has experienced these or if I reasonably suspect such, I must report the known or suspected abuse immediately to the local ombudsman or the local law enforcement agency.

  I do not have to report such an incident if:

  1. I have not been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect;
  2. I am not aware of any independent evidence that corroborates the statement that the abuse has occurred;
  3. the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia; and
  4. In the exercise of clinical judgment, I reasonably believe that the abuse did not occur.

- **Health Oversight:** If a complaint is filed against me with the Louisiana State Board of Nursing, the Board(s) has/have the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services that I have provided you, I must not release your information without 1) your written authorization or the authorization of your attorney or personal representative; 2) a court order; or 3) a *subpoena duces tecum* (a subpoena to produce records) where the party seeking your records provides me with a showing that you or your attorney have been served with a copy of the subpoena, affidavit and the appropriate notice, and you have not notified me that you are bringing a motion in the court to quash (block) or modify the subpoena. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.
- **Serious Threat to Health or Safety:** If you communicate to me a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police. If I have reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, I may release relevant information as necessary to prevent the threatened danger.
- **Worker's Compensation**: If you file a worker's compensation claim, I must furnish a report to your employer, incorporating my findings about your injury and treatment, within five working days from the date of the your initial examination, and at subsequent intervals as may be required by the administrative director of the Worker's Compensation Commission in order to determine your eligibility for worker's compensation.

IV. Patient's Rights and Provider's Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills or correspondence to another address.
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Provider's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a revised notice by mail or in person and in writing within 7 days of such change in notice, if at all possible.

V. Complaints

If you are concerned that I, Alicia Seicshnaydre, PMHNP, have violated your privacy rights, or you disagree with a decision made about access to your records, you may contact the Louisiana State Board of Nursing, 17373 Perkins Rd., Baton Rouge, La 70810; Phone: (225)755-7500

You may also send a written complaint to the Secretary of the U.S. Department of Health Services, 200 Independence Avenue, S.W., Washington, D.C. 20201; Phone: (877) 696-6775.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

Notice of any future restriction to this notice or of change will be posted promptly within 14 days of such change.
This notice goes into effect on February 19, 2021.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE CAREFULLY REVIEWED AND UNDERSTAND THE PRIVACY INFORMATION OUTLINED ABOVE.

_____ _____
Patient Signature (Legal Guardian if Minor) Date

_____ _____
Witness Date

NORTHLAKE MEDICAL
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Refill Policy

DearPatient,

Because of the high volume of patients that Alicia Seicshnaydre, PMHNP sees, Northlake Medical Psychology and Counseling has implemented a 48-hour policy concerning all prescription refills. Please contact our office at least 48 business hours before any prescriptions are needed and allow up to 48 business hours for your prescription to be sent electronically to your pharmacy. Prescriptions for controlled substances will not be called in before they are due.

Please note that at times some insurance companies may require Prior Authorization for a new or existing medication. In the event that a Prior Authorization is needed, please have your pharmacy contact our office and allow an additional 1-3 business days for processing. Processing times vary depending on medications and insurance plans.

_____ _____

Patient Signature (Legal Guardian if Minor) Date

By signing above, you agree that you have read and understand the 48-hour policy.

We appreciate your cooperation.

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Authorization Request for Release of Confidential Health Information Patient Identification

Patient name: _____ Date of Birth: ____/____/____ Age: _____

Address:_____ Phone: (_____) _____

Authority to Release Protected Health Information: When you complete and sign this form, it authorizes this provider to release protected information from your own (or your child's) clinical records to the person or agency below, or to obtain information from this person or agency. You have the right to revoke this authorization, in writing, at any time by sending notification of this revocation to my office address.

I _____, hereby authorize Alicia Seicshnaydre, PMHNP (and/or her staff) to disclose or obtain the following information in regard to the above-named or the above-named minor's psychological/medical/ psychiatric/psychoeducational treatment or evaluation.

Purpose of Requested Disclosure of Protected Health Information: The particular information to be disclose/obtained is the following (please be specific) :

_____

The information should be disclosed to/obtained from the following (please provide full addresses and telephone numbers) :

Name of Agency Provider(s): _____

Address: _____ Phone: (_____) _____

Fax: (_____) _____ Email: _____ **Right to Revoke Authorization:** Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting written notice to Alicia Seicshnaydre, PMHNP. Unless revoked, this authorization will remain in effect until the following date, and/or will expire after the following time period or event:

_____

e-Disclosure: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Personal Representative Who May Request Disclosure: I understand the statements above, and I voluntarily consent to disclosing/obtaining this information to/from the person or agency named above. I also understand that I do not have to sign this authorization. However, if health care services are being provided to me for the purpose of providing information to a third party (e.g., fitness-for-work test), I understand that services may be denied if I do not authorize the release of information related to such health care services to the third party. I can inspect or copy the protected health information to be used or disclosed. I hereby release Alicia Seicshnaydre, PMHNP (and/or his staff) from any liability that could arise from disclosing or obtaining this information as long as the information is disclosed or obtained in accordance with applicable laws and/or in compliance with this Authorization.

_____ Patients Name Printed	_____/_____/_____ Today's Date	_____ Signature
_____ Signature/Assent of Child/ Adolescent (If Appropriate)	_____/_____/_____ Today's Date	_____ Relationship to Patient
_____/_____/_____ Witness Date		

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Clinical History Form

Date: ____/____/____

Your Background Information

Name: _____ DOB: ____/____/____ SS#: _____-_____-_____

Address:_____

City: _____ State: _____ Zip Code: _____

Phone: (_____)_____ Cell: (_____)_____ E-mail: _____

Primary Care Physician: _____ Physician Phone: (_____)_____

Last time you were examined: _____

Emergency Contact: _____ Phone: (_____)_____

Your Present Problem

What are the problem(s) you are seeking help for? Give a date for the onset of each problem.

1._____

_____

_____

2._____

_____

_____

3._____

_____

_____

What are your treatment goals? _____

_____

_____

Current Symptoms Checklist (check once for any symptoms present, twice for major symptoms):

( ) Depressed mood	**( ) Racing thoughts**	**( ) Crying spells**
( ) Unable to enjoy activities	**( ) Impulsivity**	**( ) Anxiety attacks**
( ) Sleep pattern disturbance	**( ) Avoidance**	**( ) Decreased libido**
( ) Concentration/forgetfulness	**( ) Decrease need for sleep**	**( ) Change in appetite**
( ) Excessive energy	**( ) Increased irritability**	**( ) Fatigue**

Your Medical History

Drug Allergies: _____

Current Weight: _____ Height: _____

List ALL current prescription medications and how often you take them (if none, write NONE):

Medication Name	**Total Daily Dosage**	**Estimated Start Date**
_____	_____	Mo: _____ Year: _____
_____	_____	Mo: _____ Year: _____
_____	_____	Mo: _____ Year: _____
_____	_____	Mo: _____ Year: _____
_____	_____	Mo: _____ Year: _____
_____	_____	Mo: _____ Year: _____
_____	_____	Mo: _____ Year: _____
_____	_____	Mo: _____ Year: _____
_____	_____	Mo: _____ Year: _____

List All current over-the-counter medications and how often you take them (if none, write NONE):

Medication or Supplement Name	**Frequency**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List all current medical problems: _____

_____

_____

Please indicate with a check if you have any of the following medical conditions:

( ) Hepatitis	**( ) Pregnancy**	**( ) Seizures**
( ) HIV	**( ) High Blood Pressure**	**( ) Pacemaker**
( ) Blood Thinning Meds	**( ) _____**	**( ) _____**

List any past medical problems, non-psychiatric hospitalization or surgeries:

_____

_____

_____

For Women

Date of last menstrual period ___/___/___ Are you currently pregnant or do you think you might be pregnant? **( ) Yes ( ) No** If no, are you planning to get pregnant in the near future? **( ) Yes ( ) No**

How many times have you been pregnant? _____ How many live births? _____

Birth control method: _____

Are there any concerns about your physical health you would like to discuss with me? **( ) Yes ( ) No**

Date and place of last woman's physical exam: ____/____/____ _____

Your Personal and Family Medical History

If you or a family member have been diagnosed with a condition listed below, circle (S) for Self or (f) for Family (if Family, which family member?):

(S) (F) Thyroid Disease _____
(S) (F) Infertility _____
(S) (F) Autoimmune Disease _____
(S) (F) Anemia _____
(S) (F) Liver Disease _____
(S) (F) Chronic Fatigue) _____
(S) (F) Kidney Disease _____
(S) (F) Diabetes _____
(S) (F) Asthma/respiratory problems _____
(S) (F) Stomach or intestinal problems _____
(S) (F) Cancer (type) _____
(S) (F) Fibromyalgia _____
(S) (F) Heart Disease _____
(S) (F) Epilepsy or seizures _____

(S) (F) Chronic Pain _____
(S) (F) High Cholesterol _____
(S) (F) High blood pressure _____
(S) (F) Head trauma _____
(S) (F) Liver problems _____
(S) (F) Orthopedic _____
(S) (F) Other _____

Is there any additional personal or family medical history? **( ) Yes ( ) No** If yes, please explain:

_____

_____

_____

Your Family Psychiatric History

Has anyone in your family been diagnosed with or treated for any of the following conditions:

( ) Yes ( ) No Attention Deficit
( ) Yes ( ) No Bipolar disorder
( ) Yes ( ) No Schizophrenia
( ) Yes ( ) No Depression
( ) Yes ( ) No Post-traumatic stress
( ) Yes ( ) No Anxiety
( ) Yes ( ) No Alcohol abuse
( ) Yes ( ) No Anger Management
( ) Yes ( ) No Other substance abuse
( ) Yes ( ) No Suicide
( ) Yes ( ) No Violence

If yes, please provide details: _____

_____

_____

Have any of your family members been treated with a psychiatric medication? **( ) Yes ( ) No**

If yes, who was treated and what medications and how effective was the treatment?

_____

_____

_____

Your Past Psychiatric History

Have you ever received outpatient treatment for a psychiatric condition? **( ) Yes ( ) No** If yes, please provide the following details:

Treatment Dates	**Treated by**	**Reason for Treatment**
___/___ to ___/___	_____	_____
___/___ to ___/___	_____	_____
___/___ to ___/___	_____	_____
___/___ to ___/___	_____	_____

Have you ever been hospitalized for a psychiatric condition? **( ) Yes ( ) No** If yes, please provide the following details:

Dates	**Facility Name**	**Reason for Hospitalization**
___/___ to ___/___	_____	_____
___/___ to ___/___	_____	_____
___/___ to ___/___	_____	_____

Your Past Psychiatric Medications

If you have ever taken any of the following medications, please provide details as you can recall (if you can't remember all the details, just write down what you do remember):

Medication Name	**Dates**	**Dosage**	**Response**	**Side Effects**
Antidepressants:				
Prozac (fluoxetine)	___/___ to ___/___	_____	_____	_____
Zoloft (sertraline)	___/___ to ___/___	_____	_____	_____
Luvox (fluvoxamine)	___/___ to ___/___	_____	_____	_____
Paxil (paroxetine)	___/___ to ___/___	_____	_____	_____
Celexa (citalopram)	___/___ to ___/___	_____	_____	_____
Lexapro (escitalopram)	___/___ to ___/___	_____	_____	_____
Effexor (venlafaxin)	___/___ to ___/___	_____	_____	_____
Cymbalta (duloxetine)	___/___ to ___/___	_____	_____	_____
Wellbutrin (bupropion)	___/___ to ___/___	_____	_____	_____
Remeron (mirtazapine)	___/___ to ___/___	_____	_____	_____
Viibryd (vilazodone)	___/___ to ___/___	_____	_____	_____
Anafranil (clomipramine)	___/___ to ___/___	_____	_____	_____
Pamelor (nortrptyline)	___/___ to ___/___	_____	_____	_____
Tofranil (imipramine)	___/___ to ___/___	_____	_____	_____
Elavil (amitriptyline)	___/___ to ___/___	_____	_____	_____
Pristiq (desvenlafaxine)	___/___ to ___/___	_____	_____	_____
Trintellix (vortioxetine)	___/___to___/____	_____	_____	_____
Mood Stabilizers:				
Tegretol (carbamazepine)	___/___ to ___/___	_____	_____	_____
Lithium	___/___ to ___/___	_____	_____	_____
Depakote (valproate)	___/___ to ___/___	_____	_____	_____
Lamictal (lamotrigine)	___/___ to ___/___	_____	_____	_____
Tegretol (carbamazepine)	___/___ to ___/___	_____	_____	_____
Topamax (topiramate)	___/___ to ___/___	_____	_____	_____
Antipsychotics/Mood Stabilizers:				
Seroquel (quetiapine)	___/___ to ___/___	_____	_____	_____
Zyprexa (olanzepine)	___/___ to ___/___	_____	_____	_____
Geodon (ziprasidone)	___/___ to ___/___	_____	_____	_____
Abilify (aripiprazole)	___/___ to ___/___	_____	_____	_____
Latuda (lurasidone)	___/___ to ___/___	_____	_____	_____
Vraylar (cariprazine)	___/___ to ___/___	_____	_____	_____

Medication Name	Dates	Dosage	Response	Side Effects
Clozaril (clozapine)	___/___ to ___/___	_____	_____	_____
Haldol (haloperidol)	___/___ to ___/___	_____	_____	_____
Prolixin (fluphenazine)	___/___ to ___/___	_____	_____	_____
Sedative/Hypnotics:				
Ambien (zolpidem)	___/___ to ___/___	_____	_____	_____
Sonata (zaleplon)	___/___ to ___/___	_____	_____	_____
Rozerem (ramelteon)	___/___ to ___/___	_____	_____	_____
Restoril (temazepam)	___/___ to ___/___	_____	_____	_____
Desyrel (trazodone)	___/___ to ___/___	_____	_____	_____
Other: _____	___/___ to ___/___	_____	_____	_____
ADHD medications:				
Adderall (amphetamine)	___/___ to ___/___	_____	_____	_____
Concerta (methylphenidate)	___/___ to ___/___	_____	_____	_____
Ritalin (methylphenidate)	___/___ to ___/___	_____	_____	_____
Strattera (atomoxetine)	___/___ to ___/___	_____	_____	_____
Vyvanse(lisdexamfetamine)	___/___ to ___/___	_____	_____	_____
Other: _____	___/___ to ___/___	_____	_____	_____
Anti-anxiety medications:				
Xanax (alprazolam)	___/___ to ___/___	_____	_____	_____
Ativan (lorazepam)	___/___ to ___/___	_____	_____	_____
Klonopin (clonazepam)	___/___ to ___/___	_____	_____	_____
Valium (diazepam)	___/___ to ___/___	_____	_____	_____
Tranxene (clorazepate)	___/___ to ___/___	_____	_____	_____
Buspar (buspirone)	___/___ to ___/___	_____	_____	_____
Other: _____	___/___ to ___/___	_____	_____	_____

Your Health

Physical Exercise:

Do you exercise regularly? **( ) Yes ( ) No** How many days a week do you get exercise? _____

How much time do you exercise? _____ What kind of exercise do you do? _____

Substance Use:

Have you ever been treated for alcohol or drug abuse? **( ) Yes ( ) No**

If yes, for which substances? _____

If yes, where were you treated and when? _____

_____

Have you abused prescription medication? **( ) Yes ( ) No**

If yes, which ones and for how long? _____

Alcohol Consumption:

How many alcoholic beverages do you drink a day? _____ Per week?_____

Caffeine Consumption:

How many caffeinated beverages do you drink a day? Coffee: _____ Sodas: _____ Tea: _____

Tobacco History:

Have you ever smoked cigarettes? **( ) Yes ( ) No** Do you currently smoke? **( ) Yes ( ) No** How many cigarettes per day on average do you smoke? _____ How many years have you smoked? _____

Have you quit? **( ) Yes ( ) No** How many years did you smoke? _____ When did you quit? _____

Have you used a pipe, cigars, or chewing tobacco in the past? **( ) Yes ( ) No** Currently? **( ) Yes ( ) No**

What kind? _____ How often per day on average?_____ How many years?_____

Your Family Background and Childhood History

Where were you born? _____ Where did you grow up? _____

Who was your primary caretaker? _____

List the first names of your siblings indicating (B) for brother and (S) for sister and include their age:

(B) (S) _____ _____ **(B) (S)** _____ _____

(B) (S) _____ _____ **(B) (S)** _____ _____

(B) (S) _____ _____ **(B) (S)** _____ _____

What was your father's occupation? _____

What was your mother's occupation? _____

Educational History:

What is your highest educational level or degree attained? _____

Did you attend college? **( ) Yes ( ) No** Where? _____ Major? _____

Occupational History:

Your current work status: **( ) Working ( ) Not working by choice ( ) Unemployed ( ) Disabled ( ) Retired**

How long in present position? _____ What is/was your occupation? _____

If currently employed, where? _____

Have you ever served in the military? **( ) Yes ( ) No** If so, what branch and when? _____

Relationship History and Current Family:

Your current relationship status: **( ) Married ( ) Divorced ( ) Separated ( ) Single ( ) Widowed**

How long in current situation? _____

If not married, are you currently in a relationship? **( ) Yes ( ) No** If yes, how long? _____

Are you sexually active? **( ) Yes ( ) No**

What is your spouse or significant other's occupation?

_____ Have you had any prior marriages? **( ) Yes ( ) No**

If yes, how many? _____ How long? _____

Do you have children? **( ) Yes ( ) No** If yes, list gender and age for each child:

(M) (F) _____ (M) (F) _____ (M) (F) _____ (M) (F) _____ (M) (F) _____ (M) (F) _____

Describe your relationship with your children: _____

_____

List everyone who currently lives with you? _____

_____

Legal:

Have you ever been arrested? **( ) Yes ( ) No** If yes, please give the reason: _____

_____

Do you have any pending legal problems? **( ) Yes ( ) No** If yes, explain: _____

_____

Spiritual life:

Do you belong to a particular religion or spiritual group? **( ) Yes ( ) No** If yes, what is the level of your involvement? _____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? **( ) more helpful ( ) more stressful**

Your Comments

Is there anything else you would like Alicia Seicshnaydre, PMHNP to know about you that might be useful to her helping you?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? **( ) Yes ( ) No**

If YES, please answer the following. If NO, please skip the following and sign at the bottom.

Do you currently feel that you don't want to live? **( ) Yes ( ) No**

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____

Would anything make it better? _____ _____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and /or worthless? _____

Have you ever tried to harm yourself before? _____

***Office Policies: If you need to contact me by phone, do not hesitate to call my office phone. If you cannot reach me in an emergency, it is best to contact your primary care provider, go to the emergency room or dial 911. If applicable, my office may bill your insurance; however, by signing below you acknowledge responsibility for all expenses incurred. This form also serves as consent for evaluation.**

Signature of Patient : _____ Date____/____/____

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Patient Pharmacy Information

Name of the pharmacy you use: _____

Pharmacy Address: _____

_____

Pharmacy Phone Number: (_____)_____

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Linda Collings, Ph.D., MP
Kristen UnKauf, Ph.D., LPC
Robert Gardner, PhD., LPC
Alicia Seicshnaydre MSN, APRN, PMHNP-BC
215 St. Ann Drive, Suite 2 Mandeville, La 70471 Phone (985)
951-2250 Fax (985) 951-2253

Missed Session Policy:

The fee for a missed session is $95.00. In order to cancel your appointment without being charged the $95.00 missed session fee, you must contact Northlake Medical Psychology and Counseling to cancel the appointment no later than 24 hours PRIOR to the appointment time.

By signing below, you verify that you understand this policy regarding the cancellation of sessions:

_____

Client Signature Date

I, _____ authorize Northlake Medical Psychology and Counseling to charge the fees related to services received to my credit card:

Card Type: Visa MasterCard American Express Discover

Name on Card_____

Card # _____Expiration Date_____ CVC _____

Billing Zip Code_____

By signing below, I understand that I will NOT be billed to this card automatically, but only in the event that I have an unpaid balance and have not made other arrangements to pay that balance. I authorize Northlake Medical Psychology and Counseling to use this card for session fees, including the collection of balances due that are not otherwise paid in full on my account, even if such balances are due after therapy is terminated.

_____

Client Signature Date