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Notice of Policies and Practices to Protect the Privacy of Your Health Information

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.

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 Licensed Professional Counselors Board of Examiners, the Board has 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 Counselor'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.

Counselor'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 have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact the Louisiana Professional Counselor's Board of Examiners, 8631 Summa Ave., Baton Rouge, La. 70809 (225) 765-2515.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human 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 January 1, 2024.

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
PSYCHOLOGY AND COUNSELING

Intake Form

COUNSELING INTAKE FORM

Date: ____/____/____

Name: ____ DOB: ____/____/____ Age: ________

Address: ____

City: ____ State: ________ Zip Code: ____________

Home Phone: (_____)______________ Cell Ph: (_____)____________ Email: _______________________

Preferred Communication: ________ Emergency Contact: __________________Phone:(_____)_________

Physical History

General Health: ____

____

Are you now under a doctor's care? YES NO If yes, name of doctor: ____________________________

____

Reason for doctor's care ____

Are you taking any medication? YES NO If yes, what kind? ____________________________________

____

Reason for medication: ____

Last medical examination ____

Have you ever been hospitalized for a physical illness? YES NO Reason: _________________________

____

____

Have you ever been hospitalized for a mental illness? YES NO Reason: __________________________

____

Any recent major illnesses or surgeries?

____

____

NORTHLAKE MEDICAL
PSYCHOLOGY AND COUNSELING

Intake Form

Any recurrent or chronic conditions?

____

____

Do you smoke? YES NO Do you take non-prescribed drugs? YES NO If yes, what kind?____________

Do you drink? YES NO If yes, how much? ______________________ How often?______________

Previous psychotherapy? YES NO If yes, describe, when, where, how long, & reason:

____

____

What do you hope to achieve with therapy?

____

____

Work History

Occupation __________________________________ How long? ____________________________

If presently unemployed, describe the situation:

____

____

Hobbies/Avocations

____

____

Family Systems Information

Where Born: ____________________ How Long There: ________________ Ethnic ID: ______________

nts: Pare

Father Alive ___________ Where Residing _______________ Relationship _______________

Mother Where Residing _______________ Relationship _______________

Alive____________ # of marriages _________________ Spouse's Name _____________

Marital Status ________

With whom do you live? ____________________________How long?_________________________

Children:
#1 M F Age ____ #2 M F Age ____ #3 M F Age ____ #4 M F Age ____ #5 M F Age ____ #6 M F Age ____

Siblings: Circle your place in the family. If a sibling is deceased, put an X through the placement number. #1

M F Age ____ #2 M F Age ____ #3M F Age ____ #4 M F Age ____ #5 M F Age ____ #6 M F Age ____

Family Alcoholism or Domestic Violence? __________ Sexual Addictions or Abuse? __________________

Parents Divorced? ___________ If yes, What Year? _________Your age at the time: __________________

If deceased, what year? ___________ Your age at the time? ____________ Cause of death _____________

Any step-parents? ________ If yes, describe when and your relationship with them: ___________________

____

____

If raised by someone other than your birth parents, describe the situation in some detail:

____

____

Tell anything else in the space below that you think would be helpful for me, as your therapist, to know.

____

____

Spiritual History

Spiritual Upbringing ______________________ Present Affiliation _______________________________

Is this an important part of your life? _______Would you like this to be different?_____________________

Emotional Status

Are you currently experiencing strong emotions? _______ If yes, describe ___________________________

____

____

Do you make decisions based on your emotions? ________ How well does that work for you?

____

Intake Form

Did you have what you would consider to be childhood or other traumas? _______ If yes, describe : _____

____

____

Have you been treated for emotional disturbances? _________ If yes, when? _________________________

Have you had any thoughts of suicide? _____ If so, when? ______

Do you have any thoughts now? ________

Present Situation

Please state why you decided to come for counseling/therapy ______________________________________

____

What is the nature of your situation ____

____

What would you like to experience that is different from what you are experiencing now ________________

____

How long has this been a problem for you: ____

____

Please state what you would like to work on in therapy:____

____

DECLARATION OF PRACTICES AND PROCEDURES

Dr. Kristen UnKauf, LPC
215 St. Ann Drive Suite 2
Mandeville, La. 70471
985-951-2250

Qualifications: I earned a Ph.D. in Counselor Education in 2010 from the University of New Orleans. I am licensed as an LPC (#3492) with the LICENSED PROFESSIONAL COUNSELORS BOARD OF EXAMINERS, 8631 SUMMA AVENUE, BATON ROUGE, LOUISIANA 70809 TELEPHONE 225.765.2515.

Counseling Relationship: I see counseling as a process in which you, the client, and I, the counselor, come to understanding 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 systemic fashion toward realizing these goals.

Areas of Expertise: I focus on clients with relationship and adjustment issues, as well as general mental and emotional well-being. I am certified and specialize in the use of Eye Movement Desensitization and Reprocessing (EMDR).

Fee Scales: The fee for my services is $225.00 for the initial session and 200.00 per 50 minute follow-up sessions. Payment is due at the beginning of each session. Clients are seen by appointment only. Clients will be charged $95.00 for appointments that are broken or canceled without 24-hour notice. Payment is accepted from insurance companies. Please be advised that you are responsible for any fees that are not covered by insurance.

Services Offered and Clients Served: I approach counseling from a family systems perspective which views the family as an emotional unit of interlocking relationships which have an impact on the thinking, feeling, and behavior of each family member. I work with clients 18 years of age and older.

Code of Conduct: As a Counselor, I am required by 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 to you upon request.

Privileged Communication: Materials revealed in counseling will remain strictly confidential except for the following circumstances in accordance with state law: 1) The client signs a written release of information indicating informed consent of such a release, 2) the client expresses intent to harm him/herself or someone else, 3) there is a reasonable suspicion of abuse/neglect against a minor child, elderly person (60 or older), or a dependent adult, or 4) a court order is received directing 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 and family counseling, material obtained from an adult client individually may be shared with the client's spouse or other family members only with the client's written permission. Any material obtained from a minor client may be shared with the client's parent or guardian. I do not consent to sessions being audio or video taped.

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

Client Responsibilities: You, the client, are a full partner in counseling. Your honesty and effort are 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 may 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 from another mental health professional, I expect you to inform me of this and grant me permission to share information with this professional so that we may coordinate our services to you.

***Electronic Communication*:** As I may be professionally subscribed to various forms of social media and electronic communication, any on-line connection could compromise your confidentiality as a client. Any attempt to contact me via these methods is not in any way a vehicle to message me. Aside from telephone calls to the office (985-951-2250), please utilize the patient portal secure message feature in my electronic medical records system to send me a secure message. Please be advised that it could take up to three business days for me to access electronic messages.

Court Appearance and Records Requests: Should you wish or I am required to appear in Court or at a Deposition, you are financially responsible for my time for that appearance at a rate of $350 per hour. You are responsible for any legal fees incurred by Northlake Medical Psychology and Counseling relevant to any Court actions sought on your behalf.

Physical Health: Physical health can be an important factor in emotional well being of an individual. If you have not had a physical examination in the last year, it is recommended that you do so, and to list any medications that you are now taking.

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 is not initially aware. If this occurs, the client should feel free to share these concerns with me.
I have read and understand the above information.

Client Signature____ Date ____________________

Counselor Signature ____ Date ____________________

Linda Collings, Ph.D., MP
Kristen UnKauf, Ph.D., LPC
Alicia Seicshnaydre MSN, APRN, PMHNP-BC
Shanda Keaton 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

Card#____

Expiration Date_______________ CVC_________ Billing Zip Code________

Name on Card: ____

Client Name (if different on card):______________________________________

By signing below, I understand that I will NOT be billed to this card automatically, but only in the event that I have missed a session, not canceled an existing appointment within the required time frame or 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. If the card listed above is no longer active or expired, the most recent card used at our office will be charged.

____
Client Signature Date

Linda Collings, Ph.D., M.P
Kristen UnKauf, Ph.D., LPC
Alicia Seicshnaydre MSN, APRN, PMHNP-BC
Shanda Keaton MSN, APRN, PMHNP-BC
215 St. Ann Drive, Suite 2
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Phone (985) 951-2250
Fax (985) 951-2253
Email: info@northlakemedpsych.com

Missed Session Policy

Please review all of the information below regarding our Missed Session/Late Cancellation Policy.

FEE:

The fee for missed appointments or late cancellation is 95.00 and will be charged to either the card provided on your intake forms, or the most recent card used on file. If we are unable to charge the card on file, the payment will be accepted at the time of your next appointment.

LATE CANCELLATIONS:

Appointments cancelled within 24 hours of the scheduled appointment time will be assessed a 95.00 fee. Cancellations for ANY reason MUST be made at least 24 hours prior to your scheduled appointment time. If the 24 hour window falls on a weekend, please contact the office via email or leave a voicemail letting us know that you will be cancelling your scheduled appointment and we will follow up with you on the next business day to get you rescheduled.

MISSED SESSIONS:

Missed appointments will be assessed a 95.00 fee on the day of the scheduled (missed) appointment. The client is responsible for contacting the office to reschedule their missed appointment. Missed session fees must be paid prior to rescheduling appointments. Missed appointments with our prescribing providers may impact future refills of prescribed medications. It is the client's responsibility to follow-up with the office after a missed appointment.

RESCHEDULING AFTER A MISSED/LATE CANCELLATION:

-After 2 consecutive late cancellations, rescheduling will be at the provider's discretion.
-After 2 consecutive missed appointments, rescheduling will be at the provider's discretion. If seeing one of our prescribing providers, missed sessions may have an impact on refills of your medications.
-If you have a standing appointment with one of our providers and have 2 or more missed or late cancelled appointments, your standing appointment will be automatically removed and we will schedule you for one appointment at a time or make arrangements for an alternate day/time that may work better for you.

LATE ARRIVALS:

If you arrive late for your scheduled appointment, your appointment will still end at the designated time. If you are more than 15 minutes late, you will be rescheduled to the next available time appointment with your provider. Multiple late arrivals will be addressed during session and may result in termination of care.

Client Signature ___________________________ Date____________________