Robert Gardner, PhD, LPC 215
St. Ann Drive, Suite 2
Mandeville, La 70471
Phone (985) 951-2250
Fax (985) 951-2253

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) 6966775.

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 November 11, 2015.

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

_____ _____

Client Signature (Legal Guardian if Client is a Minor) Date

COUNSELING INTAKE FORM

Today's Date: ____/____/____

Name: _____ DOB: ____/____/____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: -_____

Home Ph: (____)_____ Cell Ph: (_____)_____ Work Ph: (____)_____

E-mail: _____ Preferred Communication: 1st: _____ 2nd: _____

Family Information

Where born? _____ How long there? _____ Ethnic ID: _____

Parents

Parents still married? YES NO Describe their relationship: _____

Parents divorced? YES NO If yes, your age at the time? _____ Reason: _____

Father alive? YES NO Where residing: _____ Relationship: _____

If deceased, what year? _____ Your age at the time? _____ Cause of death: _____

Mother alive? YES NO Where residing: _____ Relationship: _____

If deceased, what year ?_____ Your age at the time? _____ Cause of death: _____

Any step-parents? YES NO If yes, describe when and your relationship with them: _____

_____

_____

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

_____

Family-Related Trauma

Family alcoholism? YES NO Briefly describe: _____

Domestic violence? YES NO Briefly describe: _____

Sexual addiction or abuse? YES NO Briefly describe: _____

Regarding your family history please tell me anything else you think would be helpful for me to know:

_____

_____

Siblings

Circle the number to represent your place in the family. If a sibling is deceased, place an X for age:

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

Marital Status

Your marital status _____ # of marriages _____ Spouse's name _____

Living with a partner _____ How long? _____ Partner's name _____

Children

Circle the sex of each child and provide a current age. If a child is deceased place an X for age:

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

Physical Health

Describe your general health: _____

_____

Do you smoke? YES NO If yes, how long: _____ How often: _____

Do you use drugs? YES NO If yes, what kind: _____ How often: _____

Do you drink? YES NO If yes, type: _____ How much: _____

Are you currently 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, list each medication and reason: _____

_____

_____

Date of last medical examination: Month: _____ Year: _____

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

_____

Recent major illnesses or surgeries: _____

_____

Recurrent or chronic conditions: _____

_____

Work History

Presently employed? YES NO If yes, describe your present occupation: _____

_____

If presently unemployed, describe the situation: _____

_____

Spiritual History

Religious upbringing: _____ Present affiliation: _____

Is your faith an important part of your life? YES NO Please explain: _____

_____

Psychological History

Have you ever been diagnosed with a mental health condition? YES NO If so, please list diagnosis & year:

_____

_____

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

_____

Previous psychotherapy? YES NO If yes, describe reason, how long & the outcome: _____

_____

_____

_____

Emotional Status

Are you currently experiencing strong emotions? YES NO If yes, please describe: _____

_____

_____

Have you experienced any trauma in the past? YES NO If yes, please describe: _____

_____

_____

Have you had thoughts of suicide in the past? YES NO If so, how recent: _____

Do you have any thoughts now? YES NO Please explain: _____

_____

Present Situation

Please state what made you decide to come to therapy: _____

_____

_____

Describe the nature of your current mental health issue(s): _____

_____

_____

_____

How long has this been a problem for you: _____

Please describe what you want to achieve in therapy:_____

_____

_____

_____

_____

Declaration of Practices and Procedures
Dr. Robert Gardner, LPC
Northlake Medical Psychology and Counseling
215 St. Ann Drive, Suite 2
Mandeville, LA 70471
(985) 951-2250

Qualifications: I earned a Ph.D. degree from the University of New Orleans in 2008. I am licensed as a Licensed Professional Counselor (LPC) with the State of Louisiana Licensed Professional Counselors Board of Examiners which is located at 8631 Summa Avenue, Baton Rouge, Louisiana 70809; phone: (225) 765-2515. My license number is 3619.

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. Contact between client and counselor is limited to scheduled sessions unless phone or email contact is mutually agreed upon for critical situations.

Areas of Focus: Much of my experience as a Licensed Professional Counselor has been working in clinical hospital settings. I focus on helping individuals, couples, and families address a variety of mental health issues including, but not limited to, psychosocial distress (e.g., depression, anxiety) adjustment, and grief and bereavement.

Fees and Office Procedures: The fee for a 50-minute individual or couples psychotherapy session is $140. The fee for a 75-minute family psychotherapy session is $200. The per-person fee for groups varies depending upon the nature of the group. Payment is due at the beginning of each session and should be made out to Northlake Medical Psychology and Counseling. I accept cash, check, or credit/debit card (AMEX, Visa, Master Card, Discover).

Insurance from selected providers is accepted and Northlake Medical Psychology and Counseling will file the claim for the client. However, the client is responsible for any portion of the fee that is not paid by the insurance company. Discuss insurance filing procedures with the receptionist at Northlake Medical Psychology and Counseling by calling (985) 951-2250.

Appointments are typically set at the close of each session. Appointments may be scheduled, rescheduled, or cancelled with the receptionist from 8:00 a.m. to 4:00 p.m. Monday through Thursday by calling (985) 951-2250. After hours, the client may email the counselor at rgardnerphd@gmail.com to cancel an appointment.

If the client is unable to attend a scheduled session, the client should contact the counselor at least 24 hours prior to the appointment time to avoid being charged for that session. The fee for a missed session is $95.00.

Services Offered and Clients Served: I approach counseling from a variety of theories depending on the individual needs of the client. However, I tend to use an integrative approach to counseling that includes cognitive-behavioral, acceptance-based, and solution-oriented therapies. Additionally, I incorporate into the counseling session mindfulness practice as a way to heighten awareness and promote relaxation. I provide mental health counseling to clients in a variety of formats, including individuals, couples, families, and groups. I work with adults over the age of 18 from all socioeconomic backgrounds.

Limitations of Therapy: Therapy is available to adult clients only as individuals and couples. Family therapy may include an individual(s) under the age of 18; however, when a client is under the age of 18, that individual's parent must be present in therapy at all times. Another limitation of therapy involves the scope of the client's presenting issue(s). Because the client's presenting issue(s) is not fully known until therapy begins, the number of therapy sessions cannot be determined upfront.

Focus of Therapy: Depending on the client's presenting issue(s), the focus of therapy can change from one session to the next. The reason for the shift in the focus of therapy is to address the most immediate need(s) the client brings into a session and to make the therapeutic process as effective as possible.

Code of Conduct: As a Licensed Professional Counselor (LPC), 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.

Confidentiality: Material revealed in counseling will remain strictly confidential except for material shared under the following circumstances in accordance with the law:

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

In the event of marriage or 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 permission. Any material obtained from a minor client may be shared with that client's parents or guardian.

Privileged Communications: 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.

Emergency Situations: Should you believe you are in need of immediate help and/or believe you have suicidal thoughts that you could act upon, you should go to the emergency room of the nearest hospital and ask for psychiatric services or by calling 911. In addition, you can call the COPE line at 800-749-2673 to receive assistance.

Client Responsibilities: You, the client, are a full partner in counseling. Your honesty and full participation is essential to a successful outcome. As we work together, if you have suggestions or concerns about your counseling, I expect you to share these with me so that we can make the necessary changes. Should it develop 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 fact and grant me permission to share information with this professional so that we may coordinate our services to better serve your needs.

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 communicate with me. Aside from telephone calls to the office at (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 to access any electronic messages and reply.

Court Appearances and Records Request: 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 $250 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 the emotional well-being of an individual. Please contact your physician to make sure you are physically able to engage in counseling. Also, please provide me with a list of the medications you are currently taking.

Potential Counseling Risk: The client should be aware that counseling poses potential risks. In the course of the counseling process, unanticipated problems or issues may surface of which the client may not initially be aware. If this occurs, the client should feel free to share these new concerns with me to be discussed during counseling.

Termination: The client and/or mental health counselor may terminate the counseling relationship when it is reasonably clear that the client is no longer benefiting, when services are no longer required, or when counseling no longer serves the needs and interests of the client.

I have read and understand the above information. My signature below indicates my full informed consent to services provided by Dr. Robert Gardner, LPC.

_____ _____/_____/_____

Client Signature Date

_____ _____/_____/_____

Robert Gardner, Ph.D., LPC Date

Linda Collings, Ph.D., MP
Kristen UnKauf, Ph.D., LPC
Robert Gardner, PhD., LPC 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 call 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 (Circle): 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 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