the Psychology clinic

PLEASE COMPLETE ALL PAPERWORK AND RETURN TO OUR OFFICE:

The Psychology Clinic
2000 Southwood Drive
Lake Charles, LA 70605

THANK YOU FOR CONTACTING OUR OFFICE

WE HAVE SET YOUR APPOINTMENT FOR:

PLEASE COMPLETE AND RETURN THE ENCLOSED FORMS TO OUR OFFICE BY:

IF WE ARE HOLDING AN APPOINMENT TIME AND DON'T RECEIVE THE FORMS 48 HOURS IN ADVANCE OF THE APPOINTMENT TIME WE'LL CANCEL YOUR APPOINTMENT. UPON RECIEIVING YOUR PAPER WORK WE'LL THEN CONTACT YOU TO RESCHEDULE.

PLEASE ARRIVE 15 MINUTES EARLY SO WE CAN MAKE COPIES OF INSURANCE CARDS.

AGREEMENT TO PAY
ONCE AN APPOINTMENT IS SCHEDULED I UNDERSTAND IT'S MY RESPONSIBILITY TO NOTIFY THE OFFICE ABOVE 24 HOURS BEFORE THE SCHEDULED APPOINTMENT TIME IF I CHOOSE TO NOT KEEP THE APPOINTMENT OR IF I NEED TO RESCHEDULE DUE TO UNFORSEEN DIFFICULTIES. I AGREE TO PAY THE NON-REFUNDABLE FEE OF $50 (LCSW/LPC) or $75 (Ph.D) IF I GIVE LESS THAN 24 HOURS NOTICE OR IF I DO NOT SHOW UP FOR MY SCHEDULED APPOINTMENT.

_____ _____
(Print Name) (Date)

_____ _____
(Signat ure of Responsible Party) (Date)

Assignment of Insurance Benefits
Acknowledgement of Indebtedness
& Consent to Release Information

Insured Patient: _____
(Please Print)

For services provided, I hereby irrevocably assign and transfer to The Psychology Clinic of Lake Charles, LA, my rights and interest in all benefits due under the applied insurance policy or in my rights against any third party who might be held liable for the services described in the statements rendered by the hospital.

I hereby consent that The Psychology Clinic may release information concerning the above party and furnish copies of my records if requested by the insurance company. I hereby release The Psychology Clinic from legal responsibility or liability for furnishing such records or information to the extent indicated and authorized herein. I acknowledge that the Law of the State of Louisiana controls and governs the interpretation of this agreement.

I understand that I am personally and directly responsible for all bills submitted by The Psychology Clinic for professional services rendered to me and that I have the primary duty and obligation to pay my doctor for these services, notwithstanding any contract that I may have with any third party, such as an insurance company, employer, union or the government.

_____ _____ _____
Date Signature Relationship to Patient

Person Responsible for Payment

I understand that I am personally and directly responsible for all bills submitted by The Psychology Clinic of Lake Charles for professional services rendered to me and that I have the primary duty and obligation to pay my doctor for these services, notwithstanding any contract that I may have with any third party, such as an insurance company, employer, union or the government.

I hereby stipulate and agree to pay all cost of collections or attorney fees and court fees should it becom e necessary to resort to court action or turn my account over to a collection agency.

_____ _____
Date Signature

In order to control our costs of billing, office visits are to be paid at the time the service is rendered.

ADULT INTAKE FORM

THE PSYCHOLOGY CLINIC
2000 SOUTHWOOD DRIVE, LAKE CHARLES, LA 70605

DATE: _____

IDENTIFYING INFORMATION:
Client Name: _____
Address: _____
Date of Birth: _____

Contact Information: Indicate your preferred means of communication:

		OK to leave a message:	
Cell Phone:	_____	YES	NO
Home Phone:	_____	YES	NO
Work Phone:	_____	YES	NO

Emergency Contact Information:

In case of emergency, I give permission for the following party to be contacted:
Name: _____
Relationship: _____
Phone: _____

Does this person know you are coming to therapy? YES NO

PSYCHO-SOCIAL HISTORY

The following information is requested in order that your therapist may develop an initial understanding of the issues for which you are seeking counseling. It is okay to leave questions unanswered if you do not know an answer or are uncomfortable providing the information.

PRESENTING PROBLEM (reason you are seeking counseling):
Please provide a brief description of the problems you are experiencing:

_____
_____
_____
_____

How long have you been experiencing these problems? If possible, provide the approximate date/time-period during which you first began to have concerns about these issues.

_____
_____
_____

PSYCHIATRIC/MENTAL HEALTH HISTORY

Have you received previous counseling for these or other concerns? YES NO
Approximate dates of treatment: _____

Have you ever received psychiatric out-patient treatment? YES NO
Approximate dates of treatment: _____

Have you ever been hospitalized for mental health issues? YES NO
Approximate dates of hospitalization/s: _____
_____

Is there a family history of psychiatric problems? YES NO
If you are able, please provide the relationship of family member/s and the diagnosis/es.
_____
_____
_____

Have you experienced any trauma, recently or in the past? YES NO
If so, please provide a brief description and time frame of the event/s.

_____
_____

MEDICAL CONDITIONS/HISTORY:

Please list your current medical providers:

Primary Care Physician: _____

Psychiatrist: _____

Other: _____

Please provide a brief explanation of any chronic medical conditions:

_____

_____

_____

Have you experienced any significant injuries or illnesses recently or in the past? If so, please provide a brief explanation.

_____

_____

_____

_____

_____

Please list current medications:

Medication	Dose	Prescribing Physician:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If necessary, please use an additional sheet of paper to complete medication list.

SUBSTANCE USE:

Have you received substance abuse treatment previously? YES NO

If so, approximate dates?

_____

Do you drink alcohol? YES NO

Approximately how many drinks per week? _____

Do you use any substance other than alcohol? YES NO

FAMILY HISTORY:

Were you raised by your: Birth parents? YES
Another: _____ (Relationship)

Are both your parents still living? YES NO
Date of death: Mother _____ Father _____

Are/were your parents divorced? YES NO
Your age at time of divorce: _____

RELATIONSHIP HISTORY:

Are you currently married or in a committed partnership? YES NO
Date met current partner/spouse: _____
Date married/committed to current partner/spouse? _____

Are you currently experiencing difficulty with your relationship? YES NO

Have you previously been in a committed relationship/marriage? If more than one previous relationship/marriage, please provide dates for each:

Date married/committed:	Date separated/divorced
_____	_____
_____	_____
_____	_____

Please list your children and dates of birth:

_____
_____
_____
_____
_____

Are there any other children in your household? YES NO
If so, please indicate relationship to you or your partner/spouse.

_____
_____
_____

SOCIAL HISTORY:

Are you active in any social/civic/religious organizations? YES NO

Do you enjoy supportive friendships? YES NO

DEVELOPMENTAL HISTORY:

Provide a brief explanation of any significant developmental delays/learning difficulties in childhood:

_____

_____

Provide a brief explanation of any life situations which interfered with your education:

_____

_____

_____

EDUCATIONAL/OCCUPATIONAL HISTORY:

Highest level education:(Please circle)

High School:	Attended	Graduate		
College:Attended	Graduate	Bachelors	Masters	Doctorate

Current Employer: _____

Job Title: _____

LEGAL HISTORY:

Are you currently involved in any legal proceedings? YES NO

If so, please indicate the nature of the legal proceeding:

Family/divorce/custody: _____

Criminal: _____

Civil: _____

Do you have any previous convictions? YES NO

Please complete the symptom checklist on page 6.

Thank you for your time in completing this information packet. This information is kept strictly confidential.

Client Name: _____
Date: _____

Form completed by (if other than client): _____

Check the following symptoms/ behaviors you are currently experiencing (have been occurring in recent weeks or regularly for the past 2 to 3 months):

Physical Symptoms

____ Insomnia
____ Nightmares
____ Headaches
____ Weight loss
____ Too much sleep
____ Too little sleep
____ Loss of appetite
____ Weight gain

Mood

____ Angry
____ Quarrelsome
____ Depressed
____ Tired
____ Withdrawn
____ Lonely
____ Drastic & quick mood changes
____ Feeling inferior
____ Irritable
____ Not enjoying things
____ Lack of interest
____ Detached

Behavior

____ Shy
____ Impulsive
____ Lethargic
____ Have run away
____ Physically abusive
____ Verbally abusive/threatening
____ Problems with drugs/alcohol
____ Cheating/lying
____ Legal problems
____ Sexual problems
____ Unassertive
____ Blaming of others
____ Uncommunicative

____ Compulsions
____ Physically abused
____ Verbally abused
____ Difficulty in relationships
____ Controlling/domineering
____ Demanding

____ Opposition to authority
____ Irresponsible
____ Lack self-control
____ Make inappropriate noises
____ Violent
____ Temper outburst
____ Failing at school
____ Behavior problems at school
____ Attention seeking
____ Unusual sexual behavior
____ Work difficulties
____ Dangerous behaviors
____ Damaged/stolen property of others
____ Overeating
____ Binging/purging
____ Gambling Excessively

Anxiety

____ Nervous
____ Anxious
____ Stressed
____ Phobic
____ Worry a lot
____ Panic
____ Frustrated easily
____ Tense
____ Shaky/Jittery

Thought

____ Seeing/hearing things that aren't there
____ Suicidal thoughts
____ Homicidal thoughts
____ Want to run away
____ Difficulty concentrating
____ Distractible & inattentive

____ Lack of trust
____ Feelings of unreality
____ Forgetful
____ Difficulty with memory
____ Lack self-esteem
____ Obsessive thoughts
____ Spiritual confusion
____ Racing Thoughts

the Psychology clinic

Patricia D. Post, Ph.D.
Jodie Guth, Ph.D.
Jerry Whiteman, Ph.D.
Clarke McLaughlin, L.P.C., L.M.F.T., L.A.C.
Alice P.Williams, L.P.C., L.M.F.T.
Brenda Hollenbeck, L.P.C., L.M.F.T.
Brenda LaFleur, L.C.S.W.

For Your Information

We have prepared this form because we want you to know your rights and responsibilities as a client. Please read this information and sign at the end. Your signature documents that you have read and that you understand this information. We will be pleased to answer any questions you have regarding this or any related material.

Fees & Payment

The fee for an Intake first appointment is $150 for a Clinician or $190 for a Psychologist (Ph.D.); following appointments are $100 for a Clinician or $190 for a Psychologist (Ph.D.) per visit. There may be charges for other services such as testing, court appearances or depositions, reports, phone calls exceeding ten minutes with you or third parties (attorneys, doctors, insurance carriers, and managed care reviewers). Payment is expected at the time of service.

Missed Sessions

We will try to call you to verify your appointment a day in advance. It is your responsibility, however, to call and cancel an appointment at least 24 hours in advance to avoid being billed for missing a session. Missed session fees are half of the fee for a regular visit: $50.00 for a Clinician and $75.00 for a Psychologist (Ph.D.). Fees for a missed session are NOT covered by insurance.

Insurance

The charges for our services are covered to varying extents by most health insurance policies. Our billing office is happy to assist you in filing with your insurance carrier for reimbursement. Our contract for payment, however, is with the client and NOT with the client's insurance carrier.

Insurance coverage varies a great deal among different policies. We will be happy to contact your insurance carrier for you and verify your coverage. The basic questions to be answered include:

- Is there a deductible to be met?
- Are outpatient mental health benefits covered and is pre-certification necessary?
- What percentage of the fee will the insurance cover, and is there a limit on the eligible charges?
- Is there a limit on the number of sessions allowed?
- Are reviews by managed care required?
- If there is more than one insurance company, are there special rules to follow?

Clients must make full payment at the time service is rendered until the deductible has been met. Thereafter, clients must pay their co-payment amount and we will submit claims to the

insurance company for the remaining amount. It is the client and NOT the insurance company who is ultimately responsible for payment.

Insurance companies require that a diagnosis be provided in order for a claim to be processed. In some cases, insurance companies will not pay for a certain diagnoses. If you have any concerns about your insurance billing, please feel free to discuss them with our staff.

Confidentiality

Any information that you reveal to your therapist is considered "privilege communication", and it is your right to have that information kept confidential. Mental health professionals are not allowed to release any information about clients without a signed "Release of Information" form that permits the transfer of specific information to a specified individual. This form is valid for one year.

There are only rare situations in which information about clients may be released with or without the client's permission. These situations are as follows:

- When a child is physically abused, neglected, or sexually abused, we are required by law to contact the proper authorities (Police, State Department of Family Services).
- When a client or another individual is in clear and immediate life threatening danger as with homicide or suicide, we are required by law to take steps to insure their safety, even if it means contacting authorities without the client's permission.

In addition, there are situations in which the client is involved in civil or criminal litigation where the therapist and his/her records can be subpoenaed, particularly when the client is suing someone for damages based on emotional injury or when the client is involved in a child custody proceeding.

Emergency Coverage

Each therapist can be reached during office hours at (337)474-2682. After ours, the phone will be transferred to an answering service that will locate either your therapist or the therapist on call for emergency situations. Please let the operator know if your call is an emergency. When your therapist is out of town, he/she will make arrangements for another therapist to cover crisis situations. In the unlikely event that your therapist and the on-call therapist cannot be reached quickly in an emergency, you may consider calling your family physician, a local hospital, or the Lake Charles Mental Health Center at (337)475-8022

I have read and I understand the office policy.

_____ _____

Signature Date

_____ _____

Witness Date

Insurance Information

Clinician: Appointment Date:

Patient Name: DOB: SSN:

Patient Address: City: State: Zip:

Phone: (_____) _____ Alternate Phone: (_____) _____

Insurance Company:_____ Phone: (_____)_____

Subscriber ID: _____ Group No: _____

Subscriber's Name: _____ DOB: _____ SSN: _____-_____-_____

Subscriber's Address: _____ City, State, Zip: _____

Phone: (_____) _____ Alternate Phone: (_____) _____

Employer:_____

OFFICE USE ONLY
Effective Date:_____

Co-Pay/Co-Insurance: _____

Deductible:_____ Deductible Met?:_____

No. of Visits:_____

Authorization:_____

Out of Pocket _____

Psychological Testing Covered the Same?_____

Mail Claims To:

_____

_____

DECLARATION OF PRACTICES AND PROCEDURES

Brenda T. Hollenbeck, M.A., LPC, LMFT
The Psychology Clinic, 2000 Southwood Drive, Lake Charles, LA 70605
337.474.2682

I am pleased that you have chosen me for your mental health counselor. This document is designed to inform you of my background and ensure that you understand our professional relationship.

Qualifications

I hold a Master of Arts degree in Psychology from McNeese State University. I hold License #2693 as a Licensed Professional Counselor and License #182 as a Licensed Marriage and Family Therapist with the LPC Board of Examiners, 8631 Summa Avenue, Suite A, Baton Rouge, Louisiana, 70809, telephone (225) 765-2515.

Clients Served

I primarily counsel with adults of all backgrounds, including geriatric clients. I generally do not work with children under 17 years of age. I provide individual, couple, family, and group therapy.

Areas of Focus

I have a general mental health practice and see clients with a variety of concerns, including depression, anxiety, marital, family and other relationship issues, stress, growth issues, parenting concerns, grief, and abuse issues (sexual, physical, and emotional).

Counseling Relationship (What to Expect from Therapy)

My goal as a counselor is to provide a safe, caring, and supportive environment that facilitates the client's self-awareness, personal growth, and improved mental health and emotional functioning. I view counseling as a process in which the client and counselor work together in an atmosphere of trust and honesty, define problem situations, develop future goals for life satisfaction, and work in a systematic fashion toward realizing those goals. This process occurs at different rates for different individuals; the client may choose to end the counseling relationship at any point. If I believe that our counseling sessions have become non-productive, I will discuss this matter with you and will provide referral information if necessary.

I use a variety of therapeutic approaches, depending on client need. I use cognitive-behavioral techniques, exploring the client's pattern of thoughts and actions, and assisting the client in developing alternative patterns. I also work with clients from a family systems perspective, exploring family interaction and dynamics, and behaviors learned in the family of origin, assisting the client to develop healthier behaviors and relationships.

Clients must make their own decisions regarding such things as deciding to marry, separate, divorce, reconcile, and how to set up custody and visitation. I will not offer specific advice but will assist my clients in problem solving and exploring possibilities and consequences.

Appointments are usually scheduled once per week initially for approximately 45-60 minutes, depending upon insurance coverage, with the first session devoted to gathering necessary information. The client and therapist may choose to increase the amount of time between sessions as therapy progresses. The time required to complete therapy is highly individualized, but on average the therapy process may take 12-20 sessions.

Client Responsibilities

I expect the client to fully participate in therapy by adhering to the following guidelines:

1. Follow procedures for making and keeping appointments.
2. Pay for the services at the time of each visit.
3. Participate equally in the counseling relationship, including participating in homework assignments or other self-help activities as recommended by me and agreed upon in session.
4. Notify the counselor of any other ongoing professional mental health relationships and terminate the counseling relationship before seeing another mental health professional.
5. Provide honest feedback concerning the professional relationship.

Code of Conduct/Ethics

I am required by state law to adhere to the Louisiana Code of Conduct for Licensed Professional Counselors and the Louisiana Code of Ethics for Licensed Marriage and Family Therapists that have been adopted by my licensing board. Copies of these Codes are available upon request.

Confidentiality

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

1. The client signs a written release of information indicating informed consent of such release. In the event of couples/family/group counseling, I cannot release information without written permission from every individual involved. Also note if you use third party insurers, such as health insurance policies, HMO or PPO plans, or EAP programs, you must sign a release of information and all required information will be disclosed.
2. The client presents a serious imminent physical threat to self or a specific other person.
3. There is a reasonable suspicion of abuse/neglect against a minor child, elderly person (65 or older), or a disabled/dependent adult.
4. A court ordered subpoena is received directing the disclosure of information. Certain types of litigation (such as child custody suits) may lead to the court-ordered release of information without your consent.
5. 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 written permission. Any material obtained from a minor client may be shared with that client's parents or guardian.

Privileged Communication

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

After Hours and Emergency Situations

A 24-hour answering service is available to handle after hour calls or emergency situations; call 337-474-2682. During normal working hours messages can be left on the voice mail if the receptionist is unavailable. If you are experiencing an emergency and need immediate attention you can call 911 or the hospital of your choice, including: Christus Ochsner St. Patrick (337.436.2511), Lake Charles Memorial Hospital (337.494.3000), or West Calcasieu Cameron Hospital (337.527.7034).

Fees and Appointments

1. A fee for service and methods of payment are determined by The Psychology Clinic. Inquiries regarding insurance status or method of payment may be made to the front office personnel.
2. Fees for written reports, letters, etc., are not reimbursable through insurance and are the responsibility of the client. Excepting initial letters of referral, reports requested by entities such as the court, attorneys, employers, insurance companies, etc., will be billed at the minimum as the hourly counseling fee per hour required to complete the report. Special arrangements for a reduced fee can be made regarding financial hardship but must be approved by your therapist.
3. Fees for court appearances and depositions are established by The Psychology Clinic; please request this information from the office manager if needed.
4. Telephone counseling lasting more than 15 minutes will be billed at the hourly counseling rate and may not be covered by insurance. If you have need of such service, please check with the office manager regarding your insurance benefits.
5. Appointments are scheduled through the front office and are generally scheduled for 45-60 minutes. Failed appointments without 24 hours' notice will result in a charge of $50.00. The Psychology Clinic will notify you if this fee is increased or decreased. Insurance companies will not cover this charge and payment for failed appointments is your responsibility.

Physical Health

Physical health can be an important factor in the emotional well-being of an individual. Any client who has not obtained a physical examination within the past year is encouraged to obtain one as soon as possible. Clients are asked about current medical conditions and prescriptions on our intake forms.

Potential Counseling Risks

Clients should be aware additional issues might surface during therapy which were not known prior to the beginning of the counseling relationship. This may temporarily produce additional distress. When a client is involved in a marriage or other intimate relationship, it is possible that therapeutic change or growth in one partner, unless accompanied by reciprocal change in the other, may produce additional stress in the relationship. We can address these changes and stressors in therapy.

Brenda T. Hollenbeck, LPC, LMFT, LLC

The Psychology Clinic
2000 Southwood Drive, Lake Charles, LA 70605
337.474.2682 fax 337.474. 4601

RECEIPT OF DECLARATION OF PRACTICES AND PROCEDURES

I have received and reviewed a copy of the Declaration of Practices and Procedures for Brenda Hollenbeck, LPC, LMFT. I agree to the conditions set forth in this declaration.

_____ _____
Client's signature Date

I, (signature of parent or guardian) _____ give permission for Brenda Hollenbeck to conduct counseling with (name of minor) _____.

the Psychology clinic

Patricia D. Post, Ph.D.
Jodie Guth, Ph.D.
Jerry Whiteman, Ph.D.
Brenda LaFleur, L.C.S.W.
Clarke McLaughlin, L.P.C., L.M.F.T., L.A.C.
Alice P. Williams, L.P.C., L.M.F.T.
Brenda Hollenbeck, L.P.C., L.M.F.T.

Privacy Consent

I understand that as a condition to my receiving treatment at The Psychology Clinic, The Psychology Clinic may use or disclose my protected health information for the purposes of 1) providing treatment and 2) obtaining payment for treatment, and 3) as necessary for the operations of The Psychology Clinic. These uses and disclosures are explained more fully in the Notice of Privacy Practices, which has been provided to me and which I have had the opportunity to review.

I understand that the privacy practices described in the Notice of Privacy Practices may be revised in the future, and that I have a right to request from The Psychology Clinic a copy of any revised Notice.

_____ _____

Name Date

_____ _____

Witness Date

2000 Southwood Drive · Lake Charles, LA 70605 · Phone 337-474-2682 · Fax 337-474-4601