THE FAMILY TREE

INFORMATION, EDUCATION & COUNSELING CENTER

Today's Date: ____/____/____

APPLICATION FOR A MINOR

Has your child ever participated in counseling before at The Family Tree? ☐ No ☐ Yes

Are you the Domiciliary (Custodial) Parent? ☐ **YES** ☐ **NO**

DOMICILIARY PARENT INFORMATION:

_____ _____ _____
(Last Name) (First Name) (Maiden, if applicable)

Mailing Address: _____

Physical Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Parish:** _____

Preferred phone number: _____ ☐ **Cell** ☐ **Home** ☐ **Business** **Email address:** _____

CHILD INFORMATION:

Child's Name: _____ _____ _____
(Last Name) (First Name) (Middle)

Child's Date of Birth: ____/____/____ **Age:** _____ **Child's Social Security Number:** ____-____-____

Referred by:

☐ Re-Opened Case
☐ Mental Health Center
☐ Doctor
☐ Other Therapist
☐ Another Client
☐ Court System/Attorneys
☐ Newspaper/TV
☐ Friend /Family Member
☐ School Personnel
☐ Insurance ☐ EAP
☐ Hospital
☐ United Way Agency
☐ Telephone Directory
☐ The Family Tree Newsletter
☐ Website
☐ Dept. of Children & Family Services
DCFS Case Worker: _____

Type of Counseling: ☐ Individual ☐ Parent & Child ☐ Family

***The first session is reserved for parents.* Who will attend subsequent sessions?**

Name	Age	Nature of Relationship

For Office Use Only:

Additional Notes: _____

PLEASE DO NOT WRITE IN THIS BOX. THIS INFORMATION WILL BE COMPLETED BY OUR STAFF.

Place of employment: Gross Annual Income: $

Place of employment (Spouse): Gross Annual Income: $

Child Support, AFDC (food stamps), TANF, Retirement, Alimony, SSI or SS, Unemployment or Other:

Payment Information
☐ Cash ☐ Check # _____
☐ Visa ☐ MC
In-take co _____
Total Amount Paid: _____

HOUSEHOLD'S TOTAL ANNUAL INCOME: $ _____

Number of Persons Living in Household: _____

FEE PER SESSION: $ _____

NON REFUNDABLE PROCESSING FEE: $ _____

TOTAL AMOUNT DUE : $ _____

Revised10/2512 wil

*Use separate credit card slip to gather information.

PLEASE INITIAL THAT THE ABOVE INFORMATION IS CORRECT _____

FLIP OVER TO BACK PAGE

THE FAMILY TREE

INFORMATION, EDUCATION & COUNSELING CENTER

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Sex: ☐ Male ☐ Female **School Child Attends:** _____ **Grade:** _____

Race: ☐ White ☐ Black or African-American ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic or Latino (of any race) ☐ Other _____

Does your child have a disability (a condition that impacts mental or physical functioning?) ☐No ☐ Yes (please indicate) _____

How did you get here today? ☐ Taxi ☐ Own Transportation ☐ Feet/Walk ☐ Public Transportation ☐ Family/Friend

What are the reason(s) for seeking counseling at this time? Please check all that apply:

☐ Marriage/Partner	☐ Job	☐ Anxiety Level/Nerves	☐ Financial Situation
☐ Family	☐ School	☐ Mood	☐ Legal Situation
☐ Friendships	☐ Addictions	☐ Ability to Control Temper	☐ Other: _____

1. Is there a history of alcohol and/or drug abuse in your family? ☐ No ☐ Yes, **by whom?** _____
2. In general would you say your child's health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
3. In the past 6 months, how many times did your child visit a medical doctor? _____

Has this child ever participated in counseling before? ☐ No ☐ Yes, **for what reason?** _____

_____

When? _____ **With whom?** _____ **Where?** _____

Was the counseling helpful? ☐ No ☐ Yes

Is your child on any medication? ☐ No ☐ Yes

Name of medication:	Prescribed by:	Reason for:	Dosage:	Length of time taken:

As a parent, please indicate which of the following external assets your child is exposed to:	Never	Seldom	Some times	Almost always
1. Our family life provides high levels of love and support.	1	2	3	4
2. My child spends three or more hours per week in sports, clubs, or organizations.	1	2	3	4
3. My child receives support from three or more nonparent adults.	1	2	3	4
4. As a parent, I am actively involved in helping my child succeed in school.	1	2	3	4
5. Our family has clear rules and consequences, and we monitor my child's whereabouts.	1	2	3	4
6. As a parent, I and other adults model positive, responsible behavior.	1	2	3	4
7. My child's best friends model responsible behavior.	1	2	3	4
8. As a parent, I communicate positively with my child, and my child is willing to seek advice and support from me.	1	2	3	4

What do you hope your child is able to achieve as a result of counseling? (Please check all that apply):

☐ Communication Skills	☐ Conflict Resolution	☐ Addiction Education	☐ Anger Management Skills
☐ Parenting Skills	☐ Stepfamily Support	☐ Grief Resolution	☐ Stress Management Skills
☐ Co-parenting Skills	☐ Divorce Adjustment	☐ Resolve Mood Issues	☐ Other: _____

Your signature below indicates that you understand that THE FAMILY TREE must receive the court documents regarding domiciliary custody of the minor child before the next appointment. **My signature also indicates all information provided is accurate and true.**

☐ **No legal documents regarding custody exist at this time.**

Signature of Responsible Party: _____ **Date:** _____

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INSURANCE FORM

Client Name: _____ Client DOB: _____

Name of Insured: _____ Insured DOB: _____

Insured's Address: _____
Street address

_____
City State Zip

Insured's Employer: _____

Insured's Social Security Number: _____–_____–_____

INSURANCE COMPANY INFORMATION

Name: _____

Address: _____

Policy #: _____ Group #: _____

Insurance Company's Phone Number: _____

AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY

I authorize The Family Tree to release any information necessary to the above named insurance company for payment, and I authorize that benefits be made payable to the agency on my behalf.

Signature of Responsible Party: _____ Date: _____

For Office Use Only:

Billing address: _____
_____
_____

Co-pay: ☐ No ☐ Yes, amount $ _____

Authorization #: _____

# of approved sessions: _____

Verified by: _____

Billing form: _____ CPT initial: _____

Follow: _____

Deductable: _____ Met: ☐ No ☐ Yes

Contracted rate: _____

Effective date: _____

Exclusions: _____

NO SHOW OR LATE CANCELLATION POLICY

I understand and agree that I will be charged the contracted rate per session. Since The Family Tree cannot bill insurance companies for sessions not attended, I understand that I will be responsible for the full contracted rate in the event of a no show or late cancellation.

Signature of Responsible Party: _____ Date: _____

☐ Client given a copy.

Revised 7/21/2011 jb

EMPLOYEE ASSISTANCE PROGRAM (EAP) FORM

Participant Name: _____ Participant DOB: _____

If individual is a minor, name of Responsible Party: _____

Participant's Address: _____
Street address

_____
City State Zip

Employer: _____

Participant's Social Security Number: _____–_____–_____

EAP COMPANY INFORMATION

Name: _____

Address: _____

EAP's Phone Number: _____

AUTHORIZATION TO RELEASE INFORMATION TO EAP

I authorize The Family Tree to release any information necessary to the above named EAP for payment, and I authorize that benefits be made payable to the agency on my behalf.

Signature of Responsible Party: _____ Date: _____

For Office Use Only:

Billing address: _____
_____
_____

Billing instructions: _____
_____
_____

Authorization #: _____

# of approved sessions: _____

Effective date: _____

Verified by: _____

Revised 7/21/2011 jb

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THE FAMILY TREE

COUNSELING SERVICE POLICIES

Regarding Arrival Time: Please arrive on time. All appointments are scheduled at the top of each hour and last 50 minutes.

Regarding Children: We are pleased to offer counseling services for members of the entire family. When parents are in a counseling session, we require parents to arrange for another responsible adult to care for minor children age 16 and under. When minor children are in a counseling session, we require that a parent will remain in the waiting room until the session ends.

Regarding Rescheduling: Clients are encouraged to reschedule a follow-up appointment at the end of each counseling session.

Regarding Missed Appointments:

- Clients will be charged their full session fees in the event of:
  - Appointments cancelled **LESS THAN 24 HOURS IN ADVANCE**.
  - **NOT SHOWING UP** for a scheduled appointment.
- Payments for missed appointments **MUST** be paid in full before the next appointment can be scheduled.
- If you would like to request a waiver of fee, please provide a written explanation of reason for missed appointment along with appropriate documentation to:

The Family Tree
Attn: Director of Clinical Services
P. O. Box 62904
Lafayette, LA 70596

To cancel or reschedule and appointment, please call 337-981-2180.

Regarding the Counseling Process: We welcome the opportunity to serve as a host agency for graduate students in the mental health disciplines. As a training site, students have the opportunity to experience the breadth of our agency. By training alongside the multidisciplinary staff, students have the opportunity to attain vast knowledge and practical skills. Master's level graduate students in the helping professions (counseling, social work, psychology) from area universities such as Louisiana State University, University of Louisiana at Lafayette, and Nichols State University may provide counseling services at The Family Tree. These counselors-in-training are provided direct supervision at their universities as well as agency supervision by The Family Tree clinical staff. To provide clients with the best possible care, the counseling process may involve various practices including a team approach. When clients receive agency services which are to be provided by a counselor-in-training, it is the practice of the agency to inform the client.

I have read and I understand this policy statement. Furthermore, I acknowledge that I have been given a copy of this policy statement.

Client's Name: _____

Printed Name of Responsible Party: _____

Signature of Responsible Party: _____ Date: _____

☐ Client given a copy.

Revised 2/3/16 jb

THE FAMILY TREE

INFORMATION, EDUCATION & COUNSELING CENTER

TREATMENT CONSENT FORM

Consent to Use and Disclose Your Protected Health Information
For Treatment, Payment, and Healthcare Operations

Statement of confidentiality: The Family Tree Information, Education & Counseling Center will not share information with any person outside of the agency without your *written permission*, except as required by law or in a situation deemed potentially life threatening.

Notice of Privacy Practices: The Family Tree Information, Education & Counseling Center understands that mental health information about you is personal. We comply with Louisiana State and Federal Laws concerning personal health information. We are providing you with a copy of our Notice of Privacy Practices.

Treatment, Payment, and Healthcare Operations: As we provide services to you, we will be collecting and retaining information about you in your record. This information is referred to as Protected Health Information or PHI. By signing this consent form, you are allowing us to use and disclose this PHI, as referenced in our Notice of Privacy Practices, for treatment, payment, and health care operations (TPO), as allowed/required by law. If you do not sign this consent form, allowing us to use and disclose your PHI for TPO, we will not be able to treat you. This is necessary for us to provide you with quality care. For example, we need to be able to use and disclose this information to be able to decide on the best treatment options for you, to receive payment, and for other business and government functions. Any uses or disclosures, beyond that which are described in the Notice of Privacy Practices, will require that you sign a *separate authorization*. Please read the notice of Privacy Practices carefully. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain. You may request a copy of the revised Notice at any time.

Contact with you: With this consent, The Family Tree may call and leave a message on voice mail or in person, mail, or email my home or other alternative location in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, billing statements, follow-up letters, and any calls pertaining to my clinical care.

Request to restrict disclosures: If you are concerned about some of your mental health information being used or disclosed, as outlined in the Notice of Privacy Practices, you have a right to request, in writing, a restriction or limitation on the mental health information we use or disclose about you for treatment, payment, or health care operations. However, we are not required to agree to your request. If we do agree to your request, we will comply with your request unless the information is necessary to treat you, is needed to provide you with emergency treatment, or if complying with the request is against the law. After signing this request, you have the right to revoke it (by submitting the request in writing) and we will comply with the request, with the understanding that we cannot take back any uses or disclosures that may have already been made with your permission, and that we are required to retain our records of the care that we have provided you.

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices for The Family Tree. In addition, I have read and I understand this consent form.

Client's Name: _____

Printed Name of Responsible Party: _____

Signature of Responsible Party: _____ Date: _____

Signature of Agency Representative: _____ Date: _____

FOR OFFICE USE ONLY:
A good faith effort was made to obtain from the client a written acknowledgment of his/her receipt of the Notice of Privacy Practices; however, I was unable to do so as documented below.

Reason: _____

Employee Name: _____ Date: _____

Revised 8/18/2011 jb

THE FAMILY TREE
INFORMATION, EDUCATION & COUNSELING CENTER

NOTICE OF PRIVACY PRACTICES

In compliance with Federal Law, Effective: January 1, 2011

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THIS NOTICE

This notice describes the Agency's practices and that of:

- All employees, staff, volunteers, contractors, and other personnel.
- All departments and units of the agency.
- Any members of a volunteer group we allow to help you while you are our client.
- All entities, sites, and locations will follow the terms of this notice. When this notice refers to "we" or "us", it is referring to the following entities, sites, and locations. In addition, these entities may share PHI with each other for treatment, payment, or health care operation purposes described in this notice.
- Counseling sites in New Iberia, Abbeville, and Lafayette.

OUR DUTIES

- We are required by law to make sure that PHI that identifies you is kept private;
- We are required to provide you this notice of our legal duties and privacy practices; and
- We are required to follow the terms of this notice. We reserve the right to change the terms of this Notice at any time. Any changes will be effective for all PHI that we maintain. You may request a copy of the revised Notice at any time.

OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION (PHI)

We understand that PHI about you is personal, and we are committed to protecting PHI about you. We create a record of the care and services you receive at our agency. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our agency, whether recorded in your counseling record, invoice payment forms, recordings, or other ways, whether made by The Family Tree personnel or your personal counselor.

ACKNOWLEDMENT OF RECEIPT OF THIS NOTICE

You will be asked to provide a signed acknowledgement of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your PHI and your privacy rights. The delivery of healthcare service will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide you treatment, and will use and disclose your PHI for treatment, payment, and healthcare operation when necessary.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

By State law and the ethics of our mental health professions, we must have your written, signed Consent to use and disclose PHI for the following purposes. For each category of uses or disclosures we will explain what we mean and list an example. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- For Treatment. We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with third parties. We may disclose PHI about you to other Family Tree personnel who are involved in taking care of you at the agency.
- For Payment. We may use and disclose medical information about you so that the treatment and services you receive at The Family Tree may be billed to and payment may be collected from you, an insurance company, or a third party. For

example, we may inform your health insurance company of your diagnosis and treatment in order to assist the insurer in processing our claim for the healthcare services provided to you.

- For Healthcare Operations. We may use or disclose, as needed, PHI about you in order to support The Family Tree business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training, licensing, and educational activities. These uses and disclosures are necessary to run The Family Tree and ensure that all of our clients receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine PHI about many clients to decide what additional services The Family Tree should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to other Family Tree personnel for review and learning purposes. We may also combine the PHI we have with PHI from other mental health counseling centers to compare how we are doing and see where we can make improvements in the care and services we offer. We will remove information that identifies you from this set of PHI so others may use it to study health care and health care delivery without learning who the specific clients are.
    - Appointment Reminders. We may use and disclose PHI to contact you as a reminder that you have an appointment for mental health care at The Family Tree. Please notify us if you do not wish to be contacted for appointment reminders, or if you want to make restrictions about such contact.

You may revoke your Consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures that occurred before that time.

SPECIAL SITUATIONS

We may use or disclose PHI about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

- To Avert a Serious Threat to Health or Safety. Based on professional judgment, we may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- Required By Law. Based on professional judgment, we will disclose PHI about you when required to do so by federal, state or local law. Disclosures may be compelled by DHHS for compliance and enforcement purposes.
- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose PHI about you in response to a subpoena. Such disclosures would be based on professional judgment.
- Law Enforcement. We may release PHI if required to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
- Family and Friends. In situations where you are not capable of giving authorization (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we would disclose only PHI relevant to the person's involvement in your care. For example, if you were in a mental health crisis, we might involve a family member or friend in helping you get to an appropriate care facility.
- Research. PHI about you can be used for research projects that are subject to a special approval process. You may be asked for your permission, if the researcher will have access to your name, address or other information that reveals who you are.
- Military, Veterans, National Security and Intelligence. If you are or were a member of the armed forces, or part of the national security or intelligence communities, military command or other government authorities may require the release of PHI about you. HIPAA also permits release of information about foreign military personnel to the appropriate foreign military authority.
- Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution. We will almost always ask you to sign an Authorization form before releasing such information.

- Workers' Compensation. PHI about you may be released for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- Public Health Risks. PHI about you may be disclosed for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- Health Oversight Activities. PHI about you may be disclosed to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- Information Not Personally Identifiable. PHI about you may be disclosed in a way that does not personally identify you or reveal who you are.

OTHER USES AND DISCLOSURES OF PHI

This agency will not use or disclose your PHI for any purpose other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any *Consent* we may have obtained from you. If you give us Authorization to use or disclose PHI about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the *Authorization* and *Consent* mentioned above) from you. In order to disclose these types of records for purposes of *treatment, payment or health care operations*, we will require a special written authorization that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS

You have the following rights regarding PHI we maintain about you:

- Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Usually, this includes mental health and billing records, but does not include psychotherapy notes. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- Right to Amend. If you think that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- Right to an Accounting of Disclosures. You have the right to request an accounting of certain of disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- Right to Request Confidential Communication. You have the right to request that we communicate with you about mental health matters in a certain way or at a certain location.
- Right to a Copy of this Notice. You have the right to a copy of this notice.

To exercise any of these rights, please submit a written request form to Clinical Director, The Family Tree, P.O. Box 62904, Lafayette, LA 70596.

COMPLAINTS

If you believe we have violated you privacy rights, you have the right to file a complaint in writing with our Chief Executive Officer or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

CONTACT INFORMATION

You may contact The Family Tree, (337) 981-2180 or P.O. Box 62904, Lafayette, LA 70596, for further information about the complaint process or for further information about this document.

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Memorandum of Understanding

As a person receiving Behavioral Health Services, you have the right to:

1. Have the option to refuse, accept, or modify services because participation is voluntary. Each individual and the organization should negotiate the best possible arrangement for services, including referral to other agencies.
2. Have the right, as well as a responsibility, to participate in the development of program planning. To whatever extent possible, each individual must be encouraged to take responsibility for himself/herself and the process and outcomes of services made available.
3. Expect and receive services without regard to age, sex, race, color, religion, marital status, disability, vocational barrier, national origin, or any non-merit factor in accordance with all state and federal regulations.
4. Have the opportunity to make informed choices.
5. Treated with respect, consideration, dignity, and full recognition of his/her individuality and right to privacy.
6. Receive care and services which are adequate, appropriate and in compliance with relevant Federal and state laws, rules and regulations regarding search and seizure and to maintain his/her constitutional rights.
7. Be free of mental, psychological, and physical abuse, neglect and exploitation, including fear or concern, regarding unwarranted suspension, expulsion, discharge or unnecessary and unwarranted search and seizure while receiving services.
8. Receive assistance with following grievance procedure in order to get a satisfactory resolution to complaints made.
9. Have his/her personal, program, and medical records kept confidential and not disclosed, according to policies and procedures regarding confidentiality and release or disclosure of confidential information.
10. Receive a reasonable response to his/her requests from the facility administrator and staff.
11. Associate and communicate privately and without restriction with people and groups they choose at any reasonable hours the facility is in operation.
12. Be encouraged to exercise his/her rights as a client and citizen, and to be permitted to make complaints and suggestions without fear or coercion or retaliation. To be informed and educated in how to file a complaint and to secure an advocate.
13. Be notified when the facility is issued a provisional license or notice or revocation of license by the Louisiana Dept. of Health and the basis on which the provisional license or notice or revocation of license was issued. The client's responsible family member or guardian is also notified.
14. Receive upon request a copy of the Client Policy and Procedure Manual, which includes, but not limited to, abuse and neglect policies, record access, grievance procedures.

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I have read and understood the above documents, stating my rights as a client at this agency.

_____	_____
Client or Legal Representative Name	Date
_____	_____
Witness	Date