Eric M. Dishongh, PhD, LPC, LLC

Professional Counseling Private Practice
www.ericdishongh.com

Important Info for New Clients

Thank you for choosing me for your professional counseling needs. I recognize that you have many choices, and I appreciate your trust in me.

I also appreciate you downloading and completing the paperwork prior to your first session. Completing the paperwork allows me the opportunity to spend a greater amount of time on clinical rather than administrative issues.

Please complete the following forms:
1. Client Intake Form
2. Adult Checklist of Concerns
3. Child Checklist of Concerns (only if the client is your child)
4. Locke-Wallace Marital Adjustment Test (couples only)
5. Declaration of Practices and Procedures
6. Notice of Privacy Practices

Some other things to keep in mind:

- You don't need to print the Notice of Privacy Practices at the conclusion of this paperwork, but please review it.
- I will review and answer any questions about this paperwork or other matters.
- Please bring your insurance card and authorization number, if applicable.
- I will need information about your copayment and/or deductible. If you do not know this information, please contact your insurance company and ask for an explanation of benefit coverage for mental/behavioral health issues.
- It is very helpful for the therapy process if you bring a list of goals for therapy. This will help us make better use of the first session.
- Please provide a 24-hour notice if you need to change or cancel your appointment. A no-show fee of up to $75 will be applied for not providing a 24-hour notice and/or missed appointments.

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Client Intake Form

Name: _____ Date: _____

Address: _____ City:_____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Date of Birth: _____

Who is referring you? (or How did you hear about me?) _____

May I add you to my email list? Yes or No

May I text you appointment reminders? Yes or No

Person to Contact in Case of an Emergency:

Name: _____ Phone: _____

What would you like to accomplish as the result of being here today?

_____

_____

Please review the "Notice of Privacy Practices." Please also review and sign the "Declaration of Practices and Procedures."

Eric M. Dishongh, PhD, LPC

Name: _____

Demographic Information Form

** Please check one answer for each of the following.*

1. **Gender**: ___ Male ___ Female

2. **Age**: ___ 18-29 ___ 30-44 ___ 45-59 ___ 60 & Older

3. **Ethnicity**: ___ African American ___ Caucasian ___ Hispanic/Latino ___ Other

4. **Years Married**: ___ 0-10 ___ 11-20 ___ 21-30 ___ 31-40 ___ 41 or More

5. **Number of Children**: ___ 0 ___ 1 ___ 2 ___ 3 ___ 4 or more

6. **Education**: ___ High School ___ 4-yr College ___ Graduate School ___ Other

7. **Employment**: ___ Full-Time ___ Part-Time ___ Retired ___ Unemployed

8. **Your Income**: __ $49,999 or Less __ $50,000-$74,999 __ $75,000-$99,999 __ $100,000 or More

9. **Religion**: ___ Church of Christ ___ Catholic ___ Protestant ___ Other

10. **Faith Importance**:___ Very Important ___ Important ___ Somewhat ___ Not Much

Adult Checklist of Concerns

Name: _____ Date:_____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. (For a child, mark any of these and then complete the "Child Checklist of Characteristics.")

- ❑ I have no problem or concern bringing me here
- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Inferiority feelings
- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk taking
- ❑ Legal matters, charges, suits
- ❑ Loneliness

❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
❑ Memory problems
❑ Menstrual problems, PMS, menopause
❑ Mood swings
❑ Motivation, laziness
❑ Nervousness, tension
❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
❑ Oversensitivity to rejection
❑ Panic or anxiety attacks
❑ Parenting, child management, single parenthood
❑ Perfectionism
❑ Pessimism
❑ Procrastination, work inhibitions, laziness
❑ Relationship problems (with friends, with relatives, or at work)
❑ School problems (see also "Career concerns . . . ")
❑ Self-centeredness
❑ Self-esteem
❑ Self-neglect, poor self-care
❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
❑ Shyness, oversensitivity to criticism
❑ Sleep problems—too much, too little, insomnia, nightmares
❑ Smoking and tobacco use
❑ Spiritual, religious, moral, ethical issues
❑ Stress, relaxation, stress management, stress disorders, tension
❑ Suspiciousness
❑ Suicidal thoughts
❑ Temper problems, self-control, low frustration tolerance
❑ Thought disorganization and confusion
❑ Threats, violence
❑ Weight and diet issues
❑ Withdrawal, isolating
❑ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition

Any other concerns or issues: _____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is: _____

Child Checklist of Characteristics

Name: _____ Age: _____ Date: _____

Person completing this form:_____

Many concerns can apply to both children and adults. If you have brought a child for evaluation or treatment, first please mark all of the items that apply to your child on the "Adult Checklist of Concerns." Then review this checklist, which contains concerns (as well as positive traits) that apply mostly to children, and mark any items that describe your child.

Feel free to add any others at the end under "Any other characteristics."

❑ Affectionate
❑ Argues, "talks back," smart-alecky, defiant
❑ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
❑ Cheats
❑ Cruel to animals
❑ Concern for others
❑ Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
❑ Complains
❑ Cries easily, feelings are easily hurt
❑ Dawdles, procrastinates, wastes time
❑ Difficulties with parent's paramour/new marriage/new family
❑ Dependent, immature
❑ Developmental delays
❑ Disrupts family activities
❑ Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
❑ Distractible, inattentive, poor concentration, daydreams, slow to respond
❑ Dropping out of school
❑ Drug or alcohol use
❑ Eating—poor manners, refuses, appetite increase or decrease, odd combinations, overeats
❑ Exercise problems
❑ Extracurricular activities interfere with academics
❑ Failure in school
❑ Fearful
❑ Fighting, hitting, violent, aggressive, hostile, threatens, destructive
❑ Fire setting
❑ Friendly, outgoing, social
❑ Hypochondriac, always complains of feeling sick
❑ Immature, "clowns around," has only younger playmates
❑ Imaginary playmates, fantasy
❑ Independent
❑ Interrupts, talks out, yells
❑ Lacks organization, unprepared
❑ Lacks respect for authority, insults, dares, provokes, manipulates
❑ Learning disability
❑ Legal difficulties—truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales

❑ Likes to be alone, withdraws, isolates
❑ Lying
❑ Low frustration tolerance, irritability
❑ Mental retardation
❑ Moody
❑ Mute, refuses to speak
❑ Nail biting
❑ Nervous
❑ Nightmares
❑ Need for high degree of supervision at home over play/chores/schedule
❑ Obedient
❑ Obesity
❑ Overactive, restless, hyperactive, overactive, out-of-seat behaviors, restlessness, fidgety, noisiness
❑ Oppositional, resists, refuses, does not comply, negativism
❑ Prejudiced, bigoted, insulting, name calling, intolerant
❑ Pouts
❑ Recent move, new school, loss of friends
❑ Relationships with brothers/sisters or friends/peers are poor—competition, fights, teasing/provoking, assaults
❑ Responsible
❑ Rocking or other repetitive movements
❑ Runs away
❑ Sad, unhappy
❑ Self-harming behaviors—biting or hitting self, head banging, scratching self
❑ Speech difficulties
❑ Sexual—sexual preoccupation, public masturbation, inappropriate sexual behaviors
❑ Shy, timid
❑ Stubborn
❑ Suicide talk or attempt
❑ Swearing, blasphemes, bathroom language, foul language
❑ Temper tantrums, rages
❑ Thumb sucking, finger sucking, hair chewing
❑ Tics—involuntary rapid movements, noises, or word productions
❑ Teased, picked on, victimized, bullied
❑ Truant, school avoiding
❑ Underactive, slow-moving or slow-responding, lethargic
❑ Uncoordinated, accident-prone
❑ Wetting or soiling the bed or clothes
❑ Work problems, employment, workaholism/overworking, can't keep a job

Any other characteristics: _____

Please look back over the concerns you have checked off and choose the one that you most want your child to be helped with. Which is it? _____

Name _____

Locke-Wallace Marital Adjustment Test

1. Circle the dot on the scale below which best describes the degree of happiness, everything considered, of your present marriage. The middle point, "happy," represents the degree of happiness which most people get from, marriage, and the scale gradually ranges on one side to those few people who are very unhappy in marriage, and on the other, to those few who experience extreme joy or felicity in marriage.

. . . . . .

Very Unhappy **Happy** **Perfectly Happy**

State the approximate extent of agreement or disagreement between you and your mate on the following items. Please check each column.

	Always Agree	**Almost always Agree**	**Occa-sionally Disagree**	**Fre-quently Disagree**	**Almost always Disagree**	**Always Disagree**
2. Handling family finances						
3. Matters of recreation						
4. Demonstration of affection						
5. Friends						
6. Sex relations						
7. Conventionality (right, good, or proper conduct)						
8. Philosophy of life						
9. Ways of dealing with in-laws						

10. When disagreements arise, they usually result in:
Husband giving in *Wife giving in* *Agreement by mutual give and take*

11. Do you and your mate engage in outside interests together:
All of them *Some of them* *Very few of them* *None of them*

12. In leisure time do you generally prefer: *To be "on the go,"* *To stay at home?*

13. Do you ever wish you had not married?
Frequently *Occasionally* *Rarely* *Never*

14. If you had your life to live over, do you think you would: *Marry the same person*
Marry a different person *Not marry at all*

15. Do you confide in your mate: *Almost never* *Rarely* *In most things* *In everything*

Eric M. Dishongh, PhD, LPC, LLC

2201 Hickory Avenue, Harahan, LA 70123 (Office)
13101 River Road, Luling, LA 70070 (Office & Mail)

Telephone #504.606.1267
Email: ericdishongh@yahoo.com
Website: www.ericdishongh.com

DECLARATION OF PRACTICES AND PROCEDURES

Qualifications: I earned a Doctor of Philosophy in Marriage and Family Therapy from Amridge University in 2009, and I earned a Master of Arts degree in Marriage & Family Counseling from the New Orleans Baptist Theological Seminary in May 2005. I am licensed as an LPC (# 3602) with the LPC Board of Examiners (8631 Summa Avenue, Baton Rouge, LA 70809, ph. 225.765.2515).

Counseling Relationship: The central purposes of marriage, family, or individual counseling are to allow the clients to better understand themselves and their relationships with others. Enhanced functioning as couple, family, or individual is stressed to promote healthy interactions and greater satisfaction. I am willing to address spiritual concerns in therapy if you express such a desire. I do not use social media sites such as Facebook, Twitter, LinkedIn, Instagram, etc. with past or current clients.

Areas of Focus: In addition to my academic studies in marriage and family counseling, I have individual and group experience in anger management with children, adolescents, and adults. I have experience dealing with inpatient child and adolescent clients. Also, I have experience with individuals, couples and families dealing with divorce, parenting/family issues, alcohol/drug abuse, academic/career concerns, and death.

Office Procedures & Fee Scales: Clients are seen by appointment only. Initial appointments can be made in my office or by telephone. I have appointments available Monday through Friday from 8am to 5pm. After the initial counseling session, appointments will be scheduled with me. You will be given a reminder slip with the date and time of the next appointment. If you need to cancel or reschedule your appointment, please provide a 24-hour notice. ***Clients will be charged the full fee for appointments that are broken or canceled without a 24-hour notice.***

My fee is $115 for the initial session (60-75 minute) and $100 for all following sessions (55-60 minutes). Please make checks payable to Eric Dishongh. Credit card payments are accepted on my website and in my office. Payment is due at the time of service. If you are utilizing insurance, please make sure you have your insurance card with you. For insurance plans that I am not a network provider, I will provide a detailed receipt for you to submit directly to your insurance company.

Services Offered & Clients Served: My therapeutic orientation is systemic but also depends on the type of problem being addressed. Although my approach is eclectic and appreciative in nature, I will draw from the following therapies: solution-focused, cognitive-behavioral, and structural therapies. I serve couples, families, and/or individuals. I work with adults and children.

Code of Conduct: I am required by law to adhere to the Louisiana Code of Conduct for Licensed Professional Counselors. A copy of this code is available upon request.

Confidentiality: Material revealed in counseling will remain strictly confidential except under the following circumstances in accordance with state law: 1) The client signs a written release of information indicating informed consent of such release; 2) The client expresses intent to harm himself/herself or others; 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 (such as child custody suits) is received directing the disclosure of information.

Privileged Communication: 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 emergency, before mandated disclosure. Verbal authorization to release information will not be sufficient except in emergency situations. I will endeavor to apprise clients of all mandated disclosures as conceivable.

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 the client's parent or guardian.

When working with a family or couple, information shared by individuals in sessions where other family members are not present must be held in confidence (except for the mandated exceptions already noted) unless all individuals involved sign written waivers at the outset of therapy. Clients may refuse to sign such a waiver but should be advised that maintaining confidentiality for individual sessions during couple or family therapy could impede or even prevent a positive outcome to therapy. If an impasse results from such confidentiality, referral to another therapist might result.

See also the "Notice of Privacy Practices" pertaining to the disclosure of medical information.

Emergency Situations: If an emergency situation should arise, you may seek help through hospital emergency room facilities or by calling 911. Other helpful numbers: River Oaks Hospital (504-733-2273) St. Charles Hospital (985-785-6242)

Client Responsibilities: You, the client, are a full partner in counseling. You must make your own decisions regarding such things as deciding to marry, separate, divorce, reconcile and how to set up custody and visitation. That is, I will help you think through the possibilities and consequences of decisions, but my Code of Ethics does not allow me to advise you to make a specific decision. If as we work together you have suggestions or concerns about your counseling, I expect you to share these with me so that we can 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 form 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.

Physical Health: Physical health can be an important factor in the 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 current medications.

Potential Counseling Risks: The client should be aware that counseling poses potential risks. In the course of working together additional problems may surface of which the client was not initially aware. If this occurs, the client should feel free to share these new concerns with me.

Coordination of Treatment: It is important that all health care providers work together. As such, I would like permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. If you prefer to decline consent, no information will be shared.

_____ Eric M. Dishongh may inform my physician(s) _____ I decline for Eric M. Dishongh to inform my physician(s)

Physician Name: _____ Phone: _____

Address: _____

Notice of Privacy Practices and Client Rights: I/We have read the Notices of Privacy Practices, Client Rights and Office Privacy Policies and Procedures.

Client Signature(s) _____ Date _____

I have read and understand all of the above information.

Client Signature(s) _____ Date _____

_____ _____
Eric M. Dishongh, PhD, LPC Date

Parental Authorization:
I, _____, give permission for Eric Dishongh to conduct counseling with my _____ (relationship).

Name of Minor _____ Signature of Guardian _____Date _____

Eric M. Dishongh, PhD, LPC, LLC

Phone: 504-606-1267
Email: ericdishongh@yahoo.com
Website: www.ericdishongh.com

NOTICE OF PRIVACY PRACTICES

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.

What is "Medical Information"?

The term "medical information" is synonymous with the terms "personal health information" and "protected health information" for purposes of this Notice. It essentially means any individually identifiable health information (either directly or indirectly identifiable), whether oral or recorded in any form or medium, that is created or received by a health care provider (me), health plan, or others and 2) relates to the past, present, or future physical or mental health or condition of an individual (you); the provision of health care (e.g., mental health) to an individual (you); or the past, present, or future payment for the provision of health care to an individual (you).

I am a mental health care provider. More specifically, I am a Licensed Professional Counselor, licensed by the State of Louisiana's Licensed Professional Counselors Board of Examiners. I create and maintain treatment records that contain individually identifiable health information about you. These records are generally referred to as "medical records" or "mental health records," and this notice, among other things, concerns the privacy and confidentiality of those records and the information contained therein.

Uses and Disclosures Without Your Authorization - For Treatment, Payment, or Health Care Operations

Federal privacy rules (regulations) allow health care providers (me) who have a direct treatment relationship with the patient (you) to use or disclose the patient's personal health information, without the patient's written authorization, to carry out the health care provider's own treatment, payment, or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization.

An example of a use or disclosure for treatment purposes: If I decide to consult with another licensed health care provider about your condition, I would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist me in the diagnosis or treatment of your mental health condition. Disclosures for treatment purposes are not limited to the minimum necessary standard because physicians and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care among health care providers or by a health care provider with a third party, consultations between health care providers, and referrals of a patient for health care from one health care provider to another.

An example of a use or disclosure for payment purposes: If your health plan requests a copy of your health records, or a portion thereof, in order to determine whether or not payment is warranted

under the terms of your policy or contract, I am permitted to use and disclose your personal health information.

An example of a use or disclosure for health care operations purposes: If your health plan decides to audit my practice in order to review my competence and my performance, or to detect possible fraud or abuse, your mental health records may be used or disclosed for those purposes.

PLEASE NOTE: I, or someone in my practice acting with my authority, may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your prior written authorization is not required for such contact.

Other Uses and Disclosures Without Your Authorization:

I may be required or permitted to disclose your personal health information (e.g., your mental health records) without your written authorization. The following circumstances are examples of when such disclosures may or will be made:

1. If disclosure is compelled by a court pursuant to an order of that court.
2. If disclosure is compelled by a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority.
3. If disclosure is compelled by a party to a proceeding before a court or administrative agency pursuant to a subpoena, subpoena duces tecum (e.g., a subpoena for mental health records), notice to appear, or any provision authorizing discovery in a proceeding before a court or administrative agency.
4. If disclosure is compelled by a board, commission, or administrative agency pursuant to an investigative subpoena issued pursuant to its lawful authority.
5. If disclosure is compelled by an arbitrator or arbitration panel, when arbitration is lawfully requested by either party, pursuant to a subpoena duces tecum (e.g., a subpoena for mental health records), or any other provision authorizing discovery in a proceeding before an arbitrator or arbitration panel.
6. If disclosure is compelled by a search warrant lawfully issued to a governmental law enforcement agency.
7. If disclosure is compelled by the patient or the patient's representative pursuant federal statutes or regulations (e.g., the federal "Privacy Rule," which requires this Notice).
8. If disclosure is compelled by a reasonable suspicion of child abuse or neglect.
9. If disclosure is compelled by a reasonable suspicion of elder abuse or dependent adult abuse.
10. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or to the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
11. If disclosure is compelled or permitted by the fact that you tell me of a serious threat (imminent) of physical violence to be committed by you against a reasonably identifiable victim or victims.
12. If disclosure is compelled or permitted, in the event of your death, to the coroner in order to determine the cause of your death.
13. As indicated above, I am permitted to contact you without your prior authorization to provide appointment reminders or information about alternatives or other health-related benefits and services that may be of interest to you. Be sure to let me know where and by what means (e.g., telephone, letter, email, fax) you may be contacted.
14. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law, including but limited to, audits, criminal or civil investigations, or licensure

or disciplinary actions. The Louisiana Licensed Professional Counselors Board of Examiners, who license professional counselors, is an example of a health oversight agency.

15. If disclosure is compelled by the U. S. Secretary of Health and Human Services to investigate or determine my compliance with privacy requirements under the federal regulations (the "Privacy Rule").
16. If disclosure is otherwise specifically required by law.

PLEASE NOTE: The above list is not an exhaustive list, but informs you of most circumstances when disclosures without your written authorization may be made. Other uses and disclosures will generally (but not always) be made only with your written authorization, even though federal privacy regulations or state law may allow additional uses or disclosures without your written authorization. Uses or disclosures made with your written authorization will be limited in scope to the information specified in the authorization form, which must identify the information "in a specific and meaningful fashion." You may revoke your written authorization at any time, provided that the revocation is in writing and except to the extent that I have taken action in reliance on your written authorization. Your right to revoke an authorization is also limited if the authorization was obtained as a condition of obtaining insurance coverage for you. If Louisiana law protects your confidentiality or privacy more than the federal "Privacy Rule" does, or if Louisiana law gives you greater rights than the federal rule does with respect to access to your records, I will abide by Louisiana law. In general, uses or disclosures by me of your personal health information (without your authorization) will be limited to the minimum necessary to accomplish the intended purpose of the use or disclosure. Similarly, when I request your personal health information from another health care provider, health plan or health care clearinghouse, I will make an effort to limit the information requested to the minimum necessary to accomplish the intended purpose of the request. As mentioned above, in the section dealing with uses or disclosures for treatment purposes, the "minimum necessary" standard does not apply to disclosures to or requests by a health care provider for treatment purposes because health care providers need complete access to information in order to provide quality care.

Your Rights Regarding Protected Health Information

1. You have the right to request restrictions on certain uses and disclosures of protected health information about you, such as those necessary to carry out treatment, payment, or health care operations. I am not required to agree to your requested restriction. If I do agree, I will maintain a written record of the agreed upon restriction.
2. You have the right to receive confidential communications of protected health information from me by alternative means or at alternative locations.
3. You have the right to inspect and copy protected health information about you by making a specific request to do so in writing. This right to inspect and copy is not absolute – in other words, I am permitted to deny access for specified reasons. For instance, you do not have this right of access with respect to my "psychotherapy notes." The term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical (includes mental health) record. The term excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.
4. You have the right to amend protected health information in my records by making a request to do so in a writing that provides a reason to support the requested amendment. This right to

amend is not absolute – in other words, I am permitted to deny the requested amendment for specified reasons. You also have the right, subject to limitations, to provide me with a written addendum with respect to any item or statement in your records that you believe to be incorrect or incomplete and to have the addendum become a part of your record.

5. You have the right to receive an accounting from me of the disclosures of protected health information made by me in the six years prior to the date on which the accounting is requested. As with other rights, this right is not absolute. In other words, I am permitted to deny the request for specified reasons. For instance, I do not have to account for disclosures made in order to carry out my own treatment, payment or health care operations. I also do not have to account for disclosures of protected health information that are made with your written authorization, since you have a right to receive a copy of any such authorization you might sign.
6. You have the right to obtain a paper copy of this notice from me upon request.

PLEASE NOTE: In order to avoid confusion or misunderstanding, I ask that if you wish to exercise any of the rights enumerated above, that you put your request in writing and deliver or send the writing to me. If you wish to learn more detailed information about any of the above rights, or their limitations, please let me know. I am willing to discuss any of these matters with you. As mentioned elsewhere in this document, I am the Privacy Officer of this practice.

My Duties

I am required by law to maintain the privacy and confidentiality of your personal health information. This notice is intended to let you know of my legal duties, your rights, and my privacy practices with respect to such information. I am required to abide by the terms of the notice currently in effect. I reserve the right to change the terms of this notice and/or my privacy practices and to make the changes effective for all protected health information that I maintain, even if it was created or received prior to the effective date of the notice revision. If I make a revision to this notice, I will make the notice available at my office upon request on or after the effective date of the revision and I will post the revised notice in a clear and prominent location.

As the Privacy Officer of this practice, I have a duty to develop, implement and adopt clear privacy policies and procedures for my practice and I have done so. I am the individual who is responsible for assuring that these privacy policies and procedures are followed not only by me, but by any employees that work for me or that may work for me in the future. I have trained or will train any employees that may work for me so that they understand my privacy policies and procedures. In general, patient records, and information about patients, are treated as confidential in my practice and are released to no one without the written authorization of the patient, except as indicated in this notice or except as may be otherwise permitted by law. Patient records are kept secured so that they are not readily available to those who do not need them.

Because I am the Contact Person of this practice, you may complain to me and to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights may have been violated either by me or by those who are employed by me. You may file a complaint with me by simply providing me with a writing that specifies the manner in which you believe the violation occurred, the approximate date of such occurrence, and any details that you believe will be helpful to me. My telephone number is 504-606-1267. I will not retaliate against you in any way for filing a complaint with me or with the Secretary. Complaints to the Secretary must be filed in writing. A complaint to the Secretary can be sent to U.S Department of Health and Human Services, 1301 Young St., Dallas, TX 75202.

If you need or desire further information related to this Notice or its contents, or if you have any questions about this Notice or its contents, please feel free to contact me. As the Contact Person for this practice, I will do my best to answer your questions and to provide you with additional information.

This notice first became effective on April 14, 2003.