

### Forms for adult couples beginning counseling

- Pgs 1-8: **Adult Information Form**-To be completed **separately** by **all** adults attending counseling
- Pgs 9-11: **Declaration Statement**-To be signed and initialed by **all** adults attending counseling
- Pg 12: **Couples Release of Information**-To be signed by **all** adults attending couples counseling
- Pgs 13-16: **HIPAA Overview**-To be reviewed by all adults attending counseling sessions (this is to be kept for your records and does not need to be brought to the counseling session)
- Pg 17: **HIPAA Acknowledgement**-to be signed by **all** adults attending counseling



### ADULT INFORMATION FORM

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Spouse's Social Security #: \_\_\_\_\_

Address Physical (include city, state, zip): \_\_\_\_\_  
\_\_\_\_\_

Address Mailing (if different): \_\_\_\_\_  
\_\_\_\_\_

Cell # ( ) \_\_\_\_\_

Home # ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_

Email address: \_\_\_\_\_

May I contact you by e-mail? \_\_\_\_\_

Occupation: \_\_\_\_\_ Years of Education/Degree: \_\_\_\_\_

Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's Employer: \_\_\_\_\_

Policy Holder's full address: \_\_\_\_\_

RESPONSIBLE PARTY/GUARANTOR: Name: \_\_\_\_\_

Referred By: \_\_\_\_\_

May I thank the referral? \_\_\_\_\_

**RELEASE/PAYMENT AUTHORIZATION:** I agree to provide payment in full at the time of service to Belaire Counseling Services, LLC 5536 Superior Dr. Suite B, Baton Rouge, LA 70816. I authorize the release of medical information necessary to process an insurance claim on my behalf. I acknowledge that I received a copy of the HIPAA Privacy Notice.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Christine Belaire, Ph.D., LPC,  
LMFT, NCC  
5536 Superior Dr., Suite B  
Baton Rouge, LA 70816



(225) 291-1335  
fax (225) 291-1336  
www.BelaireCounseling.com  
DrBelaire@BelaireCounseling.com

**The following are common concerns of individuals. Please check all that apply to you.**

**1. My family has a history of (check all that apply):**

- poor communication       counseling       abuse  
 depression       hospitalization       alcoholism  
 eating disorders       drug or gambling addiction

**2. I use alcohol:**

- less than once per week       more than once per week       never

**3. I use drugs:**

- less than once per week       more than once per week       never

**4. The following have resulted from my use of alcohol/drugs (check all that apply):**

- traffic violation       black outs       financial problems  
 ruined relationship       health problems       work or academic problems

**5.  I have been in trouble with the legal system.**

**6.  I have had an unwanted sexual experience.**

**7. I have experienced (check all that apply):**

- emotional abuse       sexual abuse       physical abuse

**8. I've tried to control my weight with (check all that apply):**

- vomiting       laxatives       not eating  
 diet pills       excessive exercise       other

**9. I have thought or tried to (check all that apply):**

- harm myself       harm another person

**10.  At times, I have acted in a violent manner.**

**11. I have recently had problems with the following (check all that apply):**

- sleeping       appetite       fatigue  
 concentration       weight loss/gain       mood shifts  
 headaches       anxiety       medical problems

**12. I have difficulty (check all that apply):**

- expressing my emotions       controlling my anger       handling stress  
 accepting myself       accepting compliments

**13. I have experienced a recent (check all that apply):**

- death       relationship that ended       major move

**14.  Sometimes I hear unwanted voices in my head.**

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**FOR EACH ISSUE, MARK THE NUMBER THAT INDICATES HOW MUCH EACH ISSUE HAS DISTRESSED, WORRIED, OR BOTHERED YOU IN THE PAST TWO WEEKS.**

**1-Notatall      2-Slight      3-Moderate      4-Considerable      5-Extreme**

1	Feeling angry	1	2	3	4	5
2	Feeling timid or shy	1	2	3	4	5
3	Feeling depressed	1	2	3	4	5
4	Being easily embarrassed	1	2	3	4	5
5	Feeling like a failure	1	2	3	4	5
6	Feeling on the verge of tears	1	2	3	4	5
7	Being ill at ease with others	1	2	3	4	5
8	Feeling discouraged	1	2	3	4	5
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21	Suicidal thoughts	1	2	3	4	5
22	Problems with family	1	2	3	4	5
23	Upset by academic concerns	1	2	3	4	5
24	Problems with spouse or significant other	1	2	3	4	5
25	Stress related to work	1	2	3	4	5
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27	Being overweight	1	2	3	4	5
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Please indicate how important spiritual and religious issues are in your life.

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How much do spiritual and religious concerns affect your daily decision making?

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List all persons living in the home including age and relationship to you.

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List all current medications you are taking including dosage, reason for taking the medication, and the physician who prescribed the medication.

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In order of importance, list the goals you have for counseling? Please be as specific as possible.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

How many total sessions do you anticipate you will need to accomplish these goals?

1\_\_ 2-4\_\_ 5-8\_\_ 9-12\_\_ 13-15\_\_ 16+\_\_

Circle the number that best describes how much your concerns are interfering with your personal functioning.

(Not at all) 0 1 2 3 4 5 6 7 8 9 10 (A great deal)



ADULT INFORMATION FORM

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How much do spiritual and religious concerns affect your daily decision making?

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- 2. \_\_\_\_\_
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How many total sessions do you anticipate you will need to accomplish these goals?

1\_\_ 2-4\_\_ 5-8\_\_ 9-12\_\_ 13-15\_\_ 16+\_\_

Circle the number that best describes how much your concerns are interfering with your personal functioning.

(Not at all) 0 1 2 3 4 5 6 7 8 9 10 (A great deal)

## Declaration of Practices and Procedures

Christine Belaire, Ph. D.  
LPC-S<sup>1</sup> #2770, LMFT<sup>2</sup> #543  
National Certified Counselor (NCC).

5536 Superior Dr., Ste B.  
Baton Rouge, LA 70816  
225-291-1335  
225-291-1336 fax  
[DrBelaire@BelaireCounseling.com](mailto:DrBelaire@BelaireCounseling.com)  
[www.BelaireCounseling.com](http://www.BelaireCounseling.com)

Education:

Ph. D, Mississippi State University, 2001, Major: Counselor Education, Community Counseling  
MA, Louisiana State University, 1998, Major: Counselor Education, Agency Counseling

Areas of Expertise:

Marriage and Family, Depression/Anxiety, Play Therapy, Custody Evaluations, Parenting Disputes, Parenting Education, Women's issues, and Spirituality

<sup>1</sup>Licensed Professional Counselor Board of Examiners 11410 Lake Sherwood Avenue North, Suite A, Baton Rouge, Louisiana 70816 (phone 225-295-8444).

<sup>2</sup>Licensed Professional Counselor Board of Examiners (licensing board for Marriage and Family Therapists) 11410 Lake Sherwood Avenue North, Suite A, Baton Rouge, Louisiana 70816 (phone 225-295-8444).

1. **Counseling Relationship:** I view counseling as a collaborative relationship in which the client and counselor work together to explore the current problematic issues and develop goals to address these issues. Within the counseling relationship, I may focus on patterns of thoughts, behaviors, moods, and relationships that cause you concern.
2. **Fee Scales:**
  - The fee for “non-legal” counseling is \$125.00 per fifty-minute session. “Non-legal” counseling is defined as counseling that is not affiliated with the court system or an attorney in any form.
  - The fee for “legal” services is \$150.00 per fifty-minute session. “Legal” services include, but are not limited to, child custody evaluations, post-judgment monitoring, court mandated counseling, court-mandated parenting or anger management courses, and any other services requested by the court or an attorney.
  - If during the course of “non-legal” counseling you request that I submit a verbal or written report to an attorney or court, or if you request that I testify in court pertaining to your (or minor child's) case, the fee for services will be \$150.00 per fifty-minute session and will not be reduced back to the \$125.00 fee for any subsequent sessions.
  - Payment is due at the time of service.
  - Returned checks or denied charges are subject to a \$35 fee. **Int.**

- A balance on an account that is more than 90 days old is subject to being reported to the credit bureau along with pertinent personal information and turned over to a collection agency.
  - I am a provider for Blue Cross Blue Shield PPO and Humana. If you hold a policy that covers outpatient mental health benefits with any of these companies, I will file the insurance claim on your behalf. You are responsible for paying the co-pay and/or deductible according to your insurance plan. If a claim is rejected, you are responsible for paying the full fee.
  - If you want to file with another insurance company for out of network services, I will file the claim on your behalf. You are responsible for paying the percentage of the fee that the insurance does not cover. If a claim is rejected, you are responsible for paying the full fee.
  - Pre-payment discounts for multiple sessions are available- cash or check payments only **Int.**
  - If a deposition is requested, the fee is \$200.00 per hour with a minimum of four hours for court appearance and a minimum of two hours for a deposition. Payment in full is due at least one week prior to an appearance in court or deposition, and any payment exceeding the minimum is due at the deposition appearance.
  - If an appearance in court is requested, the fee is \$500.00 per ½-day. If the court appearance lasts into the second ½ of the day, the fee will increase to \$1000.00 to be paid by the end of that court day.
  - Charges apply for all emergency contact and phone sessions.
  - Any no show or cancellation with less than twenty-four-hour notice will incur the full charge for the scheduled session. **NOTE:** insurance companies will not reimburse for missed sessions; therefore, you will incur the full responsibility for payment of missed sessions. **Int.**
  - Any reminder calls, texts, or emails are a courtesy and not a requirement of this office. Any no-show or cancellation with less than twenty-four-hour notice is the sole responsibility of the client and will incur the full charge for the scheduled session. **Int.**
  - All payments are made directly to Belaire Counseling Services, LLC.
3. **Services Offered and Clients Served:** I approach counseling from an integrative approach based on the client's needs and the nature of the presenting issues. The approaches that I frequently use based on the most common presenting issues are cognitive behavioral, interpersonal, and family systems. I believe that change occurs through the development of a collaborative working relationship and through changing negative thoughts and behaviors that affect changes in mood. I work with clients in a variety of formats, including individually, as couples and as families, and groups. In addition, I conduct play therapy with children. I work with clients of all ages and backgrounds.
  4. **Code of Conduct:** I am required by law to adhere to the Codes of Conduct for practice that have been adopted by the Licensed Professional Counseling Board and the Licensed Marriage and Family Therapist Board. Copies of the codes of conduct are available to you upon request.
  5. **Privileged Communication:** I am required to abide by the professional practice standards for Licensed Professional Counselors, Licensed Marriage and Family Therapists, and Louisiana law. Information revealed in counseling will remain strictly confidential except under the following circumstances in accordance with state 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 (65 or older), or a dependent adult, or (d) a court order is received directing the disclosure of information.

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

In the event of marriage or family counseling, all parties involved in counseling share the responsibilities as a client and enter into a joint counseling relationship. All contact with the counselor (inside or outside of the scheduled counseling session) is considered part of the therapeutic session. Therefore, all information and material obtained individually from an adult client becomes a permanent component of the joint record. Any information in the joint record is the legal property of all parties

involved and subsequently may be shared with the respective parties. Every effort will be made to protect an individual's confidentiality unless it is detrimental to treatment or meets the exceptions noted above. Any material obtained from a minor client may be shared with the client's parent or guardian at the counselor's discretion. In order for material in a joint record to be released to a third party, all adult members must sign a release of information form. 11

6. **Emergency Situations:** If an emergency situation should arise, you may seek help through hospital emergency room facilities. The emergency services number at Baton Rouge General Medical Center-Bluebonnet is 225-763-4400. If you have after hour critical needs that do not require the emergency room, leave a message on our primary office telephone number at 225-291-1335, and a staff member will respond as soon as possible.
7. **Client Responsibilities:** You are a full partner in counseling. Your honesty and effort are essential to success. As we work together, if you have suggestions or concerns about your counseling, I expect you to share these with us so that we can make the necessary adjustments. You, as the client, are responsible for making all final decisions regarding your treatment. If it develops that you would be better served by another mental health provider, I will help you with the referral process. If you are currently receiving services from another mental health professional, I expect you to inform me of this and grant me permission to share information with this professional so that we may coordinate our services for you or make a decision about which mental health professional may serve you best.
8. **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. As a routine part of the initial session, you will be asked the name of your physician and to list any medications that you are currently taking. In addition, a medical referral may be suggested if a medical problem is suspected.
9. **Potential Counseling Risk:** You should be aware that counseling poses potential risks. In the course of working together additional problems may surface of which you were not initially aware. If this occurs, please feel free to share these new concerns with me so that we can help you work through the issues.
10. I have read, understand, and agree to the information contained in the Declaration of Practices and Procedures for Belaire Counseling Services.

Client #1 signature \_\_\_\_\_ Date \_\_\_\_\_

Client #2 signature \_\_\_\_\_ Date \_\_\_\_\_

Counselor signature \_\_\_\_\_ Date \_\_\_\_\_

If the client is a minor, the parent or guardian must also sign.

I \_\_\_\_\_ (print parent's name) give permission for my child

\_\_\_\_\_ (print child's name) to receive counseling at Belaire Counseling

Services, LLC \_\_\_\_\_ (parent's signature).



### Couples Release of Information

In marriage or family counseling, all parties involved in counseling share the responsibilities as a client and enter into a joint counseling relationship. In order to provide the best possible counseling services, I must remain neutral and not side with any one part of the group. The best method for me to accomplish this is to not keep secrets. Therefore, all contact with me (Dr. Belaire) (inside or outside of the scheduled counseling session) is considered part of the therapeutic session. All information and material obtained individually from an adult client becomes a permanent component of the joint record. Any information in the joint record is the legal property of all parties involved and subsequently may be shared with the respective parties. Every effort will be made to protect an individual's confidentiality unless it is detrimental to treatment or meets the exceptions noted in the Declaration Statement. Any material obtained from a minor client may be shared with the client's parent or guardian at the counselor's discretion. In order for material in a joint record to be released to a third party, all adult members must sign a release of information form.

I understand and agree to the terms of confidentiality listed above.

I understand that I may revoke this consent to the release of information in writing at any time and that this consent will expire at the termination of the counseling relationship or no later than sixty (60) days from the last appointment. I further understand that any release which has been made prior to my written revocation and which was made in reliance upon this authorization shall not constitute a breach of my right of confidentiality.

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Signature

Date

---

Signature

Date

## **Your Information ■ Your Rights ■ Our Responsibilities**

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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.**

### **Your Rights**

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

### **Your Choices**

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

### **Our Uses and Disclosures**

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

### **Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you. You have the right to:

#### **Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

**Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## **Our Uses and Disclosures**

### **How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

#### **Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

#### **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

#### **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

### **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

#### **Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

#### **Do research**

We can use or share your information for health research.

#### **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

#### **Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.



### **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

### **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

### **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

## **Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

## **Other Instructions for Notice**

- Effective 01/01/2014
- Christine Belaire, Privacy Officer, [drbelaire@belairecounseling.com](mailto:drbelaire@belairecounseling.com), (225) 291-1335
- We never market or sell personal information. We do not keep or give information for any hospital's directory. We do not use personal information for the raising of funds.
- We may not comply with a subpoena unless it is accompanied by a separate written order issued by a judge authorizing disclosure of information or issuance of the subpoena. The patient/client has the right to take legal action to restrain the release of records.

## Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form you acknowledge receipt of the Notice of Privacy Practices for Belaire Counseling Services, LLC. Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. Our Notice of Privacy Practices is subject to change.

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Signature of Patient /Patient Representative

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Date

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Name of Patient/ Patient Representative (please print)

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Relationship to Patient

### COMPANY USE ONLY:

We attempted to obtain written acknowledgement of patients' receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained from the patient for the following reason:

- Patient Refused to Sign
- Patient Representative Refused to Sign
- Emergency Situation Prevented Signature
- Other (please specify)