

**CONSENT AND AUTHORIZATION TO RELEASE
INFORMATION TO YOUR PHYSICIAN**

In order to coordinate your medical and psychological treatment your therapist would like to communicate with your primary care physician or pediatrician during the course of your treatment. This may involve sending copies of notes and treatment plans or consulting by telephone. Please complete one of these forms also for any psychiatrist treating you.

I, acting on behalf of

_____ DOB _____

request and authorize
Dr. Sarah Tester
1186 Fremaux Avenue
Slidell, LA 70458

to exchange medical information from my medical records with

(Name of Physician)

(Street)

(City, State, Zip Code)

Telephone # of MD

Please check all of the specific information below which you agree to release.

- | | |
|--|--|
| <input type="checkbox"/> Admission Record | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Psychiatric Evaluations |
| <input type="checkbox"/> Educational Evaluations | <input type="checkbox"/> Psychological Tests |
| <input type="checkbox"/> Social History | <input type="checkbox"/> Progress Notes |

PURPOSE FOR RELEASE OF INFORMATION IS COORDINATION OF TREATMENT.

I understand that I may revoke this consent at any time; and in any event, it shall expire 6 months from date unless sooner revoked, but not retroactive to the release of information made in good faith; and further, that upon fulfillment of the above stated purpose this consent will automatically expire without my express revocation.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from confidential medical records protected by federal law. Federal regulations prohibit you from re-disclosure of this information without specific written consent.

SIGNED: _____ DATE: _____

WITNESS: _____

LEGAL GUARDIAN IF UNDER AGE 16: _____

Notice of Health Information Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

We are committed to treating and using protected health information about you responsibly. This notice of health information practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit our office, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used, helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of **Dr. Sarah Tester**, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect & copy your health record as provided for in 45 CER 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

We are required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

**ASSIGNMENT OF OBLIGATIONS
TO PAY FOR HEALTH CARE BENEFITS**

In consideration of professional services rendered to:

_____ (Patient Name) I hereby assign, transfer and convey all rights for payment, arising under any and all insurance policies, programs of self-insurance or any other obligation to pay for health care and any penalties arising under L.S.A.R.S. 22:657 or any other law to **Dr. Sarah Tester**. Further, I hereby authorize any and all payments to be made directly to **Dr. Sarah Tester**.

Date

Owner of Health Care Benefit

Nature of Relationship to Patient

**YOUR SIGNATURE ON THIS FORM SIMPLY AUTHORIZES
YOUR INSURANCE COMPANY TO PAY US DIRECTLY**

**REQUEST AND AUTHORIZATION
TO RELEASE MEDICAL INFORMATION:**

I hereby request and authorize: **Dr. Sarah Tester** to release any and all medical information: regarding diagnosis and treatment rendered to:

_____ (Patient Name) to insurance carriers or other third parties which may be obligated to pay for the services provided.

Date

Patient (Age 16 Or Above)

Parent/Guardian (If Under 18 Yrs Of Age)

Name: _____ DOB: _____ SSN#: _____

Address: _____
(City/State/ Zip)

Education: _____ Preferred Phone _____

Telephone: (Days): _____ (Evenings): _____

May I leave a message? Yes: _____ No: _____ I prefer you speak with me.

Spouse/Partner: _____ DOB: _____

Marriage Date: _____ If Divorced, When? _____

Children: _____ Age: _____

_____ Age: _____

_____ Age: _____

Other Household Members:

_____ Age: _____

_____ Age: _____

Employment: At home: ___ Self: ___ Business Name: _____

Employer: _____ Position: _____

Spouse/Partner's Employer: _____

Previously
Married? _____

List Year of Marriage & Divorce

In Case of Emergency Notify:

Name & Telephone

Name: _____

Date: _____

Quality of your overall health: _____ Height _____ Weight _____

Caffeine: Decaf/Regular Coffee: ___ per day Decaf/Regular Tea: ___ per day
Decaf/Regular Cola: ___ per day Non-Cola soft drinks: ___ per day

Tobacco: *Smokeless Chew*: ___ times per day or week Age Started: ___ Age Stopped: ___
Cigarettes: ___ packs per day Age Started: ___ Age Stopped: ___

Alcohol: Beer ___ per week Age Started: ___ Age Stopped: ___
Mixed Drinks: ___ per week Age Started: ___ Age Stopped: ___
Wine: ___ per week Age Started: ___ Age Stopped: ___

Surgeries: _____

Check any of the following you now have or have had in the past:

<u>Condition</u>	Current or Past (Use C or P)
Tired Most Of The Time	[___]
Loss Of Appetite	[___]
Sleep (Night Terrors; Lack Of; Unable To; Too Much; Fitful)	[___]
Weight Change (In Last 3 Months)	[___]
Blood Pressure (High; Low)	[___]
Breathing (Emphysema Asthma TB)	[___]
Heart Condition/Disease	[___]
Anemia (Low Blood Count)	[___]
Diabetes (High Blood Sugar)	[___]
Hypoglycemia (Low Blood Sugar)	[___]
Sores That Do Not Heal	[___]
Bones (Soft Brittle; Osteoporosis)	[___]
Cancer/Tumors	[___]
Liver (Jaundice; Cirrhosis; Damage)	[___]
Memory (Recent Remote)	[___]
Headaches (Migraine; Cluster; Tension; With Nausea)	[___]
Skin Disease	[___]
Eating Disorder (Anorexia; Bulimia)	[___]
Thyroid (High; Low)	[___]
Stomach (Ulcers; Indigestion; Acid Reflux; IBS)	[___]
Stroke	[___]
Dizziness/Fainting	[___]
Bowels (Blood In Stool; Diarrhea; Constipation)	[___]
Kidney/Bladder (Infections; Stones; Frequent Urination; Bedwetting) ...	[___]
Eyes (Eyeglasses; Contacts; Blindness; Disease)	[___]
Chills; Fevers; Night Sweats	[___]
Hoarseness Or Nagging Cough	[___]
Sinus Allergies	[___]
Extremities Shaking	[___]
Sexually Transmitted Disease (Gonorrhea Syphilis; HIV; Herpes)	[___]
If you are sexually active, do you engage in protected sex?	[___]
Pregnancies: ___ Live Births ___ Miscarriage ___ Still Born ___ Abortion	

Prescription Drugs You Now Take:

Drug Name	Dosage	Taken How Long	Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies to Medications: _____

Vitamin Supplements: _____

Over The Counter Remedies: _____

Date of last exam: _____

Additional History:

Dr. Tester's Practice Policies
for
New and Established Clients
Effective August 1, 2006

Insurance reimbursement for outpatient psychotherapy is based on a 45~minute hour, as allowed by insurance companies.

If in crisis, you may speak with Dr. Tester or the clinician On-Call by dialing *985.643.5145* at any time. Your call will be returned within 30 minutes.

Dr. Tester requires a 24-Hour Notice for appointment changes and/or cancellations. The minimum fee for Late Cancellations or Missed Appointments is \$75. (Reminder: Insurance companies Do Not pay for missed appointments.)

Between 9AM — Noon and 1PM — 5PM Monday through Friday, you may speak with someone at the front desk. During lunch, after 5PM and on weekends, you may leave a message with the answering service.

There is a charge for writing narrative reports based on length of time required to prepare the report.

Sarah A. Tester, PhD, LMFT, LPC
1186 Fremaux Avenue
Slidell, LA 70458

Informed Consent for Outpatient Psychotherapy

To demonstrate our commitment to professionalism and the highest ethical standards, the risks of psychotherapy are mentioned here for your consideration. Your informed choice at all times will facilitate the best possible outcome. At anytime you may ask for an explanation for why information is gathered or a new approach is prescribed. You can trust that sensitive information will be carefully weighed.

Confidentiality

As is customary for the purpose of ensuring quality services, your therapist may review her work with peers in this office, and on occasion with supervising mental health professionals. Your therapist is ethically required to keep information including records, confidential except in the following instances:

- If you desire your therapist to formally consult with other professionals in the community, an authorization is available for you to sign.
- Any reasonable suspicion of child abuse, physical or sexual, is required to be reported to the state child protection service. Ideally, therapist and client make the report together.
- If you use insurance as reimbursement, information you have authorized the therapist to disclose may be available for retrieval or review,
- Confidentiality may be broken in an effort to protect you from self-harm in suicidal situations,
- In situations of extreme violence or potential harm to others, confidentiality may be broken in order to warn another person his or her life may be in danger.
- Records may be subpoenaed in some court cases.

As Dr. Tester's client, if I have questions about this therapy, I understand she will either answer them, or find answers for me. I understand I may leave therapy at any time; although I am aware that this is best accomplished in consultation with my therapist.

Signed: _____ Date: _____

_____ Date: _____