LIGHTHOUSE
COUNSELING CENTER

To help with your first session, please provide the following information as completely as possible.
Please know that all information will be kept confidential.

Today's Date: _____ Counselor: Sarah Easterly

Date of Birth: _____ Age: _____

Name: _____ Male ☐ Female ☐

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

May we leave a message at these numbers? Yes ☐ No ☐

E-mail: _____

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Widowed ☐

Employer: _____ Occupation: _____

Spouse's Name: _____ Age of Spouse: _____ Number of years married: _____

Employer: _____ Occupation: _____

Person responsible for bill: _____

Church membership? _____

Briefly describe your spiritual life: _____

Person to contact in case of an emergency: _____

Relationship: _____ Phone number: _____

Who referred you to Lighthouse Counseling? Search Engine ☐ Our Website ☐ Family Member ☐

Court ☐ Work ☐ Pastor ☐ Advertisement ☐ Other _____

May I acknowledge this recommendation? Yes ☐ No ☐

Family physician: _____ Phone number: _____

May I contact this physician to discuss your treatment? Yes ☐ No ☐

Are you taking prescription medications at this time? Yes ☐ No ☐

Lighthouse Counseling Center

4728 Jefferson Highway
Jefferson, Louisiana 70121
504-734-0501

8676 Goodwood Boulevard, Suite 204
Baton Rouge, Louisiana 70806
225-636-2011

If yes, what type, for what purpose, and who prescribed this medication?

Do you have children? Yes ☐ No ☐ If yes, how many?

Name	Age	Biological/Step

Father's Name: _____ Living/Age: _____ or deceased? Yes ☐ No ☐

Mother's Name: _____ Living/Age: _____ or deceased? Yes ☐ No ☐

Number of brothers? _____ Number of sisters? _____

Has anyone in your family had counseling before? If so, for what? _____

Any history of drug/alcohol abuse with father, mother, siblings, or extended family? Yes ☐ No ☐

If yes, please describe: _____

Any history of sexual abuse with father, mother, siblings, or extended family? Yes ☐ No ☐

If yes, please describe: _____

Do you use alcohol and/or drugs? Yes ☐ No ☐

If yes, please describe frequency and type: _____

Have you ever experienced sexual difficulties? Yes ☐ No ☐

If yes, please describe frequency and type: _____

Have you ever had therapy? Yes ☐ No ☐

If yes, please describe and list therapist: _____

Describe any major changes that have occurred to you or your family in the last few years (i.e., hurricanes, moves, changes in number of family members, marital status, income, employment, etc.).

List any major health problems for which you are currently receiving treatment:

Please check all of the following problems, which pertain to you.

Nervousness	☐	Depression	☐	Fears	☐
Shyness	☐	Sexual problems	☐	Suicidal thoughts	☐
Separation	☐	Divorce	☐	Finances	☐
Drug use	☐	Alcohol use	☐	Friends	☐
Anger	☐	Self-control	☐	Unhappiness	☐
Sleep	☐	Stress	☐	Work	☐
Relaxation	☐	Headaches	☐	Tiredness	☐
Legal Matters	☐	Memory	☐	Ambition	☐
Energy	☐	Insomnia	☐	Making decisions	☐
Loneliness	☐	Inferiority feelings	☐	Concentration	☐
Education	☐	Career choices	☐	Health problems	☐
Temper	☐	Nightmares	☐	Marriage	☐

Lighthouse Counseling Center

Policy and Treatment Agreement

The following information will acquaint you with the policies and procedures of Lighthouse Counseling Center. After reading this agreement, please feel free to discuss your questions and/or comments with me.

1. **APPOINTMENTS:** Individual, couple, and family sessions are 50 minutes in duration. Groups are usually 1½ to 2 hours in duration.

2. **TARDINESS:** All appointments will begin on time and end 50 minutes later, or at the end of the schedule time. The session will end on time and the client will be expected to pay for the full visit in cases where the client arrives late for visits.

3. **CANCELLATION OF APPOINTMENTS:** Provided an appointment must be cancelled, client is asked to give at least 24-hour notice. Clients will be charged for appointments missed including those, which are not cancelled on time. Full payment for delinquent appointments will be payable at the next scheduled session.

4. **FEES:** The regular fee for individual therapy, couple therapy, and family therapy is $100.00 per 50-minute session. The regular fee for group therapy is $50.00 per 60-minute session. Payment for therapy is due at the end of the session unless alternative arrangements are made in advance.

5. **TELEPHONE CALLS:** In person therapy is preferred to telephone calls. Telephone calls regarding information other than scheduling can be billed to your account.

6. **INSURANCE:** Full payment is expected for services at the time they are rendered, unless alternative arrangements are made in advance. However, we will assist clients in filing their insurance claims, at the request of the client.

7. **CONFIDENTIALITY:** No information about the content of any session will be communicated to anyone without your expressed and written consent. One exception to this important rule is cases of child or elder abuse, or a suicidal or homicidal emergency. In addition, please know that our counselors meet together regularly for consultation. Information that you share in your counseling sessions may be shared in these meetings for consultation purposes. All counselors in these meetings are ethically required to maintain your confidentiality.

8. **TERMINATION:** It has been our experience that clients often end therapy in a manner similar to how they end other relationships. We feel that it is essential, should you decide to end therapy, which you do directly with the counselor rather than by phone or letter. In order for clients to feel positive about themselves, as well as their therapy, this agreement is vital.

Your signature below indicates you have read the information stated above, that you understand it, and that you agree to comply with these policies.

_____ _____

Client's Signature Date

I agree to make full payment for any counseling appointments cancelled without 24-hour notice.

Signature _____ Date _____

Lighthouse Counseling Center

4728 Jefferson Highway • Jefferson, Louisiana 70121 • 504-734-0501
8676 Goodwood Boulevard, Suite 204 • Baton Rouge, Louisiana 70806 • 225-636-2011

Consent to use and disclose your health information

This form is an agreement between you, _____ and me/us, Lighthouse Counseling Center. When we use the word "you" below, it will also include your child, relative, or other person if you write their name here: _____.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide which treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to let us use your information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent for agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future we may change how we use and share our information and so may change our Notice of Privacy Practices. If we do change it, you may get a copy from our Privacy Officer, Carol Meche.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

Signature of client or his/her personal representative.	Date
Printed name of client or personal representative.	Relationship to client

Description of personal representative's authority

Lighthouse Counseling Center

4728 Jefferson Highway • Jefferson, Louisiana 70121 • 504-734-0501
8676 Goodwood Boulevard, Suite 204 • Baton Rouge, Louisiana 70806 • 225-636-2011

Notice of Practices and Procedures (NPP)

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; our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information. We are required also by law to do this. These laws are complicated, but we must provide you with important information. This is a short version of the full, legally required Notice of Practices and Procedures (NPP). However, we cannot cover all possible situations so please talk to our Privacy Officer (noted at the end) about any questions or problems.

We will use the information about your health, which we get from you or from others mainly to provide you with **treatment**, to arrange **payment** for services, or for some other business activities, which are called, in the law, health care operations. After you have read this NPP, please sign page six to let us use and share your information (if needed). If you do not consent to sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes, we will discuss this with you and ask you to sign an authorization to allow this.

Of course we will keep your health information private, but there are some times when the law requires us to share it such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires us to do so.

4. For Worker's Compensation and similar benefit programs.

There are some other situations like these, which do not happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information.

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we do not have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records, but we may charge you. Contact our Privacy Officer listed below to arrange to see your records.

4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some changes (amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell me the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change the NPP, we will post it in our waiting room and you can always get a copy of the NPP from the Privacy Officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the healthcare I provide to you in any way.

If you have any questions regarding this notice or my health information privacy policies, please contact Carol Meche, Privacy Officer. She can be reached by telephone at 504-734-0501 or email carol@lighthouse-counseling.com.