New Client Orientation Packet

Therapeutic Partners, LLC.

60 Louis Prima Drive, Suite A

Covington, LA 70433

Phone: (985) 327-5427

Fax: (985) 327-8800

Office Hours:

Monday – Thursday 9am to 4:30pm

Friday – 9am to 3:30pm

HIPAA

Notice of Privacy Practices

Therapeutic Partners, LLC

60 Louis Prima Dr. Ste. A
Covington, LA. 70433
Office: (985)327-5427
Fax: (985) 327-8800
Email: admin@therapeuticpartners.net

Introduction

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.

This facility is committed to treating and using protected health information about you responsibly. This Notice describe the personal information we collect, and how and when we use or disclose that information. It also describes your right as they relate to your personal health information.

This Notice of Privacy Practices is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Protected Health Information

Each time you visit this facility, a record of your visit is made. This record is often referred to as your "medical record" or "health record". Typically, this record contains information such as:

- Your medical and/or psychiatric history;
- You diagnosis(es);
- Progress notes(treatment details);
- A plan for current and future care;
- Treatment goals;
- Records from others who treated you;
- Information about medication you take;
- Legal matters; and
- Billing and insurance information

The protected health information contained in your medical record serves as a:

- Basic for planning your care and treatment.
- Means of communication among the health professional who contribute to your care.
- Legal document describing your treatment.
- Means for you or third party to verify that services billed were actually provided.
- A tool to educate 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 data source for 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 medical record and how your health information is used helps to: ensure it's accuracy; better understand who, what, when, where and why others may access your health information; and make more informed decisions when authorizing disclosure of your health information to others.

Your Health Information Rights

Although your medical record is the physical property of this facility, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Practices upon request;
- Inspect and copy your medical record (psychotherapy notes are subject to release at the discretion of the treating physician/therapist/agency and require a separate written request)
- Request an amendment your health record. While you may request to amend an "incorrect" record, under 45 CFR 164.526, a request does not automatically grant a right to amend. Therapeutic Partners, LLC. Reserves the right to deny any such request.
- Obtain an accounting of disclosure of the health information in your medical record
- Request a restriction on certain uses and disclosures of your health information
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

This Facility's Responsibilities

In accordance with State and Federal laws, it is the responsibility of this facility to:

- Maintain the privacy of your health information;
- Provide you with this notice describing 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;
- Accommodate reasonable requests you may have to communicate protected health information by alternative means or at alternative locations;
- Not use or disclose your protected health information without your authorization, except as described in this notice; and
- Discontinue to use or disclose your protected health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Right to Revise Privacy Practices

As permitted by law, this facility reserves the right to change or amend our privacy practices and to make the new provisions effective for all protected health information we maintain. Such changes may be required by changes in State or Federal HIPPA laws and regulations concerning protected health information. Upon request, a copy of the most recently revised Notice of Privacy Practices will be provided to you.

Use and Disclosure of Your PHI

When your PHI is viewed within this facility, it is called "use". When it is sent to or shared with others outside this facility, it is called "disclosure". In all circumstances, this facility will only disclose the ***minimum necessary*** PHI required for the needed purpose.

PHI Use and Disclosure With Your Consent

After you read this Notice, you will be asked to allow this facility to use and share your PHI. In most cases, your PHI will be used at this facility or shared with others to provide treatment to you, arrange for payment for services, or other business functions called health care operations. These three things are called TPO, and the Consent form allows us to use and disclose your PHI for TPO purposes.

In order for your treatment to begin, you must consent to allow this facility to collect, use, and share information about you. If you do not consent we cannot treat you. Several staff members at our facility may collect information about you and place it in your health record here.

For Treatment

We use your medical information to provide you with psychiatric treatment or services including individual, family, or group therapy; psychological, educational, or vocational testing; treatment planning; or measuring the effects of our services. We may also share or disclose your PHI to others who provide treatment to you including your personal physician and other treatment team providers, if applicable.

In the event you are in need of special testing or treatments not available at this facility, you will be provided with a referral to an appropriate provider. When this happens, the facility will share some of your PHI with your new provider, and they will provide this facility with results of their treatment. All of this shared information will become a part of your medical record at each provider location. Your PHI may also be shared with other care providers you may have in the future, who may, in turn, share their treatment information with this facility or other care providers. These are examples of how your PHI is shared for treatment purposes.

For Payment

In order for this facility to be paid for treatment provided to you, your PHI may be used to bill you, your insurance company, or others. You insurance company may require some of your PHI including your diagnosis, treatment(s), expected treatment outcomes, treatment dates/times, treatment details/progress, and other similar things.

For Health Care Operations

Your PHI may also be used in daily business functions of this facility called health care operations. Examples include (1) use in this facility to find areas in need of improvement and (2) when required to disclose your PHI to government health agencies so they may study disorders and treatment for research, your name and identity will be removed from what is disclosed.

Other Uses In Healthcare

Appointment Reminders: Your PHI may be used/ disclosed to remind you of appointments for treatment or other care. If you want restrictions on how you are contacted, simply tell any employee.

Treatment Alternatives: Your PHI may be used/ disclosed to tell you about treatments or other care alternatives.

Other Benefits & Services: Your PHI may be used/disclosed to tell you about health related benefits or services.

Business Associates: Your PHI may be used/ disclosed to other persons, called Business Associates, who do things that we do not do at this facility. All Business Associates sign a contract which includes their agreement to honor your right to privacy.

PHI Use and Disclosure Which Requires Your Authorization

This facility cannot use your PHI for any purpose other than TPO without your permission on an *Authorization for Release of PHI* form. Such Authorizations expire after a certain period of time and can be revoked (canceled) by you, in writing, at any time.

PHI Use and Disclosure NOT Requiring Consents or Authorizations

When Required by Law: Some states, Federal or local laws require that PHI be disclosed.

- Suspected child abuse must be reported.
- A subpoena or other lawful process may require PHI disclosure.
- PHI will be disclosed to government agencies to ensure this facility obeys the HIPAA privacy laws.

Law Enforcement Purposes: PHI may be disclosed to a law enforcement official to investigate a crime or criminal.

Public Health Activities: PHI may be disclosed to agencies who research diseases/ injuries.

Specific Government Functions: PHI may be disclosed to military or veteran benefit programs, to Worker's Compensation programs, or to government agencies for national security reasons.

To Prevent A Serious Threat to Health or Safety: If the staff of this facility believes that there is a serious threat to your health or safety or that of another person or public, your PHI may be disclosed to persons who can prevent the danger.

An Accounting of Disclosures

A record is kept of all PHI disclosures including whom it was sent to, What was sent, and when it was sent. You can get an accounting (a list) of many of these disclosures by requesting it from a staff member.

More Information or Complaints

This agency does not advocate the use of Telecommunications as part of the therapeutic process. This includes but is not limited to text and email communication. Should you decide to communicate with your therapist in this way, you assume the full risk of limitations with regard to confidential information and understand that information communicated via text will be printed and made a part of your medical record. Therapeutic Partners, LLC is in no way, liable for communication or personal information that may be viewed or accessed, by a third party, from your phone, computer, tablet or other mobile device.

Therapeutic Partners staff members comply with local, regional, and national guidelines to ensure protection of your confidential information on mobile devices.

If you have questions or need additional information, please contact the facility whose name and telephone number are shown on the front of this document.

If you feel your privacy tights have been violated, you have the right to file a complaint with this facility. There will be no retaliation against you for filing a complaint with this facility.

Therapeutic Partners, LLC
60 Louis Prima Ste. A
Covington, LA 70433

Rights & Responsibilities

Getting mental health services is private. We respect your right to privacy. You have, at the very least, the rights and responsibilities listed below.

Your Rights

If you receive services through Therapeutic Partners, LLC, you have the right to:

- Be treated with respect and consideration for your dignity and privacy.
- To select a mental health provider of your choice.
- Be treated fairly regardless of race, religion, gender, ethnicity, sexual orientation, disability or source of payment.
- Have your treatment and other information kept private. Records may be released without your permission only where permitted by law.
- Receive information on available treatment options and alternatives in a way that is appropriate to your condition and easy to understand.
- Share in developing your plan of care.
- Receive information about Therapeutic Partners, LLC, its practitioners, programs, services, and role in the treatment process.
- Receive information about the clinical guidelines used in providing and managing your care.
- Ask providers about their work history and training.
- Not be restrained or secluded to make you do something you do not want to do (as specified in federal regulations on the use of restraints and seclusion).
- Have provider decisions about your care made on the basis of treatment needs.
- Be given health care services that obey state and federal laws that have to do with your rights.
- Participate in decisions regarding your health care. You have a right to self-determination which includes the right to refuse treatment (except when ordered by a court).
- File a complaint/grievance about Therapeutic Partners, LLC, a provider or the care you receive without fear of reprisal.
- Request and receive a copy of your medical records. There may be a charge for the copies to cover cost and labor.
- Exercise your rights. If you do this, it will not affect the way Therapeutic Partners, LLC and its providers treat you.

Your Responsibilities

Service recipients also have responsibilities with Therapeutic Partners, LLC. Accepting these responsibilities supports your recovery and helps you get the most benefit from your mental health services. It also helps us work with you better. You have the responsibility to:

- Seek treatment that you need from a Therapeutic Partners, LLC provider.
- Treat those giving you care with dignity and respect.
- Give providers and Therapeutic Partners, LLC information they need. This is so providers can deliver quality care, and Therapeutic Partners, LLC can deliver appropriate service.
- Ask your providers questions about your care. This is to help you and your providers understand your health problems and develop treatment goals and plans that you both agree on, as much as possible.
- Follow your treatment plan. You and your provider should agree on this plan.
- Follow the plan for taking your medication that you and your provider agreed on.
- Tell your providers and primary care physician about medication changes. This includes medicines given to you by others.
- Keep your appointment. You should call your provider(s) as soon as you know you need to cancel visits.
- Let your provider know when the treatment plan is not working for you.
- Let your provider know about problems with paying for any required co-pays.
- Openly report concerns about the quality of your care.
- Participate in services without the abuse of alcohol or illicit drugs.
- Report abuse and fraud. You can report concerns by requesting to speak to the Corporate Compliance office or by emailing your concerns to: admin@therapeuticpartners.net

Complaint/ Grievance Process

If, at any time you or a family member believe that your treatment at Therapeutic Partners, LLC is not adequate, safe or in your best interest, you have the following rights which will not in any way serve to compromise your future treatment or access to care:

1. You have the right to voice your complaint expressing your concern regarding the care you receive.
2. You may seek remedy for any complaint.
3. You may complain directly to any staff member.
4. You may submit the complaint in writing and may have assistance in writing the complaint if you are unable to read or write.
5. Staff will initiate an investigation of your complaint within 72 hours of receipt of the complaint.
6. You may request direct access to the Compliance Officer or Chief Administrative Officer at any time during the grievance process.
7. If you believe any of your rights have been violated or you have other concerns about your care in this facility, you may contact one or more of the following:

Department of Health & Hospitals
628 N. 4th Street
Baton Rouge, LA 70802
Phone: (225) 342-9500
Fax: (225) 342-5568

Mental Health Advocate
150 3rd St.
Baton Rouge, LA 70802
Phone: (225) 342-6678

Therapeutic Partners, LLC has a designated Compliance Officer. This person will act on behalf of the patient and/ or family and is responsible for reviewing, investigating, and analyzing all complaints and making recommendations to administration for resolution of all complaints. If at any time you wish to speak to out Compliance Officer you may do so by calling:

Deana Jacob
Email: admin@therapeuticpartners.net
985-327-5427
10a.m.-3p.m. Mon-Fri

You have the right to make a Mental Health Advance Directive:

This document allows you to make decisions in advance about mental health treatment, which includes but is not limited to psychoactive medication, short-term (not to exceed 15 days) admission to a treatment facility, electroshock therapy and outpatient services. The instructions that you include in this directive will be followed only if two physicians believe that you are "incapable", which means that, due to any infirmity, you are currently unable to make or to communicate reasoned decisions regarding your mental health treatment.

Your instructions cannot limit the state's authority to take you into protective custody, or to involuntarily admit or commit you to a treatment facility. Your instructions can be disregarded in an emergency if your instructions have not reduced the behavior that has caused the emergency. In a nonemergency, you may be medicated contrary to your wishes only after an administrative review in which you are provided legal counsel.

You may also appoint a person as your representative to make treatment decisions for you if you become incapable. The person you appoint must act consistently with your wishes as expressed in this document or, if not stated, as otherwise known by your representative. If your representative does not know your wishes, he or she must make decisions in your best interest. For the appointment to be effective, the person you appoint must accept the appointment in writing. The person has the right to withdraw from acting as your representative at any time.

This document will continue in effect for a period of five years unless you become incapable. If this occurs, the directive will continue in effect until you are no longer incapable. You have the right to revoke this document in whole or in part at any time you have not been determined to be incapable.

You may not revoke this advance directive when you are determined incapable by two physicians.

A revocation is effective when it is communicated to your treating physician or other provider.

This advance directive will not be valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature. Also, it must be accompanied by a written mental status examination performed by a physician or psychologist attesting to your ability to make reasoned decisions about your mental health treatment.

If there is anything in this document that you do not understand, please ask for additional information.

THERAPEUTIC PARTNERS, LLC.
IMPORTANT INFORMATION ABOUT AUTHORIZATION

We may need your authorization to use, disclose or obtain your health information for some of our services.

You do not have to sign this form. If you agree to sign this authorization to release or obtain information, you will be given a signed copy of the form.

A separate signed authorization form is required for the use and disclosure of health information for:

- Psychotherapy notes
- Employment-related determinations by an employer
- Research purposes unrelated to your treatment

When required by law or policy, THERAPEUTIC PARTNERS, LLC may only obtain, use and disclose your health information if the required written authorization includes all the required elements of a valid authorization.

An authorization is voluntary. You will not be required to sign an authorization as a condition of receiving treatment services or payment for health care services. If your authorization is required by law or policy, THERAPEUTIC PARTNERS, LLC will use and disclose your health information as you have authorized on the signed authorization form.

You may be required to sign an authorization before receiving research-related treatment.

You may be required to sign an authorization form for the purpose of creating protected health information for disclosure to a third party. *Example:* In a juvenile court proceeding where a parent is required to obtain a psychological evaluation on their minor child by THERAPEUTIC PARTNERS, LLC, the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to THERAPEUTIC PARTNERS, LLC.

You may cancel an authorization in writing at any time. THERAPEUTIC PARTNERS, LLC can not take back any uses or disclosures already made before an authorization was cancelled.

Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by THERAPEUTIC PARTNERS, LLC privacy policies.

Your right to file a privacy complaint

You may contact the Privacy Office listed below if you want to file a complaint or to report a problem about how THERAPEUTIC PARTNERS, LLC has used or disclosed information about you. Your benefits will not be affected by any complaints you make. THERAPEUTIC PARTNERS, LLC cannot punish or retaliate against you for filing a complaint, cooperating in any investigation, or refusing to agree to something that you believe to be unlawful. Your Privacy office contact is:

Therapeutic Partners, LLC
60 Louis Prima Drive, Suite A
Covington, Louisiana 70433
Phone: (985) 327-5427
Fax: (985) 327-8800

Email: admin@therapeuticpartners.net

24 – Hour Access to Services

1. All clients have access to 24-hour emergency consultation and brief intervention services that MAY include direct contact and/or consultation with the psychiatrist and/or psychiatric nurse.

2. After hours, clients are able to access emergency services by calling the main office number. When a voicemail message is received and considered emergent, a return phone call is made to the client immediately to assess the situation. If necessary, the on call psychiatrist is contacted by the LMHP.

3. All crisis situations are assessed by a licensed mental health professional via face to face evaluation and/or telecommunication.

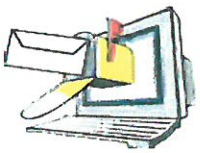
Therapeutic Partners, LLC contact information:

Main Office
60 Louis Prima Dr., Ste. A
Covington, LA 70433

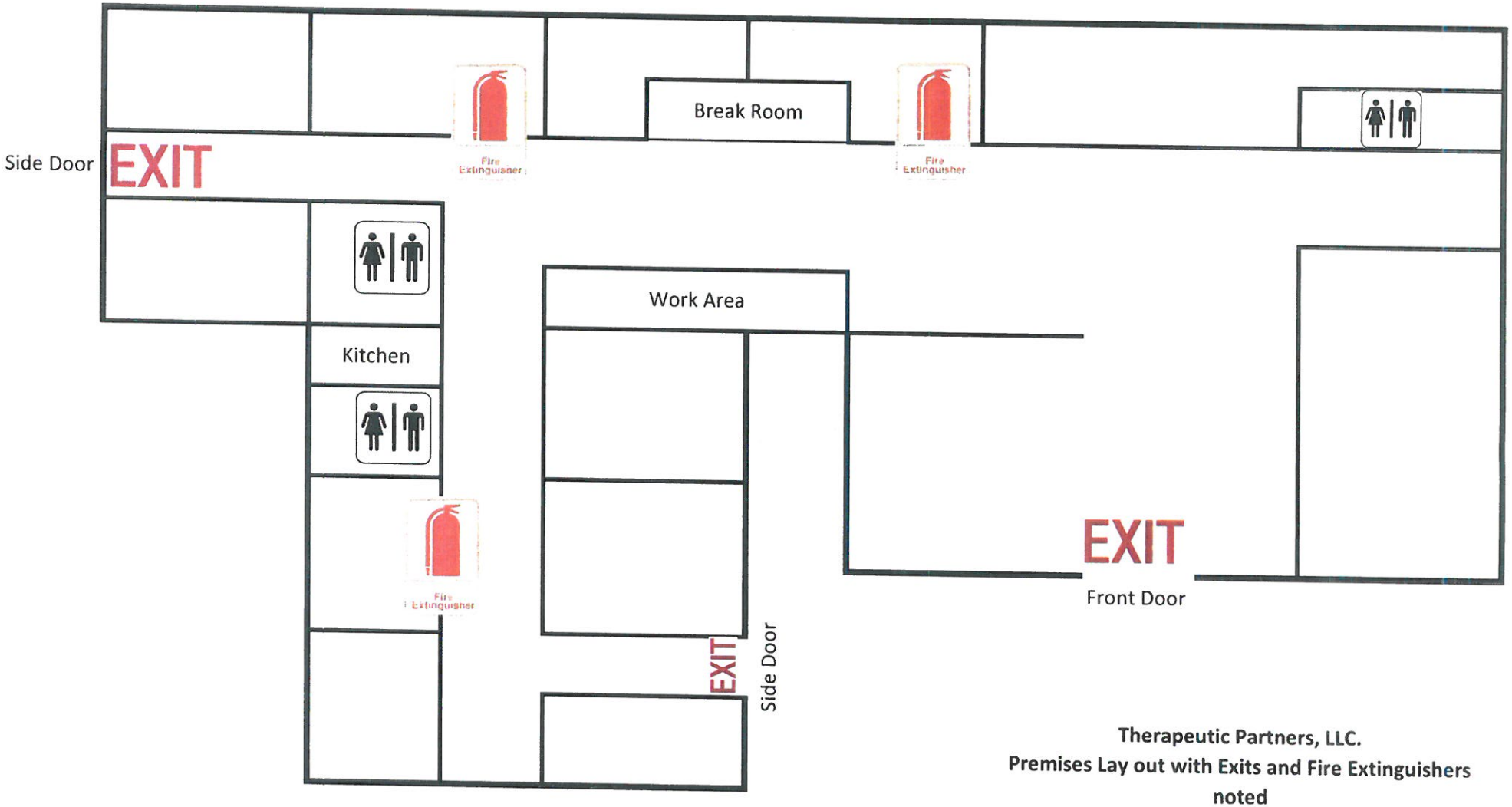
Phone: (985) 327-5427
Fax: (985) 327-8800

Hours of Operation
9:00 am to 4:30 pm
Monday thru Thursday
9:00 am to 3:00 pm
Friday
Additional Hours by Appointment Only

Emergency Services
24 Hours a Day, 7 Days a week
(985) 327-5427



Email Address:
admin@therapeuticpartners.net



Therapeutic Partners, LLC.
Premises Lay out with Exits and Fire Extinguishers noted

FEE and INSURANCE COMMITMENT

Therapeutic Partners, LLC

60 Louis Prima Dr. Ste. A

Covington, LA 70433

Phone: 985-327-5427, Fax 985-327-8800

Fees are discussed at the time the appointment is scheduled or at the initial session. Payment is expected at the time of Service. Office visits, Psychological testing, school visits, letters, reports, telephone conferences or prolonged . Psychotheraphy sessions are charged according to the time involved.

The Financial aspects of therapy are part of the contract between us. Insurance may help you to fulfill your financial obligation. The final obligation for payment lies with you, not your insurance company. We will assist you in filling your insurance claims one time if you wish. Unless there is an error on our part, it is the patient's responsibility to deal with the insurance company.We will also attempt to verify your coverage on the first visit.Please understand that this verification is not a guarantee of what your insurance company will cover as benefits are sometimes misquoted to us. We suggest that you also contact your insurance company to determine your coverage for "Outpatient psychotherapy" at the onset of therapy. This will give you a better expectation of possible reimbursement.

We will be happy to file for insurance company reimbursement; however, you will need to complete the insurance information portion below.You will also need to sign the "Release of Information" form before any insurance can be filed. If your company requires the use of a special insurance form, please supply this form.

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INSURANCE INFORMATION

Client's Name:
Policyholder Name:
Address:
Policyholder Date of Birth: SS#
Primary Care Physician: Phone #
Employer:
Insurance company Name:
Primary Insurance:
Address:
Policy Number:

☐ I authorize Therapeutic Partners, LLC to release any medical information necessary to process this claim for insurance reimbursement. I authorize payment of medical benefits to Therapeutic Partners, LLC for the counseling services provided. I understand that I am responsible for any fees that my insurance company refuses to pay.

****

☐ Person responsible for all charges not covered by insurance.This includes any fees for missed /canceled appointments in which I do not give 24-hour advance notice.

Name:

Address:
Phone# Relationship to Pt:

Driver's License # SS#

****

I agree to pay the full fee of $35.00 for any session missed or canceled in which I do not give a 24-hour advance notice of cancellation.

Please note: There is a $25.00 charge for each check that is returned for NSF. After the second check that has been returned for NSF,cash payments are required.

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I have read the above information and agree to the policies of Therapeutic Partners, LLC

Patient Signature: Date :

☐ Click this check box to eSign.

Parent/Guardian Signature:

Date :

☐ Click this check box to eSign.

Staff Signature : Date :

☐ Click this check box to eSign.

Therapeutic Partners, LLC
60 Louis Prima Suite A
Covington, LA 70433
985-327-5427 fax: 985-327-8800

Acknowledgements/Consents

□ I acknowledge receipt of Therapeutic Partners, LLC Notice of Privacy Practices and Consent to the uses of my Personal Health Information (PHI) as described within. I also understand the limits of confidentiality as described in the notice, specifically the limits of PHI protection when utilizing text and email communication.

□ I acknowledge receipt of client rights and responsibilities, including procedure to file a complaint or grievance.

□ I acknowledge receipt of information about Mental Health Advance Directives and have been informed of my rights to formulate a Mental Health Advance Directive.

□ I HAVE executed an Advance Directive.
□ I HAVE NOT executed an Advance Directive.

□ I authorize Therapeutic Partners, LLC to release information to Payors (i.e. insurance companies) as required for billing purposes. I also authorize the insurance companies to pay directly to Therapeutic Partners, LLC, benefits due on my behalf, if any, as provided by my policy.

□ I understand that if I miss three or more scheduled appointments without calling to cancel or reschedule, it MAY result in termination of services or transfer of care to another clinician.

□ I understand that 24hr notice is required for all in-office sessions to avoid a cancellation fee ($35) for appointments scheduled with any of our therapists, psychiatrist, or nurse practitioner. I understand that insurance and third party payers will NOT cover any portion of this fee. For in-office appointments, 24hr notice is required directly with office staff BY TELEPHONE. Since email or text may not be checked consistently, cancellation of your appointment directly to your therapist, or by email to administrative staff, does not constitute acceptable communication for cancellation of your appointment.

□ I understand that I am responsible for payment at the time services are rendered, including but not limited to previous balance, insurance copayments, and insurance deductibles.

□ I consent to treatment by Therapeutic Partners, LLC and have had my questions answered so that I understand the above.

□ If telehealth is recommended as part of my behavioral health treatment, I acknowledge that I have been made aware of its' benefits and limitations. I further acknowledge the risks and limitations with confidentiality and agree to assume responsibility for ensuring confidentiality is upheld to my standards if my own personal device is used. I also acknowledge that I have a right to refuse Telehealth and that this refusal may impact my ability to access certain mental health services through Therapeutic Partners, LLC.

□ I acknowledge I have received information in regards to 24 hours access to care.

□ I request the following people to participate in my/my child's treatment. This may include participation during session, signing of treatment plans, coordination of visits, and any other activity beneficial to the progression of my/my child's treatment.

1.
2.
3.

Therapeutic Partners, LLC

60 Louis Prima, Covington, La, 70433, 985-327-5427

Therapeutic Partners, LLC - Client ROI	
Patient Name :	Patient DOB :
1. **RECORDS AUTHORIZED BY CLIENT:** With this document, I authorize Therapeutic Partners, LLC to receive and disclose the following protected healthcare information:	

Initials	Information
Yes No	Identity, dates, diagnoses, prognoses, recommendations, treatment rendered, assessments, locations, progress notes, treatment status, dialogue with recipient, treatment summary and treatment coordination.
Yes No	Mental Health Treatment, to include Psychiatric/Medication History (past and present)
Yes No	Medical Services, to include Medication History and Prior Hospitalizations (past and present)
Yes No	Family (past and present)
Yes No	Employment (past and present)
Yes No	Education (past and present)
Yes No	Legal Involvement (past and present)
Yes No	Alcohol and Drug Treatment(past and present)
Yes No	Other:

2.**ORGANIZATION OR INDIVIDUAL AUTHORIZED BY CLIENT:** The following individual or organization has been authorized to receive or disclose this patient's protected healthcare information with Therapeutic Partners, LLC, Inc of La:	
Organization:	
Name/Title and/or Individual:	
Mailing Address:	
City: State:	Zip Code:
Phone:	Fax :

3. **PURPOSE OF AUTHORIZATION:** The patient has agreed to this authorization for the following purpose(s):
Patient Request Court/Litigation Counseling/Therapeutic Value Other :
Specify:
I understand that my mental health and/or alcohol/drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol/Drug Abuse Patient Records, **42 C.F.R.,Part 2**, and the Health Insurance Portability and Accountability Act (HIPPA) of 1996,**45 C.F.R. Pts. 160 & 164**, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This Disclosure Authorization is specifically intended to include any references to diagnosis, testing, and/or treatments for communicable diseases, including sexually transmitted, mental health services and alcohol/drug services. **I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, including provision of health care services requiring subsequent disclosure to effect payment.** Unauthorized re-disclosure by recipient is prohibited, but may be a potential risk. I understand that I do not have to sign this authorization in order to receive health care benefits, except for health care services necessary to create an assessment or report for disclosure to the recipient identified in this authorization. **In any event, this authorization expires automatically as follows: 1 year from patient's authorization and signature or immediately after the patient's revocation of authorization.**

4. **SIGNATURES :** Patient's Printed Name & DOB : Test Patient & 06/22/1988