FAMILY FOCUS & ASSOCIATES

Clinic Policies

IMPORTANT CLINIC INFORMATION
PLEASE KEEP THIS PAGE FOR YOUR RECORDS

APPOINTMENT POLICY

- 48-hour cancellation policy
- Office does not make reminder calls
- Full amount of session charged if unexcused
- Rescheduling fee charged for missed appointments
- Excused appointments also subject to rescheduling fee
- Being late to appointment reduces session time
- Charts closed after 12 months of inactivity

PAYMENT FOR SERVICES

- Family Focus is a private pay clinic
- Full payment is due when services are rendered
- Keep your receipt to file for reimbursement
- Please keep your credit card authorization current
- Payment must otherwise be made at time of scheduling

PRESCRIPTION REFILLS

- 48-hour notice required for prescription refills
- Fee charged for rush requests

CONTACT US

- frontdesk@familyfocusbr.com
- familyfocusbr.com
- (225) 231-7155 front desk
- (225) 379-2130 after hours
- (225) 231-7160 fax

New Patient Registration

PATIENT INFORMATION

Last Name ______________________ First Name ______________________

Gender ______________________ Pronouns ______________________

Address ____

City ______________________ State __________ ZIP __________

Birthdate ___/___/______ Age ______ Social Security _____–_____–______

Email ______________________ Driver's License ______________________

Preferred Phone (   )   – __________ Alternate Phone (   )   – __________

PHARMACY

Name ______________________ Phone (   )   – __________

Location ____

INSURANCE

We are required to submit your insurance information when obtaining prior authorization for prescriptions. ***Please attach copy of insurance card, front and back.***

Insurance Company ______________________ Name of Insured ______________________

Member ID ______________________ Group Number ______________________

BIN # ______________ PCN # ______________ Medicare/Medicaid Y N

EMPLOYER

Employer ______________________ Phone (   )   – __________

Occupation ____

SPOUSE / PARTNER

Last Name ______________________ First Name ______________________

Email ______________________ Phone ( ) –

PARENT / GUARDIAN

Last Name ______________________ First Name ______________________

Address ______________________

City ______________________ State ________ ZIP ________

Birthdate / / Age ________ Social Security – –

Email ______________________ Driver's License ______________________

Employer ______________________ Preferred Phone ( ) –

PARENT / GUARDIAN

Last Name ______________________ First Name ______________________

Address ______________________

City ______________________ State ________ ZIP ________

Birthdate / / Age ________ Social Security – –

Email ______________________ Driver's License ______________________

Employer ______________________ Preferred Phone ( ) –

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INITIAL

Family Focus may contact me using the information I have provided on this form and may leave messages for me as needed.

Welcome to Family Focus

Welcome to Family Focus! We are excited about embarking on this journey with you and look forward to a time of growth and possibility. It's important to begin with a clear understanding of expectations: The information in this packet will help you understand each of our rights and responsibilities. Please read these policies carefully and sign where indicated. If our services are for a child who's reached the age of 17, they must consent for themselves.

Important information is listed at the beginning of each section. We are happy to provide you with a copy of these policies as well as answer your questions about the information in this document or about any other aspect of our work together.

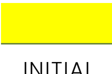
Family Focus refers to Family Focus LLC, its facilities, stakeholders, contractors, employees, volunteers and all other persons directly or indirectly associated with the enterprise. All clinicians at Family Focus abide by clinic policies but are independent contractors and not otherwise employed by the practice. Family Focus assumes no liability for the actions or inactions of independent contractors.

MANAGING APPOINTMENTS

- ***48-hour cancellation policy***
- ***Full amount charged for late cancellations and no-shows***
- ***Missed appointments subject to rescheduling fee***

Initial visits typically take about 80 minutes and range from $150-$525. Ongoing sessions are 30-90 minutes and range from $110-$175. The frequency of visits suggested by your clinician will depend on your needs and preferences. Please feel free to discuss your schedule with your clinician at any time.

Managing appointments is your responsibility. We do not make reminder calls. Minimum notice of 48 hours is required to cancel or reschedule your appointment without being charged for the full session. At clinician's discretion, a minimum rescheduling fee of at least $35 will apply to all missed appointments, including excused appointments.


INITIAL

Arriving late to an appointment reduces session time. Children under age 10 must have adult supervision.

PAYMENT FOR SERVICES

- ***Payment is due when services are rendered***
- ***Please keep credit card authorization up to date***
- ***Store receipts carefully***

Family Focus is a private pay clinic. We do not accept insurance. We will keep your credit card securely on file to be charged when services are rendered. Unless other arrangements are made, the same card will be used for all family members seen at Family Focus. If no credit card is available, payment for appointments must be made as they are scheduled.

We will provide a detailed receipt of each visit should you choose to file for reimbursement with your insurance provider. Please store receipts securely: There is a $30 per-event fee to reproduce them.

Unpaid bills over 90 days late will be sent to collections. A $50 collection fee will be added to each unpaid bill sent to collections.

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If more than one person will be responsible for payment, all parties should submit their own credit card authorization indicating the percentage of each payment to be charged to each card.

CREDIT CARD AUTHORIZATION

Please remember to keep your credit card information up to date.

Cardholder Name ______________________ Phone ( ) – __________

Card Number ______________________ Expiration ___/___ CVC ______

Debit ☐ Credit ☐ Visa ☐ Mastercard ☐ ZIP Code ________

Cardholder Signature ______________________ Percentage ______ %

CONFIDENTIALITY

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Collaboration is considered a standard of good practice for mental health professionals. The clinicians at Family Focus function as a team. Staff meetings are held to discuss best practices in patient care. Your information will only be shared as outlined in our HIPAA Privacy Notice.

PRESCRIPTION REFILLS

- ***48-hour prescription refill policy***
- ***Fee charged for rush requests***

Please request prescription refills from your clinician during your office visit or regular clinic hours. Your pharmacy can also fax requests for non-stimulant refills to (225) 231-7160.

Please allow 48 hours for your refill to be processed. If you need it faster, and we can accommodate your request, there will be a $20 rush fee.

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If the prescription for a controlled substance or the medication itself is lost, the prescription will not be rewritten.

ADDRESSING CONCERNS

Brief consultation with your clinician outside your regular session is included in our service. Consults longer than 15 minutes will be charged at your clinician's regular hourly rate.

HAVE A CONCERN ABOUT YOUR TREATMENT?
Call or email your clinician, allowing up to 48 hours for reply.

HAVE A SAFETY CONCERN DURING BUSINESS HOURS?
Call front desk at (225) 231-7155 and we will page your clinician.

HAVE A SAFETY CONCERN AFTER HOURS?
Call answering service at (225) 379-2130 or go immediately to emergency room.

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HAVE A NON-SAFETY CONCERN AFTER HOURS?
Call front desk (225) 231-7155 and leave message on voicemail.

TERMINATION OF SERVICES

You may terminate services at any time. If you were to terminate, your clinician would decide whether a therapeutic relationship could be reestablished. A pattern of unscheduled, cancelled or missed appointments could result in termination. In such case, referral to another clinician would be provided. After 12 months of inactivity, your chart will be closed. If your chart is closed, you will revert to new patient status, and any future treatment will be as a new patient.

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AUTHORIZATION FOR ELECTRONIC COMMUNICATION

I hereby request that Family Focus communicate with me electronically about my treatment. I understand there are risks associated with the electronic transmission of my protected health information (PHI). Electronic communication could be lost, intercepted, altered, corrupted or incomplete, or could fail to be delivered.

I also understand my electronically transmitted PHI may not be encrypted. After receiving notice of these risks, I authorize Family Focus to communicate with me electronically, including the transmission of my PHI. I understand I may revoke this authorization by writing the Privacy Offer at Family Focus, 8303 O'Hara Court, Baton Rouge LA 70806.

This authorization allows my PHI to be electronically transmitted only to me, not any third party. I understand I must submit a separate authorization to allow the disclosure of my PHI to any third party. Family Focus bears no responsibility or liability for any error, omission, claim or loss in connection to the electronic transmission of any information to me by Family Focus.

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ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I confirm I have been given a copy of the HIPAA Privacy Notice describing how Family Focus may use or disclose my protected health information. I understand I should read it carefully. I am aware the notice may be updated from time to time and that I can always request a copy from the front desk or download it from the website.

NOTICE TO MINORS

Your mental healthcare provider has the right to disclose your protected health information to your parent/guardian if deemed necessary.

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I understand the clinic guidelines provided in this consent. I understand I am encouraged to ask questions about this information, now or at any time in the future. I have read this consent in its entirety and agree to abide by its terms. I hereby consent to being contacted by Family Focus and agree that Family Focus may leave messages for me as needed.

SIGNATURE OF PATIENT *(or guardian if a minor)*	PRINTED NAME	DATE

Authorization for Release of Information

PATIENT

Last Name ______________ First Name ______________
Address ______________________________
City ______________ State ________ ZIP ________
Phone ( ) – ______________ Birthdate / /

REASON

- [x] Communication about treatment between healthcare providers
- [ ] At request of patient or patient's representative
- [ ] Records copied, sent to requestors and billed to patient

DATES

- [x] Beginning of treatment through continuity of care
- [ ] Dates of / / through / /

RECORDS

- [ ] Complete records **excluding** psychotherapy notes
- [x] Complete records **including** psychotherapy notes
- [ ] Other: ______________________________
- [ ] Information to be excluded: ______________________________

Release of Information

I authorize Family Focus to verbally release the information identified in this authorization to:

____
____
____

Release of Records

I authorize Family Focus to release the medical records identified in this authorization to:

____
____
____

I understand that I am not required to sign this authorization and treatment will not be denied if I do not. I understand that the records I authorize for release may contain private information about me or my significant others, including any history of substance abuse, genetic conditions or psychiatric issues. I understand that once information has been released, it could be redisclosed. I hereby release, discharge and hold harmless Family Focus LLC and its independent contractors from any liability for complying with this authorization.

______________________ ______________________ / /

SIGNATURE OF PATIENT
(or parent/guardian if a minor)

PRINTED NAME

DATE

Patient Health Questionnaire

Patient Name ______________________ Date ____/____/____

Completed By ______________________

Has there ever been a time when you were not your usual self and:	YES	NO
You felt so good that people thought you weren't acting like yourself or were so hyper you got in trouble?	☐	☐
You were so irritable that you started fights and arguments?	☐	☐
You felt much more self-confident than usual?	☐	☐
You got much less sleep than usual and didn't really miss it?	☐	☐
You were more talkative or spoke much faster than usual?	☐	☐
Your mind was racing or you couldn't slow your thoughts down?	☐	☐
You were easily distracted and had trouble staying on track?	☐	☐
You had more energy than usual?	☐	☐
You were much more active or did many more things than usual?	☐	☐
You were much social than usual, like calling friends very late at night?	☐	☐
You were much more interested in sex than usual?	☐	☐
You did things that were unusual for you or things other people might have thought were excessive or risky?	☐	☐
You spent money that got you or your family in trouble?	☐	☐

Have several symptoms ever occurred over the same period of time?

☐ Yes ☐ No

How much of a problem were your symptoms? Were you able to work or go to school? Did you have family, money or legal trouble? Did you get into fights or arguments?

☐ No problem ☐ Minor ☐ Moderate ☐ Serious

Patient Name ______________________ Date ____/____/____

Completed By ______________________

Check one box that best describes the patient:	NOT AT ALL	A LITTLE	QUITE A BIT	VERY MUCH
Often overlooks details and makes careless mistakes in activities and schoolwork	☐	☐	☐	☐
Often has difficulty maintaining attention on tasks	☐	☐	☐	☐
Often seems not to listen when directly addressed	☐	☐	☐	☐
Often fails to follow through with instructions on tasks	☐	☐	☐	☐
Often has difficulty organizing tasks and activities	☐	☐	☐	☐
Often avoids or is reluctant to engage in tasks requiring sustained mental effort	☐	☐	☐	☐
Often loses tools, supplies and things necessary to complete schoolwork or tasks	☐	☐	☐	☐
Is often distracted by extraneous stimuli	☐	☐	☐	☐
Is often forgetful in daily activities	☐	☐	☐	☐
Often fidgets with hands or feet or squirms in seat	☐	☐	☐	☐
Often leaves seat when staying seated is expected	☐	☐	☐	☐
Often climbs or fidgets at inappropriate times	☐	☐	☐	☐
Often has difficulty engaging quietly in activities	☐	☐	☐	☐
Is often "on the go" or acts as if "motorized"	☐	☐	☐	☐
Often talks excessively or loudly or is overly animated	☐	☐	☐	☐
Often blurts out answer before hearing full question	☐	☐	☐	☐
Often interrupts or has difficulty awaiting turn	☐	☐	☐	☐
Often procrastinates	☐	☐	☐	☐
Is often bored or needs stimuli to feel entertained	☐	☐	☐	☐
Often fixates on interesting or exciting things and has trouble shifting focus to less appealing things	☐	☐	☐	☐

Patient Name ______________________ Date ____/____/____

Completed By ______________________

How much were you bothered by these symptoms during the last month?	**NONE**	**MILD**	**MODERATE**	**SEVERE**
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Racing or pounding heart	0	1	2	3
Unsteady	0	1	2	3
Afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky or unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Feeling faint or lightheaded	0	1	2	3
Flushed face	0	1	2	3
Hot or cold sweats	0	1	2	3
COLUMN TOTALS				

0-21 *Indicates low anxiety. Your assessment could be unrealistic or you may have learned to mask common symptoms. Too little anxiety could also indicate detachment.*

22-35 *Indicates moderate anxiety. Look for patterns when you experience these symptoms. You may have some conflict issues that need to be resolved.*

36+ *Indicates high anxiety. Persistent high anxiety is not a sign of personal weakness. It is a sign of an issue that needs to be treated to avoid negative mental impact.*

Patient Name ______________________ Date ___/___/___

Completed By ______________________

Over the last two weeks, how often have you experienced each of these symptoms?	NOT AT ALL	SEVERAL DAYS	MOST DAYS	EVERY DAY
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, thinking of yourself as a failure, feeling you have let yourself or your family down	0	1	2	3
Trouble concentrating on activities such as reading the newspaper or watching TV	0	1	2	3
Moving or speaking so slowly that other people have noticed	0	1	2	3
Being fidgety or restless and moving around more than usual	0	1	2	3
Having thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any symptoms, how difficult have those symptoms made it for you to do your work, take care of things at home and get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult