**LOUISIANA NOTICE FORM**

**Notice of Psychologist’s Policies and Practices to Protect the Privacy of Your Health Information**

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

# I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

* “*PHI”* refers to information in your health record that could identify you.
* *“Treatment, Payment, and Health Care Operations”*

– *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

- *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. Payment may also include disclosing information to a collection agency or court for the purposes of obtaining payment, should reimbursement not be obtained through other means. In most collection situations, the only information released regarding your treatment would be your name, the nature of services provided and the amount due.

- *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.

* “*Use*” applies only to activities within my [office, clinic, practice group, etc.], such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
* “*Disclosure*” applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries or copies of your entire clinical record. By signing this agreement, you agree that I can provide requested information to your carrier.

## II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An “*authorization”* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

# III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

* **Child Abuse** – If I have cause to believe that a child's physical or mental health or welfare is endangered as a result of abuse or neglect or that abuse or neglect was a contributing factor in a child's death, I must report this belief to Louisiana Department of Social Services.
* **Adult and Domestic Abuse** – If I have cause to believe that an adult's physical or mental health or welfare has been or may be further adversely affected by abuse, neglect, or exploitation, I must report this belief to the appropriate authorities as required by law. Please note that the term “adult”, for the purposes of this section, means any person sixty years of age or older, any disabled person eighteen years of age or older, or an emancipated minor.
* **Health Oversight Activities –** The Louisiana Board of Psychological Examiners may subpoena records from me relevant to its disciplinary proceedings and investigations.
* **Judicial and Administrative Proceedings** – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without your written authorization, or a court order. In the event of your death, your legally-appointed representative will be given access if a suit is brought on behalf of the estate. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I will inform you in advance if this is the case.
* **Serious Threat to Health or Safety** – If you communicate to me a threat of physical violence, which I deem to be significant, against a clearly identified victim or victims, coupled with the apparent intent and ability to carry out such threat, I must take reasonable precautions to provide protection from the violent behavior. These precautions include communicating the threat to the potential victim(s) and notifying law enforcement.

**Worker’s Compensation** – If you file a worker’s compensation claim and I have treated you relevant to that claim, I must disclose any requested medical information and records relative to your injury to your employer, to a licensed and approved vocational rehabilitation counselor assigned to your claim, another health care provider examining you, or the worker’s compensation insurer.

## IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

* *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
* *Right to Receive* *Confidential Communications by Alternative Means and at Alternative Locations* –You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
* *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
* *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
* *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
* *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist’s Duties:

* I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
* I reserve the right to change the privacy policies and practices described in this notice. If I revise my policies and procedures, I will provide you with a written copy at your next appointment.

# V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact **Louisiana State Board of Examiners of Psychologists, 8280 YMCA Plaza Drive, Building 8B, Baton Rouge, Louisiana 70810, (225) 763-3935**.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

# VI. Effective Date, Restrictions, and Changes to Privacy Policy

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain.

**Tracy H. Dossett, J.D., Ph.D., L.L.C.**

**Licensed Psychologist**

**7913 Wrenwood Blvd.**

**Baton Rouge, LA 70809**

**(225) 763-6300**

**Receipt of Notice of Privacy Practices**

This is to certify that the HIPAA Notice of Privacy Practices has been made available to me regarding me as a patient or regarding my child, for whom I am a legal guardian.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Authorized Party

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness

**CONSENT FOR TREATMENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent to diagnosis and treatment of myself by **Tracy H. Dossett, J.D., Ph.D., L.L.C..** In entering into this agreement, I understand that all mental health care, diagnosis and treatment is provided by the licensed professional named above.

I accept responsibility for payment of all usual and customary professional fees charged, **or** insurance deductibles and copayments set by my insurance carrier, managed care company, or other third party administrator, **and** understand that I am responsible for any expenses incurred that are not covered by such other entities (i.e. un-authorized procedure, telephone communications to third parties or yourself, filling out of forms or other documents, letters, reports or other written communications, etc.). I understand that payment is due at the time services are rendered, unless other arrangements have been made in advance. I understand that if my account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, Dr. Dossett has the option of using legal means to secure the payment, which may involve hiring a collection agency or going through court. If such legal action is necessary, I understand that its costs will be included in the claim as well as standard interest charges.

Dr. Dossett is both a licensed psychologist and attorney.  However, she does not currently practice law and does not provide legal advice to clients. I understand that I am here as a psychological client and that nothing that is discussed with Dr. Dossett is to be construed as legal advice.  Should I need legal counsel, I understand that I will need to contact another licensed attorney.

I understand further that all communications shall be held in professional confidence except for those circumstances provided by law or when I have given permission in writing for release of information on my behalf to a third party. Examples (**not a complete list**) of legal exceptions to the patient's privilege of confidentiality include the following:

\* When you have filed a lawsuit placing your mental status at issue;

\* When you have signed an agreement with some other person or company, such as your insurer, authorizing release of information;

\* When your condition poses a danger to yourself or someone else;

\* When evidence of abuse is revealed.

*Cancellation of sessions, and re-scheduling of sessions, must be done at least 24 hours in advance.* ***If you do not cancel/reschedule at least 24 hours in advance, you will be billed for that session.*** *If you are going through an insurance company, you should know that they will not pay this cancellation fee; it will be an out-of-pocket expense for you.*

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| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Date | Signature |

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|  | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  | Witness |
|  |  |

INFORMED CONSENT FOR PSYCHOEDUCATIONAL

ASSESSMENT

Dr. Dossett performs psychoeducational evaluations as part of services offers. The following facts are important for you to know if you plan to request a psychoeducational evaluation or if one is recommended.

1. Evaluations may or may not confirm that you or your child’s results are consistent with ADHD, a Learning Disorder, or another mental health condition. If they do not, you will still receive information that may be valuable in devising remediation plans.
2. Actual testing often takes anywhere from 4 to 8 hours, and may be scheduled in a single session or over a one to two week period, depending on the battery. Individuals receive feedback on results about two weeks after the last testing session, provided that cancellations or unforeseen problems do not arise. If you need academic accommodations or are interested in requesting academic accommodations for your child, please note that it may take approximately 6 to 8 weeks from initial interview to receive a report containing a summary of testing results and recommendations. This time interval is needed for the evaluator to administer and score the tests, interpret results, write the report, and provide you with feedback..

3. Payment for testing is due at the time of service. The cost of assessment varies depending on the

battery of tests administered. If you are requesting that we file with your insurance company, please note that filing of a claim does not guarantee payment by your insurance company. Examples of reasons for nonpayment may include: a policy does not cover psychological testing or excludes a diagnosis from coverage. In some instances, we cannot know the total cost of evaluation or if insurance will pay for provided services until after they have been provided to you. Please note that you are responsible for paying for services not covered by your insurance company. For a complete psychoeducational evaluation, this may up to $2000.

1. Test reports will be sent only to qualified professionals with your written consent. Actual test protocols cannot be sent because they are protected by copyrights and they may be misinterpreted by persons who are not trained in interpreting psychological tests. We make great efforts to protect your privacy and identity, so we cannot talk or reveal information about you or your child to anyone, except for specific individuals that you have identified in a signed, written release.
2. Any information presented at intake or subsequent contact with Dr. Dossett or office staff that is considered important in regards to the referral question or diagnosis may be included in the final report.

I AGREE WITH THE CONDITIONS OF TESTING THAT ARE LISTED ABOVE.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tracy H. Dossett, J.D., Ph.D., L.L.C.**

**Licensed Psychologist**

***Client Information***

**\*\*Please fill out entire form to the best of your ability\*\***

**Patient Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Today’s Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Birthdate** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age** \_\_\_\_\_\_\_\_\_\_\_\_ **Height** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Weight** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip code** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone** (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell** (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SSN#** \_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

**Email Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer/Occupation** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone** (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Highest Grade Completed or Degree** \_\_\_\_\_\_\_\_ **School** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status** Single \_\_\_\_\_\_\_ Married \_\_\_\_\_\_ (Date \_\_\_\_\_\_\_\_\_\_\_) Widowed \_\_\_\_\_\_ (Date \_\_\_\_\_\_\_\_\_\_\_)

Separated \_\_\_\_\_\_\_ (Date\_\_\_\_\_\_\_\_\_\_\_) Divorced \_\_\_\_\_\_\_\_ (Date \_\_\_\_\_\_\_\_\_\_\_)

**Spouse/Partner’s Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birthdate** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age** \_\_\_\_\_\_\_\_

**Address (if different)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telephone** (\_\_\_\_ )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SSN#** \_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ **Cell** (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer/Occupation** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone** (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Children (names and ages)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Parents** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Marital Status** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Brothers/Sisters (names and ages)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Chief Complaint** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Previous Evaluation/Treatment (where, when, who)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications (Current/Past)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Referred by** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADULT SYMPTOM CHECKLIST**

In order to assist your clinician in the assessment process, please check any of the following symptoms that you have experienced within the *last month*.

\_\_\_\_\_ Irritability \_\_\_\_\_ Frequent sadness

\_\_\_\_\_ Sleep problems \_\_\_\_\_ Recent loss

\_\_\_\_\_ Worry a lot \_\_\_\_\_Parenting problems

\_\_\_\_\_ Tense \_\_\_\_\_ Marital problems

\_\_\_\_\_ Nightmares \_\_\_\_\_ Sexual problems

\_\_\_\_\_ Poor appetite \_\_\_\_\_ Family problems

\_\_\_\_\_ Excessive appetite \_\_\_\_\_ Work or school problems

\_\_\_\_\_ Binge eating \_\_\_\_\_ Hearing voices

\_\_\_\_\_ Weight loss \_\_\_\_\_ Do things over and over

\_\_\_\_\_ Crying \_\_\_\_\_ Suicidal thoughts

\_\_\_\_\_ Poor concentration \_\_\_\_\_ Drug usage

\_\_\_\_\_ Low energy \_\_\_\_\_ Drink too much

\_\_\_\_\_ Energy loss \_\_\_\_\_ Family members drink

\_\_\_\_\_ Hopelessness \_\_\_\_\_ Overspending

\_\_\_\_\_ Fearfulness \_\_\_\_\_ Gambling

\_\_\_\_\_ Lying \_\_\_\_\_ Jealousy

\_\_\_\_\_ Shyness \_\_\_\_\_ Hurts self

\_\_\_\_\_ Vomiting after eating \_\_\_\_\_ Trouble with law

\_\_\_\_\_ Laxative use to control weight \_\_\_\_\_ Memory problems

\_\_\_\_\_ Trouble expressing feelings \_\_\_\_\_ Feel someone is out to get you

\_\_\_\_\_ Trouble managing anger \_\_\_\_\_ Feel taken advantage of

\_\_\_\_\_ Physical Violence \_\_\_\_\_ Fears of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Chronic Pain \_\_\_\_\_ Trouble making decisions

\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tracy H. Dossett, J.D., Ph.D., L.L.C.**

**Licensed Psychologist**

**7913 Wrenwood Blvd.**

**Ste. A**

**Baton Rouge, LA 70809**

**(225) 763-6300**

HEALTH REVIEW

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PRIMARY CARE PHYSICIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU EVER HAD OR HAVE ANY OF THE FOLLOWING PROBLEMS (PLEASE CIRCLE):

1. Weight changes more than 6 pounds in last 3 months YES or NO

2. Recent chills or fever YES or NO

3. Weakness or fatigue YES or NO

4. Major surgical operations YES or NO

5. Serious injuries YES or NO

6. Allergic reaction to a medicine YES or NO

7. Cancer or malignant disease YES or NO

8. Amount of alcohol intake, \_\_\_\_\_\_\_ day YES or NO

9. Smoking, packs/day \_\_\_\_\_\_ duration \_\_\_\_\_\_yrs. YES or NO

10. Vision problems YES or NO

11. Glaucoma or cataracts YES or NO

12. Inflamed eyes YES or NO

13. Difficulty in hearing YES or NO

14. Ear infections YES or NO

15. Noises in ears YES or NO

16. Severe dizziness YES or NO

17. Sinus or allergy problems YES or NO

18. Persistent hoarseness YES or NO

19. Frequent colds or sore throats YES or NO

20. Bleeding or sore gums YES or NO

21. Soreness in mouth or tongue YES or NO

22. Nosebleeds YES or NO

23. Lumps or swelling in neck YES or NO

24. Persistent cough YES or NO

25. Coughed up blood YES or NO

26. Shortness of breath YES or NO

27. Pneumonia or lung infections YES or NO

28. Tuberculosis YES or NO

HAVE YOU EVER HAD OR HAVE ANY OF THE FOLLOWING PROBLEMS (PLEASE CIRCLE):

29. Abnormal chest x-ray/spot on lungs YES or NO

30. Asthma or wheezing YES or NO

31. A known heart disease YES or NO

32. Heart attack or failure YES or NO

33. High blood pressure YES or NO

34. Irregular or fast heartbeat YES or NO

35. Chest pain or tightness when active YES or NO

36. Need to sleep on several pillows YES or NO

37. Heart murmurs YES or NO

38. Swelling of legs or ankles YES or NO

39. Leg pain with or after walking YES or NO

40. Varicose veins YES or NO

41. Poor appetite YES or NO

42. Difficulty swallowing YES or NO

43. Heartburn or indigestion YES or NO

44. Recent changes in bowel movements/habits YES or NO

45. Vomiting blood YES or NO

46. Passing black stools or rectal bleeding YES or NO

47. Stomach abdominal pain YES or NO

48. Stomach or duodenal ulcers YES or NO

49. Hepatitis or liver diseases YES or NO

50. Frequent nausea or vomiting YES or NO

51. Gallstones or gallbladder problems YES or NO

52. Chronic constipation YES or NO

53. Chronic diarrhea or loose stools YES or NO

54. Hemorrhoids or rectal problems YES or NO

55. Excessive gas or bloating YES or NO

56. Passing blood in urine YES or NO

HAVE YOU EVER HAD OR HAVE ANY OF THE FOLLOWING PROBLEMS (PLEASE CIRCLE):

57. Frequent or painful urination (3 or more times) YES or NO

58. Frequent urination at night YES or NO

59. Difficult to start urination YES or NO

60. Difficult to control bladder YES or NO

61. Changes in urine color YES or NO

62. Sugar or albumin in urine YES or NO

63. Kidney or bladder stones YES or NO

64. Known kidney disease YES or NO

65. Frequent bladder or kidney infections YES or NO

66. Venereal diseases (syphilis or gonorrhea, etc.) YES or NO

67. Lumps in groins or genitals YES or NO

68. Hemias YES or NO

69. Impotence or sexual dysfunction YES or NO

70. Menstrual problems or irregularity YES or NO

71. Unusual vaginal bleeding YES or NO

72. Frequent vaginal infections YES or NO

73. Lumps in breast YES or NO

74. Nipple discharge YES or NO

75. Frequent or chronic joint pain YES or NO

76. Joints swollen for weeks YES or NO

77. Bursitis or tendonitis YES or NO

78. Injections in the joints YES or NO

79. Gout YES or NO

80. Bone diseases or osteoporosis YES or NO

81. Back or neck injuries YES or NO

82. Frequent back or neck pain or stiffness YES or NO

83. Numbness or tingling in hands or feet YES or NO

FAMILY HISTORY (SIBLINGS, CHILDREN, PARENTS, RELATIVES)

High blood pressure YES or NO

Heart disease YES or NO

Stroke YES or NO

Cancer type YES or NO

Kidney diseases YES or NO

Lung Diseases YES or NO

List medications you are allergic to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior hospitalizations and why

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU EVER HAD OR HAVE ANY OF THE FOLLOWING PROBLEMS (PLEASE CIRCLE):

84. Rash or itching YES or NO

85. Psoriasis YES or NO

86. Skin ulcers YES or NO

87. Hives or eczema YES or NO

88. Frequent headaches or migraine YES or NO

89. Head injuries or loss of consciousness YES or NO

90. Convulsions or fits YES or NO

91. Fainting or blackout spells YES or NO

92. Numbness or paralysis (temporary or permanent) YES or NO

93. Nervous breakdown YES or NO

94. Consulted a psychiatrist/psychologist YES or NO

95. Taken medicine for nervousness YES or NO

96. Difficulty sleeping YES or NO

97. Crying or blue spells YES or NO

98. Anemia YES or NO

99. Bruise easily YES or NO

100. Frequent bleeding YES or NO

101. Blood transfusion(s) in the past YES or NO

102. Diabetes YES or NO

103. Goiter YES or NO

104. Taken thyroid medications YES or NO

105. Heat or cold intolerance YES or NO

106. Hormone medication YES or NO

107. Cortisone medications YES or NO

108. Excessive water drinking YES or NO

109. Excessive sweating YES or NO

110. Chronic Pain YES or NO

Blood diseases YES or NO

Tuberculosis YES or NO

Diabetes YES or NO

Epilepsy YES or NO

Asthma YES or NO

Other diseases (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES or NO

Any other information pertinent to your physical and psychological health problems?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tracy H. Dossett, J.D., Ph.D., L.L.C.**

**Licensed Psychologist**

**7913 Wrenwood Blvd.**

**Ste. A**

**Baton Rouge, LA 70809**

**(225) 763-6300**

**Authorization for Release of Confidential Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give my consent for the

release of confidential information concerning:

\_\_\_\_\_\_myself\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be released is limited to:

\_\_\_\_\_\_all findings\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disclosure of this information is for the purpose of:

\_\_\_\_\_\_evaluation or treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information shall be exchanged between:

\_\_\_\_\_\_Tracy H. Dossett, J.D., Ph.D., L.L.C.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This consent may be revoked in writing at any time, but such revocation

shall not be retroactive.

This consent shall expire not later than one year after treatment or evaluation ends.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness

**Tracy H. Dossett, J.D., Ph.D., L.L.C.**

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**Baton Rouge, LA 70809**

**(225) 763-6300**

**Authorization for Release of Confidential Information**

I, , give my consent for the

release of confidential information concerning:

myself \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be released is limited to:

my findings\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disclosure of this information is for the purpose of:

evaluation or treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information shall be interchanged between:

Tracy H. Dossett, J.D., Ph.D., L.L.C.

and:

Your insurance provider

This consent may be revoked in writing at any time, but such revocation shall not be retroactive.

This consent shall expire not later than one year after treatment or evaluation ends.

Date Signature

Witness

**Tracy H. Dossett, J.D., Ph.D., L.L.C.**

**Licensed Psychologist**

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**Authorization for Release of Confidential Information**

I, , give my consent for the

release of confidential information concerning:

myself \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be released is limited to:

my findings\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disclosure of this information is for the purpose of:

evaluation or treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information shall be interchanged between:

Tracy H. Dossett, J.D., Ph.D., L.L.C.

and:

This consent may be revoked in writing at any time, but such revocation shall not be retroactive.

This consent shall expire not later than one year after treatment or evaluation ends.

Date Signature

Witness