CLIENT INFORMATION FORM—
PARENT/GUARDIAN OF ADOLESCENT

Date of Initial Appointment _____

Parent/Guardian's Name

_____

Adolescent's Name and Date of Birth

_____

Parent Telephone #1 _____ home work mobile

Parent Telephone #2 _____ home work mobile

Mailing Address _____

_____

From whom did you learn of Dr. Nkongho?

___ Psychology Today ___ www.boldquestions.com

___ Pine River Psychotherapy Associates ___ BTB Fitness

___ My physician/therapist _____(Name)

___ Other source _____(Name)

May I thank this person for the referral? Y N

Emergency Contact Name and Telephone Number _____

_____

Current Medications Adolescent is taking (prescriptions and over-the-counter)

_____

With whom does the adolescent live? Who are all the members of the household(s) and their ages?

_____

_____

If the adolescent has any parent(s) or sibling(s) who do not live with the adolescent, please list those people here and indicate where they live.

_____

_____

What school does the adolescent attend? What grade is he/she in? Please also indicate whether the adolescent receives any special services (IEP, 504 Plan, Magnet, Gifted Program) within the school setting.

_____

_____

Administrative Information

Payment of Fees: By signing below, you agree that you responsible for full payment of session fees at the time of service. The initial appointment is $225 for a 90-minute session; both you and the adolescent will be present for the beginning portion of the initial appointment. Follow-up appointments (usually for the adolescent alone; occasionally you will be asked to join) are billed at $175 for 45-minute sessions.

Insurance: If you plan to use insurance, you are responsible for your bill with me, and the insurance company is responsible for reimbursing you. I will cooperate with you in filling out your forms. You will receive a statement of charges and payments after the end of each month.

Cancellation Policy: If you cancel a session without providing a 24-hour notice, you understand that you will be charged and be responsible for paying a regular session fee for that cancellation. Unless we determine otherwise, you (the parent/guardian) will be responsible for scheduling and/or cancelling appointments with me.

Confidentiality: Georgia law protects the privacy of all communications between a client and a psychologist. This means that all of my exchanges with your adolescent—with a few specific exceptions—are kept **confidential and private**. The confidentiality of the adolescent's psychotherapy is guaranteed unless (1) your adolescent presents a serious danger to him/herself or others or (2) I know or have a reason to believe your adolescent

has been or is being physically abused, sexually abused, or neglected. As parent/guardian, I will share general reports of your adolescent's progress in psychotherapy under this agreement. If there is **any** custodial agreement in place concerning this adolescent, you will need to submit a copy of that to me for my records.

Role of Parent/Guardian in the Adolescent's Therapy: As the parent/guardian, you play an essential role in the life of this adolescent. Your willingness to examine your contribution to the adolescent's challenges and to contribute solutions is a key part of the change process. It is very difficult for an adolescent to experience lasting positive change when the parent/guardian is uninvolved in the change process. By signing below, you acknowledge that, at times, you will be asked to join in the therapy process (in the therapy room) to participate in the adolescent's steps towards positive growth.

Please ask any questions you might have about the administrative information above.

I understand and agree to these policies.

Signature: _____

Date: _____

NDIYA NKONGHO, PH.D., P.C.
1145 SHERIDAN ROAD NE
ATLANTA, GA 30324

Health Insurance Portability and Accountability Act (HIPAA)

NOTICE OF PRIVACY PRACTICES

Effective 7/1/2008

I. COMMITMENT TO YOUR PRIVACY: I am dedicated to maintaining the privacy of your protected health information (PHI). PHI is information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. This Notice of Privacy Practices ("Notice") is required by law to provide you with the legal duties and the privacy practices that I maintain concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

II. LEGAL DUTY TO SAFEGUARD YOUR PHI: By federal and state law, I am required to ensure that your PHI is kept private. This Notice explains when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share applies, utilizes, examines, or analyzes information within its practice; PHI is disclosed when I release, transfer, gives, or otherwise reveals it to a third party outside of the Institute. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

III. CHANGES TO THIS NOTICE: The terms of this notice apply to all records containing your PHI that are created or retained by Dr. Ndiya Nkongho. Please note that I reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that I have created or maintained in the past and for any of your records that I may create or maintain in the future. I will have a copy of the current Notice in the office in a visible location at all times, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of my Notice of Privacy Practices.

IV. HOW I MAY USE AND DISCLOSE YOUR PHI: **I will not use or disclose your PHI without your written authorization, except as described in this Notice or as described in the "Information, Authorization and Consent to Treatment" document. Below you will find the different categories of possible uses and disclosures with some examples.**

1. For Treatment: I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If you are also seeing a psychiatrist for medication management, I may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, I will always ask for your authorization in writing prior to any such consultation.

2. For Health Care Operations: I may disclose your PHI to facilitate the efficient and correct operation of its practice. Example: Quality control - I may provide your PHI to its office personnel, accountants, practice consultants, attorneys and others to make sure that I am in compliance with applicable practices and laws. It is my practice to conceal all client names in such an event and maintain confidentiality. However, there is still a possibility that your PHI may audited for such purposes.

3. To Obtain Payment for Treatment: I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or managed health care plan, in order to get payment for the health care services that have been provided to you. I could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for my office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, I will always do its best to reconcile this with you first prior to involving any outside agency.

4. Employees and Business Associates: There may be instances where services are provided to my office by an employee or through contracts with third-party "business associates." Whenever an employee or business associate arrangement involves the use or disclosure of your PHI, I will have a written contract that requires the employee or business associate to maintain the same high standards of safeguarding your privacy that is required of me.

Note: Georgia and Federal law provides additional protection for certain types of health information, including **alcohol or drug abuse, mental health and AIDS/HIV,** and may limit whether and how I may disclose information about you to others.

V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES – I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **Law Enforcement:** Subject to certain conditions, I may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **Lawsuits and Disputes: I** may disclose information about you to respond to a court or administrative order or a search warrant. I may also disclose information if an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. I will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the information requested.
3. **Public Health Risks:** I may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.
4. **Food and Drug Administration (FDA):** I. may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
5. **Serious Threat to Health or Safety:** I may disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, I may provide PHI to law enforcement personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.
6. **Minors:** If you are a minor (under 18 years of age), I may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.
7. **Abuse and Neglect:** I may disclose PHI if mandated by Georgia child, elder, or dependent adult abuse and neglect reporting laws. Example: If I have a reasonable suspicion of child abuse or neglect, I will report this to the Georgia Department of Child and Family Services.
8. **Coroners, Medical Examiners, and Funeral Directors:** I may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death or other duties as authorized by law. I may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.

9. **Communications with Family, Friends, or Others:** I may release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related decisions for you), or any other person you identify, relevant to that person's involvement in your care or payment related to your care. In addition, I may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.
10. **Military and Veterans:** If you are a member of the armed forces, I may release PHI about you as required by military command authorities. I may also release PHI about foreign military personnel to the appropriate military authority.
11. **National Security, Protective Services for the President, and Intelligence Activities:** I may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law.
12. **Correctional Institutions:** If you are or become an inmate of a correctional institution, I may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others
13. **For Research Purposes:** In certain limited circumstances, I may use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified, directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.
14. **For Workers' Compensation Purposes:**
    I may provide PHI in order to comply with Workers' Compensation or similar programs established by law.
15. **Appointment Reminders:** I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that you may need or that may be of interest to you.
16. **Health Oversight Activities:** I may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
17. **If Disclosure is Otherwise Specifically Required by Law.**

VI. Other Uses and Disclosures Require Your Prior Written Authorization: In any other situation not covered by this notice, I will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying me in writing of your decision. You understand that I am unable to take back any disclosures it has already made with your permission, I will continue to comply with laws that require certain disclosures, and I am required to retain records of the care that its therapists have provided to you.

VII. RIGHTS YOU HAVE REGARDING YOUR PHI:

1. The Right to See and Get Copies of Your PHI: In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but knows who does, you will be advised how you can get it. You will receive a response from me within 30 days of receiving your written request. Under certain circumstances, I may feel it must deny your request, but if it does, I will give you, in writing, the reasons for the denial. I will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged not more than $.25 per page and the fees associated with supplies and postage. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

2. The Right to Request Limits on Uses and Disclosures of Your PHI: You have the right to ask that I limit how it uses and discloses your PHI. While I will consider your request, it is not legally bound to agree. If I do agree to your request, it will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

3. The Right to Choose How I Send Your PHI to You: It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience.

4. The Right to Get a List of the Disclosures. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, or to corrections or law enforcement personnel. The request must be in writing and state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case it will charge you a reasonable sum based on a set fee for each additional request.

5. The Right to Amend Your PHI: If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if it finds that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, or (c) not part of its records,. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial will be attached to any future disclosures of your PHI. If I approve your request, it will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

6. The Right to Get This Notice by Email: You have the right to get this notice by email. You have the right to request a paper copy of it as well.

7. Submit all Written Requests: Submit to my office address.

VIII. COMPLAINTS: If you are concerned your privacy rights may have been violated, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services Office of Civil Rights. I will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Your signature below indicates that you Acknowledge receipt of this notice:

_____ **Client Name (please print)**

_____ **Client Signature**

_____ **Date**

If Applicable:

_____ Parent/Legal Guardian Name (please print)

_____ Parent/Legal Guardian Signature

_____ Date

Date of Last Revision: 01/01/16

ADOLESCENT INFORMATION FORM

Name _____

Current Age _____

School/Grade _____

What three words best describe your school? _____

_____

With whom do you live? Include pets, if any. _____

_____

How would you describe your physical health? _____

_____

Do you do any kind of paid work? If so, please describe what you do and how much you earn.

_____

_____

Whose idea was it for you to come here today? Why did s/he (or you) believe therapy would be a good idea?

_____

_____

If there's a question you wish you could have answered, please list that question here.

_____

_____

Confidentiality: Georgia law protects the privacy of all communications between a client and a psychologist. This means that all of my exchanges with you—with a few specific exceptions—are kept **confidential and private**. The confidentiality of psychotherapy is guaranteed unless (1) you present a serious danger to yourself or others or (2) I know or have a reason to believe you have been or are being physically abused, sexually abused, or neglected. I will share general reports of your progress in psychotherapy with your parent/guardian under this agreement—and I usually do this with you in the room. Please discuss with me any concerns you may have about this.

Role of Parent/Guardian in the Adolescent's Therapy: This is your psychotherapy. However, I do **not** think your parent/guardian can "check out," have no involvement whatsoever in your therapy, and expect you to change for the better. Your parent/guardian has an essential role in your life, which means s/he has an important role in your therapy too. Your parent/guardian's job is to examine and improve the contributions s/he is making in your family life. By signing below, you acknowledge that, at times, you and I invite your parent/guardian into the room to be an active part of the change process.

If you have any questions about the policies above, please ask! I'm happy to discuss them with you.

I understand and agree to these policies.

Signature: _____

Date: _____