Jocelyne Counseling & Consulting Group

COUPLE'S COUNSELING QUESTIONNAIRE

Please help me to get to know you and your relationship by completing without your partner's help. Each partner will complete their own questionnaire. (If more space is needed to answer, use back.)

Preferred Pronoun:_____Cell Number:_____Email Adress_____

Name Date of Birth Education Occupation Religion, if any

You _____

Your partner _____

Your SS#_____Current Home Address:_____

(Circle One) Engaged / Married / Separated / Divorced / Live Together / Other _____

How long have you been in this relationship? _____

If married, how long have you been married?_____ If you lived together before marriage, how long?

_____

Children: Name Sex Date of Birth Is child yours? Your Partner's ? Or both? Living at home?

_____

_____

_____

_____

If anyone else lives in your household, please list including age and relationship:

_____

_____

List major relationships you had before your partner:

When Current status (divorced, friends, etc.) Children from this relationship?

_____

_____

_____

What concerns bring you to couple's counseling? _____

_____

_____

What goals do you have for your relationship? _____

_____

_____

Have you had therapy or couple's counseling in the past and, if so, what and when? _____

_____

If so, what was helpful? _____

What was not helpful? _____

What traits do you appreciate in your partner? _____

_____

What traits do you think your partner appreciates in you? _____

_____

Describe 2 behaviors which you <u>personally</u> could change to make relationship better: _____

_____

_____

Describe 2 of your partner's behaviors which are challenging to you: _____

_____

_____

Have there been any incidents of physical violence or threat of violence? _____

If yes, describe: _____

Do you or your partner have difficulties with alcohol or substance abuse? _____

If yes, describe: _____

<u>FAMILY OF ORIGIN</u>

We often bring what we have learned about family in childhood to our current relationships. Please help me to get to know your family of origin.

What words describe the home in which you were raised (ex. loving, unsafe, hectic, etc.)

_____

What words come to mind when you think of your parents' relationship to each other? _____

_____

Are your parents:

(Circle One) Engaged / Married / Separated / Divorced / Living Together / One or both deceased

If your parents separated from each other or remarried/entered into new partnerships, how old were you at the time? Separated _____ New Spouse/ Partner: Mom _____ Dad _____

If you were adopted, how old were you when placed? _____

If you have siblings, please list below:

Name	Age	Occupation	Parent (Mom, Dad or both?)	Lived with you growing up?

What strengths do you remember in your family of origin? _____

_____

_____

What weaknesses do you remember in your family of origin? _____

_____

_____

Was there any physical or sexual abuse in your family? _____ If yes, what kind of abuse and with who? _____

List any important events or "family secrets" in your family of origin: _____

_____

_____

TJocelyne Counseling & Consulting LLC.
425 Pleasant Street, Brockton MA 02301
Phone: 508-580-0364 Fax: 888-506-6021

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY.

This information can be made available in Spanish, French and Haitian Creole. Please ask a staff member if you need a copy in either of these languages. Esta información esta disponible en español. Se usted necesita una copia en español, por favor pregunte a miembro del personal. Si vous avez besoin d'une copie en Francais, s'il vous plait addressez vous aux membre du bureau. Si ou bzwen on copi an kreyol,tanpri mande on moun nan biro a.

When we refer to "you" or "your" in this Notice we refer to the person or persons receiving the services provided by *TJocelyne Counseling & Consulting LLC.*. When we refer to disclosures of information to "you", we mean disclosures to adults or children, the parent of the children, guardian or other person legally authorized to receive information about the person or persons receiving services from *TJocelyne Counseling & Consulting LLC.*.

Who follows this Notice:

This Notice applies to all **protected health information** (**PHI**) maintained by *TJocelyne Counseling & Consulting LLC.* for services provided at any office of *TJocelyne Counseling & Consulting LLC.* or services provided at non-office locations by any employee of *TJocelyne Counseling & Consulting LLC.* in the course of their employment. If you have any questions after reading this Notice, please contact the *TJocelyne Counseling & Consulting LLC.* Privacy Officer.

Each time you receive services from *TJocelyne Counseling & Consulting LLC.*, a record of the services provided is created. Typically this record could contain information about the type of service you have received the dates of service and the results of the service provided. At times this will include the reason you have come to *TJocelyne Counseling & Consulting LLC.* for service and the agreed upon goals of the service provided.

This Notice applies to all of the records containing PHI created as a result of services provided by *TJocelyne Counseling & Consulting LLC.*.

Our Pledge to Protect Your Health Information: We are required by law to maintain the privacy of your PHI and provide you with a description of our privacy practices. We will abide by the terms of this Notice.

How We May Use and Share Your Health Information With Others

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. For example, a worker or therapist may use PHI about you or your child from a clinic record to determine which treatment option, such as family or individual therapy, best addresses your needs. Your worker or therapist may discuss information found in your record with our consultants, a colleague or their supervisor to assist in treatment planning for you or your child.

For Payment: We may use and disclose PHI to send bills and collect payment from you, your insurance company, or other payors, such as governmental agencies, for the treatment or other related services you receive from *TJocelyne Counseling & Consulting LLC.*, so *TJocelyne Counseling & Consulting LLC.* can receive payment for the treatment services provided to you. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing and sending claims to your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

For Health Care Operations: We may disclose PHI about you for business operations of *TJocelyne Counseling & Consulting LLC.*. These uses and disclosures are necessary for *TJocelyne Counseling & Consulting LLC.* to provide quality care and cost-effective services. The operations where we may need to disclose PHI includes, but is not limited to, quality assessment activities, employee review activities, and licensing activities. For example, we may share your PHI with third parties that perform various business activities (such as billing or typing services). We will require these third parties to have a contract with us that requires them to safeguard the privacy of your PHI. Quality assessment activities may include evaluating the performance of your therapist or examining the effectiveness of treatment provided to you when compared to patients in similar situations.

Future Communications and Fundraising Activities: We may use your name, address and telephone number to contact you to provide newsletters, information about programs or other services we offer or to raise money for health programs. We may disclose this information to the *[name hospital and its foundation]* so that the Foundation may contact you relating to raising money for *[above named hospital]*, of which *TJocelyne Counseling & Consulting LLC.* is an affiliate. If you do not want the *[name hospital and its foundation]* to contact you relating to fundraising efforts, you must notify us in writing. Please contact the Privacy Officer to assist you with this request.

Appointments: We may use your PHI for the purpose of sending to you appointment reminders through the mail or by telephone. Messages left for you will not contain specific health information.

Required or Permitted by Law: *TJocelyne Counseling & Consulting LLC.* is required by law to disclose your PHI in certain circumstances:

- For public health oversight activities
- To facilitate the functions of federal or state governmental agencies
- To report suspected elder or child abuse to law enforcement agencies responsible to investigate or prosecute abuse
- In response to a valid court order
- To the Department of Health and Family Services, a protection or advocacy agency, or law enforcement authorities investigating abuse, neglect, physical injury, death or violent crimes
- To your court-appointed guardian or an agent appointed by you under a health care power of attorney
- Prison officials if you are in custody
- Worker's Compensation officials if your condition is work-related
- If necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public

When sharing PHI with others outside of *TJocelyne Counseling & Consulting LLC.*, we share only what is reasonably necessary unless we are sharing PHI to help treat you, in response to your written permission, or as the law requires. In these cases, we share all the PHI that you or the law requires.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your PHI we maintain. To exercise any of the rights discussed in the remainder of this section, please contact the Privacy Officer for *TJocelyne Counseling & Consulting LLC.* [give name and address here].

Right to Request Restrictions: You have the right to request certain restrictions of use and disclosure of your PHI by *TJocelyne Counseling & Consulting LLC.* for treatment, payment or health care operations. You also have the right to request a restriction on our disclosure of your PHI to someone who is involved in your care or the payment for your care. *TJocelyne Counseling & Consulting LLC.* is not required to agree to restrict the use and disclosure of your PHI. A request for restriction must be made in writing using the form available from the Privacy Officer.

Right to Inspect and Copy: With a few exceptions you have the right to inspect and receive a copy of your PHI. Should you wish to review or copy your PHI you should make a request using the form available from the Privacy Officer. We will arrange for your therapist or another health professional in our clinic to review the PHI with you in our office or to copy the information requested. We may charge you a reasonable fee if you want a copy of your PHI.

Right to Amend or Correct Your Record: If you feel the PHI we have about you is incorrect or incomplete, you may ask us to amend the information for as long as the information is maintained by *TJocelyne Counseling & Consulting LLC.*. Requests for amendment or correction

should be made by submitting a form requesting amendment or correction available from the Privacy Officer. We will respond to your request within 60 days after you submit the form. We are not required to agree to the amendment.

Right to an Accounting of Disclosures: You have a right to request an accounting for disclosures. This is a list of those people with whom *TJocelyne Counseling & Consulting LLC.* may have shared your PHI, with the exception of information shared for purposes of treatment, payment or health care operations or when you have provided us with an authorization to do so. We may charge you a reasonable fee if you request more than one accounting for disclosures in any 12-month period. The request cannot include any disclosures made before January 14, 2015. Requests for an accounting of disclosures should be made by submitting a form requesting an accounting of disclosures to the Privacy Officer. This form is available from the Privacy Officer. We will respond to your request within 60 days after you submit the request.

Right to Request Confidential Communications: You have the right to ask that we communicate your PHI to you in a certain way or a certain location. For example, you can request that we contact you only at work or by mail. We will accommodate reasonable requests.

Right to Revoke Authorization: Uses and disclosures of PHI not covered by this Notice or the laws that apply to *TJocelyne Counseling & Consulting LLC.* will be made only with your authorization. If you authorize *TJocelyne Counseling & Consulting LLC.* to use or disclose your PHI, you may revoke that authorization in writing at any time. We are unable to reverse any disclosures we have made previously with your authorization. To revoke an authorization please contact your therapist or the clinic where you receive services.

Right to Complain: If you believe your privacy rights have been violated, you may file a complaint with [name hospital or health system] or with the Secretary of the Department of Health and Human Services. To file a complaint with *TJocelyne Counseling & Consulting LLC.*, contact the Privacy Officer. All complaints must be made in writing. The Privacy Officer will assist you in filing your complaint. Filing a complaint will not affect your care.

We reserve the right to revise or change this Notice. Each time you sign consent for treatment at a site covered by this Notice we will provide a copy of this Notice in effect at that time.

Effective Date: March 10, 2016

How to Contact Us

TJocelyne Counseling & Consulting LLC. Privacy Officer:….(508) 580-0364.

Secretary of Department of Health and Human Services……(**617) 573-1600**

PLEASE SIGN AND RETURN THIS PAGE TO YOUR CLINICIAN

Client's Name (print please) _____

By signing below you, the client consent to treatment and attest that you have read understand, and received a copy of the TJocelyne Counseling & Consulting LLC Notices of Privacy Practices.

Client Signature:_____**Date**_____

Therapist/Witness:_____Date_____

Authorization to Release or Obtain Health Information (including paper, oral and electronic information)

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid # or Social Security #:

I authorize: PRIMARY CARE SERVICE PROVIDER/FACILITY

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number:_____

❒ **RELEASE Information TO** **or** ❒ **OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: TJOCELYNE COUNSELING & CONSULTING LLC /TAMARRA ARISTILDE, LMFT, NCC

Mailing Address: 425 PLEASANT STREET FIRST FLOOR, LEFT OFFICE

City, State, Zip Code: BROCKTON, MASSACHUSETTS, 02301

Relationship: BEHAVIORAL HEALTH SERVICE PROVIDE Telephone Number: 5085800364

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

❒ Further Medical Care ❒ Personal ❒ Legal / PROTECTIVE SERVICES

❒ Changing PROVIDER ❒ Research related treatment

❒ Creating health information for disclosure to a third party.

❒ Other: (Specify)_____

I authorize the release of the following protected health information.
(Place an "X"in the box(es) that apply to the information you want released or you want to obtain.)

✓Entire Record ❒ Medical History, Examination, Reports ❒ Treatment or Tests
❒ Prescriptions ❒ Immunizations ❒ Hospital Records including Reports
❒ X-ray Reports ❒ MR/DD Records ❒ Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

❒ Alcoholism ❒ Drug Abuse ❒ Mental Health ❒Vocational Rehabilitation ❒ HIV (AIDS)
❒ Sexually Transmitted Diseases ❒ Genetics ❒ Psychotherapy Notes
❒ Other_____

This authorization shall expire on _____ (date or event) and is needed for the period beginning _____ and ending _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form. I authorize a copy (including electronic or faxed copy) of this form for the disclosure of the information described above.

_____ _____
Signature of Individual or Personal Representative authorized by law Date

Please submit medical information to:

Agency Representative	**Title**	**Date**
Telephone	**Fax**	**Email**

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 copy of the signed form, upon request

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, **TJCCS** 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, **TJCCS** 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 **TJCCS** the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to **TJCCS.**

- ✓ You may cancel an authorization in writing at any time. **TJCCS** 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 **TJCCS** 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 **TJCCS** has used or disclosed information about you. Your benefits will not be affected by any complaints you make. **TJCCS** 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

TJocelyne Counseling & Consulting Privacy Office	**508-580-0364**
Massachusetts Department of Health and Human Services Secretary	**617-573-1600**