Dr. Noah N. Zapf, Ph.D., LPC-MHSP
HIPAA Privacy Practices

We are required by law to follow the practices described in this letter. This letter is a summary of our Privacy Practices. This notice applies to personal medical/mental health information that we have about you, and which are kept in or by this facility. With some exceptions, we must obtain your authorization to disclose (or release) your health care information. There are some situations in which we do not have to obtain your authorization. We can use your protected health information and share it with members of our organized health care arrangement (like a community provider). Neither this pamphlet nor the full Notice of Privacy Practices covers every possible use or disclosure. If you have any questions, please contact the Privacy Office for this facility.

Who Has Access To Your Personal Information?
Medical/Mental health information about you can be used to:

- Plan your treatment and services. This includes releasing information to qualified professionals who work at our facility and are involved in your care or treatment. It may also include provider agencies whom we pay to provide services for you. We will only release as little as possible for them to do their jobs.
- Submit bills to your insurance, Medicaid, Medicare, or third party payers.
- Obtain approval in advance from your insurance company.
- Exchange information with Social Security, Employment Security, or Social Services.
- Measure our quality of services.
- Decide if we should offer more or fewer service to clients.

Without your permission, we may use your personal information:

- To exchange information with other State agencies as required by law.
- To treat you in an emergency.
- To treat you when there is something that prevents us from communicating with you.
- To inform you about possible treatment options.
- To send you appointment reminders.
- For agencies involved in a disaster situation.
- For certain types of research.
- When there is a serious public health or safety threat to you or others.
- As required by State, Federal or local law. This includes investigations, audits, inspections, and licensure.
- When ordered to do so by a court.
- To communicate with law enforcement if you are a victim of a crime, involved in a crime at our facility, or you have threatened to commit a crime.
- To communicate with coroner, medical examiners and funeral homes when necessary for them to do their jobs.
- To communicate with federal officials involved in security activities authorized by law.
- To communicate with a correctional facility if you are an inmate.

What Are Your Rights?

- To see and get a copy of your record (with some exceptions).
- To appeal if we decide not to let you see all or some parts of your record.
- To ask for the record to be changed if you believe you see a mistake or something that is not complete.
- You must make this request in writing. We may deny your request if:
  1. We did not create the entry
  2. The information is not part of the file we keep; or
  3. The information is not part of the file that we would let you see; or
  4. We believe the record is accurate and complete.
- To know to whom we have sent information about you for up to the last six years.
- The first request in a 12 month period is free. We may charge you for additional requests.
- To limit how we use or disclose information about you. For example-not to release information to your spouse or a particular provider agency. This must be made in writing, and we are not required to agree to the request.
- To ask that we communicate with you about medical matters in a certain way or at a certain location. This must be made in writing.
- To tell us (authorize) other released of your personal information not described above. You may change your mind and remove the authorization at any time (in writing).

Signature of Responsible Party(ies):_____

Dr. Noah N. Zapf, Ph.D., LPC-MHSP
Practice Policies

In order to answer questions that are frequently asked by clients regarding fees, confidentiality, services, etc., I have developed these policy statements for your information. I value you as a client and want you to be informed.

Fee Policy
I am committed to offering the highest quality, professional counseling services. My fee for all types of counseling services is $215 per clinical hour (50 min). A session is typically based on a 50-minute hour, however, when working with couples or families the session may exceed this time. Unless this time is excessive, the rate will still be based on the regular hourly fee. I request that cancellations be made 24 hours in advance; otherwise, you will be billed for the full session fee. Inpatient visits, or significant telephone counseling, etc. are based on the same sliding scale fee you would pay for an in-office visit in addition to transportation expenses. I do not testify unless a required by a court order. Court appearances or related calls and documentation are $300 per hour. I take payment and schedule for the next week at the beginning of each appointment. If you do not have your payment at the beginning of session we will have to reschedule to another time when you can make the payment. You will owe for that session as well as the rescheduled one.

Confidentiality
Professional ethics and Tennessee State law indicate that confidential information is controlled by the client. This means that, as a general rule, information shared in sessions with a counselor will be held in confidence.

There are two exceptions to this general rule, however. In the case of an emergency where the counselor believes the client is at risk of hurting himself/herself or another person, the counselor may breach the requirement of confidentiality. Secondly, Tennessee law requires that child abuse in any form be reported to the Department of Human Services or other authority such as a Juvenile Judge.

When working with minors, I will not share the content of sessions with parents/guardians, unless the content must be shared for safety reasons or if my therapist judgment warrants sharing content for the welfare and health of the minor. I will discuss progress and treatment plan in general terms with parents/guardians. Parents are encouraged to be a very active part of the counseling process; be prepared to be in session with your child at times and to have "homework assignments" for your family.

If you are referred by a physician or other health care professional, it a professional courtesy to maintain contact, as necessary, with that referral source. That may be done unless you request otherwise.

Professional Services
I am available for counseling appointments on Tuesday-Friday. You can contact me at 662-415-9370 to schedule or change a session. If you need immediate help for an emergency situation, you may obtain assistance by calling the Crisis Help Line at 244-7444, the YW Domestic Violence Center at 242-1199, or by going to your local hospital emergency room. For a crisis with minors you can call the mobile crisis line at 866-791-9222. I will be unable to respond to texts and emails in a timely manner, therefore do not text or email me when you are in a crisis and feeling suicidal, overwhelmed, or unsafe. Please call the crisis line or go to your nearest emergency room in these instances.

Benefits and Risks of Counseling
Persons contemplating counseling should realize that they may make significant changes in their lives. People often modify their emotions, attitudes, and behaviors. They may also make changes in their marriages or significant relationships, such as with parents, friends, children, relatives etc. They may change employment and begin to feel differently about themselves, and may change other aspects of their lives. While I will assist the client in effecting change, I cannot guarantee a specific outcome. Clients are ultimately responsible for their own growth.

Credentials
I have a PhD in Clinical Counseling, and am licensed in the state of Tennessee as a Licensed Professional Counselor, with a Mental Health Service Provider designation (LPC-MHSP).

- **Do you have any questions about fees, confidentiality, or other matters? Yes____ No____**
- **Do you agree with the conditions and provisions of these Practice Policies? Yes____ No____**

Signature of Responsible Party(ies): _____

Dr. Noah Zapf, Ph.D., LPC-MHSP

Demographics : Couples Intake Form

Name:_____ Date: _____

Address: _____ City:_____State:_____Zip:_____

County:_____ Phone: (H) _____ (C) _____ (W) _____

Email: _____ Method of contact: **Phone** or **Email** (circle one)

Couple Information: *Please list those who will be present for counseling*

Name: _____ Age: ___ DOB: _____ Religious Affiliation: _____

Employer: _____ Occupation: _____

Marital Status: (circle one) **Single** **Married** **Divorced** **Widowed**

Name: _____ Age: ____ DOB: _____ Religious Affiliation: _____

Employer: _____ Occupation: _____

Marital Status: (circle one) **Single** **Married** **Divorced** **Widowed**

Children*: If children are stepsiblings or partial siblings please indicate next to their name*

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____

Mental Health:

- Has anyone in the immediate family currently or historically been suicidal? (if so who and when?) _____

- Has anyone in the immediate family ever been hospitalized for mental health related issues? _____

- Is anyone in the immediate family currently receiving counseling services with another professional? If so who and for how long?

_____

1) What is the primary concern or issue that led you to decide to seek therapy?

_____

_____

2) Do either you or your partner drink alcohol to intoxication or take drugs to intoxication? If yes for either, who, how often and what substances are used?

_____

3) Has anyone in the family ever struck, physically restrained, used violence against or injured any other person within the family? (If yes, please explain)

_____

_____

4) Have either of you considered separating or divorce as a result of the current marital problems? If so, when?

_____

5) List some strengths in your relationship.

Partner 1: _____

Partner 2: _____

6) List some weaknesses in your relationship.

Partner 1: _____

Partner 2: _____

7) How would you know that your time in therapy has been successful? What looks different in your relationship?

Referred by: _____

Emergency contact information:

Name _____

Relationship: _____ **Phone:** _____

Client Signature: _____ **Date:** _____

Client Signature: _____ **Date:** _____