

Client Information Forms

Payment and Appointment Policies



Napa Valley Counseling Center exists to assist individuals, couples and families in making more effective life choices through the process of professional counseling. In keeping with this commitment, we ask each client to read and complete the following forms before counseling begins:

1. Payment and Appointment Policies (this page)
2. Confidential Client Information
3. Confidentiality and Mandatory Disclosure/Client Signature

If you have any questions, please don't hesitate to ask your counselor. We consider it a privilege to serve you!

Our Payment Policy

Napa Valley Counseling Center is a not-for-profit corporation that exists to provide quality, Christian counseling services at a reasonable cost. Each of our counselors is employed and compensated by Napa Valley Counseling Center, but we rely upon fees paid by our clients in order to provide salaries and services.

Our policy is that each person receiving counseling services is to pay their portion in full at the time services are rendered. The standard fee for the initial assessment is \$140. The standard fees for follow-up sessions range from \$120-\$150, dependent upon length of sessions, out-of-pocket expenses and insurance coverage determination. If the client is a minor, it is our policy that the parent/guardian bringing the child to therapy is responsible for delivering payment at the time of service. If the client fails to follow through with payments, it is the ethical prerogative of the individual counselor to terminate counseling until the client's payments are current.

Insurance

Napa Valley Counseling Center and some of its counselors have contracts with insurance companies. Our office will file claims with your insurance company. Although we will file the claim, it is your responsibility to know the mental health provisions of your insurance policy (co-pay amount, number of sessions allowed, etc.). Ultimately, your account with this office is your responsibility regardless of insurance coverage.

Cancellations or Missed Appointments

A canceled appointment delays our work. If you must cancel, we ask for at least a **24-hour advance notice**. If less than 24 hours notice is given, we have the discretion to charge you a fee of \$25 for your missed session. It is worth noting that insurance companies will not reimburse for missed sessions. The only time this fee will be waived is in the event of an emergency or illness.

Confidential Client Information

The following information is designed to assist us in becoming better acquainted with you and in providing the help you need. All information is confidential and will remain in your file. No individual or institution will be contacted without your prior knowledge and permission. Thank you.

Today's Date: _____ **Referred by:** _____
☐ Mr. ☐ Ms. ☐ Dr. ☐ Rev.

I am scheduled to see (which therapist?): ☐ Gray LeMaster ☐ David Sullivan ☐ Janet Hedges
☒ Rebecca Bakke ☐ Lynn Cook ☐ Kelley Flaming
☐ Amelia Lewis ☐ Jenny Register ☐ Julie Hardin Whalen
☐ Tracy Williams ☐ Seth Latture

If you are coming in for couple, conjoint or family counseling:

Which spouse or family member will be scheduling appointments?

☐ Husband ☐ Wife ☐ _____
(Other—describe)

Which spouse or family member will be responsible for payment of services?

☐ Husband ☐ Wife ☐ _____
(Other—please explain clearly)

Identifying Information

***Email address:** _____
*(Optional)

Client Name: _____ **Age:** _____ **Date of Birth:** _____

Street or P.O. Box: _____ **Apt. or Suite:** _____

City: _____ **State:** _____ **Zip Code:** _____

Hm Ph: (____) _____ **Wk Ph:** (____) _____ **Cell Ph:** (____) _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Important Contact Information

If we need to contact you, can we contact you using the above information? ☐ YES ☐ NO

If **YES**, please skip to Person to notify in case of emergency:

If **NO**, provide a contact name and telephone message number (*please print*):

_____	_____	(____) _____
Contact person's name	Relationship to client	Phone, pager or message no.

Person to notify in case of emergency:

_____	_____	(____) _____
Contact person's name	Relationship to client	Phone, pager or message no.

Occupation: _____ Where Employed: _____

Social Security Number: _____ - _____ - _____ (or Driver's License Number _____)

Spouse's Name: _____ Children's Names & Ages: _____

Medical Information

Family Physician: _____ Office Ph Number: (____) _____

Currently taking any prescribed medications? ☐ Yes ☐ No

Name of Medication:

Reason for Medication:

If yes, please list: _____

Insurance Information

Name as listed on Policy: _____

Primary Insurance Company: _____

Member ID#: _____

Group ID#: _____

Secondary Insurance (if applicable): _____

Member ID#: _____

Group ID#: _____

Reasons For Seeking Counseling

In your own words, describe why you are seeking counseling:

Current areas of concern: *(Please check items applicable to you.)*

- | | | | |
|--|--|--|--|
| ☐ Marital Conflict | ☐ Substance Abuse | ☐ Physical/Sexual Abuse | ☐ Spiritual Concerns |
| ☐ Financial Stress | ☐ Eating Disorder | ☐ Depression | ☐ Chronic Health Problems |
| ☐ Parent/Child | ☐ Sexual Addictions | ☐ Anxiety/Panic | ☐ Grief/Loss |
| ☐ (Other—describe): _____ | | | |

Please check any of the following that you have experienced in the last month:

- | | | |
|--|--|--|
| ☐ Depressed Mood | ☐ Difficulty Breathing | ☐ Difficulty Concentrating |
| ☐ Irritability | ☐ Disturbing Thoughts | ☐ Restlessness |
| ☐ Anger Outbursts | ☐ Reduced Appetite | ☐ Nightmares |
| ☐ Insomnia | ☐ Loss of Interest | ☐ Dizziness |
| ☐ Excessive Worry | ☐ Suicidal Thoughts | ☐ Difficulty Making Decisions |
| ☐ Fatigue | ☐ Lack of Productivity | ☐ Excessive Fears |
| ☐ Guilt | ☐ Increased Heart Rate | ☐ Doing Something Over and Over |
| ☐ Extreme Sadness | ☐ Uncharacteristic Crying | ☐ Weight Gain/Weight Loss |

Previous Treatment

Have you ever been under the care of a psychiatrist, psychologist or other counselor?

☐ Yes ☐ No

If yes, please briefly explain the nature of the problem, the diagnosis (if you know) and its duration:

Have you taken any psychiatric medications in the past? ☐ Yes ☐ No

If yes, please list these medications: _____

Other Information

What is your primary personal support system? Check all that apply.

- | | |
|---------------------------------------|--|
| ☐ Spouse | ☐ Family |
| ☐ Church | ☐ Pastor or Priest |
| ☐ Close friend | ☐ Support or Recovery group |
| ☐ God | ☐ Other _____
(describe) |

I am a member and/or attend:

Church: _____

I consider my level of church attendance or involvement to be:

- ☐ Active (several times per month)
☐ Somewhat Active (4-6 times in six-month period)
☐ Inactive (rarely or never)

I was referred by:

☐ Pastor: _____
(name)

☐ Doctor: _____
(name)

☐ Insurance: _____
(name)

☐ Friend: _____
(name)

☐ Family Member: _____
(name)

☐ Other: _____
(name)

Confidentiality and Mandatory Disclosure



Counseling often involves sharing sensitive and personal information. In recognition of this, ethical guidelines, as well as the statutory laws of Arkansas, require that all interactions between a client and Napa Valley Counseling Center remain confidential. This includes your records, content of your sessions and our appointment schedule. Our staff will take the utmost care to protect your privacy and confidentiality.

Exceptions to Confidentiality

For the vast majority of clients, no exceptions to confidentiality are made. But confidentiality is not absolute. The following is a list of the only exceptions in which our staff would disclose information regarding a client.

1. If a client requests in writing that information about their counseling be released and shared with a specific individual(s). A "Release of Information" form must be completed and signed by the client before this communication can take place. The client can specify what information can (and cannot) be released. These forms are available at our office.
2. If a client poses clear and imminent danger to themselves or to others, a mental health professional is legally required to report this to the proper authorities for the protection of the individual and the community.
3. If a client discloses that physical or sexual abuse or neglect has occurred to
 - a. a person who is under 18 years of age,
 - b. an elderly person, or
 - c. a mentally incompetent person,the counselor is required by Arkansas law ("our counselors are considered "mandated reporters") to report this information to the proper authorities.

The above information describes the limits of professional confidentiality in an individual and/or group session. By signing below you are saying:

I attest that I have read this information form and that I understand the conditions stated above, and I agree to receive counseling under these conditions.

Signature of client or legal guardian

Date

Please print your name here

Informed Consent

Rebecca Bakke, LPC

In order to serve you most effectively, this profile is designed to better acquaint you with your counselor, her expectations and the philosophy regarding your counseling process.

Professional Profile

I received my professional training at Covenant Theological Seminary where I earned a Master's Degree in Counseling in 2008. I have worked in outpatient community mental health for seven years and, prior to that, have one year's experience working in adolescent residential care. I have a history of treating a variety of clients and issues. These clients include the following populations: children, adolescents and adults in the following modalities: individual, couples and family. Specific issues I have worked with include, but are not limited to: relational conflict, depression, anxiety, grief/loss, trauma, interpersonal, family and work related problems, as well as issues that surround physical, emotional and sexual abuse.

I am not a physician and cannot prescribe or provide medication, nor perform medical procedures. If you are under current medical treatment, I will work in cooperation with your doctor. If medical treatment is needed, I will recommend competent medical personnel and work in cooperation with them towards your best interest.

The Counseling Process

I believe that everyone has a story—a story that has already started, yet has many parts still to be written. My passion and desire to help others has grown out of my own path to finding hope, strength and meaning in the midst of pain and brokenness. As a licensed professional counselor, I am honored to partner with you wherever you are at in your story and help you to continue your life's journey on the path of your choosing.

I believe we, as people, are drastically impacted today by the things we have experienced in the past and the environments in which we have lived. Unfortunately, these past experiences can cause us difficulty in maintaining our current responsibilities in life, our healthy relationships with others and even our own mental and physical health. I believe in the process of restoration and desire this for all my clients.

Many of the results of counseling will depend upon your determination to deal honestly with the issues that powerfully affect your life. My counseling style is relationship driven, in which I see growth and change as possible through collaborative efforts of both the client and the counselor.

As a Christian, it is my belief that all problems have a spiritual dimension, and biblical themes inform my beliefs about the nature of problems and the subsequent process of change. These spiritual aspects of your problem areas will only be discussed in therapy to the degree you feel comfortable.

Counselor's Responsibilities

As a client, I am committed to you. My goal is to help you know and to be known by yourself, others and God. I hope that through our encounters you will stop simply surviving and begin living the abundant life that God intends for each one of us in our daily interactions with other people. Hopefully, together, we can lessen the ache and begin finding satisfaction in your soul. In order to achieve this, I plan on engaging in conversation asking both probing and insight-oriented questions that help you learn to think in context. With your cooperation, together we will set goals, look at their progress and evaluate obstacles along the way. I will speak the truth straightforwardly with love, and am always open to suggestions and feedback from you. I will keep necessary financial and progress notes, and as

discussed in other paperwork, according to the law, I will keep your confidentiality. If we come to an area of expertise that has not been part of my training or experience, I will recommend a referral and sincerely aid you in the process of obtaining additional professional treatment for your further growth and development.

Client's Rights and Responsibilities

Generally, the client and what he/she wants to accomplish determine the direction of the counseling process. Ultimately, my authority is under God, and I will serve you under the ethical guidelines by my licensing boards, always looking out for your best interest. It is your responsibility to evaluate whether the services provided are satisfactory. I will attempt to offer frequent opportunities for you to evaluate me as well as your goals and progress. If you have questions or concerns, please do not hesitate to ask or comment. For you, this could be a pivotal point in your counseling process, and I would welcome that opportunity. You have the right to end the counseling process at any point without any further legal, moral or financial obligation, other than what has already occurred. Serious professional or ethical complaints or grievance may be reported to the Arkansas Board of Examiners in Counseling P.O Box 70 Magnolia, Arkansas 71754-0070.

Acknowledgment

By signing this disclosure and informational statement, the client acknowledges having been informed of his/her rights and responsibilities under regulatory laws for counselors in Arkansas, as well as the counseling process for this particular counselor. In addition, the client acknowledges reading and understanding the administrative policies for this counseling office.

Please print name

Signature of Client (or guardian)

Date

Signature of Counselor

Date

Privacy Practices of Napa Valley Counseling Center

This notice describes how health information about you may be used and disclosed. It also explains how you can get access to your information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your mental health information. The federal Health Insurance Portability and Accountability Act (HIPPA), implemented in 2003, set a national standard for privacy of health information. Our office strictly adheres to the guidelines established by HIPPA, as well as all other state and federal laws pertaining to your privacy.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment and payment purposes only. For example:

Treatment: In an emergency, we may use or disclose your mental health information to a physician or other healthcare provider for your protection and the protection of others.

Payment: We may use and disclose your mental health information to obtain payment from a third-party provider for services we provide to you.

Your Authorization: In addition to our use of your mental health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke in writing at any time. However, your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your mental health information for any reason except those described in this notice.

To your Family: Family members will not have access to your mental health information unless you give us authorization or in case of an emergency. In the case of a minor, mental health information will only be released for the purpose of payment, scheduling, or an emergency, or for therapeutic purposes at the therapist's discretion. Only a custodial parent or legal guardian can have access to this information.

Marketing Health Related Services: We will not use your mental health information for marketing communications without your written authorization.

Legal Subpoenas: Your mental health records will not be released by an attorney's subpoena unless we receive written consent from you. Under circumstances in which you were seen at Napa Valley Counseling Center with your spouse, records that pertain to your sessions as a couple cannot be released without consent from each individual.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you, or a minor in your care, are a possible victim of abuse or neglect. We may disclose your mental health information to the extent necessary to avert a serious threat to your health or safety or the health of others. We may disclose your mental health information if we have reasonable cause to believe that you are the perpetrator of child abuse or neglect.

National Security: We are required by law to disclose to authorized federal officials mental health information that represents a threat to national security.

Patient Rights

Access: You have the right to obtain copies of your mental health information and records. You must make a request in writing to obtain access to your mental health information. You may obtain your records by submitting a written request to our office manager.

Disclosure: You have the right to be informed of instances in which your mental health information or records were disclosed, if for reasons other than treatment or payment.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your mental health information. We are not required to agree to these additional restrictions but if we do, we will abide by our agreement, except in the case of an emergency.

Amendment: You have the right to request that we amend your mental health information. Your request must be in writing, explaining why the information should be amended. We may deny your request under certain circumstances.

If you have any questions regarding this notice or our Privacy Policies, please contact:

Napa Valley Counseling Center
Redding Building, Westlake Office Park,
1701 Centerview Dr., Suite 102
Little Rock, Arkansas 72211
501.224.0318



Receipt of Notice of Privacy Practices Received

You have the right to refuse this notice.

I, _____ have read and/or received a copy of the Notice of Privacy Practices of Napa Valley Counseling Center.

(Please print name)

(Signature)

(Date)

FOR OFFICE USE ONLY

We attempted to obtain signed acknowledgment of our Notice of Privacy Practices, but acknowledgment could not be obtained because of the following:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please specify): _____

(Signature of NVCC Staff Member)

(Date)