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
□ Church
□ Close friend
□ God
□ Family
□ Pastor or Priest
□ Support or Recovery group
□ 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

Napa Valley COUNSELING CENTER

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

Counselor Disclosure Information

Janet Hedges, LCSW

The following information is to give you an idea of my view of the counseling process, as well as clarify administrative policies and inform you of your rights and responsibilities as a client.

Educational/Professional Background

I received a Bachelor of Science Degree in Education from the University of Arkansas at Fayetteville. I taught for seven years in the classroom setting, before completing my Masters Degree in Social Work in 1990, from the University of Arkansas at Little Rock. Over the past twenty years in this field, I have worked in a variety of clinical settings, where I have provided group, family and individual treatment in both inpatient and outpatient environments. I have experience in working with both adults and adolescents who are dealing with issues related to 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 therefore cannot prescribe medication. If you are under current medical treatment, I will work in cooperation with your doctor(s). If medical treatment is needed, I will recommend competent medical personnel and work in cooperation with them towards your best interests.

The Counseling Process

I view the counseling process as relationship driven, in which growth and change are possible through the collaborative efforts of both the client and the counselor. Together we will explore and define the problems that brought you into therapy, set goals for deeper understanding of these issues and take steps towards resolution. It is an honor for me to be a part of your journey towards healing. Steps towards growth will involve both elements of joy and pain; eliciting, at times strong emotion. Fostering an environment in which this journey can be accomplished through a sense of safety and trust, is an essential component within my counseling practice.

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 be discussed in therapy as you feel comfortable.

Confidentiality

Confidentiality is an important element of the counseling process. Your identity, records and ongoing work in counseling will be kept strictly confidential unless I am given your prior written consent to release information, with only the following exceptions:

- State law requires that suspected child abuse be reported to the Dept. of Human Services or to law enforcement officials.
- Threat of harm to self or others (suicidal or homicidal statements) may be reported to family and/or appropriate mental health or law enforcement officials.
- A client requests in writing (Release of Information) that their records be shared with a specific individual or another professional.

Client's Rights and Responsibilities

While I will always strive to offer services that are appropriate and in your best interest, it is your responsibility to determine whether the services are ultimately helpful. You have the right to end counseling at any time without moral, legal or financial obligations other than those already accrued.

Complaints and/or grievances may be reported to the Arkansas Social Work Licensing Board, 2020 W. 3rd St, Little Rock, AR 72205; 501.372.5071. As a private practice counselor, I must operate as a small business. This means that unless clients pay their bills, I cannot afford to continue offering services. Appointment times are not automatically held open for you from week to week. It is your responsibility to reschedule at the end of a session.

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

Napa Valley
COUNSELING CENTER

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)

Beck Inventory

Name: _____ Date: _____

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group, which best describes the way you have been feeling the **PAST WEEK, INCLUDING TODAY**! Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice

1. 0 I do not feel sad.
   1 I feel sad.
   2 I am sad all the time and I can't snap out of it.
   3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I use to.
   2 I don't get a real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. 0 I don't cry anymore than usual.
    1 I cry more now than I used to.
    2 I cry all the time now.
    3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated now than I ever am.
    1 I get annoyed or irritated more easily than I used to.
    2 I feel irritated all the time now.
    3 I don't get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to be.
    2 I have lost most of my interest in other people.
    3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
    1 I put off making decisions more than I used to.
    2 I have greater difficulty in making decisions than before.
    3 I can't make decisions at all anymore.

14. 0 I don't feel I look any worse than I used to.
    1 I am worried that I am looking old or unattractive.
    2 I feel that there are permanent changes in my appearance that make me look unattractive.
    3 I believe I look ugly.

15. 0 I can work about as well as before.
    1 It takes an extra effort to get started at doing something.
    2 I have to push myself very hard to do anything.
    3 I can't do any work at all.

16. 0 I can sleep as well as usual.
    1 I don't sleep as well as I used to.
    2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
    3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
    1 I get tired more easily than I used to.
    2 I get tired from doing almost anything,
    3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
    1 My appetite is not as good as it used to be.
    2 My appetite is much worse now.
    3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any lately.
    1 I have lost more than 5 pounds.
    2 I have lost more than 10 pounds.
    3 I have lost more than 15 pounds.

    I am purposely trying to lose weight by eating less. Yes_____No_____

20. 0 I am no more worried about my health than usual.
    1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
    2 I am very worried about my physical problems and it's hard to think of much else.
    3 I am so worried about my physical problems, thank I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
    1 I am less interested in sex than I used to be.
    2 I am much less interested in sex now.
    3 I have lost interest in sex completely.