

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
☐ Jennifer Gillis-Eatherton

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.)*

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

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Difficulty Concentrating |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Disturbing Thoughts | <input type="checkbox"/> Restlessness |
| <input type="checkbox"/> Anger Outbursts | <input type="checkbox"/> Reduced Appetite | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Loss of Interest | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Excessive Worry | <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Difficulty Making Decisions |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Lack of Productivity | <input type="checkbox"/> Excessive Fears |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Increased Heart Rate | <input type="checkbox"/> Doing Something Over and Over |
| <input type="checkbox"/> Extreme Sadness | <input type="checkbox"/> Uncharacteristic Crying | <input type="checkbox"/> 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.

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Spouse | <input type="checkbox"/> Family |
| <input type="checkbox"/> Church | <input type="checkbox"/> Pastor or Priest |
| <input type="checkbox"/> Close friend | <input type="checkbox"/> Support or Recovery group |
| <input type="checkbox"/> God | <input type="checkbox"/> 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

Counselor Information

Kelley Langston Flaming, M.A., 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 Training and Education

This section may help you understand more of my credentials or rather hoops I jumped through in order to have the privilege of learning more about your life. Textbooks are excellent resources for information, but I learned more through my relationships with people than the combined twenty-two years of classroom endeavors. I have been tutored about life through my personal experiences of achieving my heart's desires and learning that the expectations of my heart cannot fill my soul.

I have achieved two masters degrees from Dallas Theological Seminary, a Masters of Arts in Biblical Studies and a Masters of Arts in Counseling. I am licensed in the state of Texas and Arkansas as a Professional Counselor. During my training process in Dallas, I was privileged to be mentored by Dr. Paul Meier of New Life Clinics, whom I worked with in a day program setting for two years. He truly displayed for me what speaking the truth in love looks like on a daily basis and in the counseling setting. Simultaneous to this experience, I served on the steering committee at Stonebriar Community Church to create the foundation for a lay counseling program. Under the direction of Charles Swindoll, the committee was able to teach, train and mentor members of the church to help care for one another in a ministry setting. Prior to these experiences, I worked at the Minirth Program at Green Oaks Hospital, counseling both men and women needing more critical care. I also interned under Julie Pardon, Director of Pregnancy Centers-Focus on the Family, at Prestonwood Pregnancy and Family Care Clinic, where I worked with women in many areas of their lives. I also hold a Bachelors of Science from Oklahoma State University in the area of Elementary Education.

My counseling training has been deliberately varied in order for me to discover which areas I feel most equipped to aid people in the process of growing and healing. Remarkably, I have learned that I am energized and motivated by variety. My heart is working with people in the age range of 15-35, where I have discovered that the transitions in life are most abundant.

Counseling Setting

The nature of counseling is an intricate, intimate and individual process for each person. It begins with the uniting of the counselor and client in a relationship that, throughout its course, involves mutual respect and trust. I believe that genuine change occurs within the context of connecting relationships, and ultimately, that is what I hope to achieve upon learning about your story. Within the framework of family patterns and your individual thinking, I hope to explore those heart longings that somewhere along the way have become associated with such pain that they are either despised, ignored or over-controlled. I desire for you to invite me to come alongside you and explore the depths of your aching soul that for some reason has been abandoned, avoided or feared. This is the spot in your soul where the battle is raging between being real and looking right. Somewhere along the way, the patterns that have hidden this secret place have begun controlling and maybe even started choking out your life. You may have stopped living and are now simply trying to survive.

If this is the case, you may be hurting in many different ways. Your patterns may be so tight and acceptable in society that others have no idea of the personal isolation and loneliness you are suffering. Maybe the pain has manifested into an addiction or behaviors that concerned people point out to you on a regular basis. You might know the source of the pain or it may appear that there is no apparent need for the suffering you are enduring.

Throughout this process you may have lost or never fully captured the essence of who God created and gifted you to be. As a Christian, I strive to base my life and my relationships on the truths that God has revealed in His Word. I understand that as a counselor, I am God's instrument, and I am humbled and consider it a privilege to join you in your journey of exploring who God created you to be.

I understand that as humans we are emotional, spiritual and physical beings. Some problems may be rooted in the chemistry of inherited genes, emotions and balanced nutrition. I may find it necessary to have you explore those needs with a trained physician.

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)