

# 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:**

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**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 _____<br>(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**

## **Lynn Cook, LMFT**

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

### **Educational/Professional Background**

I graduated from Harding University with a Bachelor of Arts in Family Ministry and a Master of Science in Family Therapy. I have a wife of 27 years and three sons. I spent over 22 years serving in a local church as a youth pastor, family minister and senior minister. In the local church setting, I did many types of counseling with several populations. I have worked for the last 15 years in the Bryant School System as a school-based mental health counselor, mostly in the elementary school setting.

My experiences as a counselor in these various settings have allowed me to work with clients of all ages and needs. I have worked with individual clients with depression, anxiety, crisis intervention, sexual issues, and work related difficulties. I have worked with couples experiencing marital conflict, parenting issues, premarital counseling, family counseling, and general relational difficulties. I have also worked part-time for many years in the school setting with children ages 6 – 12 years old dealing with depression, school anxiety, self-esteem issues, anger management, and social skills.

### **The Counseling Process**

I view the counseling process as the partnership between the counselor and client. The relationship is the key to personal growth and change. In the early sessions, I will spend time understanding the presenting problem(s) and getting to know you, the client. I believe that family background is very important to understanding one's struggle in life; therefore we may explore family of origin issues as needed. I will do my part to provide a safe place for personal exploration and growth. Change is possible, and, most of the time, it is easier than staying the same!

I am not a doctor and therefore cannot prescribe medicine. If you are under current medical treatment or medication management, I am willing to work in cooperation with your personal medical doctor.

### **Client's Rights and Responsibilities**

The course of the counseling process will be determined by me, the counselor, and you, the client (or parent). You may freely ask questions about the goals of counseling, therapeutic process, or any part of the specific therapy plan. It will be my goal to offer therapy services that are helpful and well informed; it will ultimately be your decision if they are helpful and worth your time, effort and money. The number of sessions will be determined by the goals and individual needs of the client, but I will always work to meet the goals of the client in the shortest number of sessions possible. Many of the results of counseling will depend on your determination to deal honestly with the issues that powerfully affect your life. In that light, having a willingness to face what is true is an important prerequisite.

You have the right to end counseling at any time without moral, legal or financial obligation other than those already accrued.

Complaints of grievances may be reported to the AR board of Examiners in Counseling at 101 E. Capital Ave, Suite 202, Little Rock, AR 72201 or call at 501.683.5800.

## **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 authorization in writing to release the information, with the following exceptions:

1. Arkansas State law requires that suspected child abuse be reported to the Dept. of Human Services or the law enforcement officials.
2. 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.
3. A client requests in writing through a Release of Information Form that their information be shared with others.

## **Acknowledgment**

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

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### 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)