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

Informed Consent
Tracy Williams, LCSW

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

Educational/Professional Background

First allow me to introduce myself. I received both my Bachelor of Arts degree in Psychology and my Master of Social Work from UALR. I am wife to my husband of over 35 years and a mother to five daughters.

I especially enjoy working with children, but we are all children at heart! My experiences as a therapist include working with clients from very young children to adolescents and their parents addressing a variety of issues from relational issues such as oppositional behaviors, poor boundaries and difficulties in communication. Other areas that I work with include anxiety and depression. I have additional training and interest in trauma and early attachment. I have worked in inpatient, school and community mental health settings with at risk families. As a therapist and fellow traveler, I consider it a sacred space to walk with someone for a while on their journey. As a believer, I will bring prayer and direction from God's word into my practice, but I will also respect your wishes if you are not comfortable with this.

As a Licensed Clinical Social Worker, I cannot prescribe medication. If you are currently receiving medical treatment, I can work with your provider per your consent at your request. I can also make recommendations of a medical provider if necessary.

The Counseling Process

I focus on the therapeutic relationship with my clients whatever their age. I believe that the trust and rapport formed through our relationship is a key component of any growth and change.

During your first session, we will talk about your struggles, as well as what you want to be different in your life. We will come up with goals and decide on how to best work toward them. The success of your treatment depends on the honesty and openness you bring to sessions and your willingness to stretch and grow.

I hope to earn your trust by offering a safe space to explore the nature of the problems that brought you to therapy, so confidentiality is assured with rare exceptions only to protect the life and safety of vulnerable individuals. (See agreement for more policy information.)

Client's Rights and Responsibilities

You are encouraged to ask me any questions you may have regarding my educational and professional background, therapeutic approach, your therapy plan and progress. It is extremely important for you to find a therapist that you feel can help you reach your goals and with which you have a good therapeutic relationship. It is your responsibility to find services that meet your unique needs and to end counseling at any time you feel is right for you. You are only responsible financially for services already rendered.

Acknowledgment

By signing this disclosure and informational 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 for this 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)