Client Information Forms

Payment and Appointment Policies

Napa Valley Counseling Center assists 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. If you have any questions, please do not hesitate to ask your counselor. We consider it a privilege to serve you!

Payment

Napa Valley Counseling Center is a not-for-profit corporation that exists to provide quality, Christian counseling services at a reasonable cost. We rely upon fees paid by our clients to provide salaries and services. All services rendered are the financial responsibility of the patient and not the insurance company. Our office will bill your insurance company as a courtesy. Your financial responsibility is to ensure that Napa Valley is paid for services rendered. If the client is a minor, 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.

Cancellations or Missed Appointments

Appointments must be cancelled **at least 24 hours** before the scheduled appointment time. Failure to cancel will be reflected as a missed appointment and fees will apply. 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. Clients who fail to pay the fees for missed appointments will not be allowed to schedule future appointments.

Missed appointment fees:

First Occurrence:	$25 fee will be charged
Second Occurrence:	$50 fee will be charged
Third and Subsequent Occurrences:	$100 fee will be charged

Telehealth Services

Napa Valley Counseling Center offers clients the opportunity to conduct certain services through electronic technologies. Telehealth involves the use of electronic communications to enable providers at different locations to share individual client information for the purpose of improving client care. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

IN CASE OF AN EMERGENCY, DO NOT ATTEMPT TO USE TELEHEALTH OR EMAIL. CALL 911.

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 "Outpatient Mental Health Coverages" 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.

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: _____

I was referred by: _____

□ Pastor □ Doctor □ Insurance □ Friend □ Family Member □ Other

Identifying Information

Client Name: _____ Age: _____ Birthdate: _____

Sex: □ Male □Female Marital Status: □Single □Married □Divorced □Separated □Widowed

E-mail: _____

Street: _____ Apt. or Suite: _____

City: _____ State: _____ Zip Code: _____

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

Spouse's Name: _____

Children's Names & Ages: _____ _____

_____ _____

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)

Occupation: _____ Where Employed: _____

I am a member and/or attend church at _____

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

□ Active □ Somewhat Active □ Inactive

Client Contacts

Name:	Phone Number:	Relationship:
_____	(____)_____	_____
□ Emergency □ Guardian □ Primary Care		
_____	(____)_____	_____
□ Emergency □ Guardian □ Primary Care		
_____	(____)_____	_____
□ Emergency □ Guardian □ Primary Care		

Insurance Information

Name as listed on card: _____

Primary Insurance Company: _____

Member ID#: _____

Secondary Insurance Company: _____

Member ID#: _____

I HEREBY AUTHORIZE THE THERAPISTS OF NAPA VALLEY COUNSELING CENTER TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY TREATMENT AND I HEREBY ASSIGN THE THERAPIST ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR AS LONG AS MY DEPENDENTS OR I REMAIN A CLIENT.

Signature of client or guardian: _____ Date: _____

Payment Authorization

Name on card: _____

Card Number: _____

Expiration Date: _____ Security Code: _____

Billing Address: _____

_____

I HEREBY AUTHORIZE THE PRACTICE TO UTILIZE MY THIS PAYMENT METHOD FOR ANY BALANCES, INCLUDING LATE CANCELLATION AND MISSED APPOINTMENT FEES, WITHOUT ADDITIONAL AUTHORIZATION.

Signature of client or guardian: _____ Date: _____

E-mail and Telehealth Consent

This form documents your consent to participate in email and telehealth services and provides guidelines regarding the use of such services.

Cancellations and Missed Appointments: All NVCC policies for cancellations and missed appointments are strictly applied to telehealth services. Please cancel all appointments 24 hours in advance to avoid fees.

Email Use: Email communications should be between the Clinic and an adult client 18 years of age or older, or the parent or guardian of a minor. Email communications are appropriate for administrative tasks only, such as the following types of transactions:

- Appointment scheduling
- Requests for resources
- Referrals

Response Time: Although Napa Valley Counseling Center will endeavor to read and respond with 24 hours to any email, we cannot guarantee that any email will be responded to within a particular period.

Telehealth Software: Napa Valley Counseling Center utilizes video conferencing host site, zoom.com. You will need a zoom.com account. You will receive an email from Zoom about scheduled appointments. The email will provide steps for you to follow to join the telehealth session. If the video conferencing software does not operate satisfactorily, you may opt to discontinue and resume the session over the telephone.

Expected Benefits:

- Improved access to care by enabling a client to remain in his/her home, or other remote location.
- Obtaining expertise of a distant specialist.

Possible Risks: There are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate decision making by the provider
- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment
- In very rare instances, security protocols could fail, causing a breach of privacy of personal health information
- In rare cases, a lack of access to complete health records may result in judgment errors

By signing this form, I understand the following:

- I understand that the laws that protect privacy and the confidentiality of health information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to other entities without my consent.
- I understand that I have the right to withhold or withdraw my consent to the use of telehealth at any time, without affecting my right to future care or treatment.
- I understand that telehealth may involve electronic communication of my personal health information.
- I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

I ATTEST THAT I HAVE READ THIS INFORMATION FORM AND THAT I UNDERSTAND THE CONDITION STATED ABOVE, AND I AGREE TO RECEIVE COUNSELING UNDER THESE CONDITIONS.

Signature of client or guardian: _____ Date: _____

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: Name of Medication: Reason for Medication:

_____ _____

_____ _____

_____ _____

Medical Information

Family Physician: _____ Office Ph: (___) _____

Currently taking any prescribed medications? ☐ Yes ☐ No

If yes, please list: Name of Medication: Reason for Medication:

_____ _____

_____ _____

_____ _____

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 your appointment schedule. Our staff will take the utmost care to protect your privacy and confidentiality.

Exceptions to Confidentiality

For most 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,

    as a Mandated Reporter, the counselor is required by Arkansas law 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 CONDITION STATED ABOVE, AND I AGREE TO RECEIVE COUNSELING UNDER THESE CONDITIONS.

Signature of client or guardian: _____ 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 may 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. When 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 your therapist.

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
1701 Centerview Drive, Suite 102
Little Rock, Arkansas 72211
501.224.0318

napa valley
COUNSELING

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.

Signature of client or guardian: _____ 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)

Counselor Disclosure Information
Gray LeMaster, LPC

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

Professional Profile
I received a Masters of Arts degree in Professional Counseling from Colorado Christian University. I previously completed a Bachelor of Arts degree in Criminal Justice from the University of Arkansas at Little Rock.
Prior to my graduate studies, I was a Little Rock police officer. I retired after 21 years of service. During most of my police career, I was a detective serving at various times on the homicide, sex crimes and youth investigations squad.

Following my graduate studies, I served an internship in the counseling program at Colorado Christian University. In this capacity, I provided counseling services and supervision to students while under the supervision of the faculty of the graduate school.
My experience includes working with individuals in the areas of depression, anxiety, crisis intervention, relational difficulties, marital conflict, parenting problems, premarital counseling, sexual issues, and physical, sexual and emotional 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 interests.

The Counseling Process
I view the counseling process as forming an alliance with you to explore the nature of your problem(s). Although we will spend much time exploring the specific problem(s) that brought you into counseling, we will also look at the nature of your relationship with other significant people in your life. According to my theoretical orientation, many of the forces and dynamics which have influenced the complexity and intensity of your problem(s) are rooted in the relational issues in your life. I believe you were made to relate in a satisfying and self-giving manner … this is the source of your greatest joy but also of your deepest pain. I believe counseling is less a well-defined set of techniques and more a creative and progressive discovery of how your relational style interferes with the enjoyment for which you are made. I believe that this process of discovery and change arises out of a trusting bond and meaningful alliance between counselor and client.

In working toward the goals of removing the initial problem and growing in relational maturity, the counseling process will require that determined efforts be made to change and may involve experiencing emotional discomfort. Remembering and resolving unpleasant events can arouse fear, anger, depression, frustration, and other powerful emotions that may feel foreign and/or disconcerting but are a normal part of the process of growth.

I believe that certain problems can have (or develop) physical components. In such cases, medical consultation will be advised.

I believe that all problems have a spiritual dimension. As a Christian, biblical themes inform my beliefs about the nature of problems and the subsequent process of change.

Client's Rights and Responsibilities

You are encouraged to ask me any questions you have regarding my educational and professional background, therapeutic approach, and the specific therapy plan and progress. 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.

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 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

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 used to.**
- **2 I don't get 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 usual.
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 & pains, 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, that 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.