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
Tracy Williams, LCSW

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
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 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