VALLEY CHRISTIAN
COUNSELING CENTER INC.

Reminders for you as you come in for your first appointment…

* Please **complete this paperwork** and bring it to your first appointment
If you are unable to complete this paperwork prior to your appointment, please arrive at least 15 minutes early to finish it

* **Please bring your insurance card** along with you to your appointment, so we may get a copy of your card for your file for insurance billing purposes. If there is a deductible payment that needs to be made or a co-pay payment, we will ask for that at the time of the appointment.

* If you need to **change or cancel any appointments**, we have a 24 hour cancellation policy. Please give us this time so you will not be charged for those appointments. Our office phone number is 701.232.6224

* **IN THE EVENT OF WINTER WEATHER/ STORMS**: In the event of winter weather or storm announcement affecting your appointment, someone from our office will contact you by phone call, text, or email regarding re-scheduling.

VALLEY CHRISTIAN
COUNSELING CENTER INC.

CLIENT INTAKE SUMMARY

Today's Date _____

Client Information:

Name (First, MI, Last) _____ Age _____

Address _____ City/State/Zip _____

Home Phone _____ Work _____ Cell _____

Date of Birth _____ Gender _____ M/F

Marital Status (circle one & give date) Single; Engaged _____ Married _____ Separated _____

Occupation _____ Employer _____

Length of employment _____

Do you attend church regularly?_____ Yes/No Name of church_____

Medical History:

Physician _____ Clinic _____

Date of last medical appointment _____ Results _____

Please list any medications currently taken _____

Please list any significant medical problems that apply to you or to members of your family.

_____

Have you seen a therapist before?_____ When? _____ With whom? _____

For what issues? _____

_____

People living in your household and children living away from home:

Name	Age	Relationship	Location

Family History:

Father _____ Age _____ Occupation _____

Health _____ If deceased, give his age at time of death _____

How old were you at the time? _____ Cause of death _____

Mother _____ Age _____ Occupation _____

Health _____ If deceased, give her age at time of death _____

How old were you at the time? _____ Cause of death _____

Siblings - Age(s) of brother(s) _____ Age(s) of sister(s) _____

Any significant details about your siblings _____

_____

Please complete both sides

	Problem Checklist Please check all that apply to yourself	**Severe**	**Moderate**	**Mild**	**No Problem**
1	Financial	☐	☐	☐	☐
2	Physical health/disability	☐	☐	☐	☐
3	Misuse of drugs or alcohol	☐	☐	☐	☐
4	Spiritual concerns	☐	☐	☐	☐
5	Depression or sadness	☐	☐	☐	☐
6	Thoughts of suicide	☐	☐	☐	☐
7	Anxiety or nervousness	☐	☐	☐	☐
8	Sexual concerns	☐	☐	☐	☐
9	Parent/Child conflict	☐	☐	☐	☐
10	Parenting concerns	☐	☐	☐	☐
11	Threatened or actual abuse/violence	☐	☐	☐	☐
12	Anger or temper	☐	☐	☐	☐
13	Problems associated with aging	☐	☐	☐	☐
14	Unusual fears	☐	☐	☐	☐
15	Job stress	☐	☐	☐	☐
16	Feelings of loneliness	☐	☐	☐	☐
17	Relationship problems	☐	☐	☐	☐
18	Lack of self-confidence	☐	☐	☐	☐
19	Eating Disorders	☐	☐	☐	☐
20	Other (please list)				

My most serious problem is: _____

I have been experiencing this for: _____

What I hope to gain or learn from counseling is: _____

_____

_____

In case of emergency, please notify:

Name _____ Relationship _____

Address _____ City, State, Zip _____

Phone # (Day) _____ (Evening) _____

I certify with my signature that the information on this form is true and accurate to the best of my knowledge.

Client or Authorized Signature _____ Date _____

If other than client's signature, state relationship to client _____

VALLEY CHRISTIAN COUNSELING CENTER

Payment Policy

Fargo Location

Thank you for choosing us to walk alongside you toward healing and wholeness in Christ. As an Image-Bearer of God, we care deeply about you and want you to have a clear understanding of our payment policy. Please read this carefully and let us know if you have any questions.

1. **Insurance.** We have providers that participate in most insurance plans. Please be prepared to present a current copy of your insurance card at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments, Co-Insurance, and Deductibles.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. We are contractually obliged to collect the co-payment at the time of service. Coinsurance and deductible amounts vary. A deposit of $75 or $100 (depending on your insurance plan) as a down payment may be required at time of service and will be applied toward your coinsurance or deductible until your coinsurance or deductible has been met. Once insurance has paid, any remaining balance on your account is your responsibility.

3. **Claims submission.** As a courtesy to all image-bearers (clients/patients) who use our services, we will submit claims on your behalf to your insurance company. *Any service denied because of a change in benefits becomes your responsibility. Services not covered by your insurance are your financial responsibility.*

4. **Direct Pay.** If you do not have insurance, are using a direct-pay-only provider, or choose to not bill your insurance, your appointment fee must be paid in full at the time of service. A "Same Day Cash Rate" may be offered and your credit card on file will be charged the day of service.

5. **Late Cancelations/Missed appointments.** Our policy is to charge for missed appointments not canceled within 24-hour notice. These charges will be your responsibility and will be charged to the credit card you have on file. Please help us serve you better by keeping your scheduled appointment.

6. **Credit Card on File.** A current debit or credit card is required to be on file in order to secure your appointments. This credit or debit card will be charged for the full amount due at the time of your appointment. This amount may include a co-pay, deposit as described above, or the full amount of the appointment, depending on your insurance or direct pay requirement. *If your account is 45 days past due, the balance of your account will be charged to this card.*

Our practice is committed to providing the best quality of care and our prices are representative of the usual and customary charges for our area.

I have read and understand the payment policy and accept all terms and conditions described above:

_____ _____

Signature of client/patient or responsible party **Date**

_____

Printed Name of Client/Patient

Valley Christian Counseling Center

Credit / Debit Card Payment Consent

Client name:

(Card holder) Name on card if different than client:

Card Type:

Last 4 digits of card number:

Expiration Date :

I authorize Valley Christian Counseling Center to charge my credit/debit/health account card for professional services. If I do not cancel before 24 hours, I recognize that Valley will charge my card as a late cancel or no show if I do not show up for the appointment.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Client Initials:

Card holder Initials (If different than client):

Date:

Signature:

VALLEY CHRISTIAN
COUNSELING CENTER INC.

Policies and Procedures

Confidentiality

The information you share with your counselor is strictly confidential and will not be shared with anyone without your written consent except in accordance with North Dakota law which requires counselors to report to the proper authorities all cases in which there is reasonable cause to suspect neglect or abuse of a child, elder, or vulnerable adult. Confidentiality may also be broken if your counselor is required to do so for legal reasons, or if there is a threat to yourself, a threat to others and their property, or a threat of transmission of contagious or transmittable diseases.

Protection of Electronic Information

When we use electronic methods for communication, billing, recordkeeping, or other elements of client care, we ensure that our electronic data storage and communications are privacy protected consistent with the Health Insurance Portability and Accountability (HIPAA) requirements.

Length of Counseling

The counseling session is between forty-five (45) minutes and sixty (60) minutes. The number of sessions varies depending on the issues involved. It is your right to discontinue counseling at any time. However, it is appropriate and helpful to discuss any dissatisfaction or desire to terminate openly with your counselor.

If you need to contact your counselor between sessions you will be charged a fee based on fifteen (15) minute increments with a minimum charge of one quarter of an hour. Insurance benefits do not cover over-the-phone counseling.

Missed Appointments

It is important to remember that your counselor commits a specific time period for you when a counseling session is scheduled. If you miss or cancel an appointment without sufficient notice the appointment time is usually lost since it is difficult to reassign the session to another client on short notice. For this reason ***we ask for a 24-hour cancellation notice if you need to cancel or reschedule your appointment.***

If you fail to give a 24-hour notice or simply forget to come to your appointment, the credit card you have on file will be charged. Insurance benefits do not pay for missed appointments so this charge would be your responsibility to pay.

Payment for Counseling

Your payment is expected at each session. Please refer to our detailed Payment Policy for additional information. If you have any questions regarding Valley Christian Counseling Center's policies and procedures please ask us at any time.

If an emergency arises, please dial 911 or call your local hospital.

I have read and agree to the policies and procedures stated above.

_____ _____

Signature Date

_____

Print Name

_____

Relationship to Client (if client unable to sign)

VALLEY CHRISTIAN
COUNSELING CENTER INC.

NOTICE OF PRIVACY PRACTICES SUMMARY

The attached Notice of Privacy Practices of Valley Christian Counseling Center describes how we may use or give out your protected health information to carry out your treatment, for payment of services you receive, or for activities needed to run our business.

It describes other situations when we may need to use or give out your information such as those that are required by law or for public health activities. Examples of situations are given in the notice to help you understand the many uses of protected health information.

In addition, it describes what your rights are with regard to your protected health information and how you may exercise those rights. On the last page of the notice, there is information on who to contact if you have questions or concerns.

Your signature on this form indicates that you have received a copy of the Notice of Privacy Practices for Valley Christian Counseling Center.

_____ _____

Client or Authorized Signature Date

_____

Print Name

_____

Relationship to Client (if client unable to sign)

VALLEY CHRISTIAN
COUNSELING CENTER INC.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

I. Uses and Disclosures of Protected Health Information

Valley Christian Counseling Center (VCCC) may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless VCCC has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

A. **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to physicians who may be treating you or consulting with VCCC with respect to your care.

B. **Payment:** We may use and disclose protected health information about you so that the treatment and services you receive from VCCC may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. We may also disclose client information to another provider involved in your care.

C. **Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of VCCC's practice. Examples of these activities include but are not limited to: quality assessment activities, employee review activities, training programs, accreditation, certification, licensing or credentialing activities, and review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities.

D. **Other Uses and Disclosures:** As part of treatment, payment, and health care operations, we may also use or disclose your protected health information to: keep you informed about appointments; program information, and benefits and services that may be of interest to you; call you by name in the waiting room when your counselor is ready to see you; or to contact you to raise funds for VCCC or an institutional foundation related to VCCC. If you do not wish to be contacted regarding fund raising, please contact our Privacy Officer.

II. Uses and Disclosures beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following: as required by law; for public health activities; victims of

abuse, neglect or domestic violence; health oversight activities; for judicial and administrative activities; for law enforcement purposes; regarding decedents; for cadaveric, organ, eye and tissue donation purposes; for research purposes; to avert a serious threat to health or safety; for specialized government functions; correctional institutions; for workers' compensation; or to share with our business associates who must abide by the same confidentiality requirements. Any health care professional authorized to enter information into your medical record, all employees, staff, and other personnel at VCCC who may need access to your information must abide by this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

III. Uses and Disclosures Permitted without Authorization but with Opportunity to Object

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your care or payment related to your care. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location or general condition.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interest for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures which you Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

V. Your Rights

You have the following rights regarding your health information.

- **A.** You may inspect and obtain a copy of your personal health information in our possession for as long as we maintain the protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; protected health information that is subject to a law that prohibits access to protected health information; information obtained from someone other than a health care provider under a promise of confidentiality and the requested access would be reasonable likely to reveal the source of information; and information that is copyright protected. Depending on the circumstances, you may have the right to have a decision to deny access reviewed. Please contact our Privacy Officer if you have questions about access to your medical records.
- **B.** In other situations we may deny you access, but if we do, we must provide you a review of our decision denying the access. These "reviewable" grounds for denial include the following: a licensed health care professional has determined that the access is reasonably likely to endanger the life or physical safety of yourself or another person; the protected health information makes reference to another person (other than your health care provider) and your health care provider has determined that the access is reasonably likely to cause substantial harm to another person; the request is made by your personal representative and a licensed health care professional has determined that giving access to such personal representative is reasonably likely to cause substantial harm to you or another person. Depending on the circumstances, you may have the right to have a decision to deny access reviewed. Please contact our Privacy Officer if you have questions about access to your medical records.

- **C.** You may request a restriction on certain uses and disclosure of your information. Your request must state the specific restriction requested and to whom you want the restriction to apply. VCCC is not required to agree to the requested restriction, but if approved, we will abide by it except in an emergency treatment situation or as required by law. You may request a restriction by contacting the Privacy Officer.

- **D.** You may request that we contact you about personal health care matters only in a certain way and at a certain location. We will accommodate reasonable requests. We may condition the accommodation by asking you for information about how payment will be handled or ask you to specify an alternate address or other method of contact.

E. If you feel that some information VCCC has created about you is wrong, you may ask to change that information. In certain situations, we may deny your request. We will notify you if we deny your request and tell you how to request a review of the denial. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendment(s).

F. You have the right to request an accounting of certain disclosures of your protected health information made by VCCC. This right applies to disclosures for purposes other than treatment, payment, or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a VCCC directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to January 1, 2011. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

G. You may request a paper copy of this notice even if you have already received a copy of this notice or have agreed to accept this notice electronically.

VI: Our Duties

Valley Christian Counseling Center is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain. If VCCC changes its Notice, we will provide a copy of the revised Notice by sending a copy of the revised Notice via regular mail or through in-person contact.

VII: Complaints

You have the right to express complaints to VCCC and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to VCCC by contacting VCCC's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

VIII: Contact Person

Valley Christian Counseling Center's contact person for all issues regarding client privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by VCCC you may submit a complaint to our Privacy Officer by sending it to:

Valley Christian Counseling Center
Attn: Privacy Officer
1112 Nodak Drive
Fargo, ND 58103

The Privacy officer may be contacted by telephone at 701-232-6224.

IX: Effective Date

This Notice is effective January 1, 2014.

VALLEY CHRISTIAN
COUNSELING CENTER INC.

Data Collection Form

The information on this sheet is used for statistical purposes. Please do not put your name on it.
We appreciate your taking time to complete this form.

Month: _____ **Year:** _____

Residence: City: _____ County: _____ State: _____

Gender: ☐ Male ☐ Female **Age:** ☐ 0-10 ☐ 11-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ 71-80 ☐ 81+

Marital Status: ☐ Single ☐ Separated ☐ Engaged ☐ Divorced ☐ Married ☐ Widowed

Household Structure: ☐ Traditional ☐ Single Parent ☐ Step-Family ☐ Live Alone ☐ Cohabiting ☐ Live w/Roommate ☐ Other (Please Specify) _____

Household Income: ☐ 0-$9,999 ☐ $10,000-$14,999 ☐ $15,000-$19,999 ☐ $20,000-$29,999 ☐ $30,000-$39,999 ☐ $40,000-$59,999 ☐ $60,000-$79,999 ☐ $80,000-$99,999 ☐ 100,000+

Occupation:
☐ Student ☐ Homemaker ☐ Retail/Sales ☐ Trade/Technical ☐ Food Service/Accommodation
☐ Education ☐ Professional ☐ Retired ☐ Transportation ☐ Other (Please Specify) _____
☐ Religious ☐ Unemployed ☐ Daycare ☐ Administrative/Clerical

Financial Responsibility:
☐ Self (Direct Pay) ☐ Insurance ☐ EAP ☐ Church ☐ Parents ☐ Other (Please Specify)_____

Do you attend a church: ☐ Yes ☐ No

Denomination Attending:
☐ Lutheran Brethren ☐ Catholic ☐ Lutheran ☐ Evangelical Free ☐ Baptist ☐ Methodist
☐ Assembly of God ☐ Pentecostal ☐ Nazarene ☐ Presbyterian ☐ Non-denominational
☐ Other (Please Specify) _____

Referral Source:
☐ Church/Clergy ☐ Physician ☐ Professional ☐ Former Client ☐ Friend ☐ Relative
☐ Internet Search ☐ Radio ☐ Yellow Pages ☐ Court ☐ Other (Please Specify) _____

Type of Counseling:
☐ Individual ☐ Couple/Marital ☐ Family ☐ Pre-Marital ☐ Group/Class

Presenting Problem:
☐ Couple Conflict ☐ Family Conflict ☐ Anxiety ☐ Depression ☐ Grief/Loss
☐ Legal Violation ☐ Abuse Issues ☐ Substance Abuse ☐ Mental Illness ☐ Resettlement
☐ Other (Please Specify) _____