ccahope

Information Sheet

PERSONAL INFORMATION

last name, first _____ age _____ M ☐ F ☐ date of birth ___/____/_____

home address _____ city _____ zip _____

PHONE	Use this number between 9am and 3pm?	May we leave a confidential message?
home _____	Y ☐ N ☐	Y ☐ N ☐
work _____	Y ☐ N ☐	Y ☐ N ☐
cell _____	Y ☐ N ☐	Y ☐ N ☐

email address _____ SSN _____-_____-_____

employer (or school attending) _____

occupation _____ how long? _____ highest education completed _____

INSURANCE INFORMATION

insurance carrier _____ **policy holder's** ID# _____

Is **policy holder** self? Y ☐ (skip remaining blanks in this section) N ☐ (complete all fields in this section)

policy holder's last name, first _____ **policy holder's** DOB ___/____/_____

policy holder's employer _____ **policy holder's** SSN _____-_____-_____

COUNSELING AND MEDICAL INFORMATION

Briefly describe the reason(s) you are seeking counseling: _____

_____

Approximately when did you begin to experience these difficulties? _____

Any previous psychological treatment or counseling? Y ☐ N ☐

if YES, focus of treatment: _____ duration _____

therapist name _____ phone _____ ending date _____

List any prescribed psychiatric medications: _____

Describe any current or recent medical treatment, including known allergies and medications: _____

_____

attending physician _____ phone _____ fax _____

address _____ city _____ zip _____

date of most recent physical exam (month/year) _____ current height _____ current weight _____

Any recent weight change (lbs.)? _____ Gain ☐ Loss ☐

REFERRAL AND OTHER CONTACT INFORMATION

name of referral source _____

referrer: ☐ physician ☐ minister ☐ therapist ☐ attorney ☐ teacher ☐ friend ☐ court ☐ family member ☐ other

emergency contact (& relationship) _____ phone _____

address _____ city _____ zip _____

Are you affiliated with a local church? Y ☐ N ☐ if YES, name of church & pastor: _____

FAITH PRACTICE SURVEY

* derived from the Duke Religion Index

Please answer these 2 statements looking back at the past twelve months.

How often do you attend church, worship, or other religious meetings?

☐ 1 - never ☐ 2 - once a year or less ☐ 3 - a few times a year
☐ 4 - a few times a month ☐ 5 - once a week ☐ 6 - more than once a week

How often do you spend time in private faith activities, such as prayer, personal worship, or Bible study?

☐ 1 – rarely or never ☐ 2 – a few times a month ☐ 3 – once a week
☐ 4 – two or more times a week ☐ 5 - daily ☐ 6 - more than once a day

The following section contains 3 statements about religious belief or experience. Please mark the extent to which each statement is true or not true for you.

In my life, I experience the presence of the Divine (*i.e.*, God).

☐ 1 – definitely *not* true ☐ 2 – tends *not* to be true ☐ 3 – unsure ☐ 4 – tends to be true ☐ 5 – definitely true

My spiritual beliefs are what really lie behind my whole approach to life.

☐ 1 – definitely *not* true ☐ 2 – tends *not* to be true ☐ 3 – unsure ☐ 4 – tends to be true ☐ 5 – definitely true

I try hard to carry my faith convictions over into all other dealings in life.

☐ 1 – definitely *not* true ☐ 2 – tends *not* to be true ☐ 3 – unsure ☐ 4 – tends to be true ☐ 5 – definitely true

FAMILY INFORMATION

MARITAL STATUS ☐ single ☐ separated / divorced – If so, when? _____

☐ widowed ☐ married – If married, how long? _____ current marital adjustment: ☐ excellent ☐ good ☐ fair ☐ poor

spouse's: name _____ DOB ___/___/____ occupation _____

List date(s) and duration of any previous marriage(s): _____

Living with spouse now? Y ☐ N ☐ your place of birth (city & state, or country) _____

If primary caregiver for anyone, list name(s) and relationship _____

Family of Origin	first name	age	city of residence	if deceased, year & cause	marital status: > divorced > married > widowed > single	occupation	rate rapport: > good > fair > poor
father							
mother							
siblings (specify gender)							
Current Family	first name	age	living w/ whom?	if deceased, year & cause	child of: > previous marriage > present marriage > spouse's previous marr.	occupation	rate rapport: > good > fair > poor
children							

CCAHope Client Information and Consent Forms

CCAHope provides quality clinical services that are distinctively Christian in orientation. We believe that upon beginning to work with us, you will experience the benefits of our commitment to excellence.

Sucessful therapeutic relationships are built on clear expectations. Here are the principles, policies, and procedures that will impact our journey together. Questions can readily be discussed during the Orientation and Assessment session or with your therapist at any time.

Counseling Care: What to Expect

Be assured that a certain amount of anxiety before and during early sessions is normal. You should also expect that you may feel worse before you begin to feel better. The process of therapy will involve speaking about experiences that are very difficult to face. Although few people find the process pleasurable, most people find counseling helpful and ultimately very rewarding.

Many people have pre-formed ideas about what a mental health professional would want them to talk about or how they "should be" during a session. Please be assured that you are not on stage. Honesty about your thoughts and feelings is the most important contribution you can make to the process. Your counselor will provide you with attention and respect along with expertise in an effort to help you resolve the difficulties that brought you to CCAHope. Our goal is to help you enjoy the fullness of all you were made to be.

Counselors and clients will jointly clarify goals, methods and approaches. Our assessment procedures are designed to be thorough and to enable you to express your story, struggles and desires. Clients are free to accept the treatment plan that your counselor offers or ask to explore alternative strategies. It is acceptable to request a referral to another therapist when additional expertise or another perspective is desired.

A unique distinctive of CCAHope is that our staff are competent and prepared to blend resources from the Christian faith into our treatment plans *when* this is the expressed desire of our clients. You will set the expectations on preferences for your counseling care.

Confidentiality, Exceptions and HIPAA Compliance

We are committed to keeping your information confidential. The law, professional ethics, and common sense prohibit anything you say or do from being shared with anyone else without your written permission. These are the exceptions that you should know about:

- If you are referred by the court or a legal agency, we may be required to furnish information to them.
- If you are involved in certain kinds of litigation and inform the court of services you have received from us, you may be waiving your right to have your records remain confidential.
- If you reveal a threat to harm yourself or someone else, we are obligated to inform helpers or those at risk.
- If there is reason to suspect child abuse or neglect, we are obligated to report this to a state agency.
- If there is reason to suspect elder abuse or neglect, we may be required to report this to a state agency.
- If you are a minor, your parents or guardians will be informed of your progress in treatment.
- If you are a member of a managed care insurance plan, we are generally required to exchange information with your primary care physician or care manager.

HIPAA Privacy Regulations have been established by the U.S. Department of Heath and Human Services to establish a minimum level of privacy protection for health care information. The Privacy Rule establishes a patient's rights regarding the use and disclosure of his/her health care information. Each medical/mental health practice that collects health care information must take steps to control access to this patient data as well as to inform patients of their privacy rights. CCAHope handles your health information in ways that are consistent with these regulations.

Our explicit policies to protect the privacy of your personal health information are as follows:

- CCAHope shares your health information only with those employees with whom it is necessary to perform the services you have requested.

- Counselors do consult on occasion with one another for peer and professional supervision to insure quality service. All CCAHope employees agree to follow privacy and confidentiality guidelines.
- Personal information is stored in a secure space or computer.
- For insurance billing, CCAHope cooperates with a local billing service, with whom CCAHope has a business associate contract designed explicitly to extend your privacy protections to their procedures and employees. Clients authorize *in advance* this exchange of essential health information for billing purposes.
- Health information is generally retained for a minimum of seven years, after which it is shredded, erased or destroyed.
- CCAHope will routinely evaluate our communication and recording procedures to maintain our commitment to your confidentiality and privacy. Our practice manager, Jean Fast, has been specifically designated to review our policies and compliance routinely.

Protecting your privacy is important. If you have any questions or concerns regarding privacy, please ask during the orientation and assessment session, speak with your counselor, or contact Jean Fast, M.A.

_____***I understand how CCAHope abides by HIPAA confidentiality and privacy guidelines.***

Parents

CCAHope is not equipped to supervise children. Please do not leave your children unattended in the waiting room.

Appointments: Scheduling and Canceling

- Appointments are about one hour, scheduled in advance, and on a weekly basis.
- Scheduling an appointment represents your counselor's commitment to reserve time for you. Any cancellations must be made at least 24 hours in advance or you will be charged for the time.
- Insurance agencies cannot be billed for late cancellations or missed appointments; this charge will be the responsibility of the client.

_____ ***I understand that I am directly responsible for the full session fee for any missed appointments unless I call to cancel/reschedule at least 24 hours before my scheduled appointment.***

Electronic Communication Policy

Various types of electronic communications are common in our society. Many individuals believe this is the preferred method of communication, whether their relationships are social or professional. Many of these modes of communication put privacy at risk. Therefore this can be inconsistent with the law and with the standards of the mental health profession. These policies are posted to assure the security and confidentiality of your treatment as well as to assure that it is consistent with ethics and the law.

- Digital communication is only done with your permission and is only available for administrative purposes while clients are getting started at CCAHope. Email exchanges should be limited to submitting forms.
- Do not email any CCAHope clinician about treatment matters. Email is not a secure way to contact a counselor. Telephone or face-to-face contact is a more secure mode of communication.
- CCAHope clinicians will not communicate or contact any clients through social media platforms. If a CCAHope staff member discovers that an online relationship has accidentally been established, they will cancel that relationship. These casual social contacts can create significant security risks.
- If you have an online presence, there is a possibility that you may encounter a CCAHope clinician by accident. If that occurs, discuss this with your counselor. Communication with clients online does have a high potential to compromise the professional relationship. Please do not try to contact a CCAHope clinician in this manner.
- Web searches are not utilized to gather information about clients without your permission. CCAHope contends that this violates your privacy rights.
- CCAHope understands that you might choose to gather information about our agency or clinicians in this way. If you encounter any information about us through web searches, or in any other fashion, please discuss this with your therapist during session so that any potential impact on your treatment can be addressed.
- There are web outlets for clients to review their health care provider on various sites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality

restrictions. Please do not rate a clinician while you are in treatment together on these websites. This is because it has potential to damage the therapeutic relationship.

- Therapy is intense interpersonal communication. There is significant benefit to working through disagreements or misunderstandings with clinicians directly. This is a superior way to constructively address concerns and thus is preferable to blogging or posting web comments.
- Some CCAHope clinicians may be willing to utilize text messaging with your permission for scheduling purposes only. Please do not send your therapist a text message unless explicit arrangements have been made.

_____***I consent to the use of texting to schedule appointments with my counselor.***

Fees

- An explanation of our usual and customary fees is available in advance from CCAHope.
- The Initial Consultation is offered at a reduced rate of eighty-nine dollars ($89). We strongly recommend this optional service (not covered by insurance) in order to provide you with the best care here at CCAHope.
- The usual and customary charge for the second visit (Orientation & Assessment session), is one hundred fifty dollars ($150).
- Counseling sessions are one hundred twenty-five dollars ($125) per visit to psychologists and one hundred fifteen dollars ($115) per visit to social workers and mental health counselors. It is most helpful if the handling of funds occurs at the onset of each session. Payments and co-payments are due at the time of service.
- If you are utilizing health insurance, you are responsible to inform CCAHope of any changes prior to an insurance billable visit. Charges denied because of policy termination, changes, or benefit limits are the patient's responsibility.
- A thirty-five dollar ($35) charge will be assessed for any returned checks.

I understand that, should I choose the Initial Consultation service, it will not be covered by insurance and I agree to pay the $89.00 out-of-pocket fee.

I understand that payment is due at the beginning of each session unless other arrangements are made.

I understand that insurance may be billed on my behalf, but I am ultimately responsible for payment of fees.

I understand that I am responsible for informing the practice of changes in my insurance.

I understand that I am responsible to meet my insurance deductible. I agree to pay the full session fee at the time of service until my insurance company notifies CCAHope that my deductible has been met. If the insurance company notifies CCAHope that the allowable amount differs from the full session fee, I understand that my account will be credited the difference.

Crisis Services

- We do not offer crisis intervention services. In the event of a life-threatening emergency, we recommend you go to an Emergency Room or call 911.
- If you have an urgent matter that you need to discuss with your counselor between scheduled sessions, you may do so by phone counseling. Follow your counselor's phone prompts to reach CCAHope's 24-hour answering service. Please clearly indicate to the answering service that the matter is urgent.
- For current patients, the fee for phone counseling will be assessed at twenty-five dollars ($25) per each 15-minute increment. Payment for this service should be made at the time of the next scheduled session.

_____***I have read and understanding the information regarding fees, insurance deductables, and crisis services.***

Information for Clients Utilizing Health Insurance

Health plan benefits may be available to cover the financial cost for psychotherapy when those services are deemed medically necessary. There are clinicians on staff who are properly credentialed and prepared to undertake the assessment, treatment planning, and implementation steps in accordance with the expectations of health insurance plans. Please sign off on this section if you would like CCAHope to coordinate your care with the procedures of your health insurance plan.

- I have chosen to receive treatment services under a benefit plan managed by _____.
- My choice is voluntary and I understand I may terminate therapy at any time.
- I understand that there is no assurance that I will feel better. Psychotherapy is a cooperative effort. I will work with my therapist in a cooperative manner to resolve my difficulties.
- I understand that I may be contacted by my managed care organization to ensure continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment.
- I have read and had explained to me the basic rights of individuals whose benefit plans are managed by _____.
- These rights include:
    1. The right to be informed of the various steps and activities involved in receiving services.
    2. The right to confidentiality under federal and state laws relating to the receipt of services.
    3. The right to humane care and protection from harm, abuse, or neglect.
    4. The right to make an informed decision whether to accept or refuse treatment.
    5. The right to contact and consult with counsel at my expense.
    6. The right to select practitioners of my choice at my expense.
- I understand that my therapist, my managed care representatives, CCAHope's billing service and my primary care physician may exchange any and all information pertaining to my therapy, to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes.
- I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid.

I authorize the release of any medical or other information necessary to process claims for services rendered at CCAHope. I authorize payment of medical benefits to be made to CCAHope.

_____ _____

Signature of Patient/Client **Date**

_____ _____

Signature of Parent/Guardian of a minor **Date**

_____ _____

Signature of Witness **Date**