VIEWPOINT
COUNSELING PROFESSIONALS

1905 4th Street Suite 4
Northport, Alabama 35476
PH: 205.632.5067
FAX: 1.833.521.1709
EMAIL: viewpoint@counselingsecure.com

INTAKE PAPERWORK

CLIENT INFORMATION

Date: _____

Your Name: _____
First Middle Initial Last

Preferred Name: _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Race and Ethnicity: _____
Please let us know about your racial and ethnic identity/identities

Home Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

City: _____ State: _____ Zip: _____

Please list other persons living in your home:

Name	Relation	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary Phone: _____ Secondary Phone: _____

□ Cell □ Work □ Home □ Cell □ Work □ Home

Email: _____

How would you like us to contact you?

□ Cell □ Home

□ Email □ Work

Education: □ High School/GED □ Some College □ College Degree □ Advanced Degree

Employer: _____Occupation: _____

Person(s) to notify in case of an emergency: _____

Name Relationship

_____

Phone

How did you hear about Viewpoint Counseling Professionals?

_____

_____

_____

Please briefly describe your presenting concern(s) that prompted seeking counseling (ex: anxiety, depression, relationship issues, etc.):

_____

_____

_____

_____

_____

PAYMENT INFORMATION

Payment Options:

□ Please bill my insurance

□ Please bill my EAP

□ Self-Pay

Insurance Information *(if applicable)*

Name of Insurance: _____ Contract #: _____ Group #: _____

Policyholder's Name: _____ Policyholder's DOB: ____/____/_____

Employer: _____ Policyholder's SSN: _____-_____-_____

Client's relationship to the policyholder: □ Self □ Spouse □ Child □ Other: _____

Policyholder's Address: □ Same as client

_____

Street City State Zip

EAP Information *(if applicable)*

Name of EAP: _____ Employer: _____

Benefitted Employee Name: _____ DOB: ____/____/_____ SSN: _____-_____-_____

Client's relationship to the benefitted employee: □ Self □ Spouse □ Child □ Other: _____

Self-Pay Information *(if applicable)*

Preferred method of payment:

□ Check □ Cash *(exact amount only)*

□ Credit/Debit Card

Name as it appears on card: _____

Card Number: _____ Expiration: ____/____ Security Code: _____

Billing Address:

_____

Street City State Zip

FINANCIAL POLICY

You are ultimately responsible for your Viewpoint Counseling Professionals, LLC bill. If you have insurance coverage with an insurance carrier with whom we are in network, we will help you with your insurance coverage by providing services such as calling to verify benefits and obtaining an estimate of coverage, filing claims, and providing whatever reasonable information your insurance company requests from us. Please be advised that working with your insurance company is a courtesy service and we cannot guarantee that your insurance company will pay. If your insurance denies payment, we will bill the session fee(s) to your designated credit/debit card. Co-payments are due at the time of service. If you have insurance coverage with a company we are not in network with, Viewpoint Counseling Professionals, LLC will provide a Superbill to submit for reimbursement after you have paid us for services. Acceptable forms of payment include exact cash, check, or credit cards.

Session Rates

- Individual Session: $140
- Couple/Family Session: $140
- Longer sessions may be available upon request at additional cost

Cancellation Policy

Your appointment time has been reserved specifically for you. Once your appointment is scheduled, you will be financially responsible for it unless you provide 24 hours' notice of cancellation. It is important to note that insurance companies do not reimburse for sessions you do not show up for. **You will be charged a fee of $50 for cancellations without 24 hours' notice and a fee of $100 for missed appointments.**

Other Fees

- There is a $35 fee for any returned checks.
- Telephone calls that exceed 10 minutes in duration will be billed at quarter hour increments of our individual session rate.
- The preparation of additional documentation requested by client (such as letters or case summaries) that exceed 10 minutes in duration will be billed at quarter hour increments of our session rate.

We require all clients to leave a credit/debit card on file.

I understand charges may be made on this card for fees as outlined above. I agree to provide my credit/debit card information for this purpose and understand it will be kept securely on file.

Name as it appears on card: _____

Card Number: _____ Expiration: _____/_____ Security Code: _____

Billing Address:

_____

Street City State Zip

I have read the above Financial Policy and understand that regardless of my benefits status I am ultimately responsible for the balance of my account for any professional services rendered by Viewpoint Counseling Professionals, LLC

Print Client's Name: _____ Date: _____/_____/_____

Client or Responsible Party's signature: _____

AGREEMENT FOR THERAPEUTIC SERVICES

Welcome to Viewpoint Counseling Professionals. This document is designed to inform you about what you can expect from us regarding confidentiality, emergencies, and several other details regarding the therapeutic process.

Office Hours

We typically are open Monday-Friday 9am-5pm. As a small private practice:

- Hours may vary and your therapist may offer different and/or additional appointment times.
- We do not have a receptionist; therefore, therapists take their own calls. If they are unavailable, please leave a message and your call will be returned promptly during available office hours.

Appointments

Session times are expected to begin promptly as scheduled. If you are late for any reason you will receive the remainder of your scheduled time, at the fee for the full session. This is necessary so that the therapists keep their following appointments at their scheduled time.

Sessions are scheduled at 50 minute increments (unless previously agreed upon).

Cancellations & No-Shows

We understand that there may be extenuating circumstances; however, we request that any cancellations or rescheduling of your appointment be made **at least 24 hours in advance.**

Once your appointment is scheduled, you will be financially responsible for it unless you provide 24 hours' notice of cancellation. It is important to note that insurance companies do not reimburse for sessions you do not show up for. **You will be charged a fee of $50 for cancellations without 24 hours' notice and a fee of $100 for missed appointments.**

After Office Hours Emergencies

If you are concerned about a risk to your health or safety, contact 911 or go to the nearest emergency department.

As Licensed Professional Counselors, we are not able to respond or intervene in clinical emergencies (suicide attempts, runaways, behavioral aggression, abuse episodes, etc.) and you should dial 911 or go to the nearest hospital emergency room. However, if you have an acute crisis situation and feel you must speak to a therapist after hours, please call the office and follow the prompts to direct your call.

Methods of Communication

Viewpoint Counseling Professionals, LLC has made every effort to establish secure and HIPPA compliant methods of communication.

We may be reached by phone, fax, or email.

Phone: (205) 632-5067
Fax: 1-833-521-1709
Email: viewpoint@counselingsecure.com
sonya.guy@counselingsecure.com
julia.madrid@counselingsecure.com

Confidentiality

Protecting your privacy is very important to us. The information in your record is confidential and will not be disclosed to anyone without your consent, unless required by law. As Licensed Professional Counselors, we are both ethically and legally bound to keep in confidence any information you divulge throughout the counseling relationship. Our professional licenses provide us with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a therapist.

In the State of Alabama, Licensed Professional Counselors are mandatory reporters. Therefore, there are some circumstances in which we are required by law to break confidentiality. The exceptions to confidentiality you should be aware of include:

- If you disclose intent to harm or kill yourself or someone else, we are required by law to do whatever we can to attempt to protect your safety and the safety of others. This may require notifying family members, parents/legal guardians, legal authorities and/or the potential victim.
- If there is reported or suspected abuse of protected populations, such as minor children and the elderly, we are required by law to make a report to the Department of Human Resources.
- If subpoenaed to provide information in a court of law, your therapist will first assert our protected status of privileged communication. However, it is possible, although unlikely, a judge could court-order your therapist to divulge confidential information.

In addition to the above, there are several other situations where confidentiality cannot be insured, including:

- If you choose to file with insurance or an Employee Assistance Program (EAP), information regarding your treatment, diagnosis, prognosis, and the specific issue for which you have come to counseling are available to the insurance company or EAP.
- If there is an outstanding balance owed to Viewpoint Counseling Professionals, LLC you or the responsible party will be contacted by phone, email, and/or receive a letter by mail. If payment or an agreement for payment is not made within 2 weeks from this contact your contact information (name, address, & phone numbers) will be released to a third party for collections.

We maintain the security of your client record. Paperwork with your identifying information will be stored in a locked cabinet in our locked office. In addition, your record will also be stored electronically in a HIPPA compliant practice management database.

In an effort to protect your confidentiality and respect the boundaries of the counseling relationship, it is our policy not to accept requests from any current or former clients on social networking sites.

Scope of Services

At Viewpoint Counseling Professionals, LLC, we provide counseling services for a wide variety of presenting problems. However, there are unique circumstances that may require referral to specialized providers, for example, but not limited to:

- Court-mandated counseling
- Acute eating disorders
- Active substance abuse

At any time during the therapeutic process, should a referral become necessary your therapist will discuss appropriate referral options based on your needs.

Minor Clients

At Viewpoint Counseling Professionals, LLC we appreciate the value of the therapeutic relationship with clients of all ages. Intake sessions for minor clients typically are conducted over two sessions. First, we meet privately with the parent(s)/legal guardian(s) to gather information, hear their concerns, and assess therapeutic needs. The therapist will then recommend scheduling to meet with the minor child for their intake session or provide appropriate referral information.

If you are the parent or guardian (with legal custody) of a minor seeking counseling *under* the age of 14 we will need your permission to provide counseling services to the minor child. If the client is *14 years or older*, they have the right to consent to their own treatment in the State of Alabama.

Counseling is most effective when clients establish rapport and trust in their therapist, therefore we maintain confidentiality for our minor clients as best we can in accordance with legal and ethical requirements.

Fees and Payments

You are ultimately responsible for your Viewpoint Counseling Professionals bill. Payment is due at the time of service.

Session Rates:

- Individual Session: $140
- Couple/Family Session: $140
- Longer sessions may be available upon request at additional cost

Other Fees:

- There is a $35 fee for any returned checks.
- Telephone calls that exceed 10 minutes in duration will be billed at quarter hour increments of our session rate.
- The preparation of additional documentation requested by client (such as letters or case summaries) that exceed 10 minutes in duration will be billed at quarter hour increments of our session rate.

Acceptable forms of payment include exact cash, check, or credit cards.

When filing with insurance:

- Co-payments are due at the time of service
- If your insurance denies payment, we will bill the session fee(s) to your designated credit/debit card

I have read and understand the Agreement for Therapeutic Services and consent to receive treatment by Viewpoint Counseling Professionals, LLC

Print Client's Name: _____ Date: _____/_____/_____

Client or Responsible Party's signature: _____

HIPPA NOTICE OF PRIVACY PRACTICES & CLIENT RIGHTS

Your Information. Your Rights. Our Responsibilities.

Viewpoint Counseling Professionals, LLC is committed to client confidentiality. We will only release your health care information in accordance with federal and state laws and the code of ethics for the counseling profession.

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

How we use or share your health information:

- Provide you with treatment
- Engage in business activities/healthcare operations
- Arrange payment for our services

Disclosing your health information without your consent:

At times, the law requires us to use or share your information. For example:

- If there is reported or suspected abuse of protected populations such as minor children and the elderly
- If there is a disclosure indicating a threat of danger to self or others
- If we are ordered by a judge to disclose information

CLIENT RIGHTS

You have the right to:

- Obtain a copy of your paper or electronic client record
    - You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
    - We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Request a correction your paper or electronic client record
    - You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
    - We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Confidential communication
    - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
    - We will say "yes" to all reasonable requests.
- Obtain a copy of this privacy notice
    - You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- File a complaint if you believe your privacy rights have been violated
    - If you believe your privacy rights have been violated, please contact us directly and discuss your concerns.
    - If you are not satisfied with the outcome, you can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights.
    - We will not retaliate against you for filing a complaint.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

Effective 9/1/2018