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The Staff of Valley Christian Counseling Welcomes You

We appreciate your selecting us and having confidence in our staff. We want you to feel comfortable coming to Valley Christian Counseling and to accomplish this we have prepared this introduction. Although this document can seem long and complex, it is very important that you read it carefully and complete all sections before our first session. We can discuss any questions you may have at that time. Please continue to ask any questions or voice concerns throughout the course of treatment so that our professional relationship will be open and satisfying for all. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time.

Appointments

Clients are seen by appointment only. To change or cancel an appointment, we require at least a 48-business hour notice to our office for any cancellations. This will help us to schedule those waiting for appointments and for you to avoid being charged for the time that was reserved for you. **Clients who cancel without a 48-hour notice or do not attend their appointment will incur a cancellation/no show fee.** If your appointment is on a Monday, and you leave a message on the machine over the weekend, that does not constitute 48-hour notice. Insurance does not pay for late cancellations or missed appointments.

Emergencies

If you experience an emergency during or after hours, you should seek immediate help by calling 911, Helpline (539-1000 or 539-3424), the mental health center (533-1970), your primary care physician, or one of the hospital emergency rooms for assistance as needed and then alert your clinician at your earliest convenience.

Clinical Record

Professional laws and standards require that a clinical record of psychological services be maintained for all treatment provided. The client record remains the property of the clinician. Patients have the right to request that a record is amended; to request restrictions on what information from your clinical record is disclosed to others; to request an accounting of disclosures that you have neither consented to nor authorized; to determine the location to which protected information disclosures are sent; and to have any complaints you make about these policies and procedures recorded in your records. Valley Christian Counseling is not a HIPAA covered entity. I am happy to discuss any of these rights with you.

Confidentiality and Disclosure Statement

The confidentiality of psychological services provided by Valley Christian Counseling is protected by professional ethics and law. Unless you grant written permission, we will neither inform anyone that you are receiving services, nor will we disclose personal information provided. Legal and ethical exceptions exist. If you would like for information from your clinical record to be sent to a third party (i.e., physician, therapist, attorney, family member etc.) you must *first* sign a Release of Authorization form provided by our office. A fee may be required before records are forwarded.

Limits On Confidentiality

The law protects the privacy of all communications between a patient and a clinician. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements. There are other situations that require that you provide written advance consent. Your signature on this Agreement provides consent for those activities, as follows:

1. I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I believe that it is important to our work together. I will note all consultations in your Clinical Record.
2. You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling and billing. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
3. I also may have contracts with other businesses such as an accounting firm or attorney. I have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.
4. If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

2. If a government agency is requesting the information for health oversight activities, I am required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, I may disclose information relevant to that claim to the patient's employer or the insurer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment.

1. If I know or suspect that a child under the age of 18 has been abused or neglected, the law requires that I file a report with the appropriate governmental agency, usually the Alabama Department of Human Resources. Once such a report is filed, I may be required to provide additional information.
2. If I know that an elderly or disabled adult has been abused, neglected, exploited, sexually or emotionally abused, the law requires that I file a report with the appropriate governmental agency, usually the Alabama Department of Human Resources. Once such a report is filed, I may be required to provide additional information.
3. If a clear and immediate threat of serious physical harm to an identifiable victim is communicated by a patient then I am required to communicate confidential information to a potential victim, the family of a potential victim, law enforcement authorities, or other appropriate authorities.

I hereby acknowledge that these limitations on confidentiality have been read by me and/or explained to me and I agree to abide by them. I have been given the opportunity to discuss these concepts and conditions and to ask for clarification. I understand that my consent to treatment may be withdrawn by me at any time without prejudice.

Client or Legal Guardian's Signature

Date

Client's Rights

You, the client, have the right to:

- Receive respectful treatment that will be helpful to you without discrimination
- Be informed about techniques, intervention strategies and procedures, or any aspect that might not be clear or understood regarding treatment
- Be informed and inquire about diagnosis, methods of assessment, and the goals of treatment
- Accept or decline treatment (except in emergency situations or when ordered by a judge or Federal/State authority)
- Seek alternative psychotherapy services and be provided with an appropriate referral

- Discuss, question, and participate in hospital, residential placement, half-way or quarter-way treatment decisions
- Ask for and receive information about the clinician’s qualifications, including license, education, training, experience, membership in professional groups, special areas of practice, and limits of practice
- Refuse to answer any question or give any information you choose not to answer or give
- Know if your clinician will discuss your case with others
- Ask that the clinician inform you of your progress
- A safe treatment setting, free from sexual, physical, and emotional abuse. In a professional relationship, sexual intimacy between a therapist and a client is never appropriate
- Report suspected immoral or illegal behavior

Other Considerations

Smoking is not allowed inside the facilities. Possession of illegal substances, alcohol, firearms, or weapons is prohibited on our premises. Being under the influence of drugs or alcohol is prohibited. If we suspect that you are in violation of these rules, or any other laws, you will be asked to leave, and /or appropriate authorities will be notified.

Our psychologist, therapists and psychiatrist are experienced, independently licensed and certified in their respective specialty areas. Each practitioner operates as the sole proprietor of his or her practice. My signature below acknowledges my understanding and acceptance that each practitioner here operates as the sole proprietor of his or her practice. I agree to hold harmless all other practitioners at this site from the actions of my psychologist or therapist.

Client or Legal Guardian’s signature

Date

Psychological Testing

Psychological testing can provide valuable information about the way a person thinks, learns and copes with stressful situations. It is useful when there is lack of clarity or understanding regarding the reasons and causes of various emotional, psychological, learning, or behavioral problems. It is a critical part of the process of accurately making a diagnosis, as well as a way of better understanding an individual's intellectual, behavioral and social-emotional development.

The profile generated through an evaluation is designed to help you to better understand your strengths and weaknesses and to clarify how you and others can best help with the identified problems. In most cases, the information gained from a comprehensive evaluation will serve as a blueprint for your care for many years.

The process of psychological testing consists of gathering information from multiple sources in a variety of ways: I will interview the individual, and parents when appropriate, to gain information about developmental history and the current concerns, review previous evaluations and information, collect information from other relevant professionals via rating scales or telephone conversations (with your consent, of course), and learn about you more directly through administering various tests in the office.

Most psychological assessments will include some combination of tests examining current intellectual functioning, academic achievement, learning style, memory, visual-motor functioning, attention, executive functioning, behavior, personality and social-emotional functioning. These assessments can be obtained for children, adolescents, young adults, and adults. The specific tests in your individualized assessment battery will be selected to answer the specific questions identified in our first appointment.

Following the evaluation, I will arrange a final session with you to go over the test results in which I will describe the tests administered, explain the results, and explain the findings as they relate to your original assessment questions. Recommendations for interventions, if needed, will also be addressed. This information will be documented in a written report and can be submitted to other professionals or schools at your request.

Signing this form means that you understand that psychological assessment interviews and devices have limited predictive validity. Participating in psychological assessment does not guarantee a diagnosis of any kind. You are entitled to disagree with my opinion. You always have the option of seeking an opinion from another mental health practitioner and to stop participating in the assessment at any time. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Financial Agreement

The charges for psychological testing are \$160 per hour, which include time spent in interviews, review of background data, test administration, scoring, interpretation, report writing time, and the follow-up session to review test results. A psychological assessment with report typically costs in the range of \$1000 to \$2000. The exact cost varies with the extent of the evaluation. I offer a range of what the expected cost will be, because it is difficult to know in advance just what and how much needs to

be assessed until we have had a chance to meet and start discussing your issues in greater detail. Occasionally, a single specific test is requested. When appropriate to do so, the fee will be based upon the test administered. Please discuss these charges in advance with me.

These fees may be covered by your health insurance. I, (your name) _____ understand that Dr. Hoffman is not in network for any private insurance providers Valley Christian Counseling does not file insurance. We cannot determine if or what you will be reimbursed for mental health services. That is between you and your insurance provider. You will be provided a complete itemized statement that contains all necessary information needed so that you can bill your insurance directly.

Insurance companies may require that you follow a specific protocol for approval of psychological testing benefits, and this may require pre-authorization and prior completion of forms. This may not be done retroactively, so it is recommended that you understand your insurance policy before beginning testing.

You may pay for evaluation services in one payment at the time of the first evaluation appointment, or you may pay one-half of the evaluation fee at the time of your first evaluation appointment with the remaining balance due prior to your final feedback conference. We accept cash, checks, and credit cards.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require the disclosure of otherwise confidential information. In most collection situations, the only information released regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

Please initial one of these three payment arrangements indicating the appropriate option.

_____ I will be paying directly for this evaluation. I will not be utilizing insurance benefits.

_____ I will be utilizing insurance benefits, however, I will pay for services directly to Valley Christian Counseling and then file with my insurance company since Valley Christian Counseling is not a participating provider in my insurance plan. I understand that some evaluation services are not considered covered benefits and have discussed any questions about covered vs. non-covered benefits with the Dr. Hoffman.

I have been given the opportunity to discuss these policies and to ask for clarification. I have read and agree with all of the above information. I understand that I will be responsible for charges and will pay for services as rendered regardless of amounts, if any, reimbursed to me by my insurance company. My signature below constitutes an understanding of and agreement to the terms and conditions above.

Client or Legal Guardian's signature

Date

Client Contact Information

Client's Name _____ Date _____
Client Age _____ Sex _____ Ethnicity _____ Date of Birth _____
Home Address _____

Email _____ Cell Phone _____
Home Phone _____ Work Phone _____ (Circle preferred contact #)
*OK to leave a voicemail at preferred contact # regarding appointments? Y N
How did you hear about us: _____
Other family members seen here: _____
In case of an emergency please contact: _____
Relationship: _____ Telephone: _____

Background Information

Reason for Seeking a Psychological Evaluation: _____

For how long have you had the current problem? _____
In what ways have you attempted to cope with this problem or concern? _____

How was the decision made to come in now? _____

Are you currently receiving psychiatric services, counseling or therapy elsewhere? Y N
Have you ever received psychological or psychiatric treatment prior to this? Y N

*If yes, please list names of providers, dates, reasons for treatment and outcomes of treatment:

Have you ever been hospitalized for psychological problems? Y N
Have you ever received psychological testing in the past? Y N

*If yes, by whom, when, where and for what reason?

Have you ever heard unusual noises or voices that other people nearby were not able to hear? Y N

Have you ever had visions of people or things that seemed real? Y N

Have you ever smelled odors that others nearby did not smell? Y N

Have you thought that someone else might be controlling your mind or putting thoughts into your head? Y N

Have you personally experienced any abuse: () None () Emotional () Physical () Sexual

Do you currently have thoughts of harming yourself? Y N

Do you currently have thoughts of wishing you were dead? Y N

Do you currently have urges to hurt, harm, or kill someone else? Y N If yes, whom? _____

Have you ever attempted suicide or intentionally harmed yourself? Y N

Have you ever seriously considered suicide or felt like harming someone else? Y N

If yes, please explain: _____

Have you lost or gained an unusual amount of weight lately Y N Lost or Gained ____ lbs

Family History

Marital Status _____ Spouse/ Partner's Name _____

How long have you been married? _____ Previous marriages? _____

Is the marriage in trouble? Y N Areas of concern: _____

Do you have any problems with relatives or in-laws? Y N

Are there any issues about your marriage you wish to discuss? _____

If never married, are you now involved in a serious relationship with anyone? _____

Are you now living alone or with somebody who is not your spouse? Y N

Where were you born/raised? _____

In general, how happy or adjusted were you growing up? () Poor () Average () Completely

Were you ever raised by someone other than your biological parents? Who: _____

Did you have an unhappy childhood? Y N

Were you ever abused or mistreated as a child or teenager? Y N

Were you often in poor health as a child or teenager? Y N

Were you very poor when growing up? Y N

Did you have a poor relationship with your mother or father? Y N

What important expectations were held for children growing up in your family of origin?

Were you especially close to any adults other than your parents? Who _____

How was affection expressed in the home where you grew up? _____

How was anger expressed in the home where you grew up? _____

Were there any unusual or disturbing experiences in your childhood? Y N

Do you feel your current problems may be directly related to the way you were raised? Y N

At what age () and under what circumstances did you leave home? _____

How much is your immediate family a source of emotional support for you?

() None () Little () Somewhat () Substantial () Always

Who in your family do you currently feel closest to? _____

Most distant from? _____ In most conflict with? _____

Do you have inadequate social support (family/friends)? Y N

Religious affiliation: _____ Was religion a major part of your upbringing? Y N

Is religion a major part of your life now? Y N

Is there a familial history of any of the following concerns with any biologic relatives (please include immediate family members and extended relatives)?

			Relationship to Patient
Autism Spectrum	Y	N	_____
Suicide	Y	N	_____
Eating Disorder	Y	N	_____
Depression	Y	N	_____
Bipolar Disorder/Manic-Depression	Y	N	_____

Anxiety Disorder	Y	N	_____
Obsessive-Compulsive Disorder	Y	N	_____
ADD/ADHD	Y	N	_____
Schizophrenia or Psychotic Disorder	Y	N	_____
Alcohol/Drug Problems	Y	N	_____
Legal Problems	Y	N	_____
Other (please specify)	Y	N	_____

Education Information and Work History

Highest education level completed: _____ History of learning problems Y N
 Were you generally a below average student? _____ Were you generally an above average student? _____
 Were you a behavior problem in school or when growing up? Y N
 Were you ever in trouble with the law or juvenile authorities while growing up? Y N

Employment status (Check all that apply):
 Employed Homemaker Retired Disabled Student Unemployed
 If/When employed, what type of work do you do? _____
 Current Employer: _____ Years on Current Job: _____
 Are you unsatisfied with your present work? Y N

<i>Previous Jobs Held</i>	<i>How Long</i>	<i>Why Left</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you been in trouble with the law as an adult? Y N
 History of Military Service: Y N Currently in military? Y N Branch: _____
 If you served in combat, when did you serve? _____
 Type of discharge: _____ Reason for discharge: _____

What are your ambitions in life? _____
 Please list any leisure activities (such as sports, clubs, religious organizations, etc.) that you are involved in currently: _____

Medical History

Your present state of health is: Excellent Good Fair Poor
 Describe any current medical problems (including allergies, asthma, injuries, etc.)

 Name of medical provider by whom you were last seen: _____ Date _____
 Address: _____ Phone # _____
 How many times a week do you exercise? _____ For how long? _____

Have you ever been hospitalized or received treatment for substance abuse problems?	Y	N
Have you ever tried to cut down on the amount of alcohol you consume?	Y	N
Has anyone close to you ever been annoyed by your drinking or drug usage?	Y	N
Do you consider your alcohol consumption or drug usage to be a problem?	Y	N

In a typical month, how often do you have 4 or more drinks in a 24 hour period? _____

If substance abuse has occurred, please provide specific information including amounts of the substance, withdrawal symptoms, successful, and unsuccessful attempts to decrease or discontinue use.

Checklist of Concerns

Please mark all of the items that apply, and add any others at the bottom.

- I have no problems
- Abortion, crises/ unexpected pregnancies, post-abortion issues
- Academic Problems, Learning Disabilities
- Adoption, infertility
- Abuse: physical, sexual, emotional, neglect (of children or elderly), animal cruelty
- Aggression, violence
- Alcohol use
- Anger
- Anxiety, nervousness
- Attention, concentration, distractibility
- Autism Spectrum Disorder, developmental concerns
- Bedwetting
- Career concerns, goals, and choices
- Child leaving home
- Childhood issues (your own childhood)
- Children, child management, childcare, parenting, child-parent relationships
- Chronic illness
- Codependence
- Confusion
- Compulsions
- Crying spells
- Custody of children, divorce litigation
- Debilitating injuries/disabilities
- Decision-making, indecision, mixed feelings, putting off decisions
- Delusions (false ideas)
- Dependence
- Depression, low mood, sadness, crying
- Divorce, separation
- Dizziness
- Drug use – prescription medications, over-the-counter medications, street drugs
- Eating problems – over-eating, under-eating, changes in appetite, vomiting
- Emptiness
- Eviction/repossession
- Failure
- Fainting spells
- Family concerns

- Fatigue, low energy, constantly tired
- Fears of specific things, phobias
- Fear of losing my mind, going crazy
- Financial or money troubles, debt, impulsive spending
- Flashbacks
- Friendships
- Gambling
- Gender identity problems
- Grieving, mourning, deaths, losses, bereavement
- Guilt
- Hallucinations, psychosis (hearing or seeing things that others don't)
- Health, illness, medical concerns, physical problems
- Heart racing
- Home life concerns
- Homicidal thoughts (current or history of)
- Identity (self-esteem, goals)
- Inferiority feelings
- Impulsiveness, loss of self-control
- Irresponsibility
- Irritability
- Job related stress
- Judgment problems, risk-taking
- Learned about a "family secret"
- Legal matters, charges, suits
- Loneliness
- Mania
- Marital conflict, distance/coldness, infidelity/affairs, remarriage
- Medical concerns
- Memory problems, forgetfulness
- Menstrual problems, PMS, menopause
- Mood swings
- Motivation, laziness
- Nausea/vomiting
- Nervousness, tension
- Obsessions, compulsions (thought or actions that repeat themselves)
- Others controlling your thoughts
- Over-sensitivity to rejection
- Overambitious
- Panic or anxiety attacks
- Perfectionism
- Pessimism
- Physical complaints, headaches, other kinds of pains
- Pornography, sexual addictions
- Premarital counseling, engagement
- Procrastination, work inhibitions, laziness
- Rebellion, oppositional behaviors
- Recent trauma (assault, burglary, accident, etc.)
- Relationship problems, difficulty making friends

- Retirement
- Seeing strange visions
- Self-centeredness
- Self-harm, cutting, burning
- Self-neglect, poor self-care
- Sexual issues, dysfunctions, conflicts, desire differences
- Shyness, over-sensitivity to criticism
- Significant property damage
- Sleep problems - too much, too little, insomnia, nightmares
- Smoking and tobacco use
- Spirituality, religious issues
- Stealing
- Stress, relaxation, stress management, stress disorders, tension
- Suspiciousness
- Suicidal thoughts (current or history of)
- Temper problems, outbursts, low frustration tolerance
- Thought disorganization and confusion
- Threats, violence
- Tics, motor or verbal
- Trust issues, mistrust of others, suspiciousness
- Uncontrolled behavior/feelings
- Unemployment
- Vandalism
- Verbal abuse
- Weight and diet issues
- Withdrawal, isolating
- Worries, excessive

Thank you for your time and effort in completing these forms prior to your session. This form is intended to help become better acquainted with you and in turn, serve you better. You may omit any item, but try to be as thorough as possible. This will allow us to use our time more efficiently during the first session.