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COUNSELING

To All New Clients,

On behalf of the entire Artisan Counseling team we would like to welcome you and thank you for trusting us as your provider of counseling services. Artisan Counseling was established to provide the highest quality of individual, couples, family and group counseling available in the Hampton Roads community. In order to achieve this goal, we always strive to demonstrate integrity and a commitment to service in all of our interactions. It is our mission to blend the craft and science of counseling to strengthen individuals, couples, families and the community through mental health counseling services.

Our office is located at:

11713 Jefferson Avenue (Suite 200)
Newport News, VA 23606

For your first appointment please bring the following:

1) **Completed new client paperwork**
2) **A form of identification that includes a photo**
3) **Current insurance card**
4) **Form of payment** (credit card, HSA or cash)
5) **Signed authorization to release information** (if applicable)

If a minor is participating in counseling, additional paperwork will be needed related to guardianship if applicable. If parents/guardians are divorced, we require a copy of the legal documents indicating the custody agreement and who has the legal right to consent to medical treatment. In cases of joint custody, we require the signature of both parents at the time of the first session, unless your custody agreement specifies otherwise.

If you have any questions about your appointment or why we need the above items, please give us a call at 757-503-2819. We will look forward to working with you or your family.

Sincerely,

Artisan Counseling Team

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GENERAL INFORMATION ABOUT ARTISAN COUNSELING

Artisan Counseling is dedicated to the craft of counseling. This means were strive to provide the highest quality individual, couples and family counseling available in the Hampton Roads area. Our counselors have specialized education and training to meet a variety of client needs. We are committed to providing an experience that is both personable and productive.

CONSENT FORM

The purpose of this intake packet is to provide you more information about your counselor, our policies and practices, and your rights and responsibilities. Your first session gives us a chance to get to know each other and to find out more about what brings you into counseling. If we decide to continue working together, we will further discuss the goals, focus, risks and benefits of treatments, the approximate time commitment involved, costs and other aspects of your particular goals for counseling. Periodically, we will evaluate our progress and, if necessary, redesign our treatment plan, goals, and methods. We may also discuss ways you can implement our work between sessions. This work can help you gain valuable skills and thoughtful growth while you are in counseling.

CONFIDENTIALITY

Generally, we will tell no one what you tell us without your written consent, unless you are under the age 18, in which case, we will discuss the legal rights your parent(s) / guardian(s) have to your records. There are two primary circumstances in which we cannot guarantee confidentiality, legally or ethically: (1) when we believe you intend to harm yourself or another person; and (2) when we believe a child or elder person has been or will be abused or neglected. In rare circumstances, a counselor can be ordered by a judge to release information. Disclosure may be required by your health insurance carrier. Please see the HIPAA policy for more information (available upon request).

EXPLANATION OF DUAL RELATIONSHIPS

Although you may share very private thoughts and emotions with your counselor, it is important for you and your therapist to maintain a professional rather than social relationship. Contact is limited to scheduled appointments and we do not participate in social media relationships. Also, it is important to discuss with your counselor what your expectations are if you happen to run into each other in public setting.

PROCESS FOR ADDRESSING A COMPLAINT

If you are not satisfied with any aspect of our work, please inform your counselor so that we can work with you to resolve the concern. At anytime you may request to speak with the practice owner (Ben Newman, LPC) at (757) 503 – 2819 to express a concern or to resolve a conflict. If you think that you have been unfairly or unethically treated, by our counselors or any other licensed professional and cannot resolve this problem within the practice, you can contact: Commonwealth of Virginia Department of Health Professions 6606 West Broad Street, Fourth Floor Richmond, Virginia 23230-1717 phone (804) 662-9575.

IF YOU EXPERIENCE A MENTAL HEALTH EMERGENCY (DANGER TO SELF OR OTHERS)

Artisan Counseling specializes in individual, couples and family counseling in a community setting. If you experience a mental health emergency, please contact your counselor at (757) 503-2819. If your counselor is not available, please contact one of the emergency contacts below.

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EMERGENCY CONTACT INFORMATION

Contact	Telephone Number
Call 911 or go to the nearest Emergency Room for immediate treatment	911
Suicide Hotline	(800) 273 – 8255
Child Protective Services	(800) 522 – 7096
Adult Protective Services	(888) 832 – 3858
National Domestic Violence Hotline	(800) 799 – 7233
Community Service Board (CSB) 24/7 Access to Crisis Services	
Hampton Newport News CSB	(757) 788 – 0011
Norfolk CSB	(757) 644 – 7690
Virginia Beach CSB	(757) 385 – 0888
Western Tidewater CSB (serving Suffolk, Franklin, Isle of Wright and South Hampton)	(757) 925 – 2484
Portsmouth CSB	(757) 393 – 8990
Chesapeake CSB	(757) 548 – 7000
Colonial Behavioral Health (Serving James City County, York, Poquoson and Williamsburg)	(757) 220 - 3200

APPOINTMENT GUIDLINES

Most often the intake session (first meeting) is scheduled for 90 minutes, which allows for additional time in counseling to begin the process. Most therapeutic sessions are approximately 50 minutes in duration. Starting and ending appointments on time allows us to best utilize your time. If you arrive more than 15 minutes late, it is at the discretion of the therapist to hold the scheduled appointment or reschedule for an alternative date and time.

FEES, METHOD OF PAYMENT, AND INSURANCE

$180 per intake assessment (90 minutes) and $130 per individual, couples or family session - Payment is required at the time of service. We keep a credit card on file for ease of payment but also accept cash. Any unpaid balance will be charged to the card on file. If you accrue an outstanding balance or missed appointment fee, payment must be received prior to scheduling your next appointment. Fees are subject to change and you will be given at least 30 days' notice of any changes. We reserve the right to use the services of a collection agency for unpaid balances. Account statements are available upon request.

INSURANCE

We accept several insurances and can discuss the details of your particular plan. Client is responsible for any fees not covered by their insurance. Please note that any insurance quotes provided are an estimate based on information provided to us by the insurance company. We strongly encourage you to speak with your insurance company to fully understand your benefits as they apply to mental health services.

MISSED APPOINTMENT POLICY

Our goal is to manage our time wisely to serve our clients in the best way possible. When timely (24 hours or more notice) cancellations occur, it is possible to offer open appointment times to clients on the appointment waiting list. We sincerely appreciate your cooperation and understanding of the following policy: (1) If you need to cancel an appointment, please give at least 24 hours' notice, (2) Please cancel Monday appointments by 6:00 PM on Friday, (3) If you cancel with less than 24 hours notice or miss an appointment, you will be charged $50, (4) Fees will be charged to the card on file at the time of the missed appointment and (5) Your account must be paid in full before rescheduling.

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NON-THERAPY SERVICES INCLUDING SERVICES RELATED TO COURT AND LEGAL ISSUES

Prep time, administrative time, time spent writing reports or assessments, phone calls and other correspondence will be billed at the rate of $150 per hour. We do not take part in any court cases unless subpoenaed. The charge for court is a minimum nonrefundable fee of $1200, paid in advance, regardless of whether we actually testify or appear in court. The first $1200 applies to a maximum of four hours of our time at an out-of-office courtroom rate of $300 per hour. Expenses we may incur such as parking, travel time, telephone calls, and time spent preparing documents will be charged at $300 an hour and are in addition to the $1200 minimum fee. If we are required to be on call beyond the first four hours for a court appearance, an additional $1200 minimum fee will be incurred, even if we must remain "on call" one minute, one hour, or all four hours beyond the first four, whether we are actually called to testify or not. If a client wants us to speak, meet, or correspond in any way with any other person to include but not limited to an attorney, probation officer, CPS worker, physician, etc., the client will be billed for the therapist's time. Clients should consider whether or not they want to issue a subpoena for a counselor to testify in court. The process is always expensive to the client, and there is no guarantee that what the therapist will say will be of benefit to the client's case.

CLOSURE OF TREATMENT

It is the goal of the Artisan Counseling team to support you with both developing and achieving your goals for counseling. As a result, the decision to close treatment is made collaboratively between the client and counselor. If you are out of contact with your therapist for 60 days at any time, your case will be considered closed.

LEAVING A MESSAGE FOR YOU THERAPIST OR THE OFFICE MANAGER

Please feel free to leave a messages on voice mail for (757) 503 - 2819. It is our goal to return all calls as soon as possible. A representative will be available to return calls between 9am and 7pm Monday through Friday.

EMAIL AND TEXTING POLICY

While we make every effort to protect text and email, we can provide no assurance confidentiality or security. The standard email you use at home or work is most likely not HIPAA secure and could be vulnerable to unauthorized access. Electronic communications are not appropriate if you are experiencing a crisis. We may not check email every day. With your consent, we may send automated email or text appointment reminders. Each client must weigh the benefits against the potential risk and determine the communication types they are comfortable using.

Initial Below		**Indicate by placing an X**			
	Please sign below that you understand and agree with the above policy. I consent to using email communication:	☐	Yes	☐	No
	I consent to using text message communication:	☐	Yes	☐	No

PLEASE CAREFULLY READ THE STATEMENT BELOW AND INITIAL

	I consent for myself (or my child) to receive behavioral health services **at Artisan Counseling.**
	I have read, understand, and agree to comply with the fee policy and the **Missed Appointment Policy.**
	I have reviewed the Notice of Privacy Practices (HIPAA)
	I will use my insurance benefits. I understand that I am responsible for all co-payments, cost share payments, or out of pocket payments for services provided to me. I authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan.

	I understand that I am responsible for any fees denied or not covered by my insurance company.
	I will pay for services out of pocket and will not use insurance or will submit my own receipts for out of network reimbursement. I understand that I am responsible for all fees for services provided to me.

I have read and understand the conditions outlined above			
Client signature:		Date:	
Parent/Guardian (if applicable) Signature:		Date:	
Counselor Signature:		Date:	

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NEW CLIENT INFORMATION

Name:		Date of Birth:		Age:		Gender:	
Address:							
May we *discretely* contact you at this address?	☐	Yes	☐	No			
Cell Phone Number:	( )						
May we *discretely* contact you on your cell phone?	☐	Yes	☐	No			
Home Phone Number:	( )						
May we *discretely* contact you on your home phone?	☐	Yes	☐	No			
Email Address:							
May we *discretely* contact you at this email address?	☐	Yes	☐	No			
Marital/relationship status:							
Ethnic/Cultural Background:							
Education:							
Occupation:							
Employer:							

REFERAL INFORMATION

How did you hear about Artisan Counseling?	☐	Google/Internet Search
	☐	*Psychologytoday.com*
	☐	*Goodtherapy.org*
	☐	My Insurance Listing
	Other (Please Provide Details):	

Were you referred by a specific person? If so who referred you to Artisan Counseling?	☐	Yes	☐	No	Referred By:

PRIMARY INSURANCE INFORMATION

Name of Insurance Company:		Policy Owner's Name:	
Policy Owners Date of Birth:		Policy Owner's SS#:	
Insurance ID#:		Policy Owner's Address:	

Do you have secondary insurance?	☐	Yes	☐	No

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We do not bill secondary insurance and will provide you with the necessary forms to submit to your insurance company.

Please be prepared to provide our office staff with your insurance card and photo ID so that we may make a copy.

EMERGENCY CONTACT

Name:		Phone Number:	( )	Relationship:	

CURRENT CONCERNS (WHAT BRING YOU TO COUNSELING?)

IN WHAT AREAS DO YOUR CURRENT CONCERNS IMPACT YOUR LIFE?

☐	Lifestyle	☐	Relationships	☐	Sleeping	☐	Activities	☐	Eating	☐	Mood

HAVE YOU EVER ATTEMPTED SUICIDE?

☐	Yes	☐	No	If yes, when?			
Have you currently been thinking about suicide?					☐	Yes	☐ No

HAVE YOU EVER THOUGHT ABOUT HARMING OR KILLING SOMEONE ELSE?

☐	Yes	☐	No	If yes, when?			
Have you currently been thinking about harming or killing some else?					☐	Yes	☐ No

DO YOU USE ALCOHOL OR DRUGS?

☐	Yes	☐	No	If yes, what type and how often?			
Have you ever received treatment for substance abuse					☐	Yes	☐ No
If yes, please provide details about SA treatment services received:							

TREATMENT HISTORY

Are you currently being treated by a mental health professional or physician for the problems noted above?	☐	Yes	☐	No

If yes, please provide additional information:	Name of Provider:	
	Agency Name:	
	Contact Information:	
	Type of Services:	

CURRENT MEDICATIONS

PREVIOUS MENTAL HEALTH TREATMENT (DATES, NAME OF PROFESSIONAL, TYPE, WHY DISCONTINUED)				
Have you ever been hospitalized for mental health treatment?	☐	Yes	☐	No
If yes, please provide the name of the hospital or facility and reason for hospitalization				

HEALTH INFORMATION (WHO IS YOUR CURRENT PRIMARY CARE PHYSICIAN?)	
Name of PCP:	
Practice Name:	
Contact Information:	
When were you last seen by your PCP?	
Current Health Concerns:	

Client Signature:		Date:	
Parent/Guardian (if applicable) Signature:		Date:	

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CREDIT CARD AUTHORIZATION

This form is necessary even if you do not intend to use credit card payment so we have a backup for any missed session fees, forgotten payments, etc.

By signing this agreement, I am authorizing Artisan Counseling to bill my credit card for professional services rendered to (client name) _____. I agree that I will not dispute valid charges, which may include:

Initial Below:	
	Agreed upon fees for services
	A missed session fee if the client does not show up for a scheduled appointment or cancels with less than 24 hours' notice
	Co-pays, cost-shares, deductibles, or any fee not covered by your insurance. You may also choose to use another form of payment at the time of service. Unpaid balances will be charged to the card on file.

CARDHOLDER INFORMATION

Name:		**Relationship to client:**			
Billing Street Address:					
City:		**State:**		**Postal Code:**	
Email:		**Phone Number:**	**( )**		

CREDIT CARD INFORMATION

Type of Credit Card	☐	**Visa**	☐	**Master Card**	☐	**American Express**	
Last 4 Digits:		**Expiration Month:**		**Expiration Year:**			
Is this an HSA or HRA card?	☐	**Yes**	☐	**No**			
Cardholder Signature:				**Date:**			

COMPLETE IF CARDHOLDER IS NOT THE CLIENT

I, (client name) _____, authorize Artisan Counseling to disclose billing information to the above named cardholder.

Cardholder Signature:		**Date:**	