Christian Counseling Services

Thank you for taking this important step to pursue counseling for you and/or your family. Please find in this packet several important documents to ensure you receive the best professional treatment possible. This includes the **Confidential Client Information Form**, **Statement of Counseling Policies and Procedures**, and **Informed Consent and Release of Liability**.

In addition, this packet includes a copy of our **Notice of Privacy Practices**. This complies with the Health Insurance Portability & Accountability Act of 1996 (HIPPA). This Federal law requires that all health care professionals notify patients of how their health information is protected and how it may be used.

New York law regarding psychotherapy is much stricter than Federal guidelines. HIPPA allows stricter state laws to prevail where conflict between the two may exist.

To best serve you, please take the time to review the attached documents, complete the necessary information, and sign the **Acknowledgement of Christian Counseling Services, Acknowledgement of Receipt of Privacy Practices, Statement of Counseling Policies and Procedures,** and **Informed Consent and Release of Liability.**

If you have questions regarding HIPPA or our privacy practices, please do not hesitate to contact us.

It is important for you to understand that The Well offers professional mental health counseling from a biblical perspective. Christianity and spiritual conversations will be part of the counsel. Please also note that you always have a choice before you begin counseling at The Well and at any point along the way to decide if Christian based counseling is what you need and want, and you may end services at any time. Before signing this document please consider the above and if it is not for you please inform counselor and we will make the best referral to meet your needs. If you do sign the below, you are agreeing to discuss Christian principles in your counseling.

Christian Counseling Services

Confidential Client Information Form

GENERAL INFORMATION

Date:_____ Referred by:_____ May we thank them? _____

Full Name: □ Mr. □ Mrs. □ Ms. □ Miss □ Dr. □ Rev. _____

Nick Name:_____ Name You Prefer: _____

Age:_____ Date of Birth: _____

Race: □ White □ Black □Hispanic □ Asian □ Other:_____ Sex: □ Male □ Female

CONTACT INFORMATION

Street Address:_____ Suite/Apartment Number: _____

City:_____ State:_____ Zip Code:_____ May We Send Mail Here: □ Yes □ No

Mailing Address or Post Office Box: _____

City:_____ State:_____ Zip Code:_____ May We Send Mail Here: □ Yes □ No

Home Phone: (_____)_____ May We Leave a Message Here: □ Yes □ No

Mobile Phone: (_____)_____ May We Leave a Message Here: □ Yes □ No Work Phone: (__)

Other: _____ May We Leave a Message Here: □ Yes □ No Email Address:_____

Email:_____ May We Send Email Here: □ Yes □ No

EMERGENCY CONTACT

Name:_____ Relationship: _____

Home Phone: (_____)_____ Mobile Phone: (_____) _____

EMPLOYMENT INFORMATION

Employer:_____ Length of Employment: _____

Occupation:_____ Average Hours Worked Per Week: _____

Average Annual Salary: □ $0 to $10,000 □ $10,001 to $20,000 □ $20,001 to $40,000 □ $40,001 to $50,000 □ $50,001 to $60,000 □ $60,001 to $80,000 □ $80,001 to $100,000 □ More than $100,000

EDUCATION INFORMATION

Last Year of School Completed: □ 9 □ 10 □ 11 □ 12 □ GED College: □ 1 □ 2 □ 3 □ 4 □ Other: _____

Are You Currently in School: □ Yes □ No. If Yes, What Level:_____ Degree Pursuing: _____

RELATIONAL INFORMATION

Current Relational Status: ☐ Single ☐ Dating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are You Content with Your Current Status: ☐ Yes ☐ No. If No, Briefly Explain: _____

If Married, How Long: _____ Number of Previous Marriages for You: _____ For Your Partner: _____

If Separated or Divorced, How Long: _____ If Widowed, How Long: _____

Partner's Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. _____

How Long Have You Known Your Partner: _____ Age: _____ Preferred Name: _____

Partner's Race: ☐ White ☐ Black ☐Hispanic ☐ Asian ☐ Other: _____ Partner's Sex: ☐ Male ☐ Female

Partner's Occupation: _____ Average Hours Worked Per Week: _____

Last Year of School Partner Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

What Words Would You Use to Describe Your Partner: _____

Is Your Partner Supportive of You Seeking Counseling: ☐ Yes ☐ No ☐ Unsure ☐ Partner Doesn't Know

With Whom Do You Currently Live (*Check All that Apply*): ☐ Alone ☐ Spouse ☐ Children ☐ Parent(s) ☐ Sibling(s) ☐ Boyfriend ☐ Girlfriend ☐ Roommate ☐ Other: _____

CHILDREN

List Your Children (Living or Deceased):

Name	Sex	Current Age or Year of Death	Relationship to You *(e.g. Natural, Adopted, Step)*	Living with You?	Describe Him/Her

Have You Ever Placed a Child for Adoption: ☐ Yes ☐ No. If Yes, When: _____

Have You Ever Had a Miscarriage or Medical Abortion: ☐ Yes ☐ No. If Yes, When: _____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members who Effected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You *(e.g. Mom, Dad, Sibling,Step)*	Occupation	Describe Him/Her

MEDICAL INFORMATION

Primary Physician:_____Phone: (_____) _____

Address:_____City:_____Zip: _____

Specialty *(e.g. Family Practice, OB/GYN, Internal Medicine)*: _____

Are You Currently Receiving Medical Treatment: □ Yes □ No. If Yes, Please Specify: _____

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had *(Use Back if Necessary):* _____

_____

MEDICATIONS

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (Use Back if Necessary):

Medication:_____Dosage: _____ □ Improves □ Prevents □ Controls: _____

Medication:_____Dosage: _____ □ Improves □ Prevents □ Controls: _____

Are You Taking these Medication(s) According to Your Doctor's Recommendations: □ Yes □ No

If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

Headaches……..	□ Past	□ Present	Dizziness……..	□ Past	□ Present	Stomach Trouble….	□ Past	□ Present
Visual Trouble…….	□ Past	□ Present	Sleep Trouble……..	□ Past	□ Present	Trouble Relaxing….	□ Past	□ Present
Weakness……	□ Past	□ Present	Tension……	□ Past	□ Present	Rapid Heart Rate…	□ Past	□ Present
Difficulty Breathing..	□ Past	□ Present	Intestinal Trouble….	□ Past	□ Present	Hearing Noises……	□ Past	□ Present
Change in Appetite.	□ Past	□ Present	Tiredness……..	□ Past	□ Present	Pain……	□ Past	□ Present
Hearing Voices……	□ Past	□ Present	Seeing Things……..	□ Past	□ Present	Other……	□ Past	□ Present

Your Height:_____Your Weight:_____How has Your Weight Change in the Last 2-3 Months: _____

CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You and/or Your Family:

Stress……	□ Past	□ Present	Nervousness……	□ Past	□ Present	Anxiety……..	□ Past	□ Present
Panic……	□ Past	□ Present	Unhappiness……	□ Past	□ Present	Depression……..	□ Past	□ Present
Guilt……..	□ Past	□ Present	Apathy……...	□ Past	□ Present	Terminal Illness…...	□ Past	□ Present
Recent Death……..	□ Past	□ Present	Grief……..	□ Past	□ Present	Hopelessness……..	□ Past	□ Present
Inferiority Feelings..	□ Past	□ Present	Defective Feelings..	□ Past	□ Present	Loneliness……	□ Past	□ Present
Shyness……	□ Past	□ Present	Fears……	□ Past	□ Present	Friends……	□ Past	□ Present
Marriage……	□ Past	□ Present	Communication……	□ Past	□ Present	Physical Abuse……	□ Past	□ Present
Emotional Abuse….	□ Past	□ Present	Verbal Abuse……..	□ Past	□ Present	Sexual Abuse……..	□ Past	□ Present
Temper……	□ Past	□ Present	Anger……	□ Past	□ Present	Aggressiveness…...	□ Past	□ Present
Bad Dreams…….	□ Past	□ Present	Concentration……..	□ Past	□ Present	Racing Thoughts….	□ Past	□ Present
Unwanted Thoughts	□ Past	□ Present	Memory……	□ Past	□ Present	Loss of Control……	□ Past	□ Present
Impulsive Behavior.	□ Past	□ Present	Self-Control…….	□ Past	□ Present	Compulsivity…….	□ Past	□ Present
Sexual Problems….	□ Past	□ Present	Pregnancy……	□ Past	□ Present	Abortion……	□ Past	□ Present
Legal Matters……..	□ Past	□ Present	Trauma……	□ Past	□ Present	Eating Problems….	□ Past	□ Present
Drug Use……..	□ Past	□ Present	Alcohol Use……	□ Past	□ Present	Trouble with Job…..	□ Past	□ Present
Career Choices……	□ Past	□ Present	Ambition……	□ Past	□ Present	Making Decisions…	□ Past	□ Present
Children……	□ Past	□ Present	Being a Parent…….	□ Past	□ Present	Finances……..	□ Past	□ Present
Recent Loss…….	□ Past	□ Present	Disaster……	□ Past	□ Present	Other……	□ Past	□ Present

LEVEL OF DISTRESS

Indicate How Distressed You Are by Placing an "X" on the Scale Below *(1 = Very Little Distress; 10 = Extreme Distress)*:

1 2 3 4 5 6 7 8 9 10

Are You Currently Experiencing Any Suicidal Thoughts: □ Yes □ No. Have You Experienced Them in the Past: □ Yes □ No

Have You Ever Attempted Suicide: □ Yes □ No. If Yes, When and How: _____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: □ Yes □ No

If Yes, When and Who: _____

PRESENTING ISSUES AND GOALS

Please Describe Why You Are Coming to Counseling *(i.e. What Are Your Issues, Problems?):* _____

_____

Why Have You Decided to Come for Counseling Now: _____

_____

What Do You Hope to Gain or Change by Coming for Counseling: _____

_____

How Long Do You Believe Counseling Should Last: _____

PREVIOUS COUNSELING

List Any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received *(Use Back If Necessary):*

Therapist:_____Location:_____Dates:_____Reason: _____

Therapist:_____Location:_____Dates:_____Reason: _____

RELIGIOUS BACKGROUND

What Words Would You Use to Describe Yourself: _____

If God Were to Describe You, What Would He Say: _____

Briefly Describe the Religious Environment of Your Home as You Were Growing Up: _____

_____

Complete the Following Thought: God Is_____

Do You Regularly Attend a Place of Worship: □ Yes □ No. If Yes, Where: _____

What Is the Name of Your Pastor, Priest or Other Spiritual Leader: _____

Do You Have a Personal Support System: □ Yes □ No. If Yes, Who: _____

TERMS OF SERVICE

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged the full administrative fee for service. By signing below I am in full agreement with the counseling process including Christian principles.

Signed: _____ Date:_____

Christian Counseling Services

Statement of Counseling Policies and Procedures

COUNSELING SESSIONS

Counseling sessions at The Well are available weekly. Sessions are 45 minutes in duration. Please arrive on time so that you can benefit from a full-length session. Because of other scheduled clients, your session will end at 45 minutes regardless of your arrival time.

PROFESSIONAL SERVICE FEES

The professional service fee per 45 minute session is $100 for Individual and $150 for Couples or Family. If a couple is in therapy together and want to come for an individual, the fee will be $90. If one person continues to come alone after 2 sessions, the price per individual session will default back to $100 for an individual session. Payment is due at the time of service. You may pay by cash, credit card, or check made payable to "The Well." A $25.00 service charge will be levied on all checks returned by a financial institution for insufficient funds. If you are unable to pay for all or part of a session, please speak with your counselor.

INSURANCE

The Well will provide you with a receipt for out of network services should you choose to pursue personal reimbursement from your insurance company. We do not accept or file any insurance on your behalf. Please inquire about current plans that we accept and how to process payments and copays.

OFFICE HOURS

The Well office hours are by appointment only. Please call and leave a message with your therapist should you need to talk outside of your regularly scheduled appointment time.

RESCHEDULING APPOINTMENTS

It is our policy to schedule you for a regular "standing appointment." This will be confirmed at each session that you intend to come at the same time for your next appointment. If you occasionally need to come at a different time you can ask your counselor to determine if an alternative appointment time is available. Please be aware that two or more cancellations or "no-shows" will result in the loss of your standing appointment.

CANCELLATIONS AND MISSED APPOINTMENTS

A 24-hour notice should be given to cancel a previously scheduled appointment. Advance cancellations allow us to make the most efficient use of counselor time and office space. Failure to give a 24-hour notice will result in you being charged the full professional service fee, payable on your next visit. A *mutually agreed upon* emergency will result in rescheduling with no charge. If you and your counselor are able to schedule another appt in the same week the cancelation fee will be waived.

CONTACTING YOUR COUNSELOR

You may leave a confidential voice mail message for your counselor 24 hours a day, 7 days a week. Telephone calls will be returned within 24 hours, between 8:00 a.m. and 5:00 p.m. Monday through Friday, unless otherwise arranged. Email and text messaging may be used for periodic business communication; including confirmation of appointments and to inform you of educational opportunities provided by The Well. Email or text messaging will not be used as a means of counseling or therapeutic exchange. In the case of an emergency, please call 911. Our office is not a crisis center and is not staffed 24 hours.

I understand and agree to the policies and procedures as written above.

_____ _____

Signature Date

_____

Print Client Name

Christian Counseling Services

Informed Consent and Release of Liability

While sensitive to other faiths, The Well Christian Counseling Services is operated to provide counseling with a distinctively Christian framework in the New York area. Counseling services are provided by independent Christian professionals who have earned a Master's Degree, or higher, from an accredited graduate program, and who have been licensed by the State of New York or provisionally licensed by the State of New York.

To begin counseling services, the completion of an intake questionnaire and the signing of an Informed Consent and Release of Liability form are required. While I expect benefits from treatment, I fully understand that such benefits and particular outcomes cannot be guaranteed. I understand that because of the treatment, I may experience emotional strain, feel worse during treatment, and make life changes, which could be distressing. I also understand regular attendance will produce the maximum benefits but that I am free to discontinue treatment at any time. If I decide to do so I will notify the provider at least two weeks in advance so that effective discharge planning can be implemented.

I understand that contents of all therapy sessions are considered confidential. Both verbal information and written information about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

- When a client discloses intentions or a plan to harm self or another person, the mental health professional is required to notify legal authorities and those people who may be impacted.
- If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.
- When a mental health professional is made aware of prenatal exposure to controlled substances that are potentially harmful, a report must be made to the appropriate authorities.
- Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.
- Insurance companies (when applicable) and other third-party payers are given information that they request regarding services to clients, such as types of service, dates/times of service, diagnosis, treatment plan, progress of therapy, case notes, and summaries.

The clinical records are the property of the mental health professionals of The Well Christian Counseling Services and as such, are deemed records of confidential sessions between counselors and clients. Other than as required by law, these records will only be released subject to the following paragraph and with the advanced written consent of the client and The Well Christian Counseling.

I waive any right I may have otherwise to seek to use my counselor records with The Well Christian Counseling Services, except as may otherwise be agreed upon in writing, in any judicial proceeding or to compel the testimony of any mental health professional, New York Statutes or supervisors providing counseling with The Well. If testimony is required, I agree to pay twice the normal hourly rate for any, and all, of these individuals for their testimony, and preparation therefore.

In consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby release and forever discharge and covenant not to sue or hold legally liable The Well Christian Counseling Services; the licensed counselors; the licensed therapists; the registered interns; the supervisors; or the staff from any and all claims, demands, damages, actions or causes whatsoever related to the counseling process.

I have read and understood the preceding information and agree to the terms and conditions of The Well Christian Counseling Services as stated. I understand that this agreement is a prerequisite to receiving and continuing counseling services through The Well Christian Counseling Services.

Signed: _____ Date: _____

Witnessed: _____ Date: _____

Christian Counseling Services

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 CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (PROTECTED HEALTH INFORMATION) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations:

• Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.
• Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.
• Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Your written authorization will be required for any other uses or disclosures. Should you choose to revoke your authorization, you may do so only in writing. We will abide by your written request, except to the extent that we have already taken actions relying on your authorization.

You may contact our Privacy Officer in writing to invoke your following rights:
• You may request in writing that we restrict using and disclosing your PROTECTED HEALTH INFORMATION to family members and relatives, friends, or others you identify. We reserve the right to deny this request. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
• You may request an amendment to your PROTECTED HEALTH INFORMATION.
• You may request alternative means or locations in which you receive confidential communications.
• You may request an accounting of disclosures of PROTECTED HEALTH INFORMATION beyond treatment, payment, and health care operations.
•The right to obtain a paper copy of this notice from us upon request.

We are required by law to protect the privacy of your PROTECTED HEALTH INFORMATION and to abide by the terms of the Notice of Privacy Practices. We will make and post revisions to the Notice of Privacy Practices in accordance with the law. You may obtain a written copy of these changes by written request. You may file a formal, written complaint with us at the address below or with the Department of Health & Human Services, Office of Civil Rights, if you feel your privacy rights have been violated.

For more information regarding our Privacy Practices, please contact:

Paul Ammendola, LCSW
Licensed Clinical Social Worker, 085424-1
The Well Christian Counseling Services
(516) 887-4614

For more information about HIPPA or to file a complaint, please contact:

The U.S. Department of
Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(877) 696-6775 (TOLL FREE)

Acknowledgement of Receipt of Privacy Practices

I,_____have received a copy of The Well Counseling's Notice of Privacy
(Full Name)

Practices.

Print Name of Client: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Signed: _____ Date: _____

Witnessed:_____Date: _____