VALLEY CHRISTIAN COUNSELING

5151 Research Drive NW Suite 1B, Huntsville, AL 35805
Tel: 256-722-8091 Fax: 256-270-7019

COUPLES COUNSELING INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here remains confidential.

Please describe the main issue, reason, or event that has brought you here today:

_____
_____
_____
_____

CONTACT INFORMATION:

Names:_____
Date of Birth:_____ Date of Birth of Partner:_____
Address:_____
City:_____ Sate:_____ Zip:_____
Email:_____ Email of Partner:_____
Cell Phone:_____ May we leave a message?_____
Cell Phone:_____ May we leave a message?_____

Partners Address if different:

_____

EMERGENCY INFORMATION

In case of an emergency please contact: _____
Relationship: _____
Telephone: _____

TREATMENT HISTORY

Are either you or your partner currently receiving any other mental health services?
( ) yes ( ) no
Have either you or your partner had previous psychotherapy?
( ) no ( ) yes, with (previous therapist's name)_____
Are you or your partner currently taking prescribed psychiatric medication (antidepressants or others)?
( ) yes ( ) no
If yes, please list: _____
Prescribed by: _____

HEALTH INFORMATION
Do you currently have a primary physician? ( ) yes ( ) no
If yes, who is it? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.:

Yourself: Partner:

Are you currently on medication to manage a physical health concern? If yes, please list:

Yourself: Partner:

SEXUAL HISTORY
What is your sexual orientation? ( ) Heterosexual ( ) Gay/Lesbian ( ) Bisexual ( ) Unsure
What is your partner's sexual orientation? ( ) Heterosexual ( ) Gay/Lesbian ( ) Bisexual ( ) Unsure

Are you currently in need of any sex therapy services? ( ) yes ( ) no
If yes, please check all that apply.
( ) Sexual Trauma/Abuse
( ) Sexual dysfunction
( ) orientation issues/Gender Identity
( ) Low/High desire
( ) Sex addiction/Porn addiction
( ) Marriage sex therapy

Please list any relative information related to you or your partners sleeping habits (excessive sleeping, insomnia, etc.)

_____
_____
_____

Please list any relative information related to you or your partners appetite (undereating, overeating, etc.)

_____
_____
_____

Substance History and Use:

Please list any legal/illegal substances you or your partner have used in the past and/or present including alcohol, and tobacco.

Who?	Current Use?	Past Use?	How much/often?	Last time used?

SOCIAL/RELATIONSHIP HISTORY

How long have you been in your current relationship? _____

Are you satisfied with your current relationship ( ) no ( ) yes ( ) Unsure

Are there past romantic relationships you would like to discuss in therapy?

_____

CHANGES/STRESSORS

In the last year, have you or your partner experienced any significant life changes or stressors? (Examples include marriage, divorce, moving, new job, children, etc.).

If yes, please list them here:

_____

_____

_____

_____

Have either you or your partner ever experienced any of the following? (If yes, who)

Extreme depressed mood	Yes / No	who?
Dramatic mood swings	Yes / No	who?
Rapid speech	Yes / No	who?
Extreme anxiety	Yes / No	who?
Panic attacks	Yes / No	who?
Phobias	Yes / No	who?
Sleep disturbances	Yes / No	who?
Hallucinations	Yes / No	who?
Unexplained losses of time	Yes / No	who?
Unexplained memory lapses	Yes / No	who?
Alcohol/substance abuse	Yes / No	who?
Frequent body complaints	Yes / No	who?
Eating disorder	Yes / No	who?
Body image problems	Yes / No	who?
Repetitive thoughts (e.g. obsessions)	Yes / No	who?
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No	who?
Homicidal thoughts	Yes / No	who?
Suicidal attempts	Yes / No	who?

OCCUPATIONAL INFORMATION

Are you currently employed? ( ) no ( ) yes partner? ( ) no ( ) yes

If yes, who is your currently employer/position? _____

_____

RELIGIOUS/SPIRITUAL INFORMATION

Please include any relative information about your religion/faith? Do you and your partner share the same faith? Please explain?

_____

_____

_____

TRAUMA ASSESSMENT

Have you or your partner experienced or witnessed any type of abuse (physical, sexual, mental, emotional, spiritual) and/or neglect? Please briefly explain.

_____

_____

_____

_____

_____

OTHER INFORMATION

Are you looking for court related services? If yes, please explain.

_____
_____
_____

What do you consider to be the strengths of your relationships?

_____
_____
_____

What do you like most about your relationship?

_____
_____
_____

What are some things you would change about your relationship?

_____
_____
_____

What are your goals for therapy?

_____
_____
_____

VALLEY CHRISTIAN COUNSELING
INFORMED CONSENT

Overview
Welcome to Valley Christian Counseling. The following information is to assist you in establishing your expectations for psychotherapy and functions as an agreement between you and your therapist. Please read the following carefully and complete all sections before the first session. Please feel free to call with any questions or concerns throughout the course of treatment.

Special Concerns
In the event of an individual session during the course of couples counseling, the individual in the session is entitled to confidentiality. However, the therapist reserves the right to terminate services if the information shared in an individual session is contradictory or counterproductive to the couples identified goals. The therapist may encourage discloser of any perinate information shared with the therapist during an individual session to the partner and/or spouse. Couples will be strongly encouraged to be transparent and honest with their partner. Furthermore, the therapist is not required to keep a secret that would require mandated reporting. (*Please see Limits of Confidentiality*)

Sessions
Therapy appointments are approximately 45-55 minutes in duration, however longer sessions are also available upon advanced request. The number of sessions is determined by both the therapist and the client depending on the client's individual needs. Sometimes couples are best served by 90-minute sessions. The therapist may suggest a 90-minute session and payment can be adjusted as needed.

Cancelation Policy
A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled without 48 hours' notice, the clinician reserves the right to charge you a missed/cancelled appointment fee equal to your agreed upon session rate. It is important to note that insurance companies will not reimburse you for canceled or missed appointments.

Confirmation Calls
To better serve our clients, our staff strives to provide confirmation calls to remind you of your appointment approximately 48 hours in advance. However, please make efforts to set self-reminders in the event we are not able to place a call.

Emergency Options and Additional Resources
If you are unable to reach our office during normal business hours and are experiencing a crisis or medical emergency please call 911 or head to your nearest emergency room.

Records
Your professional records may include information regarding your reason for seeking therapy, a description of the impact your problems may be having on your life, your treatment goals and your progress toward said goals, your medical and social history, your billing records, and any reports received from other clinicians. You have the right to review your records at any time, however, it is recommended that the records be reviewed in the presence of your therapist before viewing them individually. A fee may be applied to the request of your records. Your records are stored in a locked filing cabinet behind two locked doors, and will be stored for 7 years (per requirements of the Alabama Board of Social Work) before being properly destroyed.

Offsite Consultation
Consultation are sometimes requested by other professionals involved in your care. In the event that you or another professional request a consultation, your clinician reserves the right to bill at the hourly rate for consultation services. It is important to note that billable time may also include travel and prep time.

Minors and Parents
Children under the age of 14 cannot consent to therapy on their own, however in the State of Alabama a minor child over the age of 14 may seek therapeutic services without the consent or knowledge of their parents/guardians. Children over the age of 14 have the right to privacy and the parents are not privy to confidential information, unless a release has been obtained. The Clinician will strongly urge the teenager to sign said release as treatment is often inhibited when guardians are not involved in the process. Clients under the age of 14 can not consent for themselves and therefore will need the permission of a guardian to seek therapeutic services. If a child is in danger or is a danger to someone else, the therapist will notify the parents of this concern as well as the appropriate authorities if necessary. Before, giving sensitive information to parents, the clinician will discuss the matter with the child, if possible, and do their best to mitigation any objections and explain the benefits of guardian support.

Contacting your Clinician
If you need to contact your clinician, please call Valley Christian Counseling Center and leave a message with the receptionist or on the appropriate extension. Your therapist will periodically check messages, and return your call as soon as possible.

Release of Information
Valley Christian Counseling is not a HIPAA covered entity; however, your therapist is subject to all ethical and legal standards that protect your confidentiality. We will only disclose your personal information given legal obligations due to a duty to report, and/or given your written authorization.

Limits on Confidentiality

1. Occasional consultations with other mental health professionals about a case are helpful or even necessary in order to provide quality care. We make every effort to ensure your confidentiality during this process.
2. If you or a minor in your care are a harm to yourself or others, I have a duty to report in order to prioritize your safety.
3. The following are some examples of situations in which I may be required or legally permitted to disclose information without your consent or authorization:
    a. Requests made from court order
    b. In the event I become the defendant in a case filed against me I have the right to release privileges information that may be relevant to my defense.
4. I am considered a mandatory reporter, meaning if I suspect that any vulnerable population is being abused and/or neglected that I must report to the appropriate authorities.

Client or Guardian Name: (PRINT)_____Date:_____

Client or Guardian Signature:_____ Date:_____

Clinician's Signature:_____Date:_____

****The above signature certifies that I understand that I am consenting to counseling services, and that I understand the limits of confidentiality within those service.***

Client's Rights

- Receive humane care and treatment, with respect and consideration
- Privacy and confidentiality when seeking or receiving services except in the case of life-threatening situations or conditions
- Confidentiality of your health records
- Receive accurate information concerning diagnostic impressions, treatment, and risks
- Participate actively in decisions regarding your own treatment
- Accessible information regarding the scope and availability of services
- Be informed about any legal reporting requirements regarding any aspect of screening or treatment
- A copy of your records upon request and written authorization
- You may file a complaint with the director of VCC regarding any concerns related to the privacy, confidentiality or security of your medical record
- Receive competent treatment in a respectful environment that acknowledges your dignity and worth
- Gain knowledge regarding strategies and therapy techniques used to aid in your treatment.
- Participate in establishing and reestablishing goals throughout therapy
- Participate or refrain from services (except when mandated)
- Request referrals for alternative services

Client Signature_____ Date:_____

Client Print _____ Date:_____

VALLEY CHRISTIAN COUNSELING
FINANCIAL AGREEMENT

5151 Research Drive NW Suite 1B, Huntsville, AL 35805
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Thank you for choosing Valley Christian Counseling to be your mental health provider. We are committed to providing the best care possible. It is important that you understand that payment for services is considered part of your treatment; therefore, the following information explains our financial policies. We ask that you sign this form as an indication that you have read and agree with the information presented.

Reimbursement/Insurance Coverage
Currently, your clinician does not accept insurance, however this is subject to change depending on clinicians' preferences. Because Valley Christian Counseling is not an in network provider, you may choose to submit you receipts to your insurance company for reimbursement. Reimbursement options vary depending on your insurance provider. Each visit, you will be provided an itemized statement that contains the information needed to file a claim.

Methods of Payment
We ask that you pay in full upon the time of services, unless previously agreed upon by you and your therapist. We accept most forms of payment including cash, check, or credit card.

Unpaid Balance
If you accrue an unpaid balance, we ask that you make arrangements to pay balance within 30 days. In the event that we cannot reach you to collect payment, Valley Christian Counseling may peruse reimbursement by submitting a claim to small claims court, or hiring a collections agency. Payment plans may be offered when requested with approval from director of VCC. Confidential information may be shared in claims court or to collections agency on as needed basis.

Late Cancelation/No Show Fees
If cancelations have not been made within 48 hours of the appointment or client did not show up for the session, the client is subject to a no-show fee. Exceptions are made in cases of emergencies. Late cancelation/no show fee is $50.00; however, the clinician reserves the right to charge the entire session fee of $120.00 if the client is a repeat offender. Grace is often offered, especially in unforeseen circumstances. Your practitioner asks for communication and in response fees may be waved at your practitioners' discretion.

Court Related Fees
Clients who require court related services can expect a rate of $200 per hour. Court related work can include, but not limited to, consultations, phone calls, travel time,

depositions, and time spent at court. There is a minimum retainer fee of $1000 to appear/testify in court. Payment must be received 48 hours prior to the court appearance. Subpoenas must be received within 48-hour notice or client may be subject to an additional charge of $200. In the event that the court date is rescheduled with less than 72 business hours, the clinician reserves the right to charge an additional fee of $300 in addition to any previous accrued fees. It is important to note that any given testimony may not result in your favor. In the event that you lose your case, you will still be responsible for court related fees.

Statement of Understanding

I certify that I understand the above statement and I agree to its terms. By signing below, I am stating that I have read and agree with the financial fees set by my practitioner. I understand that Valley Christian Counseling and/or my practitioner reserve the right to adjust or lower that fee on as needed basis.

Client Print _____ Date:_____

Client Signature_____ Date:_____

Clinician Signature_____ Date:_____