PAULA HINTON CHRISTIAN COUNSELING SERVICES

Thank you for your inquiry into the services offered in this Christian Counseling practice. You are taking an important step as you pursue counseling for yourself/your family. In this packet you will find important documents to ensure you receive the best professional treatment available. This includes the **Confidential Client Information Form, 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. HIPAA allows stricter state laws to prevail where conflict between the two may exist.

To serve you best, 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, Counseling Policies and Procedures,** and **Informed Consent and Release of Liability.**

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

It is important for you to understand that Paula Hinton, LCSW-R, CASAC, BCD offers professional mental health services using a biblical perspective. Christianity and spiritual matters are an integral part of the counseling. Please also note that you always have a choice before you begin counseling with Paula Hinton and at any point along the way, to decide if Christian-based counseling is what you want and need, 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 the counselor and we will make the best referral to meet your needs. If you do sign below, you are agreeing to discuss Christian principles in your counseling.

Signature _____ **Date**_____

Print Client's Name _____

PAULA HINTON CHRISTIAN COUNSELING SERVICES

Confidential Client Intake Forms

GENERAL INFORMATION

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

Your Full Name (Please circle): Mr. / Mrs. / Ms. / Miss / Dr. / Rev. (please print name)_____

Nick Name: _____ Name Your Prefer: _____

Age: _____ Date of Birth: _____ Sex: (Please circle): Male / Female

Race (Please circle): White / African-American / Hispanic / Asian / Multi-racial / Other _____

CONTACT INFORMATION

Street Address: _____ Suite/Apartment Number _____

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

Home Phone: (_____) _____ May We Leave Message? Yes /No; Mobile Phone: (____)_____ _____May We Leave Message? Yes / No

Work Phone: (____)_____May We Leave Message? Yes / No; Other: ( )_____May We Leave Message? Yes / No

Email Address: _____ May We Send Email ? Yes / No

EMERGENCY CONTACT

Name: _____Relationship: _____

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

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____Average Hours You Work/Week: _____

Average Annual Salary: (Please circle): $0 to $10,000 / $20,001 to $40,000 / $50,001 to $60,000 / $80,001 to $100,000

$10,001 to $20,000 / $40,001 to $50,000 / $60,001 to $80,000 / More than $100,000

EDUCATIONAL INFORMATION

Last Year of School Completed (Please circle): 9 / 10 / 11 / 12 / GED / College : 1st year / 2nd year / 3rd year/ 4th year Degree: _____

Are You Currently In School? (Please circle): Yes/ No. If Yes, What Level: _____ Degree or Certificate Pursuing: _____

_RELATIONAL INFORMATION

Current Relational Status (Please circle): Single / Dating / Engaged / Married / Separated / Divorced / Widowed /

Are You Content With Your Current Status? (Please circle): 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 (Please circle): Mr. / Mrs. / Ms. / Miss / Dr. / Rev. _____

How Long Have You Known Your Partner: _____Age: _____Preferred Name: _____

Partner's Race (Please circle): White / African-American / Hispanic / Asian / Multi-racial / Other _____

Partner's Sex (Please circle): Male / Female. Partner's Occupation: _____

RELATIONAL INFORMATION

Average Hours Partner Works/Week: _____Last Year of School Partner Completed (Please circle): 9 / 10 / 11 / 12 / GED College: 1st year / 2nd year

College continued: 3rd year / 4th year Degree: _____ Other _____ Degree or Certificate Partner is Pursuing _____

What Words Would You Use to Describe Your Partner: _____

Is Your Partner Supportive of You Seeking Counseling (Please circle): Yes / No / Unsure / Partner Doesn't Know

With Whom Do You Currently Live (Please circle all that apply): Alone / Spouse / Children / Parent(s) / Sibling(s)

Boyfriend / Girlfriend / Roommate / Other _____

CHILDREN - Please List Your Children (Living or Deceased): *(use back of page if necessary)*

Name	Sex	Current Age or Year of Death	Relationship to You *(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 Affected You Positively or Negatively: *(use back of page if necessary)*

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 of page if necessary)***_____

MEDICATIONS - List All Current Medications You Are Taking, Including Those You Seldom Use or Take Only As Needed *(use back of page 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 Circle 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 Problems……..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 Changed in the Last 2 – 3 Months:** _____

CURRENT STATUS - Please Circle Any of the Following Problems Which Pertain to You and/or Your Family:

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

LEVEL OF DISTRESS

Please 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

Please List Any Previous Counseling, Psychiatric Treatment, or Residential/Inpatient Care You Have Received ***(use back of page 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:** _____

PAULA HINTON CHRISTIAN COUNSELING SERVICES

COUNSELING POLICIES AND PROCEDURES

THERAPY SESSIONS - Paula Hinton Christian Counseling Services offers weekly appointments. Sessions are 45 minutes in duration. Your arrival on time is essential so that you have a full-length session. If you arrive late, the time that your session ends will not change, as other clients are scheduled after you. The same holds true if the session is through telehealth communication.

INSURANCE - Paula Hinton Christian Counseling Services will give you a receipt for out of network services if you choose to pursue reimbursement from your insurance company. Please inquire about current plans that are accepted by this therapy practice. We do not accept or file any insurance on your behalf if this service is not covered by your insurance plan.

SERVICE FEES - The professional service fee per 45 minute session is $100 for an individual, $150 for couples and $175 for families. If a couple is in therapy together and want to come for an individual session, the fee will be $90. If one person continues to come alone after 2 sessions the price will revert back to $100 per individual session. Payment is due at the time of service. You may pay by cash or check, payable to Paula Hinton, LCSW. Any check that is returned by a financial institution will subject you to a $25 service fee. If you are unable to pay for all or part of a session, please speak to your counselor prior to the session.

RESCHEDULING APPOINTMENTS - The policy of this practice is to establish a regular time slot as a "standing appointment." This will be confirmed at each session as your intention to utilize the same time for your next appointment. If there is an occasion that you need a session at a different time, you can ask if there is an alternative time available. Please understand that two or more cancellations or "no-shows" will result in the loss of your standing appointment time.

OFFICE HOURS - Office hours are by appointment only. Please call and leave a message with your counselor should you need to talk outside of your regularly scheduled time.

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 the counselor's time. Failure to give 24-hour notice will result in you being charged the full professional service fee, payable at your next visit. ***A mutually agreed upon emergency*** will result in rescheduling with no charge. If you and your counselor are able to reschedule within the same week, the cancellation 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 Monday through Friday, unless otherwise arranged. Email and text messaging may be used for periodic business communication, including confirmation of appointments. Email and text messages will not be used as a means of counseling or therapeutic exchange. In the case of an emergency, please call 911. This practice is not a crisis center and is not staffed 24 hours a day.

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

Signature: _____ **Date:** _____

Print Client's Name: _____

PAULA HINTON CHRISTIAN COUNSELING SERVICES

Informed Consent and Release of Liability

While sensitive to other faiths, Paula Hinton Christian Counseling Services is operated to provide counseling within 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 university, and who are 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. Please understand the following statement that you are attesting to: While I expect benefits from 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 at Paula Hinton Christian Counseling Services, and as such, are 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 therapist.

I waive any right I may have otherwise to seek to use my counselor records with Paula Hinton 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 as per New York State statutes. 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 thereof. In consideration of the benefits to be gained from counseling, I hereby release and forever discharge and covenant not to sue or hold legally liable Paula Hinton Christian Counseling Services from any claims, demands, damages, actions or causes whatsoever related to the counseling process.

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

Signed: _____ Date:_____

Witnessed: _____ Date: _____

PAULA HINTON 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 aspect of running this 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 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 of 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 the 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: Paula Hinton, LCSW-R, CASAC, BCD

Licensed Clinical Social Worker 036009 - 1

Paula Hinton Christian Counseling Services

(516) 376-0922

For more information about HIPAA 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)

PAULA HINTON CHRISTIAN COUNSELING SERVICES

Acknowledgement of Receipt of Privacy Practices

I,_____have received a copy of the Paula Hinton Christian Counseling Services

(Full Name)

Privacy Practices.

Print Name of Client: _____

Street Address: _____

City:_____ State:_____ Zip Code: _____

Signed: _____ Date: _____

Witnessed: _____ Date: _____