



Hope Counseling Center

"...The Lord my God will enlighten my darkness." Psalm 18:28

926 Aspen
Fairbanks, AK 99701
Phone: 907-451-8208

Welcome to Hope Counseling Center!

We are pleased you have chosen to come to Hope Counseling Center. Our staff looks forward to working with you. Hope Counseling Center is a Christian non-profit corporation dedicated to providing the best possible spiritual and mental health services to the community. We strongly encourage you to take an active role in your counseling experience, and we're pleased to discuss any questions you may have.

Prior to your first appointment, it is important that you discuss our fee with your insurance company and inquire as to whether they accept your counselor's credentials. Ultimately, you are responsible for the fees for services rendered. Thank you.

Our office hours are Monday through Thursday, 9:00 a.m. to 12:00 p.m. and 1 p.m. to 5 p.m., and Friday, 9:00 a.m. to 4 p.m. In case of an emergency after hours, call 911. After 5 p.m., the agency is officially closed, and clients attending after-hour appointments or groups must be picked up promptly. There is no childcare available.

HCC attempts to assist clients to resolve their own problems. We believe that as you and your counselor work together to address your concerns, you will develop a sense of self-awareness that will influence your behavior and feelings. As a client, you are in complete control and may end our professional relationship at any point. We will be supportive of that decision. We also have the option of ending our counseling association if we determine it is necessary. If counseling is successful, you will feel better able to face life's challenges in the future without our support or intervention.

Because we use a team treatment approach to therapy, your case may be discussed in staffing, which is overseen by our Clinical Director. The team will maintain the same level of confidentiality as outlined in the Notice of Privacy Practices that you received. **(initial ___)** We will keep confidential anything you say to us, with the following exceptions: (1) you direct us to tell someone else; (2) we determine you are a danger to yourself or others; (3) suspicion of child abuse; and/or (4) we are ordered by a court to disclose information **(initial: ___)**.

Hope Counseling Center assures you that our services will be rendered in a professional manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your treatment goals. However, together we will work to achieve the best possible results for you. By signing this document you are giving your counselor consent to provide mental health services to the individual identified by signature below.

If you have any questions, feel free to ask. Please sign and date this form.

Client Signature

Date

Counselor/Facilitator Signature

Date

The Board of Professional Counselors requires this information, which regulates all licensed professional counselors.

Board of Professional Counselors
Division of Occupational Licensing
PO Box 110806
Juneau, AK 99811-0806
Phone: (907) 465-2551

Counseling Staff

Dr. John DeRuyter, Psy D., Wheaton College, Illinois
Executive Director/Clinical Director
Licensed Clinical Psychologist

Cathy McCarthy, LCSW, Carlton University, Canada
Licensed Clinical Social Worker

Terry Kelly, M.A., LPC, University of Alaska, Fairbanks
Counselor

Pamela Williams, LPC, Assumption College, Massachusetts
Counselor

Lisa Farrell, AA, CDC I, University of Alaska, Fairbanks
Chemical Dependency Counselor

Hayley Tonkovich, M.A., Midwestern University, Downers Grove, Illinois
Psychological Intern

Financial Policy

A clear understanding of the financial responsibility for your care is fundamental to assuring a healthy and professional relationship with our staff. Please read this form carefully and have your questions answered before signing.

Our Fees: Our fees are derived by using a system called RBRVS or the Regional Based Relative Value System. This is a commonly accepted standard method of setting fees – it uses information based on federal insurance programs and a conversion factor **(initial _____)**.

Payment: We accept cash, checks, or credit cards.

Insurance: *Remember that you are ultimately responsible for your bill.*

▶ If you have **private insurance**, as a courtesy, we will bill your carrier for our services once per visit. All **new patients** are asked to pay the full amount of your first visit at the time of the visit. We are happy to bill your insurance and refund you any overpayment. **All patients** are asked to pay the full amount of the visit at the time of the visit at **the beginning of the year** until your deductible is met. You will then be asked to continue to pay “your percentage” at the time of subsequent visits. **Any overpayment will be refunded to you.** If your insurance pays and there is still an outstanding balance, you will be billed and the amount owing will be due upon receipt of your first statement from our office. If your insurer has not paid for any reason, you will be billed and are responsible for the balance upon receipt of your first statement from our office. When we receive payment from your primary insurance company, we bill your secondary insurance **once**. *Remember that Insurance is a contract between you and your Insurer.* We will be happy to help as we can, and send records, but will not become involved in disputes concerning deductibles, co-payments, secondary insurance, or so-called “usual and customary” reductions.

▶ **Tricare, Champus, or ChampVA** clients need to check with your carrier to make sure your therapist is covered under your plan. If you are an active duty service member you must secure an authorization code before your first visit.

▶ **Church Vouchers** are accepted. Check with your church to see if there is a voucher system in place. Your voucher must be authorized and turned into the front desk before your first visit.

▶ **Client Assistance Program** is available to those who pre-qualify. Check with the front desk for paperwork. You are required to fill out a financial statement that is evaluated by the Executive Director and upon approval; the CAP will then be used to assist you with your bill.

▶ **Medicare** is not accepted at this time.

▶ **Medicaid** is not accepted at this time.

No Shows and Late Cancellations

▶ HCC is a non-profit corporation that relies heavily on your prompt payment to keep our services available. In the event that you are unable to keep an appointment, please notify the HCC office at least 24 hours in advance. If you do not call to cancel or reschedule your appointment, you will be charged \$25.00 for the missed session. **(initial _____)** Insurance and/or other third party coverage **cannot** be billed for no shows or late cancellations **(initial _____)**. Missed appointment fees are due and payable before the next session. **(initial _____)** There will be a charge of \$25.00 for **ALL** returned checks. Sessions are 50 minutes in duration. You may call 451-8208 to make or change an appointment.

This authorization shall expire upon written notice.

I have read the above and have had my questions answered.

Printed Name

Signature

Date

Billing Information

Hope Counseling Center's billing rate for an initial session is \$209.00. Sessions thereafter start at \$145.00 per 50 minute session. Our billing rate is based on the reasonable and customary charges billed by other counseling services in the Fairbanks area. Our goal is to assure quality of service and that whoever needs our counseling services is not denied due to economic need.

Hope Counseling Center offers a number of options regarding the payment of your bill. If you are in need of special assistance regarding payment of services, please check the appropriate box of listed billing options below.

Self Pay: I will pay in full at time of service.

Insurance: Please bill my insurance company(s). (If my insurance company does not pay for the entire amount of the cost of services, I understand I am responsible for the remainder of the charge.)

Chief Andrew Isaac Center Referral: You must have an authorization voucher from TCC. (If you have insurance, your insurance company must be billed before CAIC is billed.)

Church Voucher: I am coming with permission from my church to receive counseling on a church voucher plan. Please bill the church. Church Name: _____
(You must identify the church and have written authorization at the time of your first counseling appointment.)

Church Member: I am a member of a church that has an agreement with HCC. For a list of these please ask the Front Office.

Client Assistance Program: I do not have insurance and will need special assistance regarding my bill. (Please see the Office Manager for further paperwork needed to qualify for assistance.)

TriCare client: Dependents don't need pre-authorization; Service Members do need a referral from their PCM

Credit Card Payment: Please bill my credit card for the cost of services.

Visa

Master Card

American Express

Acct.#: _____ Exp. Date: _____ 3 Digit Code: _____

I authorize the release of relevant information to my insurance carrier or other provider as required to establish benefits, and I agree to assign those benefits to Hope Counseling Center. This authorization is valid unless I revoke it in writing. It may be revoked or renewed as desired by both parties.

Signature

Date

Hope Counseling Center

Client 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 IT CAREFULLY.

Our Pledge Regarding Mental Health Information

The privacy of your mental health information is critically important to us. We understand that your mental health information is personal and we are committed to protecting it. We create a record of care and the treatment you receive at our group practice. We maintain this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share mental health information about you. We also describe your rights and certain duties we have regarding the use and disclosure of protected mental health information.

Use and Disclosure of Your Protected Mental Health Information

The following section describes different ways that we use and disclose protected mental health information. Not every use and disclosure will be listed. However, we have listed all the different ways *we are* permitted to use and disclose mental health information. We will not use or disclose your mental health information for any purpose not listed below without your written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

EXAMPLES:

Treatment Purposes: We obtain treatment information about you and record it in a counselor's chart.

Payment Purposes: We submit requests for payment to your insurance company. The insurance company requests certain information from us regarding care given. We will provide the required information to them about you and the care given so that you may access your insurance benefits.

Operation Purposes: We obtain services from our insurers or other business associates such as billing, accounting and legal services. We will share certain information about you with such insurers or other business associates as necessary to obtain these services we require in order to better serve you.

OTHER DISCLOSURES & USES REQUIRED/PERMITTED BY LAW INCLUDE:

Abuse & Neglect: All practitioners of Hope Counseling Center are **mandated** by Alaska State Law to report suspected abuse and neglect of children, elderly, and persons with disabilities.

Court Proceedings: We may disclose your protected information in the course of any judicial or administrative proceeding as allowed or required by law, with your specific written consent, or as directed by a judge's court order. To avert a life-threatening situation, we may disclose your protected information consistent with applicable law to prevent an imminent threat to the health or safety of a person or the public.

Law Enforcement: We may disclose your protected information for law enforcement purposes as required by law, such as when required by a judge's court order. We do not routinely release protected information in response to an attorney's subpoena.

Notification: In the event of an emergency, hospitalization, and with your permission, we may use or disclose your protected information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition.

Workers Comp: If you are seeking compensation through Workers Compensation, we may disclose your protected information to the extent necessary to comply with laws relating to Workers Compensation.

Other Uses: Other uses and disclosures besides those identified in this notice will be made only as authorized by law or with your specific written consent, which you may revoke in writing at any time.

Hope Counseling Center

Client Notice of Privacy Practices

Your Information Rights

The health and billing records we maintain are they physical property of Hope Counseling Center. The information in it, however, belongs to you.

You have a right to:

- ✓ Request a restriction on certain uses and disclosures of your file by delivering the request in writing to our office. We are not required to grant the request, but we will carefully review any request received.
- ✓ Obtain a paper copy of this notice by making a request at our office.
- ✓ Request that you be allowed to inspect and/or receive a copy of your file and/or billing record. You may exercise this right by delivering your request in writing to our office. Payment of one dollar per page is due when file copies are picked up.

If you are a parent or legal guardian of a minor, please note that certain portions of the minor's file may not be accessible to you. This determination is made by the minor's therapist if he/she determines that your access to the file would be harmful.

- ✓ Request that your file be amended to correct incomplete or incorrect information by delivering a written request to our office. We are not required by law to make such amendments.
- ✓ File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your file.
- ✓ Obtain an accounting of disclosures of your information as required by law by delivering a written notice to our office. An accounting will not include internal uses for treatment, payment, or disclosures made to you at your request.
- ✓ Revoke authorizations that you made previously except to the extent information or action has already been taken, by delivering a written revocation to our office.
- ✓ Review this notice before signing any consent authorizing use and disclosure of your protected information for treatment, payment, and operation purposes.

If you want to exercise any of the above rights, please contact the Privacy Officer, Dr. John DeRuyter, (907) 451-8208 ext. 101, 926 Aspen Street, Fairbanks, AK, 99701, by phone or in writing during normal business hours. He will provide you with assistance on the steps to take to exercise your rights.

Our Responsibility

Hope Counseling Center is required to: Maintain the privacy of your information as required by law; Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you; Abide by the terms of this notice; Notify you if we cannot accommodate a requested restriction or request; and Accommodate your reasonable requests regarding methods to communicate information about you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected information we maintain. If our information practices change, we will amend our notice. You are entitled to receive a revise copy of this notice by calling and requesting a copy, or by picking one up at our office.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to file a complaint regarding the handling of your information, you may contact the Privacy Officer, Dr. John DeRuyter, (907) 451-8208 ext. 101, during normal business hours.

If you believe that your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Dr. DeRuyter. You may also file written complaints with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services. Hope Counseling Center will not retaliate against you if you file a complaint.

We cannot, and will not require you to waive the right to file a complaint with the Department of Health and Human Services as a condition of receiving treatment from our office.

I have read and understand Hope Counseling Center's Client Notice of Privacy Practices.

Signature

Date

Hope Counseling Center
926 Aspen/P.O. Box 73511
Fairbanks, AK 99707
907-451-8208
Fax 451-8207

Have you ever felt people were watching you?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you hear voices?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do faces ever seem distorted?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do colors ever seem to bright or dull?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you attempted suicide?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Describe childhood family experience:

[] outstanding home environment [] chaotic home environment [] normal home environment
[] witnessed physical/verbal/sexual abuse toward others
[] experienced physical/verbal/sexual abuse from others

Special circumstances in childhood: _____

Current Living situation: **Excellent** **Good** **Fair** **Poor**

Occupation: _____ **Financial situation:** **Good** **Fair** **Poor**

Military history: _____

Legal history: _____

Cultural identity (e.g., ethnicity): _____

Describe any cultural issues that contribute to current problem: _____

Please describe any special circumstances you feel the therapist should be aware of in the space below.

Hope Counseling Center
926 Aspen/P.O. Box 73511
Fairbanks, AK 99707
907-451-8208
Fax 451-8207

Yes No Prior inpatient treatment for a mental health issue? If yes, on how many _____ occasions.

Longest treatment at: _____ from _____ / _____ to _____ / _____
Name of facility Month/Year Month/Year

Yes No Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder?

Chemical Use History:

Prior use:	Yes	No	Current:	Yes	No	
Substances			Frequency		Amount	Length of use
_____			_____		_____	_____
_____			_____		_____	_____
_____			_____		_____	_____
_____			_____		_____	_____
_____			_____		_____	_____

Longest period of sobriety _____

Prior Treatment with: _____

Childhood health:

Immunization Status: Current _____ Not Current _____ Unknown _____

List any significant injuries or health issues: _____

List any chronic, serious health problems: _____



~Parents~

Children under the age of 12 are not to be left in the waiting area unsupervised. If children over the age of 12 left in the waiting room are disruptive or disturb other clients your session may be interrupted so that you can deal with the situation

Thank you,
Hope Counseling Center