926 Aspen St · P.O. Box 73511 · Fairbanks, Alaska 99707
Phone (907) 451-8208 · Fax (907) 451-8207
www.hopecounselingcenter.org

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 Friday, 9:00 a.m. to 6:00 p.m. In case of an emergency after hours, call 911. After 6 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 at any time**.

HCC attempts to assist clients 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.

Therapy appointments last fifty-three (53) minutes **(initial____).** Substance abuse clients are subject to random UA's at the clinician's discretion **(initial____).** 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 our **Notice of Privacy Practices (initial____),** which is available on our website and from our Front Office staff. We will keep confidential anything you say to us, with the following exceptions: (1) you sign a release directing 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 identified client. If the client is a minor, your signature confirms your legal authority to sign on behalf of the minor. If you have any questions, feel free to ask. **Please sign and date this form.**

Client Signature Date

Counselor/Facilitator Signature Date

Counseling Staff

Bill Couthran, LPC, Arizona School of Professional Psychology
Executive Director

John DeRuyter, Psy.D., Wheaton College, Illinois
Licensed Psychologist

Valerie Gifford, Ph.D, LCSW, University of Alaska Fairbanks
Licensed Psychologist/Licensed Clinical Social Worker

Jessica McKay, LCSW, University of Alaska Fairbanks
Licensed Clinical Social Worker

Matt Sena, LPC, University of Alaska Anchorage
Licensed Professional Counselor

Mariel Ott, LCSW, University of Montana
Licensed Clinical Social Worker

Alex Lanious, M.A. California School of Professional Psychology
Pre Doctoral Intern

Katie Dabney, University of Alaska Fairbanks
Masters Level Intern

Carolyn Lunceford, University of Alaska Fairbanks
Masters Level Intern

Kylie Gore-Hall, Capella University
Masters Level Intern

Annie Laweryson, University of Alaska Fairbanks
Pre Doctoral Student

The Board of Professional Counselors, which regulates all licensed professional counselors, requires that we provide the following contact information:

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

Hope Counseling Center, Inc.
Client Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH 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 health information is personal and we are committed to protecting it. We create a record of care and the treatment you receive here. 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 health information about you. It also describes your rights and certain duties we have regarding the use and disclosure of protected mental health information.

Our Legal Duty:

Law Requires Us to:

1. Keep your health information private
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your health information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided the changes are permitted by law.
2. Make effective the changes in our privacy practices and new terms of our notice for all health information we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Use and Disclosure of Your Protected Mental Health Information

The following section describes different ways that we use and disclose protected 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 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 submitting a written request to do so***.

Treatment Purposes: We may use health information about you to provide you with health treatment or services. We may disclose health information about you to staff who are taking care of you. We may also share information about you with other health care providers to assist them in treating you.

Payment Purposes: We may use and disclose your health information for payment purposes. We may submit requests for payment to your insurance company. The insurance company maintains the right to request 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 may share your health information for our business-related matters, such as audits, billing services, accounting and legal services. We also may use and disclose your health information for our health care operations. This may include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to service 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. We do not routinely release protected information in response to an attorney's subpoena.

Harm to Self or Others: 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: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as reporting of certain types of sounds), pursuant to court orders, reporting limited information concerning identification and location at the request of law enforcement officials, reporting death, crimes on our premises, and crimes in emergencies.

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. In case of emergency and if you are *not* able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to professional judgment.

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.

Your Information Rights

The health and billing records we maintain are the 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, Kylee Tisdell, (907) 451-8208 ext. 238, 926 Aspen Street, Fairbanks, AK, 99709, by phone or in writing during normal business hours. She 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 stating 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 revised 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, Kylee Tisdell, at (907) 451-8208, during normal business hours.

If you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Kylee Tisdell. You also may 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.

By my signature, I confirm that I have read and understood the above privacy policies. Any questions I had have been answered.

Printed Name Signature Date

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FINANCIAL POLICIES

Thank you for choosing Hope Counseling Center as your behavioral health care provider. We are committed to providing you with the highest quality care available at competitive prices. To continue this service excellence, it is very important that you follow our Financial Policy, which includes prompt payment of your bill. A clear understanding of the financial responsibility for your care is fundamental to assuring a healthy and professional relationship with our staff.

PATIENT INFORMATION FORM - Please complete the Patient Information Form, which includes demographic, emergency and insurance information. This will ensure correct billing to your insurance carrier. In the event your insurance changes and you do not notify us of the change in time for us to obtain authorizations or file claims within your insurance company's timely filing deadlines, any unpaid fees will become the subscriber's responsibility.

NEW CLIENTS - All new clients are asked to pay the full amount of their first visit at the time of that visit **(initial____).** Insurance will still be billed, and any overpayment will be applied toward future sessions.

INSURANCE PLANS - We accept most insurance plans. However, it is your responsibility to check with your insurance company prior to treatment to determine if your policy covers our providers and services. In many cases, insurance companies request preauthorization prior to seeking treatment. It is your responsibility to obtain this preauthorization.

- **Private Health Insurance**- Please contact your insurance to see if you will need a pre-authorization for outpatient behavioral health services.
- **United Health Tricare**– If you are covered by any of these policies, you must check with your carrier to ensure your therapist is covered under your particular plan. You also must have a **doctor's referral** sent to Hope Counseling before services will be scheduled. If you are an Active Duty service member, you must receive pre-authorization and a doctor referral before your first visit.
- **Medicare** – Only services by a licensed psychologist are covered by Medicare.
- **Medicaid** – Only psychological assessments completed by a licensed psychologist are covered under Medicaid.

(initial____).

BENEFITS INTERPRETATION - We will do our best to help you understand and interpret your health care benefits. However, it ultimately your responsibility to understand which services are covered and which are not under your plan. If you have any questions, please contact your insurance carrier to help you with this process.

FISCAL YEAR DEDUCTIBLES - It is our policy at the start of each insurance plan's fiscal year to collect the full amount billable for your visit at the time of your visit until your deductible has been met **(initial____).** Once verification of having met your deductible is made, you will only need to pay your insurance plan's required co-pay or percentage due.

INSURANCE BILLING - If it is determined that your insurance is one that is accepted by Hope Counseling Center, we will, as a courtesy, bill this company for you. If your insurer does not pay for any reason and an appeal is needed, your signature on this *Financial Policy* form serves as a waiver for your insurance company to grant us permission to file one appeal on your behalf **(initial____).**

MULTIPLE INSURANCE COVERAGE - For those with more than one insurance coverage, we will bill your primary insurance first. Once payment is received from that primary insurance company, we then will bill your secondary insurance company one time.

Please remember that insurance is a contract ***between you and your insurer***. We are happy to help ensure payment of your benefits, however, we cannot and will not become involved in disputes concerning deductibles, co-payments, secondary insurance, or what insurance companies refer to as "usual and customary" reductions.

CO-PAYMENT/CO-INSURANCE – After you have met your insurance company's deductible, you must pay all required co-payments or co-insurance payments at the time of your scheduled appointment.

COURT TESTIFYING
For any employee who must testify in court, Hope Counseling Center charges Three Hundred Sixty and No/100 ($360.00) per hour, with a minimum charge for one hour. **(initial____).**

COURT PREPARATION
For any employee who must testify in court, Hope Counseling Center charges Two Hundred Sixty and No/100 ($260.00) per hour for preparation time, with a minimum charge of one hour. This pays for the clinician's time to review all case notes and/or prepare required court documents. **(initial____).**

NO-SHOWS AND LATE CANCELLATIONS – Hope Counseling Center is a non-profit corporation that relies heavily on your prompt payment to keep our services available. In the event you are unable to keep an appointment, **you must notify our Front Office at least twenty-four (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____).** Missed appointment fees are due and payable *before* the next scheduled session. Insurance and/or other third-party coverage *cannot and will not* be billed for no-shows or late cancellations.

BALANCES OWED AFTER INSURANCE HAS PAID – If there is a balance owed after your insurance(s) has paid, you are responsible for payment of this balance **(initial____).** If we know what this balance will be at the time of your appointment, you are expected to pay at that time. Otherwise, we will send you a statement in the mail. Payment is due upon receipt. Hope Counseling Center reserves the right to discontinue services to you if your account is more than thirty (30) days past due or to refuse services if payments owed at the time of a scheduled service are not paid. Accounts more than ninety (90) days past due or with undeliverable addresses may be forwarded to a collections agency for recovery.

RETURNED CHECKS – There is a $50.00 charge for *all* returned checks.

REFUND REQUESTS – Please speak with the Front Desk to request a refund. If it is determined there are other outstanding balances on your account, any noted refund will be applied to the outstanding balance. **(initial____).**

ACCOUNT RESPONSIBILITY – It is our policy to bill the insurance subscriber for any balances left on accounts. "Accounts" include services rendered to you, a spouse and/or dependents. If any responsible party fails to make timely payments on their portion of the account, we reserve the right to refuse treatment. If you do not have insurance, you are personally responsible for your own debt, and payment is expected at the time of service. In the case of minor patients with no insurance, the adult accompanying the patient is responsible for payments due at the time of service.

CLIENT ASSISTANCE PROGRAM – Our financial assistance program is available to those who pre-qualify. Paperwork for this program may be obtained from our Front Office staff. Once completed and returned with the supporting financial information, the packet will be reviewed for approval. You will be advised of the amount of financial assistance for which you qualify. That amount will be good for a six (6) month period, at which time you will need to reapply if assistance is still required.

By my signature, I confirm that I have read and understood the above financial policies. Any questions I had have been answered.

Printed Name	Signature	Date

Registered in Kareo:
Date: _____
Initials:

Hope Counseling Center, Inc.
926 Aspen St./PO Box 73511 Fairbanks, AK 99707
907-451-8208 Fax 451-8207

Provider: _____
Credentials: _____

Client Registration

All fields on this page must be filled out completely before you begin your appointment:

Name: _____
Last **First** **MI**

Spouse Name: _____ **Parent/Guardian Name:** _____

Emergency Contact: _____ **Emergency Contact #:** _____

Physical Address: _____

Mailing Address: _____

Home Phone#: _____ **Cell Phone#:** _____ **Work Phone #:** _____

HCC may leave a message at: ☐ **Home** ☐ **Cell Phone** ☐ **Work** ☐ **Other** _____

Date of Birth: _____ **Age: (_____)** **DL#** _____ **SSN** _____ **Gender** _____

Marital Status: **Single** **Married** **Separated** **Divorced** **Employed:** ☐ **Yes** ☐ **No**

Ethnicity (Check all that Apply): ☐ **Caucasian** ☐ **African American** ☐ **Alaska Native/Amer. Indian**
☐ **Asian** ☐ **Hispanic** ☐ **Native Hawaiian/Pacific Islander** ☐ **Multiracial**

As a courtesy HCC will provide a reminder the day before your appointment how would you like us to contact you:

Email address: _____ **Contact #:** _____

Referring Provider: _____

All fields on this page must be filled out completely before you begin your appointment:

Insurance Information

Primary Insurance: _____
Address: _____
_____
Phone #: _____
ID #: _____
Group #: _____
Insured's Name: _____
Insured's S.S. No.: _____
Relation to Client: _____ DOB _____

Secondary Insurance: _____
Address: _____
_____
Phone #: _____
ID#: _____
Group #: _____
Insured's Name: _____
Insured's S.S. No.: _____
Relation to Client: _____ DOB _____

I understand that payment for all treatment received is my responsibility. I hereby authorize the release of any information to my insurance company that is required to process a claim on my behalf including, but not limited to, insurance appeal rights on my behalf. I also hereby authorize my insurance company to remit payment for any medical benefits due directly to Hope Counseling Center. These authorizations shall expire in one year or upon my written notice.

Signature of Responsible Party: _____ Date: _____

CONFIDENTIAL INFORMATION

Billing Information

Hope Counseling Center's billing rate for an initial session is **$360.00**. Thereafter, sessions are billed at **$260.00** per therapeutic hour (53 minutes). Our billing rate is based on the reasonable and customary charges billed by other counseling services in the Fairbanks area. Our goals are to (1) assure the highest quality of services and (2) ensure the provision of counseling services to all of those in need.

Hope Counseling Center offers a number of options regarding the payment of your bill. Below is a list of third-party billers. If you are in need of special assistance regarding payment of services, **please check the appropriate program 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.)

___ **Tricare clients**: Our services will require Active Duty Service Members, Dependents and Retirees to obtain a doctor referral from their PCM and/or medical doctor.

___ **Office of Children's Services**: A Purchase Authorization must be sent directly to Hope from your case worker. Appointments will be canceled if a proper authorization is not received in time.

___ **Division of Vocational Rehabilitation**: A Purchase Authorization must be sent directly to Hope from your case worker. Appointments will be canceled if a proper authorization is not received in time.

___ **Fairbanks North Star Borough School District**: An authorization letter must be sent directly to Hope from the district. The client will be subject to the balance if not authorized for services.

___ **Client Assistance Program**: I do not have insurance and will need consideration regarding payment for services. (Please see the Front Office staff for further paperwork needed to qualify for assistance. Supporting financial documentation ***must*** be supplied ***before*** an application will be reviewed.)

___ **Other: _____**

___ **Credit Card Payment**: Please charge my credit card at the time of service.
____ VISA ____ MasterCard
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.

Printed Name Signature Date

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In order for us to serve you better it is extremely helpful if we have some background information regarding your situation. Please answer all questions to the best of your ability.

ALL INFORMATION IS HELD IN THE STRICTEST CONFIDENCE.

NAME:_____
Last **First** **MI**

In your own words, please state the concerns that bring you to counseling: _____
_____
_____

(Use the back of this page if necessary)

Rate the items with which you are currently having difficulty coping. Circle the word(s) in brackets that best define(s) each statement and circle the number that best indicates the existence or severity of the problem according to the following scale:

O=None	1=Minor	2=Moderate	3=Significant	4=Serious

Anxiety [Worry] (Fear) [Panic] [Phobia]	0 1 2 3 4
Feelings of (Depression) [Sadness]	0 1 2 3 4
Thoughts of [Death] [Suicide]	0 1 2 3 4
Sleep Disturbance	0 1 2 3 4
Mood Swings	0 1 2 3 4
Grief over [Death of Loved One] [Major Loss]	0 1 2 3 4
Issues Related to[Pregnancy] [Abortion]	0 1 2 3 4
Abuse [Physical] (Domestic] [Emotional] (Ritual]	0 1 2 3 4
Sexual Abuse [Incest] [Rape]	0 1 2 3 4
Parent(s) had [Alcohol] [Drug] Problem(s)	0 1 2 3 4
Marriage Problems	0 1 2 3 4

Relationship Problems with Children		0 1 2 3 4
Problems with (Parents] (Family]		0 1 2 3 4
Sexual [Concerns] [Problems]		0 1 2 3 4
Problem [Alcohol] (Drugs] [Smoking] [Other]		0 1 2 3 4
Feelings of [Hopelessness] [Helplessness] [Despair]		0 1 2 3 4
Memory (Forgetfulness] [Changes]		0 1 2 3 4
Have you ever felt people were watching you?	□ Yes	□ No
Do you hear voices?	□ Yes	□ No
Do faces ever seem distorted?	□ Yes	□ No
Do colors ever seem too bright or dull?	□ Yes	□ No
Have you ever attempted suicide?	□ Yes	□ No

Describe your 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:_____

Describe any cultural issues that contribute to your current problem(s):_____

_____

Please describe any special circumstances of which you feel your counselor should be aware:

_____

_____

MEDICAL HISTORY

Describe current physical health: [ ] Good [ ] Fair [ ] Poor

Do you have a history of any of the following?

[ ] tuberculosis [ ] heart disease [ ] birth defects [ ] high blood pressure

[ ] alcoholism [ ] drug abuse [ ] diabetes [ ] emotional problems

[ ] cancer [ ] stroke [ ] thyroid problems [ ] behavior problems

[ ] Alzheimer's disease/ dementia [ ] Learning disability

[ ] other chronic or serious health problems_____

Known allergies:_____

Current medical conditions: _____

_____

List name of primary care physician:

Name:_____ Phone:_____

List name of physician who does medication management (if any):

Name:_____ Phone:_____

Prior outpatient psychotherapy? Yes No

Longest treatment by_____for_____ sessions from _____ to _____.
(Provider Name) (Year) (Year)

C**urrent prescribed medication(s) for medical or mental health conditions:**

Medication	Dosage	Date	Reason

Prior medications for treatment of mental health issues? Yes No

Medication Name	Approximate Length of Use	Effective?	
		Yes	**No**
		Yes	**No**
		Yes	**No**
		Yes	**No**

Prior inpatient (hospitalization) for a mental health issue? Yes No

- If ***yes***, on how many occasions? _____ Where?_____
- Longest treatment at: _____ from _____/_____ to _____/_____.

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

CHEMICAL USE HISTORY

Prior use: Yes No **Current Use**: Yes No

Substance	Frequency of Use	Amount	Length of Use

Longest period of sobriety:_____
Prior substance abuse treatment with:_____

CHILDHOOD HEALTH

Immunization Status: _____Current _____Not Current _____Unknown

List any significant injuries or health issues:_____
_____
_____
_____

List any chronic, serious health problems:_____
_____
_____
_____

List any history of head injuries:_____
_____
_____