Candice Newman, MABC, LPC

The Vale Counseling and Rehabilitation Center
2862 N. Beltline Road
Sunnyvale, TX 75182

Initial Interview Form & Informed Consent

Date: _____

CLIENT INFORMATION

Name: _____

Phone: (wk) _____ (hm) _____ (cell) _____

May I contact you and leave messages at these phone numbers? ___Yes ___ No

Address: _____ City: _____

State: _____ ZIP: _____ Email: _____

May I mail to this address? __Yes __No May I email you? ___ Yes ___ No

Sex: ___ male ___ female Date of Birth: _____

Others living at home: _____

Employer: _____ Occupation: _____

How long have you worked there? _____ How long in this occupation? _____

Education (list highest level): _____

Primary Physician: _____ Phone: _____

List any significant health problems: _____

List any medications you are taking & dosage: _____

Have you seen this type of therapist before ___ Yes ___ No

If yes, when and with whom? _____

Give a brief description of treatment: _____

How were you referred to our office? _____

Who may we thank for referring you? _____

Nearest relative other than spouse: _____

Have you considered or attempted suicide? ___ Yes ___ No If yes, when? _____

FINANCIALLY RESPONSIBLE PERSON'S INFORMATION

Name: _____ Relationship to Client: _____

Phone (if different): _____

Address (if different): _____

INFORMED CONSENT

The Vale Counseling and Rehabilitation Center provides biblical counseling and spiritual guidance. Candice Newman, MABC, LPC is a Licensed Professional Clinical Counselor, License #63575 issued by the Texas State Board of Examiners of Professional Counselors, Member of the American Counselor Association, Member of the Christian Association for Psychological Studies. Candice Newman, MABC, LPC has had clinical experience counseling children, adolescents, couples, families, and individuals and facilitates all professional work from a Christian worldview.

Professional Christian counselors who are not acting in a pastoral capacity are considered to be "Mental Health Professionals." This category included church counseling staff, independent Christian counseling agencies, as well as commissioned or ordained Christian counselors.

The counselee agrees to take advantage of the counselor's services and training, and understands that the Bible will be the foundational basis for all counseling.

CONFIDENTIALITY STATEMENT:

All information shared in this treatment is confidential except in circumstances governed by law.

- If you would like me to confer with another healthcare professional, you will need to sign a "Release of Information" form. You can revoke this permission at any time. Both parties agree to take all reasonable measures to ensure confidentiality with any communication over the phone and/or Internet.
- When a statement allowing release of information is signed by the client.
- When the client expresses an intent to kill themselves or someone else.
- When Child/Elder abuse or neglect is currently occurring.

FINANCIAL AGREEMENT

Fees are payable at the time of service. Your fee per session is $_____. Your regular fee will be charged for any additional professional services rendered at your request, such as phone contacts over 5 minutes, consults with other professional, etc. Preparation of special forms, reports, court time, etc. will be billed at the rate of $_____ per hour. We accept cash, check, VISA, MasterCard, and Discover.

The Usual, Customary, and Reasonable fee for individual counseling at this level is $130.00 per session. We do have a sliding scale available. Please speak to me if this is a need.

It is Life Builder's policy that no one is turned away because of lack of payment; however, this must be pre-arranged.

YOUR PAYMENT IS TO BE PAID IN FULL AT THE TIME OF EACH SESSION. FEES ARE SUBJECT TO CHANGE EVERY SIX MONTHS.

NO-SHOW AND CANCELLATION POLICY

Your visit has been reserved for you. 24 hours notice is required for cancellation or you will be charged a late cancellation fee of a full session fee. You may leave a message with our office 24 hours a day, 7 days a week.

EMERGENCIES

If it is a potential life-threatening emergency, please go to your local emergency room. For non-life threatening emergencies, you may contact me at 972-698-8478 vm# 309. Should I not be available, my message will instruct you to call one of the other counselors in our office.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

STATEMENT OF UNDERSTANDING

I have read and understand this information sheet and informed consent.

Client _____ Date _____

Provider _____ Date _____

Parent of Guardian if minor _____ Date _____