



## Northland Christian Counseling Center

### **For Your First Appointment:**

**1. Fill out these forms**

Bring them to your first appointment. If you are unable to do this, please arrive at least 15 minutes early for your first appointment to fill out forms in the office.

**2. Bring your insurance card**

If you are billing insurance, we need a copy of your insurance card on file. We ask that you make any co-pay payments at the time of your appointment.

**3. Call to change or cancel your appointment**

If you need to change or cancel your appointment, we have a **24-hour** cancellation policy. You will be charged \$100 for a “no-show” or “late cancellation” after your first visit. Our office phone number is 701-795-8550.



**CLIENT INFORMATION FORM**

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

**PHYSICAL HEALTH STATUS** (Medical, physiological)

List current medical conditions (arthritis, diabetes, etc.)

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Any areas of functional impairment?

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List all prescribed medications, over-the-counter medications, natural/herbal supplements, vitamins, minerals that you are currently taking: *(If needed, please attach an additional sheet)*

**Drug/Supplement:**

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Primary Physician and or Psychologist: \_\_\_\_\_

**LIFESTYLE & VALUES**

Do you exercise regularly? Yes or No Please explain: \_\_\_\_\_

How many hours do you sleep at night? \_\_\_\_\_ Do you sleep well? Please explain: \_\_\_\_\_

Do you place importance on what you eat and drink? Please explain: \_\_\_\_\_

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Do you struggle with any compulsive/addictive behaviors (such as sex, pornography, food, gambling, work, caffeine, nicotine, alcohol, other legal or illegal drugs)? Please describe use & frequency and how it is impacting your life?

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**FAMILY**

Any family history of mental illness? \_\_\_\_\_

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**PERTINENT DEVELOPMENTAL HISTORY**

Were there things that happened to you when you were growing up that you felt were particularly significant in your life?

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**FAMILY & COMMUNITY SUPPORT**\_(Social)

List any support systems that have been and are helpful to you. Include family members, friends and organizations.

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**EMPLOYMENT/SCHOOL**

Current occupation: \_\_\_\_\_ How many hours/week do you work? \_\_\_\_\_

Previous occupations: \_\_\_\_\_

How do you feel about your work? \_\_\_\_\_

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Are you currently enrolled in school? Yes No If yes, which school and what area of concentration?

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**ANY LEGAL ISSUES IN YOUR PAST OR PRESENT SITUATION** (Be specific) \_\_\_\_\_

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**SPIRITUALITY**

Do you consider yourself a spiritual person? Yes, or No Please explain: \_\_\_\_\_

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How would you like your spirituality acknowledged in counseling sessions? \_\_\_\_\_

**PAST COUNSELING** When? With whom? Was it helpful?

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**SELF-ASSESSMENT** (Experience)

Describe how you see yourself and your life at this time. \_\_\_\_\_

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**THERAPY GOALS** (Recovery Goals)

How do you hope to be different when your work in therapy is finished? Be specific.

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## 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.

This privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your “protected health information” means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

### I. Uses and Disclosures of Protected Health Information

Northland Christian Counseling Center (NCCC) may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless NCCC has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

- A. **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to physicians who may be treating you or consulting with NCCC with respect to your care.
- B. **Payment:** We may use and disclose protected health information about you so that the treatment and services you receive from NCCC may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. We may also disclose client information to another provider involved in your care.
- C. **Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of NCCC’s practice. Examples of these activities include but are not limited to: quality assessment activities, employee review activities, training programs, accreditation, certification, licensing or credentialing activities, and review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities.
- D. **Other Uses and Disclosures:** As part of treatment, payment, and health care operations, we may also use or disclose your protected health information to: keep you informed about appointments; program information, and benefits and services that may be of interest to you; call you by name in the waiting room when your counselor is ready to see you; or to contact you to raise funds for NCCC or an institutional foundation related to NCCC. If you do not wish to be contacted regarding fund raising, please contact our Privacy Officer.

### II. Uses and Disclosures beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following: as required by law; for public health activities; victims of abuse, neglect or domestic violence; health oversight activities; for judicial and administrative activities; for law enforcement purposes; regarding decedents; for cadaveric, organ, eye and tissue donation purposes; for research purposes; to avert a serious threat to health or safety; for specialized government functions; correctional institutions; for workers’ compensation; or to share with our business associates who must abide by the same confidentiality requirements. Any health care professional authorized to enter information into your medical record, all employees, staff, and other personnel

at NCCC who may need access to your information must abide by this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

### **III. Uses and Disclosures Permitted without Authorization but with Opportunity to Object**

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your care or payment related to your care. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location or general condition.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interest for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

### **IV. Uses and Disclosures which you Authorize**

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

### **V. Your Rights**

You have the following rights regarding your health information.

- A. You may inspect and obtain a copy of your personal health information in our possession for as long as we maintain the protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; protected health information that is subject to a law that prohibits access to protected health information; information obtained from someone other than a health care provider under a promise of confidentiality and the requested access would be reasonable likely to reveal the source of information; and information that is copyright protected. Depending on the circumstances, you may have the right to have a decision to deny access reviewed. Please contact our Privacy Officer if you have questions about access to your medical records.
- B. In other situations, we may deny you access, but if we do, we must provide you a review of our decision denying the access. These "reviewable" grounds for denial include the following: a licensed health care professional has determined that the access is reasonably likely to endanger the life or physical safety of yourself or another person; the protected health information makes reference to another person (other than your health care provider) and your health care provider has determined that the access is reasonably likely to cause substantial harm to another person; the request is made by your personal representative and a licensed health care professional has determined that giving access to such personal representative is reasonably likely to cause substantial harm to you or another person. Depending on the circumstances, you may have the right to have a decision to deny access reviewed. Please contact our Privacy Officer if you have questions about access to your medical records.
- C. You may request a restriction on certain uses and disclosure of your information. Your request must state the specific restriction requested and to whom you want the restriction to apply. NCCC is not required to agree to the requested restriction, but if approved, we will abide by it except in an emergency treatment situation or as required by law. You may request a restriction by contacting the Privacy Officer.
- D. You may request that we contact you about personal health care matters only in a certain way and at a certain location. We will accommodate reasonable requests. We may condition the accommodation by asking you for information about how payment will be handled or ask you to specify an alternate address or other method of contact.
- E. If you feel that some information NCCC has created about you is wrong, you may ask to change that information. In certain situations, we may deny your request. We will notify you if we deny your request and tell you how to request a review of the denial. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendment(s).

- F. You have the right to request an accounting of certain disclosures of your protected health information made by NCCC. This right applies to disclosures for purposes other than treatment, payment, or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a NCCC directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization.

The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to January 1, 2011. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

- G. You may request a paper copy of this notice even if you have already received a copy of this notice or have agreed to accept this notice electronically.

#### **VI: Our Duties**

Northland Christian Counseling Center is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain. If NCCC changes its Notice, we will provide a copy of the revised Notice by sending a copy of the revised Notice via regular mail or through in-person contact.

#### **VII: Complaints**

You have the right to express complaints to NCCC and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to NCCC by contacting NCCC's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

#### **VIII: Contact Person**

Northland Christian Counseling Center's contact person for all issues regarding client privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by NCCC you may submit a complaint to our Privacy Officer by sending it to:

Northland Christian Counseling Center  
Attn: Privacy Officer  
2315 Library Circle  
Grand Forks, ND 58201

The Privacy officer may be contacted by telephone at 701-795-8550.

#### **IX: Effective Date**

This Notice is effective September 1, 2013.



**NOTICE OF PRIVACY PRACTICES SUMMARY**

The attached Notice of Privacy Practices of Northland Christian Counseling Center describes how we may use or give out your protected health information to carry out your treatment, for payment of services you receive, or for activities needed to run our business.

It describes other situations when we may need to use or give out your information such as those that are required by law or for public health activities. Examples of situations are given in the notice to help you understand the many uses of protected health information.

In addition, it describes what your rights are with regard to your protected health information and how you may exercise those rights. On the last page of the notice, there is information on who to contact if you have questions or concerns.

MY SIGNATURE BELOW INDICATES THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR NORTHLAND CHRISTIAN COUNSELING CENTER.

\_\_\_\_\_  
Client or Authorized Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Client (if client is unable to sign)

**ACKNOWLEDGEMENT AND CONSENT TO RECEIVE APPOINTMENT REMINDERS**

- NCCC offers appointment reminders that can include phone calls, SMS messaging(text) or email.
- I am aware there are certain risks associated with receiving appointment reminders, including but not limited to: someone other than myself reading my text messages or emails or listening to voicemails.
- I am aware and I am responsible for ensuring my email and phone numbers are kept updated.
- I am aware I can terminate this consent to receive appointment reminders at any time.

I opt to receive appointment reminders that can include phone calls, SMS messaging(text) or email.

I opt to NOT receive appointment reminders that can include phone calls, SMS messaging(text) or email.

MY SIGNATURE BELOW INDICATES WHETHER OR NOT I HAVE CHOSEN TO RECEIVE APPOINTMENT REMINDERS.

\_\_\_\_\_  
Client or Authorized Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Client (if client is unable to sign)



## CLIENT SERVICES AGREEMENT AND INFORMED CONSENT

Welcome to Northland Christian Counseling Center. This document contains important information regarding our business policies and provides you with informed consent about your rights. The law requires that we obtain your signature acknowledging that we have provided you with this information. Please read carefully.

**About Our Counseling Services:** Accessing our services is your free choice, you have the right to active participation in your treatment, and you have the right to terminate treatment at any time. You understand that your participation at Northland Christian Counseling Center is voluntary and that you may receive services from another provider if you choose too. Be aware that there are no guarantees regarding the nature of your experience or outcome. *The Benefits of Counseling* may include relief from your emotional/mental discomfort and increased daily functioning. *Potential Risks* may include increased emotional discomfort and not achieving the outcome you were seeking. *Limitations to Counseling* also exist. You may talk with your provider about your concerns and/or alternatives to your counseling treatment. Additionally, your provider may determine that a referral to another healthcare/counseling service provider is necessary.

**Appointments:** Normally, appointments are 45 to 60 minutes in length. Future appointments will occur in intervals determined by you and your provider. In the event that you need to miss your appointment, we require **24-hour advance notice of cancellation prior to your scheduled appointment**. *Failure to do so will result in a charge of \$100 with responsibility for payment on you, the client*. NCCC provides non-emergency counseling services by scheduled appointment only. If you are unable to reach your provider to move your appointment up, and you cannot wait for a returned call or you believe you have an emergency, you should call 911 or go to your local Emergency Room.

**About Your Provider:** Your provider is a Licensed Professional Clinical Counselor (LPCC), Licensed Professional Counselor (LPC), Licensed Associate Professional Counselor (LAPC), Licensed Clinical Social Worker (LCSW), Licensed Master Addiction Counselor (LMAC) or a Licensed Addiction Counselor (LAC). Your providers are currently licensed by their North Dakota state's licensing board. In the case you are working with a provider working toward their license or being supervised to advance to a higher licensure status in their field, the name of the provider's clinical supervisor will be provided to you during the initial session.

**Billing and Payment for Services:** You are ultimately responsible for paying for services rendered. If you wish, insurance will be billed and what is not covered by your insurance plan will be left to your payment responsibility. A diagnosis is required by insurance companies to bill. Billing account limits are put in place in hopes of helping you avoid undue financial hardship. Please call our office for specific information regarding services and the accompanying fees should you want further information. If you are involved in legal proceedings or become involved in legal proceedings that require your provider to participate, you will be charged for all professional time, including but not limited to time spent in preparation, travel, deposition, and testimony.

**Services for Minors:** Children seen in individual sessions (except under certain conditions) are not legally entitled to confidentiality (also called privilege); their guardians have this right. However, unless children feel they have some privacy in speaking with their provider, the benefits of counseling may be lost. Therefore, it is necessary to work out an arrangement in which children feel that their privacy is generally being respected, while guardians have access to critical information. Your signature at the end of this Agreement acknowledges that you grant permission for your minor child to be treated by NCCC *and* that you have legal custody required to grant this permission.

**Confidentiality, Records & Disclosures:** In accordance with state and federal laws your records are kept in a HIPPA-secure electronic record keeping system. You have the right to ask that your clinical record or summary of your record be made available to another healthcare provider upon your written request authorizing the release of information. There are some exceptions where disclosure is necessary without a release of authorization from you. Examples of such circumstances are;

- It is determined you are a threat to yourself or another,
- If you disclose the abuse or neglect of children, vulnerable adults, or people with disabilities,
- In accordance with other mandated reporting laws,
- If documents are court ordered to be released to the property of the court,
- If there are legal or regulatory actions against a NCCC professional
- Health and Human Services, Office of Civil Rights to determine compliance with privacy rule.

The above list is only considered to be a summary and if you have further questions about confidentiality, please ask NCCC staff or your therapist.



**Tele-Mental Health Services Options**

Northland Christian Counseling Center offers both in-person and tele-mental health service options. In the event you choose to participate in tele-mental health services, you are made aware of further information and potential risks when engaging in this service.

1. I understand that records of all visits will be documented in my electronic medical record and that strict confidentiality of the records will be maintained
2. I understand that privacy during tele-mental health appointments will be secured on the end of my provider
3. I understand that it is up to me (the client receiving tele-mental health services) to secure my own private location while engaging in tele-mental health appointments
4. I understand that I may refuse or stop the tele-mental health appointment at any time. If direct communication is desirable, an alternative appointment can be provided face-to-face at Northland Christian Counseling Center
5. I understand that, if needed, an emergency plan will be established, and I will be made aware of the plan
6. I understand that if technical difficulty or breakdown occurs the appointment may be rescheduled
7. I understand that if contact with my tele-mental health provider is necessary between scheduled appointments, I should call Northland Christian Counseling Center and ask to speak to my provider
8. I understand that there are some risks with tele-mental health services, which include, but are not limited to:
  - a. The transmission of my medical information could be disrupted or distorted by technical failure
  - b. The transmission of my medical information could be interrupted or intercepted by unauthorized persons
  - c. The electronic storage of my medical information could be accessed by unauthorized persons
9. I understand that I may benefit from distance counseling, but results cannot be guaranteed or assured
10. I understand the same fee rates and/or co-pays apply for tele-mental health counseling as apply for in-person counseling

**Client Rights at NCCC:** As a client you have the right to:

- Be treated with respect, be treated without regard to race, gender, sexual orientation, marital status, national origin, physical/mental disability, public assistance status, age, and spiritual or religious denomination.
- Have all information handled confidentially in accord with applicable laws, regulations, and standards.
- Receive notice of Federal & State confidentiality requirements.
- Not be subject to physical, emotional, or sexual harassment by employees.
- Be informed of your rights in a language you understand.
- Expect complete and current information concerning your diagnosis and treatment plan.
- Know by name, and the competencies of, the licensed mental health professional responsible for coordination of your treatment.
- Place grievances and recommend changes in policies and services to NCCC free from restraint, interference, coercion, discrimination, or reprisal.
- Be informed of and agree or refuse to participate in any experimental and/or educational research.
- Choose freely among available mental health professionals and practitioners of your choice.
- Have the right to revoke your consent at any time in writing, except to the extent that action has been taken. Any information released prior to the revocation shall not be a breach of confidentiality.

**Questions and Complaints**

If you have questions about this notice, disagree with a decision we make about access to your records, believe that your rights have been violated and wish to file a complaint with this office or have other concerns about your privacy rights, you may contact NCCC’s privacy officer at 701-795-8550.

You may also send a written complaint to the Secretary of the US Department of Health and Human Services. The privacy officer at NCCC will provide you an appropriate contact information upon your request.

NCCC reserves the right to change the terms of this notice and will make you aware of the revised notice as the time of your first scheduled appointment after changes are made and ask you to sign the new form.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ, UNDERSTOOD, AND CONSENT TO THE ABOVE INFORMATION AND I WILL BE PROVIDED A COPY OF THIS DOCUMENT UPON REQUEST.

\_\_\_\_\_  
Client or Authorized Signatory

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Client (if client is unable to sign)