Rae of Hope Counseling Office Procedure/Guidelines:
By signing at the bottom of this page, you are agreeing to this policy.

Effective 11/01/17, the following updates will be in effect. Thank you for your cooperation.

1. *If you have made an appointment and find you are unable to keep that appointment but **fail to notify** this office by phone or email **24 hours prior** to that appointment, you will be billed for that full session at the rate of $150.00. This is not billable to your insurance. Consideration will be given to cases of emergency. As the therapist, I also have emergencies and try to be understanding when this happens to you as well.*
2. *I will continue to contact you with reminders of your appointments, but this is a **courtesy**. It is your responsibility to keep this appointment time that has been set-aside just for you.*
3. *No firearms or weapons of any kind are allowed in the office space or waiting area where my office is located. If you have a permit to carry a handgun, please understand that I need you to leave it in your vehicle or our session will be cancelled. This is a personal request and not a state mandate. Thank you for complying with this.*
4. ***BILLING AND PAYMENTS:***
   1. *This office, as a courtesy, files insurance claims at no additional charge. By signing this agreement you understand you are responsible to pay the balance due at each session. Payment may be in the form of cash, check, or debit/credit card. There will now be a 10% monthly fee charged for outstanding balances that require an invoice.*
   2. *If your policy is an HMO (requires a referral from your Primary Care Physician), the client is responsible for obtaining that referral from the physician.*
   3. *There will be a $25 fee for returned checks.*
   4. *The following fees will be charged:*
      1. *The initial diagnostic session for assessment is **$200**. All other regular therapy sessions are **$150** / 60 min. session.*
      2. ***$50*** *for completing paperwork, writing letters regarding application for disability or other legal claims.*
      3. ***$25*** *for any letter of referral to a physician, school or clinic*
      4. ***$300 per hour*** *for court testimony. Beginning 1/13/14, these cases will only be considered to continue on an individual basis. If necessary, a referral will be given to another therapist who prefers courtroom appearances.*
5. ***Emergency Calls:*** *My counseling services are provided Monday-Friday by appointment only. After hours there is a voicemail service at 479-806-2053 that will be checked frequently. If you need immediate attention, please go to the emergency room of the local hospital or call 911*
6. ***Release of Information:*** *We may ask you at some time to give us permission to contact your primary care physician or others providing care for you in order to maximize the benefits you receive. In most situations, information about your treatment can be released to others **only if you sign a written authorization form**.*
7. ***Confidentiality:*** *All information that you reveal to your therapist, including any test results, notes and records, is confidential and will not be released to any outside person or agency without your written authorization. If more than one family member is seen during a session, each of these legally competent individuals must sign for authorization for release of records. Records involving marital therapy belong to BOTH parties, not to just one individual.*
8. ***Inclement Weather:*** *Typically, I follow the Fayetteville school cancellation schedule. If you have any question about the office being open or not, please call or text me.*
9.
10. ☐

PLEASE SIGN HERE TO INDICATE YOU HAVE READ AND UNDERSTAND

CONFIDENTIAL **Client Information**

Rae of Hope Counseling
Lindsey Gipson, MS, LPC, LLC
4241 Suite 2B Gabel Drive, Fayetteville, AR 72703
PH: 479-806-2053

***Please complete all information below. If client is a minor, complete the form with their information.**

Client's Full Name: ____ Today's Date: ____________

Male / Female Date of Birth: ________________________ Age: ________

Social Security # ____ (**required** for insurance purposes only)

Address: ____

City ____________________________ State __________ Zip Code ______________

Home Phone: ____________________________ Cell Phone: _________________________

Do you give permission for me to leave voicemail? Yes No

Do you give permission for me to send text messages to remind you of your appts? Yes No

Email address: ____

Do you give permission for me to contact you by email regarding appts. or to exchange needed information (such as initial paperwork, insurance information or invoices)? Yes No

Your occupation/employer: ____ How long?____________

What is your job title/assignment at your work? ____

Address of your employer:____________________________________ Phone #_____________________

(this information is only used if your account is not kept current and has to go to a collection agency)

If in school, please name the school and present grade: _______________________________________

Emergency Contact Name & Number: ____

Present Marital Status: Single / Married / Separated / Divorced / Widow/ Co-Habitate

Name of Spouse: _______________________________ Will spouse be involved in therapy? Yes No

***List **ANYONE** living in the household (if other children live elsewhere, please list them also):

Name	Age	Date of Birth	Relationship to client:	Lives where:

Medications: Please list any/all medications you are **presently** taking **and the prescribing doctor.**
Use back of form if needed.

Name of Current Medication:	Dosage:	Taken for treatment of:	Prescribing Physician:

General Health: Please list any/all medical, physical or mental health problems you are presently or have recently been treated for. (Ex.: seizures, diabetes, hypertension,

Nature of Current Problem: Please list any recent changes such as loss of job, death of family member or friend, move, change in household, etc.

____

____

How long has this been a problem: ________________

What other ways have you tried to deal with this problem:

____

Previous Counseling Services**:** Have you ever received counseling before?

Have you been in inpatient care? If so, where and when?

____

Office located by: Yellow pages / Online search / Personal referral / Physician referral / Insurance Company Listing/ Other

Did anyone refer you to this office today? If so, whom: ____________________________________

May I send a courtesy thank you to them for the referral? Yes No

Mark any of the following that apply to you (client should complete this):

___ Thoughts of suicide ___ Thoughts of harming others ___ Phobias/fears

----- Trouble getting to sleep ___ History of suicide attempts ___ Panic Attacks

___ Waking during the night ___ Cutting or other self-harm ___ Excessive guilt

___ Waking early every day ___ Feelings of hopelessness ___ Forgetfulness

___ Financial problems ___ Inability to make decisions ___ Mood swings

___ Loss of appetite ___ Trouble controlling temper ___ Health problems

___ Hearing voices ___ Recent weight gain or loss ___ Family conflict

___ Problems at work/school ___ Seeing things others don't ___ Violence toward others

___ Trouble concentrating ___ History of physical abuse ___ Tingling or numbness

___ Racing thoughts ___ History of sexual abuse ___ Depressed mood

___ Legal problems ___ Any trauma not listed ___ Lack of enjoyment in life

___ Alcohol problems ___ Drug problems ___ Eating problems

Consent for Evaluation and/or Treatment

Counseling services can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. It may seem that you initially feel worse before feeling better.

Counseling may have many benefits such as better relationships, solutions to specific problems, and significant reductions in feelings of distress. Therapy may be slower than anticipated, but the progress you make should outweigh the potential risks. There are, however, no guarantees of what you will experience.

Any questions or concerns you may have should be first raised with your therapist. If you feel that a therapeutic relationship has not been established, please feel free to notify the therapist for a referral to another therapist. If you are not satisfied, you may wish to consider a second opinion. If the behavior of your counselor is either unethical or does not adhere to professional standards, you may bring it to the attention of the state licensing board. I am licensed through the Arkansas Board of Examiners in Counseling. That website is www.state.ar.us/abec. The telephone number is 870-901-7055.
My license is # P1609142.

The first few sessions will include an evaluation of your needs and the development of a treatment plan. This plan will be developed by the counselor and the client and will include goals, methods to accomplish these goals, and the approximate length of time needed. Periodically, this plan will need to be reviewed and adjusted according to need.

Sign: ____ Date:__________________

There are several circumstances in which records may be released without client consent:

1) If there is reason to believe a child (under age 16) is the victim of a crime—such as incest, rape or
2) Foreseeable risk of suicide of the client
3) When the client reveals intentions to commit a crime
4) When the client brings suit against the therapist
5) A determination is made that the client needs hospitalization;
6) When criminal action is involved or information is made an issue of court action.

Agreement*: Please initial beside each line.*

_____*I have received, read and understand the document regarding* ***Information for New Clients and Consent for Evaluation and/or Treatment.***

_____*I do seek and give consent to participate in this counseling service. I understand that no guarantees have been made to me regarding the results of treatment or procedures provided at this counseling service.*

_____*I am aware that I must give 24-hour notice of cancellation of an appointment and if I do not cancel or do not keep the appointment I will be charged for the appointment, which cannot be billed to insurance. I understand that after two "no-show" appointments, my therapy will discontinue and I will be discharged.*

_____*I understand and give permission for my insurance or other third-party payer to be provided with information about the type, cost and dates of any services or treatment I receive.*

_____*I understand that if I have not paid for services received, the counselor may discontinue my treatment.*

_____*I understand that this office is not responsible for any personal property or valuables I bring into its facilities.*

_____*I understand that, if I or anyone else whom I am legally responsible for deliberately causes damage or steals any property of this office, I will be held financially responsible for its replacement.*

I certify by my signature below that I have read, had explained to me when necessary, fully understand and agree with the contents of this form.

Signature: ___________________________________ *Date*__________________

By signing below you agree to pay the balance due for copays OR if the entire billed amount is applied to your annual deductible.

I authorize payment of medical benefits to this designated therapist for therapeutic services. I also authorize the release of any medical or other information necessary to process this claim to my insurance company.

****Insured's or Authorized Person's Signature**:*

X____

Insurance Information (if you would like this office to file for you) _______**COPIED CARD**

Name of Insurance Company: ____

Policyholder's Name: ____

Policyholder's S.S.#__________________________ Policyholder's Date of Birth: ____________

Group # _____________________________________ ID# ___________________________________

*Special Consent for Children Agreement

(not necessary for adults to fill this out)

In order for minor children to receive counseling services, it is necessary for the parent or legal guardian to grant permission for such services to occur.

Name of minor:_____________________________________ Date of birth: _________

School they attend:____

Presently living with:____

Person requesting services:____

Relationship to child: Parent Step-parent Grandparent Guardian Other______________

*Are you the **LEGAL** parent or guardian of the above named child? Yes No*

In instances of divorce, it is essential that the legal custodian of the child grant permission for services. You may be asked to provide a copy of the court order naming you the legal guardian in the case of a divorce.

Are you willing to do so? Yes No

Signature of person giving consent: ___________________________________ Date _____________