**NEW SONG COUNSELING CENTER**
**PROFESSIONAL SERVICES AGREEMENT**
***NEW SONG UNITED METHODIST CHURCH***
***7450 COLT'S NECK ROAD * MECHANICSVILLE, VA 23111***

*Thank you for making the decision to seek assistance from our Counseling Ministry. The counseling we provide, is both pastoral and professional, is scripturally based and psychologically sound.*

*Your response to this form will serve as a brief and helpful introduction. All submitted information is confidential. If an item does not relate to you, write "NA" meaning Not Applicable.*

*Date: _____* *Counselor: _____*

**Our Mission:**

*To serve God's people and to offer His message of hope and comfort to those who are hurting.*

**Personal Information:**

**Referred by:**

**Full Name:** **Date of Birth:**

**Address:** **City/State:** **Zip:**

**Home Phone:** **Work Phone:**

**Other Contact Numbers (cell, pager, etc.):** **SS#: - -**

**Email:**

**Who is responsible for payment:**

**Have you ever been to the New Song Counseling Center before? (please circle one) Yes No**

**How did you hear about the counseling ministry?**

**Please describe the reason for your visit today:**

**Social Information:**

**Marital Status: Never married __ Married __ Separated __ Divorced __ Other: _____**

**How long have you been in your current marriage?**

**Previous Marriages: Self: _____ Time(s) Date(s):** **Spouse: _____Time(s) Date(s):**

**Spouse's Name:** **Date of Birth:**

***Children :***

**(Self):**
**Name_____ Age_____ Sex____** **Name_____ Age_____ Sex_____**
**Name_____ Age_____ Sex____** **Name_____ Age_____ Sex_____**

**(Spouse):**
**Name _____ Age ____ Sex____** **Name_____ Age ____ Sex _____**
**Name_____ Age ____ Sex____** **Name _____ Age _____Sex _____**

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**I presently live with:_____. How would you describe your current living situation?**

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**Highest Education Completed:**

**Self:** **Spouse:**

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**Employer (Self): _____ Position:_____ Length:_____**

**Employer (Spouse):_____ Position:_____ Length:_____**

**How would you describe your current work situation?**

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**How would you describe your spouse's current work situation?**

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**<u>Please fill out the following information as it applies to the client. Thank you.</u>**

**State the nature of the problem in your own words:**

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**What is your most difficult relationship right now?**

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**What is your most difficult emotion right now?**

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**Do you experience any problems with (circle all that apply):**

**eating sleeping chronic pain recent weight change**

**Describe any answers circled above:**

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**<u>Crisis Information:</u>**

**Any current suicidal thoughts, feelings, or actions? Yes ___ No ____**

**If yes, describe:**

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**Any current homicidal or assaultive thoughts or feelings, or anger-controlled problems? Yes ___ No ___**

**If yes, describe:**

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**Any past problems, hospitalizations, or jailings for suicidal or assaultive behavior? Yes __ No ___**

**If yes, describe:**

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**Current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? Yes ___ No ___**

**If yes, describe:**

**Medical Information:**

**Do you have any medical problems? Yes ___ No___ Describe:**

**Date of Last Physical:**

**List any current medication, dosage, and reason (including vitamins/herbs/over the counter medication):**

**Have you ever been prescribed medication for a psychiatric diagnosis? Yes ___ No___**

**If yes, list medication (even if you are no longer taking it):**

**Have you received counseling previously? Yes ___ No ___**

**If yes, describe:**

**Are you currently under the care of a mental health professional (i.e. Psychiatrist, Psychologist, or Counselor)? Yes ____ No____**

**Do you or your family have any history of depression or other similar problems (i.e. anxiety, manic depression, schizophrenia)? Yes __No___**

**If yes, describe:**

**Do you or your family have any history of drug/alcohol abuse? Yes ___No___**

**If yes, describe:**

**Is there any history of sexual abuse or physical abuse toward you? Yes __No___**

**If yes, describe:**

**If you answered yes to any of the previous questions, please list the following information:**
***(please use the back of this form for additional space)***

**Treating Physician/Practice: Specialty Area: Phone #: Address: Result of Treatment:**

**Church and Spiritual Information:**

**Do you believe that Jesus is the son of God? Yes ____ No _____**

**How would you describe your current relationship with God?**

| Separated | | | | Sort of Close | | | | | Very Close | |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**Please explain:** _____

**How would you describe your spouse's current relationship with God?** _____

**What Churches, if any have you attended?**

| Church or Denomination | Self/Spouse/Both | Member Y/N | Year (s) Attended | Church Involvement: *Frequent /Seldom/None* |
|---|---|---|---|---|
| | | | | |

**Please complete the following sentences:**

**Today I feel** _____

**My marriage** _____

**Fun for me** _____

**Growing up with my family** _____

**If I could change one thing** _____

**Six months from now** _____

**God is** _____

**What I hope to gain from counseling** _____

**Thank you for taking the time to fill out this information sheet. Your counselor will review this with you in the first session and use it to best assist you in your counseling work. We will maintain your strict confidence regarding this information, subject to the exceptions noted in your service contract. Be sure you review and sign the elements of agreement detailed in your service contract.**

**NEW SONG COUNSELING CENTER**
**PROFESSIONAL SERVICES AGREEMENT**

This agreement for counseling services between New Song Counseling Center and _____ will serve to set mutual expectations between client and therapist. It is agreed that any disputes or modifications of agreement shall be negotiated directly between the parties; if these negotiations are not satisfactory, then the parties agree to mediate any differences with a mutually acceptable third-party mediator, considering first either the senior pastor or an associate pastor of this church.

A. COUNSELORS
Your counselor participates regularly in clinical consultations and Peer Review. He/she is committed to providing his or her best efforts to aid in client healing, utilizing training, experience and skills to provide services in a professional manner. Your counselor will monitor the progress of treatment. ____ (please initial)

B. FEES
The client shall make a full payment of $125.00 before the initial session and $65.00 before each additional session. Clients are fully responsible for all fees. Receipts for services will be provided upon client request for purposes of filing for insurance or reimbursement. Any and all insurance processing will be the responsibility of the client. You will be charged for a full session regardless of your arrival time. For any counseling payments made via check, clients are responsible for any charges incurred due to cancelled checks or non-sufficient funds. A $35.00 cancelled check fee will be applied to all payments not cleared by the bank for counseling services.____ (please initial)

C. CANCELLATION POLICY
We agree to and ask that clients maintain responsible relations regarding appointment times. The counselor is not required to wait past 20 minutes for the client. Any appointment cancelled less than 24 hours before the appointment or that the client does not show will be charged a cancellation fee of $50.00. _____ (please initial)

D. MEETING POLICY
Sessions will be conducted at New Song Church. Typically sessions occur once a week for 50 minutes, however frequency and length may be altered as mutually agreed by client and counselor. ____ (please initial)

E. CONFIDENTIALITY POLICY
All therapeutic communications, records, and contacts with professional and support staff will be held in strict confidence. It is agreed that the client grants the therapist permission to take session notes. Information may be released, in accordance with state law, only when (1) the client signs a written release of information indicating informed consent to such release; (2) the client expresses serious intent to harm himself/herself or someone else; (3) there is reasonable cause to suspect that an adult or child has suffered abuse, neglect, or exploitation: or (4) a subpoena or other court order is received directing the disclosure of information. It is our policy to assert either (a) privileged communication in the event of #4 or (b) the right to consult with clients, if at all possible barring an emergency, before mandated disclosure in the event of #2 or #3. Although we cannot guarantee it, we will endeavor to apprise clients of all mandated disclosures. ____ (please initial)

F. TREATMENT POLICY
New Song Counseling Center is a part of the New Song UMC. The client is entering into a counseling relationship that is value-based. Our treatment approaches integrate Scriptural, spiritual, and psychological interventions.____ (please initial)

G. WORK AGREEMENT

a. Personal Growth

It is agreed that the client shall make a good-faith effort at personal growth and engage in the counseling process as an important priority at this time in his life. Treatment goals will be defined within the first few sessions and noted on the treatment plan. Client gain is most important in professional counseling.

Suspension, termination, or referral shall be discussed between counselor and client for a pattern of behavior that reveals disinterest or lack of commitment to counseling or for any unresolved conflict or impasse between counselor and client. The client may notify the counselor at any time that they will discontinue therapy without penalty from the therapist or counseling center. ____ (please initial)

b. Benefits and Risks

Scientists in hundreds of well-designed research studies have shown the benefits of therapy. People have a chance to talk things out fully until their feelings are relieved or the problems are solved. However, as with any powerful treatment, there are some risks as well. For example, there is a risk that clients will, for a time, have uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other negative feelings. Clients may recall unpleasant memories. Sometimes, presenting problems may temporarily worsen after the beginning of treatment. Most of these risks are temporary and are to be expected when people make important changes in their lives.

The counselor does not take on clients he believes he cannot help. Therefore, the counselor will enter into the relationship with optimism about future progress. ____ (please initial)

c. Dual Relationships

Because of the nature of church and community counseling, it is likely that the counselor and client could cross paths outside of session. Should this happen in the community, in order to protect confidentiality the counselor will not acknowledge the client unless first spoken to. In a church environment, the counselor may greet or talk with the client but no conversation regarding therapy will occur outside of session. ____ (please initial)

d. No Court Appearances

If the client ever becomes involved in a divorce or custody dispute, the client agrees that the counselor will not provide evaluations or expert testimony in court. The client should hire a different mental health professional for any evaluations or testimony required. This position is based on two reasons: (1) The counselor's statements will be seen as biased in the client's favor because of the therapeutic relationship; and (2) the testimony might affect the therapeutic relationship negatively, and that relationship must be the priority. _____ (please initial)

In the event the counselor is subpoenaed for court, the client will be responsible for paying a fee of $250.00 prior to the court date to cover any paperwork, contact with lawyers, and preparation prior to the court date. The client will be expected to pay $125.00/hour for the court appearance after the first 2 hours. In the event the court date is cancelled without 24 hours' notice the initial payment of $250.00 will be due. _____ (please initial)

e. Emergency Services

New Song Counseling Center is not a twenty-four hour or seven day a week service. You may leave messages for counselors at any time and calls will be returned as quickly as possible. For immediate emergency services, please go to your local hospital emergency room or call the Crisis Hotline. ____ (please initial)

H. FEE AGREEMENT

The agreed fee for the initial session (90 minutes) is $125.00, and for additional sessions the agreed fee per 50 minute session is $65.00. In case of financial crisis the client may contact the professional counselor to discuss payment options. I understand that this process will require me to complete a financial assistance and assessment application.
_____(please initial)

**Service Agreement:**

We, the undersigned counselor and client, have read, discussed together, and fully understand this agreement and the Client's Rights Form (stated above). We agree to honor these policies, including the commitment to negotiate and mediate as stated above, and will respect one another's views and differences in their outworking. We have also agreed to the fee to be paid by the client. My signature below means that I understand and agree with all of the points above.

Client Signature Date

Counselor Signature Date

(This form will be included in the client's file.)

**NEW SONG COUNSELING CENTER**

**NEW SONG UMC**
**7450 Colts Neck Road, Mechanicsville, VA 23111**
**(804) 559-6064 (OFFICE) / (804) 559-6065 (FAX)**

## PERMISSION TO RECEIVE /RELEASE INFORMATION

I, _____, authorize Heather Shaheen, New Song Church to request, and/or receive information from behavioral healthcare, medical records, and/or verbal conversations, the following information related to services rendered beginning _____for the purposes of: _____. Information can be released and/or received from the agencies/individuals noted below. This information may take the form of written and/or oral communication.

1. Name/Organization: _____Relationship/Type: _____

Phone: _____Address: _____

2. Name/Organization: _____Relationship/Type: _____

Phone: _____Address: _____

3. Name/Organization: _____Relationship/Type: _____

Phone: _____Address: _____

4. Name/Organization: _____Relationship/Type: _____

Phone: _____Address: _____

### Signature for Permission to Receive/Release Information

Counselee (s):_____Date:_____
Counselee (s):_____Date:_____
Counselor:_____Date:_____

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 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 operation such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict and or revoke 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.

| _____ | _____ | _____ |
|---|---|---|
| Signature (Parent/Guardian/Self) | Date | Expiration Date |
| _____ | _____ | |
| Signer's Relationship to Patient | Date | |
| _____ | _____ | |
| Witness Signature | Date | |

OFFICE USE ONLY

| Date Processed: | Completed By: |
|---|---|
| | |

*I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:*

| Date: | Initials: | Reason: |
|---|---|---|
| | | |