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CONFIDENTIAL CLIENT INFORMATION

Client Name: _____ Date_____

Home Address: _____

City, State, Zip Code_____

Phone: Home _____Work _____ Cell_____

May we telephone you at work if necessary? Yes_____ No_____

What is the preferred phone number to contact you? Work____ Home ____ Cell_____

Email: _____

Date of Birth _____ Age_____ Gender(M/F) _____

Important Contact Information

If we need to contact you, can we contact you using the above information? Yes____ No____

Please provide information on who we can contact in case of emergency:

_____

_____ (___)_____

Contact person's name Relationship to client Phone number

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Minor Client

Relationship of client to responsible party_____

Name_____

Address_____

City, State, and Zip Code _____

Home Phone_____ Work Phone_____

Cell Phone _____

Marital Status

_____Single

_____Married for_____years. I have been married_____times

_____Divorced for_____years after a marriage of_____years.

_____Separated for_____years after a marriage of_____ years.

_____Widowed for_____years after a marriage of_____ years.

Name of spouse, if currently married_____

Spouse'sOccupation_____

First names and ages of children, if any _____ _____

_____ _____ _____

Education and Occupation:

Current Student? Yes___ No ___ If so, where? _____

Highest degree or year of Schooling obtained, and major: _____

_____

Current Occupation: _____ Are you happy with work? Yes ___ No___

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Other Information:

What is your primary personal support system? Check all that apply.

__Spouse __Family
__Church __Pastor or Priest
__Close Friend __Support or Recovery Group
__God __Other_____

Do you have a religious affiliation? Yes _____No_____
If so, what church or denomination_____
How often do you attend? Never_____ Seldom_____ Sometimes _____Regularly_____
If you are a member of a church, please state its name_____
How do you feel about God in your life? _____

Current areas of concern: (please check items applicable to you.)

__Marital Conflict __Substance Abuse __Physical/Sexual Abuse __Spiritual concerns
__Financial Stress __Eating Disorder __Depression __Chronic Health
__Parent/Child __Sexual Addictions __Anxiety/Panic __Grief/Loss
__ Other (Please describe below)

_____
_____
_____
_____
_____

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Please check any of the following that you have experienced in the last month:

__Depressed Mood	__Difficulty Breathing	__Difficulty Concentrating
__Irritability	__Disturbing Thoughts	__Restlessness
__Anger Outbursts	__Reduced Appetite	__Nightmares
__Insomnia	__Loss of Interest	__Dizziness
__Excessive Worry	__Suicidal Thoughts	__Difficulty Making Decisions
__Fatigue	__Lack of Productivity	__Excessive Fears
__Guilt	__Increased Heart Rate	__Doing Something Over and Over
__Extreme Sadness	__Uncharacteristic Crying	__Weight Gain/Weight Loss

Other _____

_____

_____

_____

Medical and Health

Have you ever been under the care of a psychiatrist, psychologist or other counselor?

Yes_____ No_____

If yes, please briefly explain the nature of the problem, the diagnosis (if you know) and its duration:

_____

_____

Contact information for your medical doctor (For emergencies only. We will not contact without your permission and a signed Release of Information):

Name: _____

Phone number: _____

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Current Desires and Goals for Counseling:

What do you see as the chief problem you would like to resolve with the help of a counselor?

_____

_____

Why did you choose to seek counseling at this time?

_____

_____

_____

_____

Do you have any questions or concerns reguarding counseling?

_____

_____

_____

Were you referred to me? Yes__ No__ If so, by whom?_____

Medications

Please list current medications: _____

_____

_____

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Insurance Information

Name as listed on Policy: _____

Primary Insurance Company: _____

Member ID#_____ Group ID#_____

Secondary Insurance (if applicable): _____

Member ID#_____ Group ID# _____

Drivers License

Name on DL:_____

DL number: _____

State issued: _____

I will make a copy of your DL to keep in your client file at our first session.

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Fee Policy

As a private practice Licensed Professional Counselor, my fee policy is structured to provide my clients the opportunity to use their mental health benefits provided by their health insurance carrier, or to pay for my services at the time of service with either cash or check.

I am an in-network provider for many of the products offered by Blue Cross and Blue Shield (BCBS) and can file your claim for my service. If you are a BCBS policy holder, you are responsible to pay the required co-pay at the time of service. You may have a policy benefit that requires that you pay a percentage of the set fee established by BCBS and are responsible to pay your set percentage at the time of service. Many policy holders have a deductible that must be met before their insurance benefits become active. If your policy is of that nature, you are responsible to pay my fee at the time of service. I will file your claim with BCBS so that you are given credit for the payment toward your deductible. I recommend that you call your BCBS customer service representative before our first appointment to clarify and verify your Outpatient Mental Health benefits.

If you are a Medicare policy holder and your Medicare supplement provider is BCBS, I am **not** able to process or file your claim since I am not a Medicare provider.

While am not an in-network provider for other insurance carriers, you may be able to file for reimbursement for my services as an out-of-network provider. If you desire to do so, at your request, I will provide you with a statement for services provided with the required information.

Marriage or relationship counseling is not typically a reimbursable health insurance benefit. Self-pay at my normal session rate is required for these services.

At this time the BCBS established fee and allowable charge for my services is $209.90 per session, based on their service code schedule before discounts. If you prefer to pay with cash or check at the time of service I offer a self-pay discount that equates to a session fee of $160.00

I will be glad to discuss my Fee Policy with you during my regular working hours.

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Privacy Practices of Bruce A. Dodson LPC

This notice describes how health information about you may be use and disclosed. It also explains how you can get access to your information. Please review it carefully. The privacy of your health information is important to me.

My Legal Duty

I am required by applicable federal and state law to maintain the privacy of your mental health information. The federal Health Insurance Portability and Accountability Act (HIPPA), implemented in 2003, set a national standard for privacy of health information. My office strictly adheres to the guidelines established by HIPPA, as well as all other state and federal laws pertaining to your privacy.

You may request a copy of our notice at any time. For more information about my privacy practices, or for additional copies of this notice, please contact me.

Uses and Disclosures of Health Information

I use and disclose health information about you for the treatment and payment purposes only. For example:

Treatment: In an emergency, I may use or disclose your mental health information to a physician or other healthcare provider for your protection and the protection of others.

Payment: I may use and disclose your mental health information to obtain payment from a third-party provider for services I provide to you.

Your Authorization: In addition to the use of your mental health information for treatment, payment or healthcare operations, you may give me written authorization to use your health information or to disclose it to anyone for any purpose. If you give me authorization while it was in effect. Unless you give me a written authorization, I cannot use or disclose your mental health information for any reason except those described in this notice.

To your Family: Family members will not have access to your mental health information unless you give me authorization or in case of any emergency. In the case of a minor, mental health information will only be released for the purpose of payment, scheduling, or an emergency, or for therapeutic purposes at the therapist's discretion. Only a custodial parent or legal guardian can have access to this information.

Marketing Health Related Services: I will not use your mental health information for marketing communications without your written authorization.

Legal Subpoenas: Your mental health records will not be released by an attorney's subpoena unless I receive written consent from you. Under circumstances in which you were seen by me with your spouse, records that pertain to your sessions as a couple cannot be release without consent from each individual.

Abuse or Neglect: I may disclose your health information to appropriate authorities if I reasonably believe that you, or a minor in your care, are a possible victim of abuse or neglect. I may disclose your mental health information to the extent necessary to avert a serious threat to your health or safety or the health of others. I may disclose your mental health information if I have reasonable cause to believe that you are the perpetrator of child abuse or neglect.

National Security: I am required by law to disclose to authorized federal officials mental health information that represents a threat to national security.

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Patient Rights

Access: You have the right to obtain copies of your mental health information and records. You must make a request in writing to obtain access to your mental health information. You may obtain your records by submitting a written request to my office.

Disclosure: You have the right to be informed of instances in which your mental health information or records are disclosed, if for reasons other than treatment or payment.

Restriction: You have the right to request that I place additional restrictions on our use or disclosure of your mental health information. I am not required to agree to these additional restrictions, but if I do, I will abide by our agreement except in the case of an emergency.

Amendment: You have the right to request that I amend your mental health information. Your request must be in writing explaining why the information should be amended. I may deny your request under certain circumstances.

_____: Initials indicating that you have read and understand the Privacy Practices document.

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Confidentiality and Mandatory Disclosure

Counseling sometimes involves sharing sensitive and personal information. In recognition of this, ethical guidelines, as well as the statutory laws of Arkansas, require that all interactions between a client and myself remain confidential. This includes your records, content of your sessions and our appointment schedule. I will take the utmost care to protect your privacy and confidentiality.

Exceptions to Confidentiality

The vast majority of clients, no exceptions to confidentiality are made. But confidentiality is not absolute. The following is a list of the only exceptions in which I would disclose information regarding a client.

1. If a client requests in writing that information about their counseling be released and shared with a specific individual(s). A "Release of Information" form must be completed and signed by the client before this communication can take place. The client can specify what information can (and cannot) be released. These forms are available at my office.
2. If a client poses clear and imminent danger to themselves or to others, a mental health professional is legally required to report this to the proper authorities for the protection of the individual ad the community.
3. If a client discloses that physical or sexual abuse or neglect has occurred to:
    a. a person who is under 18 years of age,
    b. an elderly person, or
    c. mentally incompetent person,

    the counselor is required by Arkansas law ("counselors are considered mandated reporters") to report this information to the proper authorities.

The above information describes the limits of professional confidentiality in an individual and/or group session. By signing below, you are saying:

I attest that I have read this information form and the Privacy Practices information form, and that I understand the information and the conditions stated in both, and I agree to receive counseling under these conditions.

_____ _____

Signature of client or legal guardian Date

_____

Please print your name here

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Disclosure Statement and Consent Agreement

Bruce Dodson, MA, LPC

- **Licensed Professional Counselor**
- **National Board Certified Counselor**

I am pleased to have the opportunity to serve you and have included some information you may find helpful for your visit.

Messages: You may call 501-318-1337 with questions and appointment request and your message will be taken by Voice Mail. I will contact you at my earliest opportunity during my normal work schedule.

In case of an emergency go immediately to your nearest Emergency Room, or call 911.

Availability: I do not provide 24 hour/ 7 day per week on-call service. There are days each week when I am not in my counseling office. If this does not fit with your needs, you may wish to seek therapy in a place where this type of service is provided. I would be glad to help you with a referral.

Appointments: Services are by appointment only. This time is reserved for you only. ***It is therefore necessary to charge for failed appointments which are not canceled 24 hours in advance. I cannot bill your insurance for missed appointments so you will be responsible for the entire fee.***

Fee Policy:

My fees are based on the Fee Policy provided. Please review this policy. I accept payment with cash or check.

I have read and understand the information contained in the Fee Policy. Please check one of the following appropriate statements.

__ I will be paying with cash or check at the time of service and I agree to a payment of $160.00 per session.

__I will use my BCBS health benefits. I agree to pay my co-pay amount of _____ at the time of service, or the percentage of the BCBS allowable charge established by my benefits in the amount of _____..

In case of overdue accounts, I reserve the right to take necessary collection procedures. I will work with you when appropriate to make payment arrangements. If you are unable to pay at the time of service, please bring this to my attention so that me may agree on an arrangement for payment. Chronic nonpayment of fees is appropriate grounds for termination from counseling services.

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Ethical Standards: The practice of counseling is regulated by the Arkansas Board of Examiners in Counseling and Marriage and Family Therapy, Act 593 of 1979 and Act 244 of 1997, The address and telephone number of the Board is: 101 E Capitol, Suite 202, Little Rock, AR 72201. 501-683-5800. If you have a complaint about my services I would ask that you discuss this with me during our counseling session so that we might address your concerns together.

If you feel that a complaint should be filed against me, you can do so by contacting this board.

You may seek a second opinion from another counselor or may terminate counseling with me at any time. If you would like my help with a referral or recommendation I am glad to assist with this.

The practice of counseling in Arkansas is held to the Ethical Standards of the American Counseling Association.

Confidentiality:

In the State of Arkansas any client of a licensed counselor licensed by the Arkansas Board of Examiners in Counseling and Marriage and Family Therapy, Act 593 of 1979 and Act 244 of 1997 have privilege communication. This is the same privilege communication that a client has with their lawyer. In order to release information to anyone, especially in a court of law, requires a written release from all parties under counseling, with the exceptions noted in the following paragraphs. In the context of marriage and relationship counseling, both parties must agree for me to release confidential information.

All information provided by and to a client during counseling sessions is legally confidential with the following exceptions: when you direct me in writing to release information to someone else, and when there is serious potential for suicide or physical harm to self or others. I am also obligated by law to report any known or suspected child/elderly citizen abuse and neglect. Otherwise, information cannot be disclosed without the client's written consent. Your signature below does authorize me to file insurance claims on your behalf when part of our financial agreement includes insurance filing.

Our sessions will be confidential in order to develop a therapeutic relationship. The issues discussed in counseling sessions will not be discussed with anyone outside the counseling session by your counselor. It is important for you to realize that we have a professional relationship, rather than a personal relationship. Our contact will be limited to the paid sessions that you have with me. Please do not invite me to social gatherings, offer me gifts, or ask me to relate to you in any way outside the counseling sessions. If we meet outside the counseling session I will not indicate that I know you (unless you choose to speak to me), or speak of or discuss any issues that are related to your counseling.

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You will be best served if the relationship stays strictly professional and our sessions concentrate exclusively on your concerns. You will learn a great deal about me as we work together during your counseling experience. However, it is important for you to remember that you are only experiencing me in my professional role. It is important that a therapeutic relationship exist so that your issues can be discussed without fear of others learning of them.

I do not accept friend request from current or former clients on social media or social networking sites due to the fact that these sites can compromise client's confidentiality and privacy. For the same reason I request that clients do not communicate with me via any interactive or social networking websites.

Please restrict email and text communications for appointment setting and rescheduling purposes only. No personal or sensitive information should be shared through email or text messaging.

Therapeutic Expectations: My role as a counselor is to assist and challenge you in movement toward your goals and increased emotional, physical, and spiritual health. Your willingness to participate in the counseling process is essential for this growth to occur. While some clients may only need a few sessions to feel successful in accomplishing their goals, others may require months or even years of counseling. The duration of counseling is determined individually on a case by case basis depending on the client's needs.

Benefits from counseling depend upon many factors, such as keeping your appointments, providing accurate information to your counselor, being receptive to change, and be willing to complete any assigned work before the next session, I assure you that my services will be provided in a professional manor based on ethical and legal standards of practice according to the most current ACA Code of Ethics.

Counseling services are voluntary in that you decide what issues to discuss in your sessions or if you want to schedule more counseling sessions unless court ordered or job related. A decision to terminate the counseling relationship is best implemented when it is a decision arrived at though an agreement of both you and your counselor.

My practice and methods of counseling consist of methods and theories that address the whole person (body, mind and soul) influenced by Adlerian concepts. My methodology is informed by developmental theories of human growth and change, awareness of self, acceptance and experiential change. I also use some forms of Cognitive Behavior based techniques. I believe in being a person centered and supportive therapist for my clients.

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I welcome and work with clients from a variety of spiritual backgrounds or with no spiritual preferences, I do have a Christian worldview that informs how I understand people, problems, and lifes difficulties along with solutions as I serve my clients. This orientation informs how I use and implement proven and effective treatments and interventions commonly found in the field of psychology and counseling.

I do reserve the right to make therapeutic decisions regarding your treatment, which may include referring you to another counselor and/or terminating treatment. That decision will be discussed and processed together when applicable.

If you are not satisfied with my services for any reason, please let me know. If I am not able to resolve your concerns, I will assist you by making an appropriate referral to the proper service or counselor.

Credentials: You are entitled to the name, business address, business phone number, and a listing of degrees, credentials, and licenses of the counselor providing counseling services to you. I hold a Master of Arts degree in Counseling from Denver Seminary, and a National Certification from the National Board for Certified Counselors. I am licensed as a Licensed Professional Counselor by the State of Arkansas.

Court Appearance: If I am subpoenaed to testify in any court setting you will be charged a daily rate of $1,000.00. This will have to be paid in cash or cashiers check prior to me going to court.

Incapacitation: In the event that I am unexpectedly unable to continue providing counseling services to you due to my illness or death, Karen Bozeman LCSW will be my Records Custodian and referral coordinator. She will have no access to your file or information prior to such an event.

_____ _____

Client signature (parent or guardian for minor) Date

_____ _____

Client Signature Date

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Arkansas Department of Health Covid-19 Guidelines

As mandated by the ADH, the following actions are necessary to provide a safe working environment and to comply with ADH guidelines.

Wear a mask while in the building and in the waiting room. Social distance 6-8 feet when possible in my office.

Each person will have to be screened according to the following ADH criteria:

Screening criteria

- Take the temperature of each person upon arrival at the facility each day. Employees, screening should be done prior to every shift.

Deny entry to any person who meets any of the following criteria:

- A temperature of 100.4°F or above.
- Signs or symptoms of a respiratory infection, such as a cough, shortness of breath, sore throat, and low-grade fever.
- In the previous 14 days has had contact with someone with a confirmed diagnosis of COVID-19 or someone who is currently being tested for COVID-19
- In the previous 14 days has traveled outside of the United States or to areas in the US with widespread transmission such as New York State, New Jersey, Connecticut and New Orleans.

If any of the above criteria are not satisfactorily satisfied, we will need to reschedule our appointment. I offer TeleMental Health as one of my services. We can discuss this option should you desire or be required to.