THE BARNABAS CENTER
A COUNSELING, TRAINING & TEACHING MINISTRY

We are grateful that you have chosen to contact the Barnabas Center. We know that the choice to call is always one that is weighed carefully. We have emailed several important papers that will assist your counselor in working with you. Please look over each of the following, and fill out the information where necessary.

- New Client Information Form - Please completely fill out all of the required information and bring it with you.
- Client Disclosure Statements - Please read over this sheet carefully. The statement reveals information about our counseling policies, what to expect from counseling, and what your counselor will expect from you. Please sign and bring **two** signed copies to your initial appointment.
- See the Disclosure Statement for details regarding counseling fees and scholarship assistance.
- Privacy Practices – Please read and sign.
- Ministry Mailings– Please sign up on the front page of the client intake sheet if you would like to receive mailings or emails. Please note clarification on the last page of this document.

Please be sure to bring the completed paperwork with you 15 minutes before your first appointment time. All personal information will be held strictly confidential.

For directions, reading materials and opportunities through the Barnabas Center, we invite you to visit our website at www.thebarnabascenter.org. Please call us if you are interested in finding out more about the groups or seminars listed there.

We look forward to working together.

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Office Use Only
Counselor: _____
DOFA: _____/_____/_____
Intake Location: _____

CLIENT INTAKE

Date Form Submitted: ___/___/____

Client Information

Title (Mr., Mrs., Dr., etc.):_____ First Name: _____ Last Name: _____
Middle: _____ Goes by: _____ Suffix: _____ Male ☐ Female ☐
Home Address: _____ City: _____
State: _____ Zip Code: _____ Email: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

*Please indicate a (_*_) by the phone number and email you prefer us to use for communications about scheduling or billing.*

Date of Birth: _____ Age: _____ Racial/Ethnic Identity: _____
Spouse (if applicable): _____ Local Church/Pastor:_____
Employer: _____ Job Title: _____
Referred by: _____ Intake location: ☐Charlotte ☐ Harrisburg ☐ Davidson
Requesting: Individual Counseling _____ Couples Counseling _____ Group ____ Family _____ Consultation: _____
Emergency Contact Person: _____ Phone: _____ Relation to You: _____
Will another party be involved in payment (Church, Sponsor, Etc.)? :_____

Ministry Mailings: *Please note that what is sent by email is different than what is sent by mail and note back page*

- ☐ Yes, I would like to receive emails about events and news for The Barnabas Center ministries and programs. If different from above, please provide appropriate email here: _____
- ☐ Yes, I would like to receive the quarterly mailings about the ministry (Barnabas newsletters, annual report, Christmas story, and end of fiscal year letter). If different from above: _____

Education

High School Grade Completed _____ Do you have a High School Diploma/GED? Yes ☐ No ☐
Business/Technical School: _____ Course of Study: _____
Name of College/University: _____ Graduate? Yes ☐ No ☐ Major: _____
Graduate School Name: _____ Area of Study: _____ Graduate? Yes ☐ No ☐

Current Relationship Status

Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other:_____
If single, are you in a significant relationship? Yes ☐ No ☐ If married, Anniversary Date: _____
Have you been previously married? Yes ☐ No ☐ If separated, divorced, or widowed, how long? _____
Do you have children, if so please list their names with their ages here:
Name: _____ DOB: _____ Name: _____ DOB: _____
Name: _____ DOB: _____ Name: _____ DOB: _____
Name: _____ DOB: _____ Name: _____ DOB: _____

Previous Counseling

When:_____ Counselor(s):_____

Reason:_____

Reason for counseling now? _____

How long have you had these concerns? _____

Medical

Are you currently taking any prescribed or non-prescribed medications? Yes ☐ No ☐

List current medications and dosage:_____

Physician's Name and Phone Number: _____

Please comment on any other physical problems that you would like us to know about: _____

_____

Are you being treated for any medical concerns at this time? Yes ☐ No ☐

Recent losses, deaths of family/friends or other significant life changes? Yes ☐ No ☐ If yes please explain:

_____

PRESENT CONCERNS

Check all that apply	Concern
❑	Abuse- I am needing to address concerns related to physical abuse, sexual abuse, verbal (emotional) abuse and / or neglect
❑	Addiction
❑	Aggression, violence
❑	Alcohol use
❑	Anger, hostility, arguing, irritability
❑	Anxiety, nervousness
❑	Attention, concentration, distractibility
❑	Career concerns, goals, and choices
❑	Childhood issues (your own childhood)
❑	Children, childcare, parenting
❑	Codependence – unhealthy attachments
❑	Confusion
❑	Compulsions, addictions
❑	Decision-making, indecision, mixed feelings, putting off decisions
❑	Delusions (false ideas)
❑	Dependence
❑	Depression, low mood, sadness, crying
❑	Divorce, separation
❑	Doubts – Spiritually, Relationally, Self
❑	Drug use—prescription medications, over-the-counter medications, street drugs
❑	Eating problems—over-eating, under-eating, appetite, vomiting (see also "Weight and diet issues")
❑	Emptiness
❑	Failure
❑	Fatigue, tiredness, low energy
❑	Fears, phobias
❑	Financial or money troubles, debt, impulsive spending, low income
❑	Friendships
❑	Gambling
❑	Grieving, mourning, deaths, losses, divorce
❑	Guilt

❑	Headaches, other kinds of pains
❑	Health, illness, medical concerns, physical problems
❑	Inferiority feelings
❑	Interpersonal conflicts
❑	Internet Addiction
❑	Impulsiveness, loss of control, outbursts
❑	Irresponsibility
❑	Judgment problems, risk taking
❑	Legal matters, charges, suits
❑	Loneliness
❑	Marital conflict, distance / coldness, infidelity / affairs, remarriage
❑	Memory problems
❑	Menstrual problems, PMS, menopause
❑	Mood swings
❑	Motivation, laziness
❑	Nervousness, tension
❑	Obsessions, compulsions (thoughts or actions that repeat themselves)
❑	Over sensitivity to rejection
❑	Panic or anxiety attacks
❑	Perfectionism
❑	Pessimism
❑	Procrastination, work inhibitions, laziness
❑	Relationship problems
❑	School problems
❑	Self-centeredness
❑	Self-esteem
❑	Self-neglect, poor self-care
❑	Sexual issues, dysfunctions, conflicts, desire differences, addiction, other (see "Abuse")
❑	Shyness, over sensitivity to criticism
❑	Sleep problems—too much, too little, insomnia, and nightmares
❑	Smoking and tobacco use
❑	Stress, relaxation, stress management, stress disorders, tension
❑	Suspiciousness
❑	Suicidal thoughts
❑	Temper problems, self-control, low frustration tolerance
❑	Thought disorganization and confusion
❑	Threats, violence
❑	Weight and diet issues
❑	Withdrawal, isolating
❑	Work problems: employment, workaholism / overworking, can't keep a job
❑	Other:

Any other concerns or comments pertaining to your current circumstance:

_____

_____

Please answer the following: (attach additional pages if needed)

1) You may have tried a number of things to cope with the issues that bring you to counseling now. Please describe what you have tried and how successful your efforts have been.

_____

2) If our work in counseling is successful, in what ways do you think you or your life might be changed?

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PRIVACY PRACTICES

This notice describes how your personal information given to us for counseling may be used and disclosed. It also explains how you can get access to your information if needed. Please review it carefully and initial or sign where indicated.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires that all health care providers protect the health information disclosed in any form (whether it be oral, written, or electronic) and that it be kept confidential. This federal law gives you, the client, significant rights to both understand and control how your health information is used. HIPAA provides penalties to covered entities that misuse personal health information. As required by HIPAA, this is an explanation of how your privacy will be maintained and how your information could be used or disclosed.

We are required by law to protect the privacy of health information that can be identified with you, which we call "protected health information, or "PHI" in the abbreviated form. It is our duty to:

- Protect PHI that we have received about your past, present, or future health condition; health care that we give to you; or in regards to payment for services.
- Provide you with information about how we protect PHI about you as well as when and how the information is disclosed.
- Make you aware of any changes to this Notice and post it here at the office.

In most cases, North Carolina law generally restricts our disclosure of your health information. However, we may use your PHI without your authorization for the following circumstances:

- To provide health care treatment to you or to refer you to another healthcare professional. This includes communicating with other health care providers in order to coordinate and manage your care.
- To obtain payment for services. When an itemized bill is requested in order to receive reimbursement for services, the procedure code and diagnosis would be disclosed by The Barnabas Center staff to your insurance company.
- To abide by the law. This includes when a disclosure is required by federal, state, or local law.
- When use or disclosure is needed for public health activities or health oversight activities. This involves reporting to appropriate authorities if you have been subjected to a communicable disease or if you are at risk to spread it to others and cause harm.
- When the disclosure is for judicial or administrative proceedings. We may disclose PHI about you in response to a court order.
- To prevent serious threat to health or safety of others. When the disclosure involves victims of abuse, neglect, or domestic violence.
- To contact you to provide a reminder about an upcoming appointment.

Effective date of this notice: December 3, 2014

Your written authorization will be required for any other uses or disclosures. Should you choose to revoke your authorization, you may do so only in writing. We will abide by your written request with the exception of information we released upon obtaining the written authorization and releasing of information as required by law.

You may contact our Privacy Officer in writing to invoke your following rights:

- You may request in writing that your PHI be restricted in use and disclosure to family members and relatives, friends, or others you identify. We do reserve the right to deny this request.
- You may request an amendment to your Protected Health Information.
- You may request alternative means or locations in which you receive confidential communications.
- You may request an accounting of disclosures of Protected Health Information beyond treatment, payment, and health care operations.

It is required by law to protect the privacy of your Protected Health Information and to abide by the terms of the Notice of Privacy Practices. Occasionally, revisions to the Notice of Privacy Practices will be made in accordance with the law. You may obtain a written copy of these changes by written request. Further, a general summary of the HIPAA Privacy Rule may be obtained at: http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html.

You may file a formal, written complaint with us at the address below or with the Department of Health & Human Services, Office of Civil Rights, if you feel your privacy rights have been violated.

For more information regarding our Privacy Practices, please contact:

The Privacy Officer

John D. Pierce, MA, LPC

413 S. Sharon Amity

Charlotte, NC 28211

For more information about HIPAA or to file a complaint, please contact:

The U.S. Department of Health & Human Services

Office of Civil Rights

200 Independence Avenue, S.W.

Washington, D.C. 20201

877-696-6775 (Toll free)

Effective date of this notice: December 3, 2014

THE BARNABAS CENTER
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NOTICE OF THE BARNABAS CENTER

PRIVACY PRACTICES

Date: ___/____/_____

My signature below on this document is an acknowledgement that I have:

_____ Been informed about how my privacy will be maintained and kept confidential by The Barnabas Center.

_____ Requested and received a copy of The Barnabas Center's Notice of Privacy Practices.

Client Signature

The Barnabas Center Witness

Effective date of this notice: December 3, 2014

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INFORMED CONSENT

Please initial to communicate your understanding:

1. Confidentiality

_____ The Barnabas Center complies with HIPAA guidelines that are relevant to our services provided.

_____ Your health information will be accessed by your counselor and other staff necessary in order to schedule, provide, and record or bill for services.

_____ Information may be released if you are thought to be an imminent threat to harming yourself or others.

_____ If you choose to use insurance to help pay, some information could be released to the insurance company that is required such as procedure code, date of service, or diagnosis. The Barnabas Center will not directly bill insurance as you are responsible for requesting reimbursement.

_____ The Barnabas Center may release protected health information if subpoenaed properly under applicable state or federal rules.

_____ The Barnabas Center counselors meet weekly for supervision in order to maintain accountability and gather other professional input about their work with you. When presented, all identifying data of the client is disguised in order to protect confidentiality.

2. Ethics

_____ Your counselor is required to adhere to a code of ethics governing conduct of his/her counseling work. A copy of the code is available upon request.

3. Clinical Processes and Disclosures

_____ Clinical Emergencies: The Barnabas Center is not a crisis center. It is not always possible for your counselor to respond to you in a crisis or emergency situation. If you cannot reach your counselor and are experiencing an emergency, you are to call 911 or go to the nearest Emergency Room.

_____ Risks Associated with Treatment: In the course of receiving services, additional psychological needs may surface which may increase your level of distress for some period of time.

_____ Treatment Outcomes: While the services provided by The Barnabas Center are intended to benefit the client, no particular treatment outcome can be guaranteed.

_____ Right to Discontinue Treatment: You have the right to discontinue treatment at any time. We recommend, however, that you discuss these plans with your counselor before making a decision to discontinue.

Effective date of this notice: December 3, 2014

_____ Complaints/Concerns: If you have complaints or concerns about the services, please contact John Pierce at (704) 365-4545, ext. 305.

4. Financial Policies

_____ Payment is expected at the time of service. We accept cash, check, or debit/credit cards. There will be a fee for returned checks.

_____ You are responsible for the full fee for any session cancelled less than 24 business hours beforehand.

5. Electronic Communications

The governance of electronic communication and provision of services through email, Skype, or other electronic means is still being discussed by professional bodies and various legislative groups. Below are potential risks:

The Barnabas Center cannot guarantee the same security, confidentiality, and privacy as is provided in face-to-face sessions. We will do all we can to protect and encrypt.

There is an indeterminable risk that electronic communications may be intercepted by a third party and shared with others without your permission.

Emails should not be used for sending sensitive info or for emergencies or urgent issues, as emails are not always delivered correctly.

I will not hold The Barnabas Center responsible for breaches of privacy that occur if a third party accesses your email to or from The Barnabas Center.

Please initial to communicate your understanding:

_____ I have read and understand the risks of electronic communications.

By signing below, I indicate that I have had the opportunity to read and ask questions before giving my consent for services. I have now read and understand The Barnabas Center's policies and give my informed consent to abide by them.

_____ _____

Signature of Responsible Party Date

Effective date of this notice: December 3, 2014

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SIGN-UP FOR MINISTRY MAILINGS

By checking the boxes on the first page of the intake packet, you are giving our ministry communications department permission to contact you via mail or email to notify you of upcoming events or general ministry news.

Our ministry communications department is a separate division of our organization and is never made aware of information pertaining to counseling clients.

Your contact information will only be used to notify you about The Barnabas Center and will never be sold or given to a third party.

Opt-out clause: *At any time if you no longer want to receive our emails you may click the "safe unsubscribe" button at the bottom of any email and you will be unsubscribed to any future email communications If at any time you would like to be removed from our mailing list please email info@thebarnabascenter.org or call 704-365-4545 and request to be removed from our mailing list.*