

**IMPROVIZION CONSULTING AT
UNITY CENTER FOR CONSCIOUS LIVING
DIAMOND HEAD CIRCLE, HONOLULU, HAWAII
808-397-1528**

COUNSELING INFORMATION FOR THE CLIENT

Improvizion Consulting, located at Unity Center for Conscious Living, provides professional counseling and coaching services. The purpose of these services is to help people help themselves. It is based on the belief that we all have or can find the necessary resources with which to cope with life's issues and problems. Sometimes, however, we don't know what to do and with the help of other support we can explore alternative ways of behaving and thinking and find new patterns of living. The therapeutic orientation of Improvizion Consulting is based on Wellness and Wholeness and Helping people help themselves through physical, mental, emotional and spiritual balance.

You will be working with Vali J. Hawkins Mitchell, Ph.D. She has a Doctorate in Health Education from Walden University, a Master's degree and Bachelor's degree in Applied Psychology from Eastern Washington University. She has been working as a counselor, coach, consultant and educator since 1985. She is a Licensed Mental Health Counselor (Hawaii Lic#214, WA Lic#3428). Her work experience includes four years for the State of Washington as a Welfare Eligibility Examiner, six months as a Child Abuse Case Manager for the State of Arizona, two years as a Counselor for Southwest Oregon Community College, and five years as faculty for Lane Community College. She has also worked as a consultant for businesses and agencies, as well as providing educational seminars and workshops nationwide. She is a well-published writer, musician, and composer. She works in the field of Critical Incident Stress Management and Disaster Services for several organizations. She has been awarded a grant to complete primary medical research in the field of Diabetes, and has received national attention on the topic of Diabetes. Her research includes the topics of: Therapeutic Writing as Diversion for Violent Felons and Victims of Violence; Diabetes and Family Violence; Psychosocial Dynamics of Families with Chronic Pediatric Illness; and The Use of Programmed Writing for Anxiety Reduction for Health. Her methods and techniques are varied, depending on the client's needs and goals. She offers a psycho-educational model, using a pro-active role with clients maintaining the responsibility to monitor their own goals and activities, while providing techniques and ideas for educational consideration. Those ideas may include but are not limited to therapeutic writing, the appropriate use of exercise, films, music, art, and suggested readings or continuing education opportunities. Coaching clients are not treated for issues related to mental health concerns, and will be appropriately referred to other licensed professionals if therapeutic services seem indicated. Dr. Vali is a mandated reporter and although not held to that standard by current coaching standards, will maintain that ethical standard as a Licensed Mental Health Counselor as agreed to by the Coaching Agreement.

You are welcome to see Dr. Vali's complete CV at www.drvali.com

IMPROVIZION CONSULTING CLIENT INTAKE INFORMATION

All information on this form is confidential and will not be released without your written consent.

SECTION 1 - PATIENT INFORMATION

First Name _____ Middle _____ Last _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Marital Status: Single Married Other

Home Phone _____ OK to Leave Message

Work/Message Phone _____ Ok to Leave Message

Cell Phone _____ Ok to Leave Message

Social Security Number _____ Gender: Male Female

Employer or School _____

Employed Full-Time Student Part-Time Student

Referred By _____

List all persons living in your household

Name	D.O.B.	Relationship to Patient
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pets _____

Emergency Contact _____ Phone _____

Relationship to Patient _____

Are you presently under a physician's care?

No

Yes

Physician's Name _____

Is the patient covered by insurance? No (GO TO SECTION 4) Yes (GO TO SECTION 2 and 3)

SECTION 2 - INSURED INFORMATION

PATIENT RELATIONSHIP TO INSURED:

SELF (Go to Section 3) SPOUSE CHILD OTHER

INSURED'S INFORMATION

First name _____ Middle _____ Last _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Date of Birth _____

Gender: Male Female

Employer or School _____

Employed Full-Time Student Part-Time Student

Work/MessagePhone _____ OtherPhone _____

Social Security Number _____

SECTION 3 - INSURANCE POLICY INFORMATION

Name of Insurance Company _____

Address _____ City/State/Zip _____

Phone _____ Plan Name _____

Policy Number _____ Group Number _____

Is the patient covered by more than one insurance company? No Yes

SECTION 4 - BILLING INFORMATION

Who is responsible for charges for this patient?

Myself the Patient - **This form is now complete.**

Other - **Please complete the following information**

Relationship to Patient _____

First Name _____ Middle _____ Last Name _____

Address City _____ State _____ Zip _____

Work/Message Phone _____ Other Phone _____

Social Security Number _____

IMPROVIZION CONSUTLING AUTHORIZATION FOR TREATMENT

I voluntarily authorize ImproVizion Consulting to provide counseling and therapeutic services. No guarantees have been given as to the result that may be obtained. I understand that the results of my treatment will be largely dependent upon my effort. I also understand that I am encouraged to take responsibility for letting my therapist know what is wanted from counseling, and to tell my therapist if those wants are not being met. I understand that I am free at any time to stop therapy or to transfer to another therapist, and that I can ask any questions concerning my treatment.

I understand that the full fee for services are:

HMSA ALLOWED SERVICES

90801 INITIAL INTERVIEW	\$120.00
90806 FOLLOW-UP SESSIONS	\$93.00

I agree to pay my co-pay of \$ _____ per session

Reduced Rate for Non-Insured and Student Discount

\$80-100 *Pick your payment fee for a Reduced Rate*

\$65-100 *Pick your payment fee at a Student Discount for Students (Current Picture ID)*

I agree to pay a fee of \$ _____ per session

- ❖ I understand that I am responsible for the full fee of each session. I understand that I will be charged for any session that I cancel with less than 24 hours notice to my therapist, or for which I fail to arrive. I understand that Insurance does not cover the fees for no-shows. If my benefits or eligibility status changes, I agree to pay the full fee of provided services
- ❖ I agree to pay a **\$35.00** service charge fee for every check returned NSF and understand that these checks will be turned over to Collections. I understand that if I have an unpaid balance at the end of treatment and do not respond to consecutive billings, that ImproVizion Consulting may release information about my account to the collection agency and that ImproVizion Consulting will be entitled to a \$25.00 administrative fee if my account is turned over to collections.
- ❖ I authorize ImproVizion Consulting to release to my insurance company information necessary to process my claim. I authorize my insurance benefits to be paid directly to the provider, and understand that I am financially responsible for non-covered services.
- ❖ I have been provided a copy of "Counseling Information for the Client" and Statement of Client Rights forms. I have read and understand all of the information provided and the terms for counseling services at ImproVizion Consulting and agree to these terms.

CLIENT SIGNATURE (PARENT SIGNATURE IF CLIENT IS A MINOR)

DATE

COUNSELOR SIGNATURE

DATE

IMPROVIZION CONSULTING CLIENT RIGHTS

(IF YOU HAVE ANY QUESTIONS, PLEASE ASK)

- A) Clients have the right to be treated with dignity and in a manner that promotes self-respect.
- B) You have the right to be protected from invasion of privacy, and have information about you treated confidentially. Any information that you share is confidential and will not be released to anyone outside the agency without your written permission except as required by Hawaii State law, which includes the following:
 - 1. If there is evidence to suggest that child abuse or neglect or elder abuse or neglect has recently occurred in your family, we are required to report this to local authorities.
 - 2. If any family members make statements to us that indicate the likelihood of harming themselves or others, we may make the judgment that it is in the member's own best interest to intervene in some way.
 - 3. If it is revealed to us that a crime has been committed, we are not required to treat this information as confidential.
 - 4. If you are under 18 years old and the victim of a crime, which includes physical and sexual abuse, we are not required to treat this information as confidential.
 - 5. If you bring charges against your counselor we may release your records.
 - 6. If we receive a legitimate subpoena we are required to comply.
 - 7. In the case of your death or disability, information may be released to your legal representative only.
 - 8. If another licensed health care provider reasonably believes that disclosure will avoid or minimize an imminent danger to the health or safety of you or another individual, we are not required to treat your information as confidential and may decide to disclose necessary information.
- C) You have the responsibility to control your own therapy, and to actively participate in the development or modification of your treatment program.
- D) You have the right to ask questions if you do not clearly understand what your counselor intends to do, and to ask about the proposed course of treatment.
- E) You have the right to be provided treatment in accordance with accepted quality-of-care standards that are responsive to your best interests and particular needs.
- F) You do not need to become dependent on your counselor, and are urged to seek assistance that puts you in control of your therapy and your life.
- G) You have the right to be treated without regard to physical or mental disability, unless such disability makes treatment non beneficial or hazardous.
- H) You have the right to be treated without regard to race, color, creed, national origin, sex, sexual preference, age, or religion.
- I) You have the right to be fully informed regarding fees to be charged and method of payment.
- J) You have the right to refuse treatment.
- K) You have the responsibility of choosing the provider and treatment that best suits your needs.
- L) A record of the mental health care provided to you is kept by this office. You may ask to see and copy that record. You may also ask this office to correct that record, if you believe the information within your record is in error. A copy of your corrections to the office records will be placed within your record, at your request. You may see your record, or get more information about it, at this office.
- M) All clients may at any time express a grievance or complaint to their counselor. If this does not bring satisfaction, the client may ask to see the counselor's supervisor. If your complaint is not resolved, you may contact the Department of Licensing in Honolulu to file a complaint. You have the right at any time to ask questions or file a complaint with the Department of Licensing but we would like to attempt to resolve the issue first!