New Leaf Counseling, PLLC

New Client Intake Form

Please answer the following questions to the best of your ability. This will help me get a better understanding of your background and the concerns you have.

Date: _____ Client Name: _____

If the client is a minor child, parent's name: _____

Date of Birth: _____ Gender: _____

Address, City, Zip:,_____

Mailing address: _____

Phone numbers: Home: _____ Cell:_____

Work:_____ Email address: _ _ _ _ _ _ _ _ _ _ _ _ _ _

**Whom may we thank for* your *referral to New Leaf Counseling?* _____

Emergency Contact & Phone: _____

Have you previously been in therapy? ☐ yes ☐ no

If yes, how old were you? _____

How long were you in therapy? _____

What issue(s) were you addressing?

_____

Do you currently see a psychiatrist? ☐ YES ☐ NO

Medications you are taking: _____

Who is your personal doctor? _____

Do you have any health issues? _____

What are you hoping to accomplish in **our counseling work together?**

_____

_____

New Leaf Counseling, PLLC

Informed Consent for Psychotherapy

Client:_____

Risks and Benefits of Therapy

By signing below, I **understand that** psychotherapy involves identifying goals for change in individuals, a couple, or a family system and working toward those goals through a therapeutic relationship. I understand that we will review goals about every ten sessions. I agree to communicate with my therapist about my progress and concerns. I know that with therapy, I may have thoughts or feelings that are uncomfortable and/or negative. I voluntarily enter into this agreement for therapy with New Leaf Counseling, PLLC and my assigned therapist. I agree to accept psychotherapy and counseling services from the assigned provider. I understand that no promises have been made to me in connection with therapy services. My questions about therapy have been answered satisfactorily. I understand that I may stop my treatment with this therapist at any time. I will, however, be responsible for paying for services I have already received.

Our therapists' work is to provide ***effective*** and ***ethical*** mental health treatment. To be ethical, therapists must avoid situations where we serve in any other role to the client (e.g. acting as a witness for a parent while also serving as a therapist to a child client or acting as a witness for an adult while also serving as the adult's therapist). **Our therapists do not participate in legal matters related to clients.** If our therapists are asked to provide relevant information via phone calls, emails or letters supporting a client's legal issues, we will charge an hourly rate of $150 for these services, and those cannot be billed to insurance. If our therapists are required by subpoena to attend court proceedings, the same rate applies. Driving time to and from court as well as any therapist preparation work is also billed to the client at the above rate.

Confidentiality

By signing below, I **understand that** all communication between the client and therapist will be held in confidence and will not be revealed to anyone outside of this office unless I give written authorization to release the information. I understand that my therapist mayseek professional consultation about my case and that in doingso, my therapist will make every effort to consult in a way that protects myidentity from being revealed. There are legal and ethical exceptions to confidentiality, however, which require that the therapist take responsible action. These limits apply:

1. When there is a clear and present danger of harm to yourself or another person.
2. In the case of apparent child abuse or abuse of a disabled or dependent adult.
3. In the event of a court order for information.

Insurance companies and other third party payers may also access information they request regarding therapy services for a covered individual.

****By signing below,** I **acknowledge that** I **have read and understand the above infOl'mation.**

Signature:_____ Date:_____ __

Relationship to Client: _____ __

New Leaf Counseling, PLLC

Patient Rights and HIPAA Privacy Information

Client's Name: _____

Client's Rights

New Leaf Counseling is legally required by HIPM to maintain the privacy of your protected health information. You have the right to ask for a copy of information that is transmitted about your care as authorized by your signed release of information. You have the right to cancel a release of information by writing to New Counseling, 910 23'd Ave, Suite 100, Coralville, IA 52241. You have the right to request treatment note summaries. You have a right to notice of any privacy breaches, and a right to restrict disclosures of protected health information if you are self-paying. You have a right to opt out of any fundraising communications *(not applicable at this office).* You have the right to address a complaint about New Leaf's HIPM privacy policies by writing to New Leaf Counseling. You may address written requests, inquiries, or complaints to Annika Ross, LISW. More information about HIPAA can be found online at www.hhs.gov. You have a right to a copy of this notice if you wish.

Care of Children

If you are the parent or guardian of a child who is a therapy client here, New Leaf Counseling requests that you do not ask to see notes about your child's care. This is to ensure the success of therapeutic relationship and to ensure the child's trust. If you consult with the assigned therapist about your child's progress, please know that your therapist may share that information with the child as a part of treatment. If a minor reveals to us that he/she is thinking seriously about killing or seriously injuring himself/herself, we will discuss this with the parents/guardians.

Use and Disclosure of Protected Health Information

We keep your protected health information confidential unless you have authorized disclosure through a signed release of information or disclosure is required by law. Protected health information is disclosed for purposes of filing claims for your health insurance. If **we learn of suspected or alleged abuse of a child, dependent, or disabled adult disclosure** to **the appropriate state agency** is **required.** If we believe a client is threatening serious bodily harm to another individual, we must disclose information to protect the individual from harm. If we suspect a client is at serious risk of harining himself or herself, we may advise hospitalization of him or her and/or contact family members or listed emergency contacts. We may occasionally seek the consultation of a professional about a case. If consultation is done, every effort is made to protect the client's identity. We may have to violate confidentiality in the event of non-payment, in the use of collections procedures.

By signing, I acknowledge that I understand and agree to the HIPM policies of New Leaf Counseling, PLLC.

Client/Parent Signature: _____ **Date:** _____

Indicate your billing preference by checking one:

_____ Iwould like to pay out-of-pocket

_____Iwould like to use my insurance to pay

Insurance Information (complete if using insurance)

Primary lnsured's name (who is listed on the card):

_____

If* **someone *other than the client is the primary insured, please indicate the following:*

Primary insured's birthdate: _____

Primary insured's address: _____

Primary insured's place of employment: __

Primary insured's phone: _____

Insurance Clients: Read and Sign Here

Acknowledgement of New Leaf Counseling's Insurance Policy

**By signing below, I show that I understand the following and agree to abide by the payment and billing policies ofNew Leaf Counseling:*

- New Leaf Counseling, PLLC is an in-network provider for my insurance policy.
- Mental health benefits that are billed as an office visit are approved.
- The credentials LISW is reimbursable.
- I know the **limited number of sessions** authorized per year as well as my co-insurance and deductible.
- **If my insurance is rejected for any reason, I am ultimately responsible for payment and will pay the full-fee amount, or will payremaining costs not covered by insurance.**
- I **agree to notify New Leaf Counseling immediately of any changes to my insurance.**
- I authorize billing and limited release of protected health information to my insurance company and their payment to New Leaf Counseling, **PLLC.**
- I agree to provide payment at the time of service. If I do not provide payment at the time of service, my treatment may be suspended.

Signed:_____ __

Date:_____ __

Full-Fee Clients (complete if paying out-of-pocket)

Fees charged at New Leaf vary according to services. If you are paying out of pocket, we will give you a fee sheet showing our charges, and a Good Faith Estimate of Services, as required by the No Surprises Act.

Acknowledgement of New Leaf Counseling's Private Pay Policy

**By signing below, I show that I understand the following and agree to abide by the payment and billing policies of New Leaf Counseling:*

- I agree to pay privately for counseling services.
- I understand that, should I start to use my insurance policy, that no previous sessions can be billed to my insurance. Our office can provide a detailed receipt upon request for your own submission to insurance.
- I agree to provide payment at the time of service. If I do not provide payment at the time of service, my treatment may be suspended.

Signed:_____ __
Date:_____ __

No-show/late cancellation policies:

- 24-hour notice is required to cancel an appointment.
- **We do not charge if you cancel for an emergency such as illness, your car breaking down, or inclement weather.**
- **We charge for appointments that are not attended/no-showed,** and for appointments that are canceled within 24 hours of the appointment for non-emergency reasons (e.g. you forgot you had to work, realized you needed to study for a test, etc.).
- If **a client does not show up by 20 minutes into his or her appointment** and does not call to let the office know he/she is running late, this is considered a no-showed appointment.
- No-show fees and late cancellation cannot be billed to insurance.

- If an appointment is not kept and ap ropriate notice is not given, the client will be charged a fee at a graduated rate (1st no-show is $50, 2nd is $70, and no-shows beyond that are billed $100).

- Failure to attend appointments and/or to pay fees for services, including no-show fees, may prohibit continued scheduling of services at New Leaf Counseling.

Payment &Billing Policies

- **We will bill your insurance company per your request for services received at our office. Most insurance plans take 3-4 weeks to process claims.**

- We accept cash, check, or debit/credit card charges as payment. **We process debit and credit card payments through Ivy Pay, a HIPAA-compliant online service. Youare required to enter your credit or debit card number and name for the first charge we run, and then we can run charges after that.**

- **We offer 3 ways to pay for services:**

1- We can charge your card on file for your amount due **as your insurance plan processes claims (or as you complete sessions,** if **paying out-of-pocket).**

2- We can charge your card on file for your amount due **on the same date of your choosing each month.**

3- We can charge your card on file for your amount due once a month, **on or about the 1st of each month.**

****Billing Preference****

I prefer to:

___ Have my debit or credit card on file charged as my insurance plan processes claims.

___ Have my debit or credit card on file charged on a date of my choosing each month. That date each month is the ____

_____Have my debit or credit card on file charged once a month on or about the 1st.

Please indicate if you would like:

☐ receipt mailed _____ receipt emailed ____ no receipt

New Leaf Counseling, PLLC
910 23rd Ave Suite 100
Coralville, IA 52241

IVY PAYPAYMENT CONSENT

(Required for treatment)

New Leaf Counseling has switched to Ivy Pay, a credit card processing service that is secure, HIPAA-compliant, and used by many therapists. **The Terms of Use for using Ivy Pay** can be found here: https://www.talktoivy.com/ivy-pay-payor-terms-of-use

Ivy Pay has a few benefits:

- We can charge you for your portion of sessions without swiping a card at each appointment
- The service is secure and compliant with HIPAA standards for client confidentiality
- Your credit card information is stored with Ivy Pay, not in our files or other records. We do not have access to your stored credit card information.

The service works simply:

1. You simply provide a phone number, which our office manager enters into our Ivy Pay app along with a charge for the session foe
2. Ivy Pay texts you a secure link leading to a page where you enter your credit card information and approve the first charge
3. After the first charge goes through, we use Ivy Pay to charge the stored card. The app sends both you and our office a receipt

You will only be asked to enter your credit card information once (unless you need or wish to change the card), and you do not need to download an app or regularly interact with Ivy Pay. We will charge your card using the frequency you selected on your billing intake forms.

******REQUIRED***By signing above, I authorize New Leaf Counseling, PLLC to initiate payment requests through Ivy Pay, a Hf PAA-compliant credit card processing service. I agree to respond to requests for payment in a timely manner and to communicate about any issues or delays I have with this (brent@newleafic.com). Charges I may incur would include co-payments, co-insurance, no-show or late cancellation fees, letter/report-writing, and session charges not covered by my insurance plan.***

Client's signature:._____

Date:_____

Appointment Reminders

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments.

Your name:_____

Where would you like to receive appointment reminders? (check one)

____ Via a text message on my cell phone (normal text message rates wil\ apply)

____ Via an email message to the address listed above

☐ Via an automated telephone message to my home phone

☐ None of the above. I'll remember my appointments on my own.
(Missed appointment fees will still apply)

Your email address:_____

Your cell phone number: _____ __

Appointment infonnation is considered to be "Protected Health Infonnation" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

Signature Date

*****PLEASE DO NOT RELY ON AUTOMATED REMINDERS ALONE TO REMEMBER YOUR APPOINTMENT TIMES-YOU ARE STILL RESPONSIBLE FOR NO-SHOWS EVEN IF YOU DO NOT RECEIVE THESE.***