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? (circle) 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? (circle) 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.

[illegible]

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 may seek professional consultation about my case and that in doing so, my therapist will make every effort to consult in a way that protects my identity 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 information.**

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 HIPAA 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 23rd Ave, Suite 100, Coralville, IA 52241. You have the write 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 HIPAA 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 harming 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 HIPAA policies of New Leaf Counseling, PLLC.

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

Witness Signature: _____ **Date:** _____

New Leaf Counseling

Informed Consent for Electronic Communications and Telehealth Services

Client Name: _____

Confidentiality Considerations Regarding Online Communication

Electronic communication with a therapist, including email and teletherapy (online therapy through a HIPAA-compliant videoconferencing platform), comes with certain inherent risks. While we take great precautions to protect the privacy of our clients while communicating online, we also understand that there is always a risk that online communication may not be secure, and we encourage clients to remember this as they communicate with us. Because we value the privacy of your protected health communication, our therapists limit their contact with clients by email as much as possible. When email is an appropriate and necessary form of communication and when protected health information or PHI is being transmitted, we use an encrypted email service to protect your health information. For our teletherapy services, we currently use a platform called We Counsel.

Risks and Benefits of Teletherapy

Teletherapy has similar benefits to face-to-face psychotherapy appointments, and can support the work done in the therapy office, where appropriate. The same policies regarding treatment, confidentiality and ethics apply to teletherapy as those that apply to face-to-face psychotherapy services. Please read the "Informed Consent for Psychotherapy" document in this packet to review this information.

Our therapists use an online videoconferencing platform called We Counsel to provide teletherapy sessions to client. This is a HIPAA compliant service. **It is important that clients ensure the privacy of teletherapy sessions by choosing a space where only the client and other pre-determined participants are present, and others can not walk in on or hear the session**. To participate in teletherapy, your computer will need a webcam and microphone, or you can use your Smartphone if you wish.

By signing below, you indicate the following:

You indicate that you understand New Leaf's email and electronic services policies, and that you voluntarily accept teletherapy services with your assigned therapist. By signing, you are indicating that no promises regarding outcomes have been made to you in connection with teletherapy services, and that you understand the risks and benefits of these services. You are indicating that any questions you have about teletherapy have been answered. You understand that you may stop teletherapy treatment with your therapist at any time. You will, however, be responsible for paying for services you have already received.

****By signing below, I acknowledge that I have read and understand the above information, and agree to the statements described above.**

Signature:_____ Date: _____

Relationship to Client: _____

New Leaf Counseling, PLLC

Annika Ross, LISW Tara Wilford, LISW Susan Bock, LMHC

Client Name: _____

Primary Insured's name (who is the policy owner):

_____

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

Primary insured's birthdate: _____ ***His/her phone:*** _____

His/her employer: _____

His/her address: _____

Payment Policies

New Leaf Counseling accepts some **private insurance** and **full-fee** payment plans. ***Please note we will process insurance claims through one company only.** If you want to submit secondary claims yourself (if you have two insurance plans), we are happy to provide "super bills" and you can submit secondary claims on your own.

Payment, including co-payment, must be made at **each** session. You are welcome to pay by cash or check. However, **a credit or debit card is required for every client**. This is to be used in the case of no-shows, if you prefer to pay by debit or credit card, or if you cannot pay your co-payment in session (e.g. you forgot your cash or check). **For many clients, we never have to charge the card, but this is a necessary safeguard for our business.**

***No-show fee

24-hour notice is required to cancel an appointment. A **phone call** is expected for cancellations within 24 hours of the appointment. Exceptions include illness and emergency. If an appointment is not kept and appropriate 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 the full out-of-pocket fee). **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 may be considered a no-showed appointment. No-show fees cannot be billed to insurance.

****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.**

Fees charged at New Leaf vary according to services. If you would like a listing of fees for services here (*note, these are subject to change over time), please ask for this.

Indicate your payment preference by checking one:

☐ I would like to pay full-fee **(fill out "full fee clients" section only on next page).**
☐ I would like to use my insurance to pay **(fill out "Insurance clients" section only below).**

Insurance Clients

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 of New 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 and LMHC are 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 pay remaining 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

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.
- 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:_____

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

CREDIT/DEBIT CARD AUTHORIZATION AND AGREEMENT

(Required for treatment)

The purpose of this agreement is twofold.

First, in the unlikely event that you no-show an appointment, and don't respond to billing, this agreement will allow New Leaf to charge the card on file.

Second, if you prefer to pay for counseling services (co-payments, etc.) with a debit or credit card on a per visit basis, this will allow you to pay with a card without worrying about remembering to do so for each appointment.

New Leaf Counseling, PLLC will not use your card information for any purpose other than stated here. This agreement remains in effect for the course of treatment.

Client Name: _____ **Date:** _____
Type of Card: _☐ VISA _☐ MASTERCARD _☐ DISCOVER _☐ AMER. EXPRESS

Name as it appears on card: _____

Card Number: _____-_____-_____-_____ **Exp Date:**_____

CVV number (3 digit number in italics on the back of the card):_____
Cardholder's Billing Address for Card Statements:

_____
Street City State Zip Code

(Required) Card holder's signature:_____

******REQUIRED***By signing above, I authorize New Leaf Counseling, PLLC to charge my debit or credit card for any applicable psychotherapy service fees not covered by insurance, including no-showed appointments, (graduated $50/$70/full-fee charge per missed appointment). Payments are made through Merchant Warehouse.***

(Optional) Card holder's signature:_____

*****By signing above, I authorize New Leaf Counseling, PLLC to charge my debit or credit card for any applicable co-payments or full-fee appointments after each session.***

If I have questions about charges, I agree to contact New Leaf Counseling at brent@newleafic.com or (319) 351-9731. I agree that I will not pursue a refund directly through my related financial institution.

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 will 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 information is considered to be "Protected Health Information" 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.***