



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.

Our therapists' work is to provide *effective* and *ethical* mental health treatment. Ethical treatment means therapists must provide a safe space where the client can feel open to express any feelings. Therapists must avoid situations where we serve in any other role to the client besides therapist, and this goes for children and adult clients. For example, we will not participate in custody disputes or make recommendations as to custody or visitation because it would be harmful to the therapeutic relationship with the child. **Our therapists do not participate in legal matters related to clients.** If our therapists are ordered to do work regarding legal matters including writing reports, making phone calls, or attending court, we will charge the client an hourly rate of \$150 for these services, and this cannot be billed to insurance.

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 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 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: _____



Indicate your billing preference by checking one:

_____ I would like to pay out-of-pocket

_____ I would like to use my insurance to pay

Insurance Information (complete if using insurance)

Primary Insured'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 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 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 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 (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 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 \$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. **A valid debit or credit card must be placed on file for any charges incurred at our office that insurance doesn't cover.**

- **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 (initial one):

_____ 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



Credit/Debit Card Information (required)

***By signing below, I authorize New Leaf Counseling, PLLC to charge my debit or credit card for services that insurance doesn't cover. If I have questions about charges, or need to amend my automatic billing preference indicated above, I agree to contact New Leaf Counseling at Christine@newleafic.com or (319) 351-9731. Automatic Monthly Billing can be changed at any time with a 24 hour notice. If your Automatic payment is rejected by your financial institution, a paper statement will be mailed to the address on file.

Client Name: _____

Type of Card: ___ VISA ___ MASTERCARD ___ DISCOVER ___ AMER. EXPRESS

Card Number: _____ - _____ - _____ - _____

Expiration Date: _____ **CVV number** (3 digit number on the back): _____

Cardholder's Billing Address for Card Statements:

Street

City

State

Zip Code

Name as it appears on card:

Card holder'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 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.**