CLIENT INFORMATION FORMS

CLIENT INFORMATION

Full Name: _____ Sex: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City State ZIP Code

Date of Birth: ____/____/____ Social Security Number: _____

Phone: _____ Email address: _____

Dependent: YES ☐ NO ☐

If yes, Guardian's Name: _____ Guardian's Phone: _____

Guardianship/Custody Info (*Documentation*): _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Relationship: _____

Home phone: _____ Cell: _____

Emergency Contact: _____ Relationship: _____

Home phone: _____ Cell: _____

INSURANCE

*Primary: *will need copy of card**

Insurance: _____ Member ID: _____

Responsible Party: _____ DOB: _____

Relationship to Client: _____ Group Number: _____

Insurance Address: _____ Provider Phone: _____

*Secondary: *will need copy of card**

Insurance: _____ Member ID: _____

Responsible Party: _____ DOB: _____

Relationship to Client: _____ Group Number: _____

Insurance Address: _____ Provider Phone: _____

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge.

I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

Printed Name: _____

Signature: _____ **Date:** _____

Client Information and Acknowledgment of Informed Consent to Treatment Form

Mental Health and Substance Abuse Services

The purpose of receiving mental health or substance abuse care services is to help you better understand your situation, change your behavior or move toward resolving your difficulties. Your therapist, using their knowledge of human development and behavior will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to examine your own feelings, thoughts and behavior, and to try new approaches in order for change to occur. You may bring your family members to a therapy session if you feel this would be helpful or if this is recommended by your therapist.

The services we offer can have benefits and risks. Since treatment often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, mental health and substance abuse care services have also been shown to have benefits for people. Treatment may often lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.

Appointments

Appointments are made by calling (937) 426-2686. A receptionist will be here to take your call; Monday through Friday from 1 PM to 5 PM. Please call to cancel or reschedule at least 24 hours in advance, or you will be charged for the missed appointment. Third party payers will not cover or reimburse for missed appointments. Appointments are 50 minutes in length but may vary for clinical reasons. The number of appointments depends on many factors and will be discussed by your therapist with you.

Relationship

Your relationship with your therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that your therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Your therapist cares about helping you but is not in a position to be your friend or to have a social personal relationship with you.

Goals, Purposes and Techniques

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by your therapist to have input into setting the goals of your therapy. As therapy progresses, these goals may change. You and your therapist will jointly determine how to effect the changes you are seeking to make for yourself.

Confidentiality

The law protects the privacy of all communications between a client and a therapist. In most situations, A New Direction For Counseling can only release information about your treatment to others if you sign a written authorization form.

There are some situations where we are permitted or required to disclose information either with or without your consent or authorization. For example,

- **If you are involved in a court proceeding and a request is made for information concerning your treatment, we cannot provide such information without your (or legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.**
- **If a government agency is requesting the information, we may be required to provide it.**
- **If you file a complaint or lawsuit against us, we may disclose relevant information about you in order to defend the therapists.**
- **If you file a worker's compensation claim, we must, upon appropriate request, provide a copy of your records or a report of your treatment.**

There are some situations in which the therapist is legally obligated to take actions which she or he believes are necessary to attempt to protect others from harm, and we may have to reveal some information about a client's treatment. If such a situation arises, your therapist will make every effort to fully discuss it with you before taking any action and will limit disclosure to what is necessary.

- **If your therapist has reason to believe that a child or vulnerable adult is being neglected or abused, the law requires that the situation be reported to the appropriate state agency.**
- **If the therapist believes you present a clear and substantial danger of harm to yourself and/or others, he or she will take protective actions. That may include contacting family members, seeking hospitalization of you, notifying any potential victim(s), and notifying the police.**
- **If you divulge that you or anyone has committed a felony, that has not already been reported or investigated, our counselors are required by law to report said activity to law enforcement.**

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the Notice of Privacy Practices which was provided to you for more detailed explanations, and discuss with your therapist any questions or concerns you may have.

Professional Records

The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways in which your problem affects your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests (including raw test data), any past treatment records that we receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of your Clinical Record, if you request in writing, except in unusual circumstances that involve danger to yourself and/or others or when another individual (other than another health care provider) is referenced and we believe disclosing that information puts the other person at risk of substantial harm. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. We therefore recommend that you initially review them in the presence of your therapist, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, we are allowed to charge a copying fee of $.25 per page. If we refuse your request for access to your records, you have the right of review, which we will discuss upon request.

In addition, as your therapist, we may also keep a set of psychotherapy notes which are for our own use and designed to assist us in providing you with the best treatment. These notes are kept separate from your Clinical Record. They are not routinely released to others with you Clinical Record, except in rare legal circumstances.

Minors

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. Before giving parents any information we will discuss the matter with you, if possible, and do our best to handle any objections you may have.

Authorization to Warn or Inform Third Parties

In the event that my therapist reasonably believes that I am a danger, physically or emotionally, to myself or another person, by signing this Client Information and Acknowledgement of Informed Consent to Treatment, I specifically consent for the therapist to attempt to warn the person in danger and to attempt to contact any person in a position to prevent harm to myself or another person, in addition to medical and law enforcement personnel, and the following persons listed below:

Name	**TELEPHONE NUMBER**
_____	_____
_____	_____
_____	_____

This information is to be provided at my request for use by said persons only to prevent harm to myself or another person. This authorization to Warn or Inform Third Parties shall expire upon termination of my therapy with ANDFC.

I acknowledge that I have the right to revoke the above authorization to warn or inform third parties, in writing, at any time to the extent that my therapist has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could still be permitted by law as indicated in the copy of the Notice of Privacy Practices of ANDFC that I have received and reviewed.

After-Hours Emergencies

We do not have therapists at ANDFC who are on call, nor do they have colleagues on call, when the office is closed. You can reach us after hours only by leaving a detailed voice mail which will be addressed as soon as possible. In the event of a physical emergency go directly to the nearest hospital emergency room or call 911. Crisis Care Centers are also available; Montgomery Co. call center (937) 224-4646, Greene Co. (937) 376-8701.

My Therapists Incapacity or Death

I acknowledge that, in the event that my therapist becomes incapacitated or dies, it will become necessary for another therapist to take possessions of my file and records. By signing this Client Information and Acknowledgment of Informed Consent to Treatment form, I give my consent to allowing another licensed mental health or substance abuse professional selected by ANDFC to take possession of my file and records and provide me with copies upon request, or to deliver them to a therapist of my choice. I will select a successor therapist within a reasonable time and will notify the appointed licensed mental health or substance abuse professional.

Consent to Treatment

I, voluntarily, agree to receive mental health or substance abuse assessment, care, treatment, or services and authorize my therapist to provide such care, treatment or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through ANDFC at any time. I also understand that there are no guarantees that treatment will be successful.

By signing this Client Information and Acknowledgement of Informed Consent to Treatment Form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____

Client Name

_____ _____

Client Signature **Date**

_____ _____

Parent or Guardian Signature (for minor child) **Date**

Address: _____

City/State/Zip: _____

Telephone #: _____

Email Address: _____

Policies Regarding Termination of Counseling

- Counseling services may be terminated any point during psychotherapy if the counselor assess that they are not effective in helping you reach your therapeutic goals. Counselors are obliged to discuss this with the client up to and including termination of treatment. Services may be reinstated at a later date, subject to discussion with counselor, and the intake process must be repeated.
- Excessive cancellations may result in a discussion of readiness or motivation for therapy and may result in services being placed on hold status at that time. Services may be reinstated at a later date, subject to discussion with counselor, and the intake process must be repeated.
- "LATE CANCELS": A late cancel occurs when a client does not cancel prior to 24 hours before the scheduled appointment. The client will be billed/charged a late cancel fee up to the full amount for the missed session. A total of (3) late cancels and/or no shows will result in the termination of services. Services may be reinstated at a later date; however, the intake process must be repeated.
- "NO-SHOWS": A no-show occurs when a client does not call ahead of time to cancel an appointment and does not attend a scheduled session. Clients who are 15 minutes or more late to appointment will have their appointment canceled and they are also considered NO-SHOWS. In the event of a no-show, the client will be billed/charged a fee up to the full amount for the missed session. A total of three (3) no-shows and/or late cancels will result in termination of services. Services may be reinstated at a later date; however, the intake process must be repeated.
- Unpaid balances on account may result in termination of services.
- Abusive behavior or Inappropriate behavior will result in termination of services. A New Direction For Counseling, LLC will not tolerate any form of violent, abusive, inappropriate, lewd or disruptive behavior committed against any member of its community. All reports of violence or abusive behavior will be taken seriously by members of this facility. Prohibited behavior includes but is not limited to: threatening, intimidating, or directing abusive language toward another person and violence or damage to a person or property. Abusive behaviors by the parent, guardian, or representative of a minor client or client who is a ward may result in the termination of the client.
- Refusal to sign any required documents will result in cancellation of appointment which will be considered a LATE CANCEL and possible termination of service.
- You have the right to terminate therapy at anytime.
- In such a case that a client relationship is terminated by the counselor you will be provided with a number of referrals that may be of help to you. In such a case that the client chooses to terminate services, they may also request referrals to other providers.

By signing this Policies Regarding Termination of Counseling Form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Printed Name: _____

Signature of Client:_____ Date: _____

Signature of client's
parent, guardian, or
personal representative:_____ Date: _____

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

_____

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www.anewdirectionforcounseling.com

Consent to Audio/Video Record/Observation of Therapy Session

Date: _____

I, _____, give consent to A New Direction for Counseling to audiotape, record, or have observation of my or my child's session.

I understand that they are confidential, except that they may be shared with my therapist's clinical supervisor, or with other clinicians/interns for licensure purposes.

I understand that these recordings will be used in my therapy to generate additional insight for my or my child's counseling.

I understand they will be part of my record at A New Direction for Counseling.

I understand that I can revoke this authorization at any time.

Signed:_____ Date:_____

(Client's Signature or Guardian/Parent Signature)

Signed:_____ Date:_____

(Therapist/Witness Signature)

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates toyour past, present and fture physical and mental health or condition and related health care services are refeITed to as Protected Health Information ("PHI").

This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the National Association of Social Workers Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. 1his will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training and teaching purposes, PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating and determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and dis-closures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect to mandatory government agency audits or investigations (such as the social work licensing board of the health department).
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat *to* the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI.

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to ANDFC at 1411 North Fairfield Drive, Beavercreek, OH 45432.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required *to* agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS.

If you believe we have violated your privacy rights, you have the right to file a complaint in writin with ANDFC at 1411 North Fairfield Road, Beavercreek OHIO 45432, or by calling 937-426-2686.

We will not and cannot retaliate if you file a complaint.

You may file a complaint ifyou believe a licensed Counselor, Social Worker or Marriage & Family Therapist has violated the law, rules or ethical standards governing the practice of social work with the Counselor and Social Worker Board of Ohio at (614) 466-0912 or online at https://cswmft.ohio.gov/for-the-public/file-a-complaint-elicense-portal/how-do-i-file-a-complaint

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FAX: 937-426-6230
www.anewdirectionforcounseling.com

Notice of Privacy Practices

Receipt and Acknowledgement of Notice

Full Name: _____

Date of Birth: _____ SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of A New Direction for Counseling's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact my therapist at 1411 N. Fairfield Drive, Beavercreek OHIO 45432 or at (937)426-2686.

Signature of Client: _____ Date: _____

Signature of client's parent, guardian, or personal representative: _____ Date: _____

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

_____

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Informed Consent for Technology-Assisted Counseling

TELEHEALTH CONSENT FORM

I, _____ (Patient) hereby consent to engage in Telehealth with A New Direction for Counseling. I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.
By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the [Informed Consent Form or Statement of Disclosures] I received from my therapist also apply to my Telehealth services.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.
3. I understand that miscommunication between myself and my therapist may occur via Telehealth.
4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
5. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.
6. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
7. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.

8. I have discussed the fees charged for Telehealth with my therapist and agree to them [or for insurance patients: I have discussed with my therapist and agree that my therapist will bill my insurance plan for Telehealth and that I will be billed for any portion that is the patient's responsibility (e.g. co-payments)], and I have been provided with this information in the Informed Consent Form and Statement of Fees form.

9. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

_____ Yes, I have read and agree to the terms listed above in the Informed Consent. I understand that psychotherapy treatment will be considered to take place in the state of Ohio (USA). I understand that telephone/online psychotherapy is not a substitute for medication under the care of a psychiatrist of doctor. I understand that online and telephone therapy is not appropriate if I am experiencing a crisis or having suicidal or homicidal thoughts. In case of emergency situations, I will contact 911 or Greene county crisis center at (937)-376-8700. I understand my signature is an agreement for psychotherapy services conducted at A New Direction for Counseling, LLC.

I have read and understand the information provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.
[For conjoint or family therapy, patients may sign individual consent forms or sign the same form.]

_____ _____

Patient's Signature Date

_____

Patient's Printed Name

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STATEMENT OF FEES

A New Direction for Counseling charges a fee for providing services. Our fees are as listed:

For Clients Without Insurance or Those Who Choose to Self -Pay: (There will be a separate Self-Pay contract for clients with Insurance or Medicare who choose to pay out of pocket)

Session(s) with Licensed Counselor

- $180 for Initial Visit- We offer a discounted rate of $100 for clients **who pay on date of service**
- $150 per session- We offer a discounted rate of $80 per 60 minute session for clients **who pay on date of service**

Session(s) with Counselor Trainee: (PAYMENT DUE ON DATE OF SERVICE)

- $80 for Initial Visit
- $60 per 60 minute session after Initial Visit

For Clients With Insurance:

- As a courtesy to our clients, we obtain benefit information and authorization necessary for your visits. However, should your insurance not cover your visit(s), you will be held responsible for payment.
- **Copays are due on date of service. (If Copay is not paid in full on date of service, we may assess an additional fee of $10 every 30 days past the date of service to your account.)**

For All Clients:

- Client account balance shall not exceed the cost of three (3) appointments or they will not be allowed to schedule appointments until payment arrangements are made, and any scheduled appointments may be canceled.
- Clients are responsible for providing ANDFC with any address, phone number, or insurance changes in a timely manner.
- Clients are responsible for canceling appointments with at least 24 hour notice. Clients who late cancel or no show an appointment are subjected to charges from ANDFC.
- **A late cancel/no-show fee up to 80 dollars** will be charged depending on the counselor.
- As a courtesy, we provide reminder texts for your appointments with the option to add to your calendar. However, should you not receive this message for any reason; you remain responsible for your appointment date and time.

These fees are for 50 minute sessions; however your managed care and insurance company contracts may have pre-set fees that we are required to accept. In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health or substance abuse treatment. We will fill out forms and provide you with whatever assistance we can (cont.)

in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of any fees. It is very important that you find out exactly what mental health or substance abuse services your policy covers. You should also be aware that most insurance companies require you to authorize us to provide them with clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands.

Fees for court actions, legal fillings and records request

The following fees are in effect when any request is made regarding legal actions or court involvement:

1. Phone calls: $100 an hour billed in a minimum of 30 minute increments.
2. Preparation time including submission of records: $50 an hour billed in 30 minute increments.
3. Depositions and Testimony: $100 an hour billed hourly
4. Mileage: $0.57 per mile.
5. Court appearance: $150 retainer which is due 72 business hours before the scheduled court appearance whether or not testimony is given once at the courthouse.
6. Filling documents with the court: $.20 per page per document
7. Any and all other legal fees and costs that are incurred by the therapist as a result of the legal action.

The remainder of the cost, if any remains, will be billed after the court appearance and will be due upon receipt.

If the therapist is subpoenaed and the case is reset with less than 72 business hour notice prior to the beginning of the day of the scheduled subpoena trial and/or testimony, then the client will be charged
$150 in addition to the original retainer of $150 for having to appear in court.

If therapist is scheduled to be away from the area all fees are billed at double and double time.

Bills regarding court action are due upon receipt. Failure to pay within 2 weeks of invoice will result in your credit card on file being charged. A zero balance will need to be kept at all times.

Client Acknowledgement

I hereby acknowledge that I am personally responsible for the fees charged for receiving services. I understand that insurance claims are submitted only as a service. I also understand that I must give a 24 hour notice of cancellation or a fee will be charged for failing to attend an appointment I have made.

_____
Client/Guardian Printed Name

_____ _____
Client/Guardian Signature Date

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A New Direction for Counseling requires a credit or debit card to be on file.

We ask all clients that do not fall under Medicaid or Medicare to keep a credit card on file with us. This policy is designed to support a seamless therapeutic and administrative process for everyone involved. Here are the key reasons for this approach:

1. Coverage of Fees: Sometimes, certain fees might not be covered by your third-party payer. This could include copayments, deductibles, or services that fall outside of your coverage plan. Having a credit card on file allows us to securely and efficiently manage these charges without disrupting your service.

2. Missed Appointments and Late Cancellations: Our practice, like many others, may charge a fee for appointments that are missed or canceled without sufficient notice. These fees are generally not covered by third-party payers. The credit card on file ensures that these fees can be processed smoothly, allowing us to maintain a fair and efficient scheduling system for all clients.

3. Simplifying the Payment Process: By keeping a credit card on file, we streamline the payment process. This helps us focus more on providing you with the best possible care rather than on administrative details.

4. Clear Financial Policies: Our policy to require a credit card on file is part of our commitment to transparent and straightforward financial practices. It helps reduce the likelihood of billing surprises and ensures that all parties have a clear understanding of our billing procedures.

This policy is in place to ensure that both the therapeutic and administrative aspects of our practice run as smoothly as possible. It allows us to focus on providing you with high-quality care, knowing that the financial aspects are handled efficiently and securely.

☐ I understand A New Direction's Policy, and am exempt due to coverage by Medicaid, Medicare or EAP. If any of this information changes it is the responsibility of the client to update A New Direction for Counseling and put a required card on file.

A NEW DIRECTION FOR COUNSELING, LLC

Counseling and Teletherapy
Credit Card Authorization Form

Patient Name (printed): _____ Patient Date of Birth: _____

Email Address: _____

Guardian Name (if applicable): _____

The undersigned Cardholder hereby authorizes A New Direction for Counseling to obtain payment of fees for above patient for counseling services from the Cardholder's Credit Card account identified below. A New Direction for Counsleing may charge the account for counseling session fees or missed counseling sessions for above patient, without requirement of the Cardholder's signature for each payment (minimum of 24 hours cancellation notice is required). A receipt of the transaction will be sent to the email address provided by the Cardholder above.

The Cardholder may also choose to have any remaining balances owed billed to this card by selecting the appropriate option below.

I authorize any remaining balance to automatically be charged to this credit card.

By signing this form, the Patient/Cardholder acknowledges and agrees as follows:

- *This signed form is confidential and will be kept in a secure file at A New Direction for Counseling*
- *The Cardholder authorizes A New Direction for Counseling to automatically charge the Credit Card referenced below.*
- *The Cardholder certifies, warrants, and represents that the Cardholder named above agrees to pay the credit charge(s) in accordance with the agreement described above.*
- *Credit Card payments will appear on your statement as A New Direction for Counseling.*
- *If the Cardholder fails to dispute a charge within 30 days from the time the Credit Card is charged, the Cardholder agrees that the charges are valid and agrees not to dispute said charges.*
- *This authorization will remain valid for 12 months or until revoked in writing with 30 days notice of revocation.*
- *Credit Card will be charged for Mental Health services the day of the scheduled appointment time, or up to 3 days after unless otherwised discussed with Admin.*

Please select one: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Name on Card (printed): _____
Credit Card #: _____
CVV Number: _____(3 digits on back of card)
Expiration Date: _____(Month/Year)
Cardholder Authorized Signature: _____

A New Direction for Counseling

INFORMED CONSENT FOR OUTDOOR THERAPY

This document contains important information about the decision (yours and your therapist's) to begin therapy sessions outdoors, or at a location other than the office. It is a supplement to the general informed consent that we agreed to at the outset of our clinical work together. Please read this document carefully and let us know if you have any questions. When you sign this document, it will be an official agreement between you and A New Direction for Counseling.

Outdoor psychotherapy may take several forms. It may involve sitting outdoors on a bench/chair outside of our offices or sitting in a public place such as a park pavilion or restaurant. It may also take the form of walking while addressing therapeutic goals and topics. If you decide to walk, some of the activities you might participate in include walking on sidewalks/bike paths and/or exploring public parks and open spaces. The focus of the experience is therapy, not exercise.

> You and your counselor will decide if outdoor counseling is an option you would like to utilize. It is not mandatory and you may decline this conset at any time.

COVID-19 Specific Information

As a way to mitigate the risk of exposure to COVID-19, our practice has begun to offer the option of engaging in therapy outdoors in order to minimize time spent in close proximity to others while indoors. The decision about whether to engage in outdoor therapy is based on current conditions and guidelines which may change at any time. It is possible that a return to remote services will be necessary at some point based on health and safety considerations. This decision will be made in consultation with you, but your therapist and/or PCPC will make the final determination based on a careful weighing of the risks and applicable regulations.

In order to engage in outdoor therapy, the following protocols must be followed by clients and providers:

- You agree to take certain precautions which will help keep everyone safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in you starting / returning to a telehealth arrangement.

- You agree to only keep your in-person appointment if you are free of COVID-19 symptoms.

- You agree that if you have been exposed to another person who is showing signs of infection or is confirmed to have COVID-19 within the last week, you will re-schedule your outdoor session or do a telehealth session instead.

- Accidental injuries from tripping or falling while walking, or potentially being struck by a bicyclist or a car.
- Physical dangers including insect stings, animal bites, falling branches or sticks, sunburn, exposure to heat/cold, and similar risks.
- Adverse weather conditions including heat, rain, and storms. Please note that when rain or storms are forecast, it may be necessary to reschedule the session or use a telehealth platform instead.
- Confidentiality issues: complete confidentiality cannot be guaranteed. Though every attempt will be made to not engage in private conversations when others are in close proximity, it is not possible to guarantee that conversations will not be heard by others.
- Coming into contact with someone the therapist or client knows. If the therapist comes into contact with a known person, therapist will not disclose that you are a client or any other confidential information. If you come into contact with a known person, therapist will not initiate interaction with that person but will follow your lead in guiding any interactions.
- Given the prevalence of cellphones, it is also possible that you may be photographed or videoed with your therapist without your knowledge and that you and your therapist would have no control over the dissemination of those photos/videos.
- Perceived informality of the interaction. Although outdoor therapy might feel more like a social interaction rather than a therapeutic interaction, it is a therapeutic activity. Despite the relative informality of the interaction, the relationship between client and therapist continues to be entirely professional, and not a social relationship.

Consent and Agreements

In order to engage in outdoor therapy, you understand and agree to the following:

- You understand that participation in outdoor therapy is completely voluntary and that there are alternative options such as teletherapy or in-office services available.
- You agree to obtain approval from your doctor before engaging in outdoor therapy if you have any medical condition that could affect your ability to participate in this activity and to disclose those conditions or limitations to your therapist.
- You agree to take full responsibility for your physical safety and to not engage in any activity in which you do not feel safe.
- You agree to let your therapist know immediately if you become physically or emotionally uncomfortable during a session.
- You agree to abide by all COVID-19 protocols noted above.

By signing below, you indicate that you understand and accept the risks of outdoor therapy, including potential risk of exposure to COVID-19, and nevertheless consent to outdoor therapy under the conditions outlined above. This consent can be withdrawn in writing at any time.

Signature_____

Printed Name_____ Date_____

Client (if not same as above)_____

Client Date of Birth _____

A New Direction for Counseling

Treatment with Intern Informed Consent Form

- I understand that my child, my family, or myself will be receiving therapy services from a student intern who is under the supervision of A New Direction for Counseling. All interns are supervised at A New Direction by Patricia Kaniuga LPCC-S and the acting supervisor for their educational institution.

- Student interns are bound by the ethical guidelines of their profession and adhere to the guidelines specified by the A New Direction for Counseling LLC services agreement, Telehealth Service Consent, Internship Supervision Agreement of their educational institution and Notice of Privacy Practices / HIPAA.

- Student interns have completed most masters level education from their educational institution in their field of study, have demonstrated core competencies and have been determined by their educational institution as ready to apply his or her clinical skills to working with clients.

- Student interns receive intensive ongoing guidance, evaluation, and education in providing excellence in clinical skills to you and your family members. By working with a student intern, each client receives the benefit of a clinically experienced supervision team assisting in assessment and treatment planning to address concerns in therapy.

- Student interns may provide counseling sessions in conjunction with a fully licensed clinician, and when deemed ready by A New Direction for Counseling, will provide counseling sessions without a supervising clinician present.

- Sessions conducted by student interns may include recording of sessions, for use in supervision. Recordings may not be used for any other purposes than for use in supervision, are stored on a password protected device and are destroyed at the termination of therapy.

- Clients may terminate this agreement at any time, but termination of this agreement will require transfer to another provider as interns cannot be adequately supervised in cases that do not consent to recording.

- Students have set schedules and as so, are unable to open them regardless of client need.

- Your care will be limited to 10 sessions per semester. These sessions can last up to an hour depending on your symptoms. After this if you need continued care your counselor will refer you to another provider within the group.

I, the client or his/her legal, custodial parent, or legal guardian, acknowledge that I am voluntarily authorizing treatment for myself or my child/ward at A New Direction for Counseling, LLC, by a Student Intern. I have been informed of the purpose of the treatment, the services which may be provided, and any attendant risks, consequences, and/or benefits.

Signature:_____ Date: _____