New Day
Family Counseling Center
Helping Families Come Together

Billing & Insurance Information

Client Full Legal Name_____
Social Security #_____ Birthdate_____
Street Address _____City_____ State _____ Zip_____
Primary Phone Number _____

It is okay to leave a message at this number: ☐YES ☐No

It is okay to text this number: ☐YES ☐No
Alternate Phone Number _____

It is okay to leave a message at this number: ☐YES ☐No

It is okay to text this number: ☐YES ☐NO
Email Address: _____
Parent or Guardian Name, if a minor _____
Emergency Contact Information _____ Phone Number _____
Please note, I will only contact this person in the event of an emergency and will always inform you if I do so.

Only needed if we are billing your insurance for services:
Insurance Information - copy of ALL insurance cards are required

Primary insurance name _____
Insurance ID #_____
Subscriber's name _____DOB_____
Subscriber address if different from client above_____

Secondary insurance name _____
Insurance ID #_____
Subscriber's name _____DOB_____
Subscriber address if different from client above_____

I _____ do hereby give full authorization to New Day Family Counseling Center to bill my health insurance for services received by my registered intern or credentialed therapist employed by New Day Family Counseling Center. I also agree to have any checks or payments made by said insurance company be payable and delivered to New Day Family.

Signature & Date _____

This is for consent to bill your insurance

☐ By checking this box, I accept the above as my signature

About You

Race/Cultural Identity: _____Preferred Language(s): _____
Spirituality/Religion: _____
Hobbies/Interests: _____
_____
What gender do you mostly identify with? _____
What gender were you assigned to at birth (Circle one) Male Female Other
Sexual Orientation? _____
Describe your sleeping habits (what time do you go to bed, wake up, sleep quality):
_____
Describe your eating habits (how often do you eat, do you eat out often, do you cook at home):_____
Reason for contacting us about starting therapy: _____
_____
_____
Goals you want to accomplish in working together: _____
_____
_____
What are some strengths/healthy habits/coping styles that you have? _____
_____
_____
If you could change three things about your life what would they be?
1)_____
2)_____
3)_____

Academic & Employment:

Name of School: _____Grade in School: _____ IEP: Y/N Designation: _____
Degree (if applicable): _____Job Title: _____
Current Employer: _____
Attendance: Excellent/Good/OK/Poor Explain: _____
School/Work Strengths: _____
School/Work Performance: _____
School/Work Concerns: _____
School/Work Behavior: _____

Family History

Currently in a significant romantic relationship? ☐YES ☐NO

Significant prior relationship (divorced, widowed, etc.)? ☐YES ☐NO
Number of children and ages (if applicable): _____

Dependent adults living with you (if applicable): ☐YES ☐NO
If yes, list relationship: _____

Who currently lives in your home (list all that apply)? _____
_____
_____
_____

Are there any pets in the home? ☐YES ☐NO

If yes, list name and type (dog, cat, etc.): _____

If client is a minor who holds legal custody? _____
Court ordered visitation schedule: _____

Any court related issues i.e. CPS involvement, restraining order, visitation requirements

etc.: ☐YES ☐NO If yes, please explain: _____

_____

Do you have any family members who are seen here? _____

_____

Family History: Frequent Moves, Incarceration, Substance Abuse, Domestic Violence, Evictions, Trauma, Death, Other Explain: _____

_____
_____
_____

What are some strengths do you have as a family? _____

_____
_____

Medical History:

Primary Care Physician: _____ Phone Number: _____
Address of Physician_____
Date of most recent physical exam: _____
Current medication taken on a regular basis and what they are for: _____

_____

Past medication taken on a regular basis, what they are for and dates taken: _____

_____

Health concerns/Issues (Thyroid Disorder, Cancer etc.): _____

_____

Health History list with dates (Cancer, Accidents, Surgeries, etc.): _____

_____

List/explain any prenatal events/concerns: _____

_____

List any advanced developmental milestones: _____
List any delayed developmental milestones: _____

Mental Health History:

Have you seen a therapist in the past? ☐YES ☐NO

If yes, when and for how long: _____

Previous therapist(s) name(s): _____

Primary reason for previous therapy: _____

Was it helpful: _____ Unhelpful: _____

Any previous diagnoses: _____

Any previous hospitalization: ☐YES ☐NO Dates: _____

Reason for Stay: _____

Were there any mental health issues with your father: _____

_____

Were there any mental health issues with your mother: _____

_____

Have you experienced any personal traumatic events: ☐YES ☐NO

Briefly explain: _____

_____

Any grief or loss: ☐YES ☐NO Briefly explain: _____

_____

Substance Abuse:

Please list any **current** substances use (Alcohol, Cigarettes, Marijuana. Etc.) : _____

_____

_____

What is the frequency of use for the above listed substances: Monthly Weekly Daily

_____

_____

When was the last time each substance was used? _____

What was your longest break from these substances in the last week? _____

What was your longest break from these substances in the last 6 months? _____

Please list any **prior** substances use (Alcohol, Cigarettes, Marijuana. Etc.): _____

_____

_____

Are you currently in a substance abuse program or support group: ☐YES ☐NO

Have you previously been in a substance abuse program or support group: ☐YES ☐NO

Number of grandparents who struggled with alcoholism or another form of addiction: _____

Have you had legal ramifications from substance use: ☐YES ☐NO

Please explain:_____

_____

Informed Consent for Psychotherapy

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with us. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process

You have taken an incredibly positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. We cannot promise that your behavior or circumstance will change. We can promise to support you and do our very best to understand you and your repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally We may need to consult with other professionals in their areas of expertise to provide the best treatment for you. Information about you may be shared in this context without using your name.

Confidentiality Continued

If we see each other accidentally outside of the therapy office, we will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and we do not wish to jeopardize your privacy. However, if you acknowledge me first, we will be more than happy to speak briefly with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

_____ ☐ By checking this box, I accept this as my signature

Signature of Patient or Legal Guardian & Date

Patient Consent for Use and Disclosure of Protected Health Information - HIPAA

We have a notice available to you that describes how your health information may be used and disclosed and how you can get access to this information. We have copies in our main waiting room, and you can ask the staff for a hard copy or get one emailed to you.

MY PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by this mental health care practice. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you and describe certain obligations we have regarding the use and disclosure of your health information. We are required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- We can change the terms of this notice, and such changes will apply to all the information we have about you. The new Notice will be available upon request, in our office, and on our website.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

_____

Signature of Patient or Legal Guardian & Date

For Patient Consent for Use and Disclosure of Protected Health Information - HIPAA

☐ By checking this box, I accept the above as my signature

Consent to Observe & Record Therapy Sessions

New Day Family Counseling Center has created a partnership with California State University, Chico Marriage & Family Therapy (MFT) Master's program. In doing so, we provide supervision to students/trainees in the MFT. To provide our clients with the highest quality of care and the highest quality education opportunity to our trainees, we ask for permission to *1)* Have supervisors join your session. *2)* Have a supervisor or other trainees observer your session. *3)* Allow your session to be video and/or audio recorded for training purposes

Purpose of Observation & Recording:

We ask for your permission to have a supervisor observe and/or record your psychotherapy session for supervision purposes. Supervision using live recordings is required by national standards for training marriage and family therapists because it ensures that clients receive the highest quality care. It accelerates the learning process for therapists. These recordings will be used only for supervision purposes. New Day Family Counseling Center will be taking the highest standards for ensuring the safety of these recordings. Having the videos include the client and therapist allows for optimal supervision. However, if you so choose, you may ask to have only your voice recorded with the camera directed exclusively at the therapist. I hereby consent to the observing and/or video/audio taping of my/our psychotherapy sessions. I/We understand that the use and viewing of the audio/video recordings in whole or part are strictly limited to the following:

1. Analysis by the therapist to optimize the quality of care
2. Used by a supervisor for professional consultation about treatment, I/We understand that the recordings are not part of our permanent medical record. The therapist will destroy the recording after it has been used for supervision and training purposes.
3. I/We understand that I/we may withdraw our consent to record at any time.

☐YES	☐NO	I give permission for a supervisor to join my session.
☐YES	☐NO	I give permission for a supervisor or other trainees to observer my session.
☐YES	☐NO	I give permission for my session to be recorded for training purposes
☐YES	☐NO	I give permission for my session to be audio recorded for training purposes

Consent for Minors to be Recorded I hereby consent to the video recording of my child(ren)'s psychotherapy sessions. I understand that the use and viewing of the audio/video recordings in whole or part are strictly limited to the following: *1)* Analysis by the therapist to optimize the quality of our care, *2)* Use by supervisor and supervision group for the purpose of professional consultation about my/our treatment.

_____		_____
Print Name of Parent or Guardian	☐ By checking this box, I accept this as my signature	Date
_____		_____
Signature		Date
_____		_____
Print Name of Child		Date

Disclosure Statement & Agreement for Services

Fee for Service and Insurance Reimbursement

Cash clients are expected to pay your therapists rate per session at the beginning of each session unless other arrangements have been made. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and otherwise agreed upon. Please notify your therapist in any problems arise during the course of therapy regarding your ability to make timely payments. Clients who carry insurance that we are not contracted with should remember that professional services are rendered and charged to the clients and not to the insurance. Unless agreed upon differently, your therapist will provide you a copy of your receipt monthly, which you can then submit to your insurance company for reimbursement if you so choose. Not all issues/problems/conditions which are dealt with in psychotherapy, are reimbursed by all insurance policies. It is your responsibility to verify whether therapy services are covered by your plan. If your account becomes overdue and there is no written agreement on a payment plan the therapist may use legal or other means such as collection agencies to collect payment. Please make all checks payable to New Day Family Counseling Center.
I have reviewed and agree to the policies regarding fees and payment_____

Court Ordered Services

Services that are ordered by the court are **not** covered by insurance. All courted orders must be presented and reviewed before services start. Fees for court ordered therapy are charged at a rate of $500 per hour with a prepayment of $2500.00 due prior to the first session. All related service including but not limited to writing reports, testifying in court, phone calls with attorneys, therapy sessions, and all documentation will be billed at a rate of $500 per hour and must be paid in advance unless otherwise agreed upon.

Cancellations and Missed appointments

I understand my psychotherapist reserves an appointment time for me**. I agree to call 48 hours in advance if I must cancel a session in order to allow my therapist time to reschedule their time.** I understand that I may be responsible for paying the therapist at their normal contracted rate **(between $75-$200)** for missed or late canceled appointments and that my insurance will not pay this fee**.** I understand that if I miss two row or **three sessions TOTAL**, my therapist will refer me to another therapist in the community and that I will need to receive my treatment elsewhere. **I have reviewed, understand and agree to the stated policies regarding cancellations_____**

Process of Therapy/Evaluation and Scope of Practice

Participation in therapy can result in several benefits to you and your family, including improving your relationships, self-esteem, the way you communicate as well as the resolution of the specific concerns that led you to seek therapy. It is your therapist's intention to provide services that will assist you in reaching your goals. Working toward

these benefits, however, requires effort on your part. Therapy is effective most of the time. Clients who are motivated to change, willing to try interventions and strategies, honest about their issues and open with their therapist, are the quickest to see their desired results. The relationship with your therapist is crucial as well and has been identified as the single largest predictor for client's success. You should expect to see some results early in treatment. If you are not getting the benefit you would expect within the first few sessions this should be addressed at the beginning of the next session to determine the best approach to move forward. Your therapist will work with you as a partner, asking for your feedback and views on the therapy process, as well as provide feedback, in order to adjust best meet your needs. Your therapist will also make suggestions, provide interventions, and make recommendations based on his or her knowledge and training. You always have the right to disagree, ask for clarification or request a different strategy if you feel uncomfortable with what has been suggested. Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result. During the course of therapy your therapist will draw upon various psychological theoretical orientations. These may include family systems, experiential, cognitive behavioral, Gestalt, Solution Focused, Narrative, Existential, and others. Your therapist does not provide custody evaluation or recommendations, legal advice or medical advice including advice regarding medications as those services fall outside their scope of practice. **I have reviewed, understand, and agree to the stated policies regarding scope of practice**_____

Confidentiality

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. However, it is important that you know that your therapist utilizes a "limited secrets" policy regarding information obtained between family sessions when conducting family therapy. This means that if you participate in family sessions, your therapist is permitted to use information obtained in an individual session that you had with them, when working with other members of your family. Please feel free to ask your therapist questions about their "limited secrets" policy and how it may apply to you. **I have reviewed, understand, and agree to the stated policies regarding confidentiality**_____

Limits to Confidentiality

There are limits to confidentiality. For example, all therapist are required to report instances of suspected child abuse, dependent adult or elder abuse or neglect. Therapists may be required or permitted to break confidentiality when they have determined that a client presents a serious danger of physical violence to another person or when a client is dangerous to him or herself. Disclosure may be required pursuant to a legal proceeding by

or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the legal right to obtain the psychotherapy records and or testimony by the therapist. In family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. The therapist will use his or her clinical judgement when revealing such information. The therapist will not release records to any outside party unless he or she is authorized to do so by all adult family members who were a part of the treatment. **I have reviewed, understand, and agree to the stated policies regarding limits to confidentiality___**

Minors and Confidentiality

Communications between therapists and clients who are minors are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his professional judgement, may discuss the treatment progress of a minor client with the parent or caretaker. Clients who are minors, and their parents are urged to discuss any questions or concerns they have on this topic with their therapist. **I have reviewed, and understand and agree to the stated policies regarding minors and confidentiality_____**

Arbitration/Mediation Agreement

I agree to address any grievances I may have directly with my therapist immediately. If we cannot settle the matter between us, then a jointly agreed-upon outside consultation will be sought. If no, an arbitration process will be initiated, which will be considered as a complete resolution and legally binding decision under state law. *By signing this contract, you are agreeing to have any issue of medical or psychological malpractice decided by neutral arbitration, and you are giving up your right to a jury or court trial.* It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly rendered, will be determined by submission to arbitration as provided by California law and in accordance with the rules of the American Arbitration Association, and not by lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury and are instead accepting the use of arbitration. Any arbitration process will be considered as a complete resolution and legally binding. The client will be responsible for the costs of this process. In agreeing to treatment, I am consenting to the above identified grievance procedures. **I have reviewed, understand and agree to the stated policies regarding arbitration/mediation_____**

Emergencies

If you need to contact your therapist between sessions, please leave them a voicemail or text and your call will be returned as soon as possible. You may also email them if agreed that is an effective method to communicate an urgent matter. They check their messages

frequently during business hours unless they are out of town. We are not able to return phone calls after 8pm or on Sundays. Non urgent calls or texts are returned during normal business hours within 24hrs. If you have an urgent need to speak with your therapist, please state that in your message. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others please call 911. If a mental health emergency should arise during non-business hours, please call Sutter-Yuba Mental Health 24-hour emergency service crisis line at (530) 673-8255 or (888) 923-3800. You can also call the National Hotline (800) SUICIDE or 911. **I have reviewed, understand, and agree to the state policies regarding emergency communications____**

Thank you for choosing to allow us to walk this journey with you!

_____

Print Name Date

_____

Signature Date

_____

☐ By checking this box, I accept the above as my signature

NOTICE TO CLIENTS SEEING A TRAINEE: *The Office Manager of New Day Family Counseling Center receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered counselor providing services at New Day Family Counseling Center. To file a complaint, contact 530-434-6318, schedule@newday.family, 1095 Stafford Way Suite J Yuba City Ca. 95991.*

NOTICE TO CLIENTS SEEING AN ASSOCIATE OR LICENSED THERAPIST: *The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapists and clinical social workers. You may contact the board on line at www.bbs.ca.gov, or by calling (916) 574-7830.*

Good Faith Estimate Notice: *You have the right to receive a "Good Faith Estimate" explaining how much your medical and mental health care will cost. Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the expected charges for medical services, including psychotherapy services. You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services. You can ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service.*
If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate.
For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises

All employees of New Day Family Counseling Center may have access to your file for the purpose of treatment, supervision & billing.

New Day Family Counseling Center 530-434-6318

New Day
Family Counseling Center
Helping Families Come Together

Patient Name: _____ Therapist Name: _____

1. I understand that my therapist wishes me to engage in a telemedicine consultation.

2. My therapist has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a in person visit due to the fact that I will not be in the same room as my therapist.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my therapist or I can discontinue the telemedicine sessions if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my therapist in order to operate the video equipment. The participating parties mentioned above will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the session and thus will have the right to request the following: (1) omit specific details of my medical history/ physical session that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine room: and or (3) terminate the session at any time.

5. I have had the alternatives to a telemedicine session explained to me and I am choosing to participate in a telemedicine session.

6. I understand that all billing will occur from by my therapist office. If I am a cash paying client, I agree to call the office prior to my session and make a payment over the phone or online to cover the cost of my session.

7. I have had a direct conversation with my therapist, during which I had the opportunity to ask questions regarding telemedicine. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

• That I have read or had this form read and/or had this form explained to me • That I fully understand its contents including the risks and benefits of telemedicine sessions. • That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____
Patient's/parent/guardian signature Date & Time

_____ _____
Therapist signature Date & Time

_____ _____
Client gave verbal consent (Therapist note in file) Date & Time

☐ By checking the box, I accept the above as my signature