



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 (circle one): Yes No

It is okay to text this number (circle one): Yes No

Alternate Phone Number _____

It is okay to leave a message at this number (circle one): Yes No

It is okay to text this number (circle one): 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.

Insurance Information - copy of insurance cards is required

Primary Insurance ID # _____

Subscriber's name _____ DOB _____

Subscriber address if different from client above _____

Secondary 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

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 a very 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/her self 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 in order 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.

Signature of Patient or Legal Guardian & Date

for Informed Consent for Psychotherapy

New Day Family Counseling Center 530-434-6318

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 of 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

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. Services that are related to court proceedings such as

New Day Family Counseling Center 530-434-6318

writing reports, testifying in court, phone calls with attorneys are billed at \$350 per hour and must be paid in advance unless 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 do not have a contract with should remember that professional services are rendered and charged to the clients and not to the insurance companies that we do not participate in their network. Unless agreed upon differently, your therapist will provide you a copy of your receipt on a monthly basis, 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**

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 \$50-\$175)** for missed or late canceled appointments and that my insurance will not pay this fee. **I understand that if I miss two sessions in a 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 aren't 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 [redacted]

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 [redacted]

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 [redacted]

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** [REDACTED]

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** [REDACTED]

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 (889) 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** [REDACTED]

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

Print Name

Date

Signature

Date

Therapist Signature

Date

Dr. Benjamin Seigler *LMFT49211*
Carol Phillips Seigler *LMFT112047*
Donna Etchison Marris *AMFT83367*
Kenneth Cunningham *LMFT109934*
Linda Mirich *AMFT87703*
Samuel Viney *AMFT82772*
Carla Olmstead *ASW87191*
Jana Santiago *AMFT109310*

Nancy Neidhardt *AMFT114936*
Cory Quinn *AMFT113162*
Jesse Downard *AMFT Trainee*
MarettaDeVenuta *AMFT Trainee*
Lori Findlaytor *LPLC*
Jamie Seigler *Biller*
Sadie Hallmark *Office Assistant*
Esther Dahm *Office Assistant*

Please share how you hear about us? _____