Patient Notifications

We are pleased you have chosen New Life Counseling. We are committed to giving you the best care possible. To acquaint you further with the procedures and policies of our clinic, we are providing the following information.

Appointments: If you need to cancel an appointment, a minimum of **24 hours notice** is required; otherwise, you are subject to a **$60 late cancellation (or no-show) fee**. In the evenings and on weekends, you may leave a message on the answering machine which will accurately record the date and time you placed the call. Early notification of your cancelled appointment allows our therapists to offer that available appointment to another person needing the time.

Our therapists will do their best to be punctual for your appointment unless they have an emergency call. We ask that you be punctual as well. If you are late for any reason, you will receive the remainder of your scheduled time. This is necessary so we can see subsequent clients at their scheduled time.

Confidentiality: If you choose to have your therapist keep your pastor, relative or friend informed of your progress in counseling, it will be necessary to complete a "Release of Information" form that will be kept on file. Without a properly executed release, everything about your visit will be held in the strictest confidence (with the exception of situations which we are required by law to report, such as suspected or reported child abuse, etc.).

HIPPA statements can be found on our website: **www.newlife-counseling.com.**

Payment:
You are fully responsible for all services rendered. Full payment is expected at the time of service unless other contractual arrangements are made. Please make all checks payable to "New Life Counseling." We will bill the insurance when we have a contract with your carrier. If you choose to bill your own insurance, you must pay New Life Counseling in full at the time of service and use your receipt for filing the claim on your own. Please understand that payment of your bill is considered part of your treatment.

IF YOU PLAN TO USE INSURANCE:

-You are responsible to pay your co-pay and deductible at the time of service.
-It is your responsibility to know what your insurance company covers through your policy.
-If you do not know your co-pay or deductible, please call your insurance provider now to find out.
-For your first session, we must have a copy of your current insurance ID card.
-Please notify us immediately of any changes in your insurance information or coverage.

****PLEASE SIGN BELOW TO INDICATE YOU HAVE READ AND UNDERSTAND THE ABOVE NOTIFICATIONS:**

X____ Date: ___/___/___
(Patient or Parent/Guardian Signature)

Patient Information

Patient Name: ____
(Last) (First) (M.I.) (Nickname)

Address: ____
(Street address) (City) (State) (Zip)

Cell Phone: _________________________ Birth Date: ___/___/___ Age: ____ Gender: ____
Other Phone: _____________________ (*mark home/work/other*)
Email: ______________________________________ Marital Status: _____________ Previously Married? Y / N

Employer (*or school*): ___________________________ If patient is a child, marital status of parents: ____________
Occupation (*or mark as student*): _____________________ S.S. # (*if patient is also guarantor*): ____________________
Full-Time_____ Part-Time _____

Religion: _______________________________________ Referred to New Life by: ___________________________
Church (*if applicable*): ____________________________

In case of emergency notify: ________________________ Relationship: ______________ Phone: ______________

Mark here if ***same as above***: ___

Financially Responsible Party (Primary on Insurance/Guarantor) Information

Guarantor Name: ____ Birth Date: ___/___/___
(Last) (First) (M.I.)

Guarantor Address: ____
(Street address) (City) (State) (Zip)
Guarantor Relationship to Patient: ________________
Guarantor Phone: ___________________________ S.S. #: ____________________________

Guarantor's Employer: ________________________ Guarantor's Occupation: ________________

Spouse's Name: _____________________________ Spouse's Phone: _____________________

Guarantor Agreement: I agree to take full responsibility for the entire amount due for any and all services rendered by New Life Counseling. If the provider is contracted with the insurance company, I will be responsible only for the co-pay, deductible and non-covered services as determined by the insurance plan. ***We will file for you if we are a preferred provider***. If I wish to file this claim with my insurance, I understand that I am responsible for payment of the full amount to New Life Counseling at the time of service and that I am responsible for filing the claim on my own if we are not on their provider list. In the case that further collection assistance would be required, I understand that New Life Counseling is authorized to sign for/release my financial information to my guarantor or a third party insurance/collection agency.

By signing below, I give consent for New Life to use the contact information written above to send me billing statements by email or mail. I also give consent for New Life to use the contact information written above to send appointment reminders to the cell phone or email listed above.

Please mark if you have a preferred type of **appointment reminder**: text___ email___ "I prefer no reminders"___

X____ Date: ___/___/___
(Patient or Guarantor Signature

HIPAA Privacy Authorization for Use and Disclosure of Personal Health Information

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations as amended from time to time. You may refuse to sign this authorization.

By my signature below, I acknowledge that I have received and read the Notice of Health Information Privacy Practices. I have been provided a copy of, read and understand NLC's HIPAA Privacy Notice containing a complete description of my rights, and the permitted uses and disclosures of my protected health information under HIPAA. Further, I acknowledge that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and is no longer protected under HIPAA.

Print Name: ____

(Last) (First) (M.I.)

X____ Date: ___/___/___
(Patient or Parent/Guardian Signature):

For office use only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained.

Reason: ____

___________________________________ *Date:* ___/___/___
Clinician Signature

Confidential Brief Medical History

Name: ____

Primary Care Physician: ______________________________

List of **current medications**:
____
____

Please list any prior **mental health services or hospitalizations** received (dates and reasons): _____________
____
____
____

Briefly describe your **overall experience** with these services: ____
____
____

Please check any area where you think you may have a problem:

___ anxiety or worry
___ communication
___ depression
___ ADHD
___ anger
___ stress
___ guilt or shame
___ previous trauma
___ chronic pain
___ body image
___ eating/nutrition
___ weight
___ physical health
___ identity
___ in-laws
___ self-esteem
___ control
___ finances
___ sexual issues
___ sleep
___ alcohol
___ drugs
___ compulsive behavior
___ work/academic
___ parenting
___ marriage
___ other:___________________________

Briefly Describe the Following:

Eating habits: ____
Sleep: ____
Alcohol use: ____
Caffeine intake: ____
Smoking: ____
Physical exercise: ____
Hobbies/interests: ____

X____ Date: ___/___/___
(Patient or Parent/Guardian Signature)