New Leaf Counseling
Client Information & History

General Information

Name (First, Middle, Last):_______________________________________
Preferred Name:____
Date of Birth:____
Client SS#:________________Occupation:_________________________
Address, City, State & Zip:_______________________________________
Home Phone:____________Cell Phone:____________________________
Work Phone:__________________Email:____________________________
Best way to contact you for appointments: Call (c or h) Text Email
Is it ok to leave a message? Yes No
Emergency Contact Person______________Relationship_____________
Emergency Contact Phone_______________________________________
Has any member of your family been treated in our office?___________
Whom may I thank for referring you to our practice?:_______________

Relationship Information

Relationship Status:____
Sexual Orientation: Straight Gay Lesbian Bisexual Questioning
If you are currently in a relationship, please rate your overall satisfaction on a scale of (1-10)_________________________________
Is there physical/emotional/sexual abuse present?__________________
Are you and/or your children in danger?___________________________

Therapy Information

What is your reason for seeking therapy:___________________________
Are you currently seeing a Psychiatrist? Name ______________________
Phone______________________
Are you currently taking medication?
Please list____
Primary Care Physician name:___________City________Phone_______
Do you have a history of substance abuse?_________________________
Are you currently using substances? Yes No
Substances Used - Please List:____________________________________
Family History of alcohol/drug abuse?
Please list who:____

Symptom Checklist

Depressed Mood	Mood Swings	Phobias	Loss of Interest
Appetite Issues	Obsession	Agitation	Avoiding places
Bowel Problems	Emotionality	Compulsions	Avoiding tasks
Irritability	Suicidal Thoughts	Panic Attacks	Fatigue/Low
Energy			
Scary Thoughts	Social Isolation	Withdrawal	Generalized Anxiety
Poor Grooming	Racing thoughts	Appetite changes	Poor Concentration
Too much sleep	Too little Sleep	Excessive Worry	Postpartum depression/anxiety
Physical Abuse	Sexual Abuse	Emotional Abuse	

Please feel free to add additional symptoms not listed here.

*If you are a mom seeing us during your postpartum phase (birth to 2 years postpartum) please fill out the Edinburgh and Postpartum Checklist.

Additional information you would like to include:

____
____
____
____
____
____
____

Office Use Only

Therapist:_________________________

Diagnosis: Axis I_______________

Axis II______________

Axis III_____________

Axis IV_____________

Axis V______________

Consent to treat signed?

Policies/Procedures signed?

Notes____
____
____
____

Consent to Release Protected Health Information

This form will allow us to share information with current or previous treatment providers (ie. Psychiatrist, Inpatient Facility, Therapist, MD, Nutritionist, etc).

Patient Name ___________________ Date of Birth:______________

I, ________________, hereby authorize New Leaf Counseling to:

( ) Release information to the following

( ) Obtain information from the following

( ) Exchange information with the following

Agencies, Individual, or Providers:_____________________________

Address:____

City:________________ State:_________ Zip:________________

Phone:____

Fax:____

Email:____

This disclosure is made:

( ) at the request of the client [to be checked only if authorization is initiated by the client]

( ) at the request of___________________________________for the following purposes:

____

____

____

This disclosure expires in one year unless revoked earlier by the client, or upon the following: ( ) Date____________________________

( ) Event___________________________

This authorization for release of protected health information is specifically limited to the information specified above and is made in accordance with the Health Insurance Portability and Accountability Act (HIPPA). State and federal laws prevent disclosure of your protected health information without your consent.

I understand that signing this release is voluntary and the provider will not condition treatment on the signing of this release. I understand that information disclosed pursuant of this release may be re-disclosed and no longer subject to federal privacy regulations.

Client signature____

____

Parent/Legal Guardian Signature (if client is a minor)

New Leaf Counseling
Service Agreement

Date___________________________ Witness_____________________

Thank you for coming to NEW LEAF COUNSELING, LLC, for mental health therapy or educational services. We look forward to working with you to improve your life and your relationships. This agreement is to clarify the business aspects of our relationship, and to help our therapeutic relationship go smoothly.

Fees and billing

- Initial assessment $100-150
- Individual therapy (45-50 min) $100-$125
- Individual therapy (25 min) $50-$60
- Couples therapy (45-50 min) $110-$135
- Couples therapy (60-75 min) $150-$180
- Family therapy (45-50 min) $110-135
- Group therapy (60-90 min) $30-50
  - Educational services - costs vary
- Payment is due in full at the beginning of each session by cash, check, or credit card. Included in the above fees are brief phone calls (under 15 min) and routine paperwork.
- There will be a $25 fee for any cancelled check or declined credit card transactions.

Health Insurance Coverage

While we don't work directly with insurance companies, we can provide you with comprehensive receipts to submit to your insurance company for reimbursement of any mental health therapy fees they will cover. Call your insurance company to find out if you have out-of-network mental health benefits.

Confidentiality

- The information you share will be kept confidential. We will ask you to *sign a release-of-information* form before discussing your treatment, or sending records about you to anyone else.

- Your confidentiality/privacy is protected by state law and by the rules of our profession, except in the following circumstances.
  The limits of confidentiality are:

1. If you were sent to me by a court or an employer for evaluation or treatment, the court or employer expects a report from me. You have a right to disclose only what you are comfortable with telling.
2. If you are **involved in a law suit,** and you tell the court that you are in therapy, we may then be ordered to show the court my records. Please consult your lawyer about these issues.
3. If you make a **serious threat to harm** yourself or another person, the law requires the therapist to try to protect you or that other person.
4. If I believe a **child, or a dependent adult, has been or will be abused or neglected,** we are legally required to report this to the authorities.
5. If you send a **health insurance** claim form to your insurance for reimbursement, it will have a mental health diagnosis listed and it will become part of your permanent medical record.
6. In order to provide you with the best treatment we may **consult with other mental health professionals** about your case.

Late Cancellation/No Show Policy

If you are unable to make your scheduled appointment, please cancel at least 24 hrs. in advance so another client can be scheduled during that time. If 24 hrs. notice is not given, you will be charged the full session amount. We reserve the right to charge credit cards that are kept on file for no shows and late cancellations.

If Case of Emergency

If you have an emotional, behavioral, or medical crisis call the University of Utah Neuropsychiatry Institute at 801-583-2500, call 911, or go to the nearest emergency room. New Leaf Counseling does not provide 24 hour crisis services.

I understand, and agree to, the policies as stated above, and I give consent for treatment at New Leaf Counseling, LLC.

Client Signature or Guardian: ____________________________ Date:

New Leaf Counseling Cancellation Policy

You must cancel 24 hours in advance to avoid being charged the full appointment amount. You may reschedule or cancel by Email or by Phone.
Please note that if you are paying by credit card, your card will be charged for the full amount or you will be billed. _________________ (initial)

CREDIT CARD PERMISSION FORM

I hereby give my permission for New Leaf Counseling to charge

my credit card for my session(s) with _____________________________________

Name:____

The information to charge my card is as follows:

Circle one:
*VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Credit card number:____

Expiration date:_____________________ Security Code:_____________________

Name printed on card:____

Billing address of card holder:____

Cardholder’s best contact phone number:__________________________________

Cardholder’s signature:____

Today’s date:_____________________________

A convenience fee of 3% for each $100 charged will be added when using a credit card.

Acknowledgment of Receipt of Notice of Privacy Practices

New Leaf Counseling, LLC

- We keep a record of the mental health care services we provide you.
- We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

By my signature below, I acknowledge receipt of Notice of Privacy Practices

*You may refuse to sign this acknowledgment

____

Patient or legally authorized individual signature   Date

____

Printed name

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

[ ] Individual refused to sign

[ ] Communication barriers prohibited obtaining the acknowledgment

[ ] An emergency situation prevented us from obtaining acknowledgment

[ ] Other (please specify)______________________________________

NOTICE OF PRIVACY POLICY

THIS NOTICE DESCRIBES HOW HEALTH 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 to your past, present or future physical or mental health or condition and related health care services is referred to as "protected health information". This Notice of Privacy Practices describes how I may use and disclose your protected health information in accordance with applicable law and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your protected health information. As part of your protected health information I keep some specific information in what are called "psychotherapy notes". These notes are kept separate from your health record and are given much higher privacy protection. They contain my impressions about you and details of the psychotherapy conversation I consider to be inappropriate for the health record. They contain information pertinent only to my future work with you. They are not available for your review, nor to insurance and managed care companies.

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

How I May Use And Disclose Health Information about You For Treatment : Your protected health information 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.

For Payment : I may use and disclose protected health information so that I can receive payment for the treatment services provided to you. This 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, I will only disclose the minimum amount of protected health information necessary for purposes of collection.

For Health Care Operations : I may use or disclose, as needed, your protected health information in order to support my business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your protected health information with third parties that perform various business activities (e.g., billing or typing services). This is allowed only if I have a written contract which requires that business to safeguard the privacy of your protected health information.

Required by Law : There are occasions which require me under law to disclose your protected health information with or without your authorization. Some examples are:

- If you are in imminent danger of committing suicide I am legally and ethically bound to intervene in anyway necessary to prevent that including contacting family members and the police.
- To the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the Federal privacy requirements.
- If you are at risk of being a serious and imminent threat to the health or safety of a person or the public, I will disclose information to prevent or lessen that serious threat. I will
  disclose it to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- If you are in imminent danger of committing suicide I am legally and ethically bound to intervene in anyway necessary to prevent that including contacting family members and the police.

- If there is suspicion of neglect or abuse of a child in the past, present or future I am required by law to report that to the Utah Division of Child and Family Services or the police.

- If I have reason to believe that a vulnerable adult is suffering from abuse, neglect, abandonment or exploitation, I am required by law to make a report to either the Utah Adult Protective Services or the nearest law enforcement agency as soon as I become aware of the situation.

- Utah law requires that I report the names of any individuals having communicable diseases to the Health Department.

- I may disclose your personal health information in accordance with workers compensation laws.

- If you become involved in the court system a judge can order that I provide information on you. Two examples of this are child custody cases and cases in which clients bring action against therapists.
  With Your Verbal Permission: I can share some information about you with your family or close others. I will only share information with those involved in your care and anyone else you choose such as close friends or clergy. I will ask you about who you want us to tell what information about your condition or treatment. You can tell us what you want and we will honor your wishes as long as it is not against the law.
  If it is an emergency - so I cannot ask if you disagree - I can share information if I believe that it is what you would have wanted and if I believe it will help you if I do share it. If I do share information, in an emergency, I will tell you as soon as I can. If you don't approve I will stop, as long as it is not against the law.
  With Your Written Authorization: Uses and disclosures not specifically permitted by the circumstances described above will be made only with your written authorization, which may be revoked.
  Your Rights Regarding Your Protected Health Information
  You have the following rights regarding protected health information I maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer, (Melissa Lambson, LCSW, 9130 South State St #124. Sandy, Utah 84070, (801) 867-1041).

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy protected health information that may be used to make decisions about your care. Your right to inspect and copy protected health information will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies.

- **Right to Amend.** If you feel that the protected health information I have about you is incorrect or incomplete, you may ask me to amend the information although I am 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 I make of your protected health information. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your protected health information for treatment, payment, or health care operations. I am not required to agree to your request.

- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about health matters in a certain way or at a certain location. For instance, you can ask me to avoid calling you on selected phone numbers or ask that I send bills to an alternate address.

- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Complaints If you believe I have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Melissa Lambson, LCSW, 9130 South State St #124. Sandy, Utah 84070, (801) 867-1041) or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. I will not retaliate against you for filing a complaint.

Client Signature or Guardian ____________________ **Date** ____________________

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- CLIENT COPY -

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Client Signature or Guardian ______________________ **Date** ______________