NAME:_____ **APPOINTMENT DATE/TIME:**_____

Welcome to New Day Counseling,

Please complete, sign, and date all forms attached to this clipboard. These forms must be completed prior to the start of your counseling session. The therapist will collect the completed forms from you and answer any questions at your scheduled appointment time. Thank you.

- ☐ **Complete attached forms**
- ☐ **Provide copy of Driver's License/ Picture ID**
- ☐ **Copy of Proof of Income if using sliding scale fees (if not provided, standard rate of $180/$160 will apply)**
- ☐ **Keep copy of "Client Rights and Information" sheet**
- ☐ **Fee:_____(Cash, Credit Card, Paypal)**
- ☐ **Request for copies of paperwork Fee:_____**
- ☐ **Other**_____

PROFESSIONAL COUNSELING AGREEMENT

Description of Counseling Services

New Day Counseling provides mental health counseling for adults, children, couples, families, and groups. New Day Counseling adheres to the American Counseling Association and National Board of Certified Counselors Code of Ethics and Standards of Practice.

Referral Policy/Disclaimer

I understand that if New Day Counseling is unable to provide the type of service I need or request, I will be referred to an appropriate outside agency. Though New Day Counseling strives to be responsible and professional in the referral procedure, it is my full right and responsibility to select the professional of my choice. Furthermore, New Day Counseling is not liable for any services provided or not provided by the referred professional.

Counseling Fees/Cancellation Policy

For counseling services rendered at New Day Counseling, I agree to pay all fees for service and debts for counseling sessions **before** each session begins: testing, and other customary charges in accordance with the terms set below-

- I acknowledge that each 50-minute session will cost $_____. The initial intake session will cost _____.
- I understand that I will be billed 100% of my established fee if I do not cancel my appointment at least ***24 hours in advance.*** I understand that if I miss two or more sessions without giving 24 hour notice, New Day Counseling and my therapist reserves the right to terminate our therapy relationship with no notification. In addition, frequent cancellations or no-shows may also lead to termination of therapy by letter or phone call.
- I understand that at no time will an outstanding fee-for-service balance of more than $50.00 be allowed and that therapy may be temporarily suspended or terminated until sufficient payment is received to place my outstanding balance below this amount.

Confidentiality

Counseling is confidential. Information obtained during counseling sessions will not be disclosed to any outside persons or agencies without your permission except when required by law (e.g., where my therapist reasonably believes that I am in danger of harming myself unless protective measures are taken, where I present a serious danger of violence to another, or where there is reasonable suspicion of abuse of children or elderly persons). As part of the counseling process, I understand that my counselor may consult with or receive peer supervision from another professional in order to ensure the quality of care for my counseling experience.

Client Rights

I have been given a copy "Clients Rights and Information" and "Recipient Rights Brochure" and I have read and understood its contents. I consent to mental health treatment as recommended by my therapist. I understand that I will participate in the development of my treatment plan and that I am free to withdraw my consent and discontinue treatment at any time.

I have read the above and understand its contents. I agree to abide by the provisions set forth above.

_____ _____

Client's Signature Date

_____ _____

Therapist's Signature Date

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home or Cellular Telephone _____ ☐ Written Communication
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ O.K. to mail to my home address
- ☐ O.K to mail to my work/office address

☐ Work Telephone _____ ☐ Other _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

_____ _____
Client's Signature Date

_____ _____
Print Name Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom – Address, Email or Fax Number	(1)	Description of Disclosure/Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check the box if the disclosure is authorized
(2) Type Key: T=Treatment Records: P=Payment Information: O=Healthcare Operations
(3) Enter ow disclosure was made: F=Fax; P=Phone: E=Email; M=Mail; O=Other