NEW Horizons COUNSELING CENTER

CLIENT REGISTRATION

PATIENT'S NAME: _____ Today's Date: _____

Nickname: _____ DOB: _____ Student? ___ Yes ___No Marital Status: __S __M __D __W

Employed? __Yes __No Gender: ___M ___F May we send mail to the home address listed below? ___ Yes ___No

May we communicate with you via email? ___ Yes ___No Email Address:_____

Address:_____ City: _____ Zip: _____

Phone: _____ ____Ok Voicemail ____Ok Text ____Appt. Reminders ____No Messages

SPOUSE/SIGNIFICANT OTHER/OTHER PARENT INFORMATION:

Name:_____ DOB: _____ Relationship to Client:_____

Address:_____ City: _____ Zip: _____

Phone: _____ ____Ok Voicemail ____Ok Text ____Appt. Reminders ____No Messages

EMERGENCY CONTACT:

Name: _____ Phone: _____ Relationship: _____

PRIMARY INSURANCE INFORMATION:

Card Holder's Name:_____ DOB: _____ Relationship: _____

Address:_____ City: _____ Zip: _____

Insurance Company Name: _____ Member ID#: _____

Group #: _____ Employer: _____

I,_____ *(Printed Name)* understand that I am responsible for all deductibles and copayments for services rendered and agree to pay them at time of service. I further understand and agree that I am responsible for payment of service if for any reason my insurance does not cover the billed serviced. I authorize New Horizons Counseling Center (NHCC) to bill my insurance for services rendered and payments to be made to NHCC. I consent to the release of my patient records to my insurance company for authorization purposes and payment of charges submitted.

Signature: _____ Date: _____

DIRECT PAY INFORMATION (*For Clients who have no insurance or other*)**:**

☐ I will **NOT** be using insurance. The cash rate for services will be: $150 for Intake, $125 for 1 hour session, $100 for 45 minute session, unless otherwise stated by appointed therapist.

Signature: _____ Print: _____ Date: _____

THERAPIST/EVALUATOR-CLIENT SERVICE AGREEMENT

ACKNOWLEDGEMENT:

By signing below, Patient acknowledges that Patient has reviewed and fully understands the terms and conditions of document **Informed Consent for Evaluation and/or Treatment** upon which Client Service Agreement is based. Patient has discussed such terms and conditions with the therapist as necessary and has had any questions with regard to its terms and conditions answered to Patient's satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with the therapist and New Horizons Counseling Center, PLLC. Moreover, Patient agrees to hold therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

FEE AGREEMENT:

Payment: I understand that I am financially responsible for payment for all services rendered and that I am obligated to pay all charges denied for whatever reason by my insurance carrier. Any assignment and authorization in no way releases me from said responsibility and imposes no obligation on my therapist to collect money on my behalf. I understand my financial responsibility with insurance and that without insurance coverage and/or cancelled/terminated insurance coverage or insurance that does not pay for whatever reason; I am responsible for payments due. **I am responsible for all payments toward my deductible as well as all co-pays before services are rendered.** _____ ***Initial***

Cancellations: I agree and understand I must provide a 24-hour advance notice to either my therapist or New Horizons Counseling Center, PLLC if I am unable to attend a scheduled appointment. If I fail to provide the described notice, I will be responsible to pay the cancellation charge described in this Agreement of **$50.00.** _____ ***Initial***

No-Shows: I agree and understand when failing to show for my scheduled appointment with no proper notification as noted in this Agreement, I will be responsible to pay a "no-show" fee as described in this Agreement of **$50.00.** _____ ***Initial***

Direct Pay Rates: $150.00 per Intake session. **$125.00** per 60-minute session. **$100.00** per 45-minute session unless otherwise noted by therapist. _____ ***Initial***

Copies/Letters: Copy of medical records, reports or letters requested by client for other professional disclosures (reviewed, compiled and sent 7-14 business days following request): **$25.00** minimum fee (fee can vary as allowed by Michigan law). _____ ***Initial***

Court Appearances: Testimony/depositions/consultations: **$450.00** initial 2 hours; **$200.00** each additional hour. Does not include travel time and may add to fee amount. _____ ***Initial***

Mileage: For out of office appearance: IRS allowable rate. _____ ***Initial***

Non-sufficient funds: (checks), bank fees (NSF) **(DUE BEFORE CONTINUING TREATMENT): $30.00.** _____ ***Initial***

COMMUNICATION:

I/we understand that there are limitations to the use of email and cell phone technology and that confidentiality cannot be 100% guaranteed in any electronic format. I/we agree to take responsibility for electronic communication and New Horizons Counseling Center, PLLC will be held harmless if there is a technical or communication failure resulting from my choice to communicate with New Horizons Counseling Center, PLLC via electronic communication.

Please refer to the "Informed Consent for Evaluation and/or Treatment" which outlines cautionary information regarding the usage of emailing and/or texting.

NOTICE OF PRIVACY PRACTICES:

I have received the **Notice of Privacy Practices** submitted by New Horizons Counseling Center, PLLC. Copies are available on line at www.nhcounselingcenter.com as well as in the Waiting Room at New Horizons Counseling Center, PLLC. ***OR*** I refuse to acknowledge a copy or accept a copy of Privacy Practice Information. *(A SEPARATE SIGNATURE SPECIFICALLY FOR THE NOTICE OF PRIVACY PRACTICES IS REQUIRED).*

ACCEPT: _____ **ACCEPT:** _____ _____
Signature of Patient (or Authorized Representative) Print Name of Patient (or Authorized Representative) Date

DECLINE: _____ DECLINE: _____ _____
Signature of Patient (or Authorized Representative) Print Name of Patient (or Authorized Representative) Date

BY PROVIDING MY SIGNATURE, I AM ACKOWLEDGING THE CONSENT TO TREAT, ALL FEES, LIMITATIONS OF COMMUNICATION VIA TECHNOLOGY, PRIVACY/HIPAA NOTICE & ALL OTHER INFORMATION PRESENTED.

Signature: _____ ***Printed Name:*** _____ ***Date:*** _____

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FEE AGREEMENT:

Payment: I understand that I am financially responsible for payment for all services rendered and that I am obligated to pay all charges denied for whatever reason by my insurance carrier. Any assignment and authorization in no way releases me from said responsibility and imposes no obligation on my therapist to collect money on my behalf. I understand my financial responsibility with insurance and that without insurance coverage and/or cancelled/terminated insurance coverage or insurance that does not pay for whatever reason; I am responsible for payments due. **I am responsible for all payments toward my deductible as well as all co-pays before services are rendered.** _____ ***Initial***

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ACCEPT: _____ _____ _____
Signature of Patient (or Authorized Representative) Print Name of Patient (or Authorized Representative) Date

DECLINE: _____ _____ _____
Signature of Patient (or Authorized Representative) Print Name of Patient (or Authorized Representative) Date

BY PROVIDING MY SIGNATURE, I AM ACKOWLEDGING THE CONSENT TO TREAT, ALL FEES, LIMITATIONS OF COMMUNICATION VIA TECHNOLOGY, PRIVACY/HIPAA NOTICE & ALL OTHER INFORMATION PRESENTED.

Signature: _____ ***Printed Name:*** _____ ***Date:*** _____

COORDINATION OF CARE WITH PRIMARY CARE PHYSICIAN

Client Name:_____ **DOB**:_____

Person Completing Form:_____**Relationship:**_____

□ I ***decline*** to have my behavioral information shared with anyone including my PCP – or -

□ I ***consent*** to share my behavioral health information with my PCP.

Name of Establishment Receiving Your Information:_____

Provider:_____

Address: _____

Phone Number:_____ Fax Number:_____

By signing this form I understand I am giving consent to share my behavioral health and substance abuse disorder information including, but not limited to, referrals and services for alcohol and substance use disorders. My information may be shared among each agency and person listed above. My information will be shared to help diagnose, treat, manage and pay for my health needs. My consent is voluntary and will not affect my ability to obtain mental health or medical treatment, payment for medical treatment, health insurance or benefits. My health information may be shared electronically. Other types of my information may be shared with my behavioral health and substance use disorder information. HIPAA allows my providers and other agencies to use and share most of my health information without my consent in order to provide me with treatment, receive payment for care, and to manage and coordinate my care. The sharing of my health information will follow state and federal laws and regulations. This form does not give my consent to share psychotherapy notes as defined by federal law. I can withdraw my consent at any time; however, any information already shared upon my consent cannot be taken back. I should tell all agencies and people listed above when I withdraw my consent. I can have a copy of this form. My consent will expire one year from signature date. I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered.

Signature:_____**Date**:_____

TO BE COMPLETED BY THERAPIST ONLY

Diagnosis:_____

Treatment Plan: □ Individual □ Marital □ Family □ Group

Therapy: □ Twice Weekly □Weekly □Bi-Weekly □Monthly □Other

Estimated Length Of Treatment: _____

Therapist Signature:_____ Date:_____

Date Faxed: _____ Faxed By (initials):_____ □ Fax □Email

CREDIT CARD AUTHORIZATION

New Horizons Counseling Center, PLLC requires every person receiving therapy services to keep a credit card on file with the Billing Department. **You are required to complete this form entirely during your first visit.** The information is kept secure and confidential. **Balances may be a result of deductibles, copays, insurance rejections and no show/late cancellation fees.**

Payment for services is due at the time services are rendered. Your card will be charged for any balances on your account that remain ***unpaid over 30 days.*** This will help our office better assist you with keeping your account up to date and at a zero balance.

You are free to speak with the Billing Department and dispute charges and/or question your insurance company payments or rejections and how claims were processed.

If you have questions about this required policy, please feel free to speak with the Office Manager or representative. New Horizons Counseling Center, PLLC desires for you to have a therapeutic experience that promotes hope, clarity, healing and change and not have to be concerned with bills, monthly payment and debt.

I authorize New Horizons Counseling Center, PLLC to charge outstanding balances that remain on my account past 30 days on the following card:

CONTACT/BILLING INFORMATION (*as shown on Credit Card*):

Client name if different from cardholder: _____

Cardholder name (as shown on card): _____

Address: _____

City: _____ State: _____

Zip Associated with Card: _____

Phone: _____

Credit Card Type: _____Visa _____ MasterCard _____ American Express _____ Discover

Credit Card #: _____ Expiration Date: _____

Credit Card Security Code: _____

CLIENT AUTHORIZATION:

I guarantee and warrant that I am the legal cardholder for this credit card. I hereby authorize New Horizons Counseling Center, PLLC to charge the indicated credit card if my account becomes 30 days past due.

Signature of Card Holder (required): _____ *Date:* _____

THERAPIST NAME: _____ File#_____ Office Initials _____ D/C Date: _____

INFORMED CONSENT FOR EVALUATION AND/OR TREATMENT

Welcome to New Horizons Counseling Center! This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a patient seeking evaluation and/or therapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be made aware. Your therapist also has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. There are no guarantees about what will happen and psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things discussed outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, the therapist will be able to offer you some initial impressions of what our work might include. You will be asked to discuss your treatment goals and the therapist will create an initial Treatment Plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with the therapist. If you have questions about any procedures, it should be discussed with the therapist whenever they arise. If your doubts persist, please ask your therapist to assist you in setting up a meeting with another mental health professional for a second opinion.

APPOINTMENTS

Appointments will ordinarily be 45-60 minutes in durations, typically once per week at an agreed upon time, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, you are asked to provide the office/therapist with 24 hours notice. **If you miss a session without canceling or cancel with less than 24 hour notice, you will be charged a $50.00 no show/no cancellation fee.** It is important to note that insurance companies do not provide reimbursement for canceled sessions; thus, you will be responsible for the fee as described above. If you miss an appointment, do not assume that your appointment will be the same time next week. It is your responsibility to call and reschedule your appointment. In addition, you are responsible for coming to your session on time. If you are late, your appointment will still need to end on time. Repeat no-show or cancellations affect treatment progress even when paying fees for no-shows and cancellations. Should repeat no-show or cancellations occur, your file may be subject to discharge with no possibility of further treatment with current or other therapist. **All fees must be paid in full before being seen for sessions at New Horizons Counseling Center, PLLC.**

PROFESSIONAL FEES

Fees for evaluations and other specialty assessments will be based on the type of service needed and negotiated with the evaluator/assessor. You are responsible for payment when services are rendered unless prior arrangements have been made. Check, cash or credit card may be used for payment. Any checks returned to New Horizons Counseling Center, PLLC are subject to an additional fee of up to $30.00 to cover bank fees incurred.

ALL CLIENTS ARE REQUIRED TO KEEP A CREDIT CARD ON FILE with the Business Office. ANY and ALL balances that are over 30 days without payment will be charged to the credit card on file. Note: your credit card information will be kept secure and confidential. You will be provided with a **Credit Card Authorization** form prior to beginning services. *This form must be completed in its entirety before any and all services can be rendered.*

In addition to weekly appointments, New Horizons Counseling Center, PLLC retains the right to charge for other services on a prorated basis for other professional services that you may require such as report writing, telephone conversations that last longer than 10 minutes, attendance at meetings or consultations which you have requested, or time required to perform any other service which you may request of the evaluator or therapist. If you anticipate becoming involved in a court case, it is recommended that you discuss this fully with your evaluator/therapist before you waive your right to confidentiality. If your case requires the evaluator's or

therapist's participation, you will be expected to pay for the professional time required even if another party compels the evaluator/therapist to testify. Please be aware that therapists will not voluntarily participate in any litigation or custody dispute in which you and another individual, or entity, are parties. We generally do not provide records or testimony unless subpoenaed or ordered by a court of law. Be aware that copies of medical records, reports or letters requested by you for other professional disclosures requires a $25.00 minimum fee that can vary allowed by Michigan law. Testimony, depositions or consultations cost **$450.00 for the initial 2 hours and $200.00 each additional hour** but can vary allowed by Michigan law. That does not include travel time to and from court or other business/governmental entity.

INSURANCE

In order for New Horizons Counseling Center, PLLC to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy it will usually provide some coverage for mental health treatment. The Business Office, Billing Department, evaluator/therapist will assist you to the extent possible in filing claims and ascertaining information about your coverage; however, **you are responsible for knowing your coverage** (benefits, deductibles, co-payments, limitations, etc.) and for notifying New Horizons Counseling Center, PLLC if/when your coverage changes.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is difficult to determine exactly how much mental health coverage is available and every plan is different. Managed Health Care plans such as HMO's and PPO's often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. You would them become a "direct pay" patient. Fees can be discussed with your therapist but generally cost $150 for the initial intake session, $125 for one-hour sessions, $100 for 45-minute sessions unless otherwise specified by assigned therapist.

You should also be aware that most insurance companies require you to authorize the treatment provider to render a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-V. There is a copy in the office and you may request to see the manual to learn more about your diagnosis, if applicable.) Sometimes, insurance companies require additional clinical information such as treatment plans or summaries or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, New Horizons Counseling Center, PLLC has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. You may be provided with a copy of any report required for submission if you request it. By signing this Agreement, you agree that New Horizons Counseling Center, PLLC can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by cash, check or credit card. In addition, some insurance plans also have deductibles that have to be met before co-pays kick in. Deductibles traditionally begin at the start of every calendar year. Until your deductible has been met, expect to pay full rate of the session (see Direct Fees above). Once the Business Office has all of the information about your insurance coverage, the evaluator/therapist will discuss what can be reasonably accomplished with the benefits that are available and what will occur if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above. Note: Should I Use My Health Insurance to Pay for Psychotherapy is a document found in our Waiting Room. Please refer to that for useful information regarding insurance.

If New Horizons Counseling Center, PLLC or associated evaluator/therapist is not a participating provider for your insurance plan, you will be provided with a receipt of payment for services that you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, please call your insurance company and ask for information regarding in-network providers.

PROFESSIONAL RECORDS

Providers of professional services are required to keep appropriate records of the psychological services that are provided. Records are maintained in an electronic medical record web-based program that is secure (Therapy Notes). The system keeps brief records noting that patient attended session, reasons for seeking therapy, goals and progress set for treatment, diagnosis, topics discussed, medical, social and treatment history, records received from other providers, copies of records sent to others and billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because records are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended that you initially review them with your evaluator/therapist or have them forwarded to another mental health professional to discuss the contents. If New Horizons Counseling Center, PLLC refuses your request for access to your records, you have a right to have the decision reviewed by another mental health professional, which will be discussed with you upon your request. You also have the right

to request that a copy of your file be made available to any other health care provider at your written request. Request to Share documents are available in the Business Office or upon request.

CONFIDENTIALITY

Policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled **Notice of Privacy Practices.** Copies are available in the Waiting Room and on the website: www.nhcounselingcenter.com. You may discuss the contents within at any time with your therapist.

Confidentiality has exceptions: 1) Supervision/consultation but any identifying information will not be used; 2) If you report abuse of a child, elderly or disabled person(s); 3) Imminent harm to self; 4) Imminent harm to others; 5) Court related proceeding and lawsuits.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress and outcomes, parental involvement can also be essential. It is New Horizons Counseling Center, PLLC's policy not to provide treatment to a child under age 13 unless he/she agrees that the evaluator/therapist can share whatever information he/she considers necessary with a parent. For children 14 and older, the evaluator/therapist requests an agreement between the patient and the parents allowing evaluator/therapist to share general information about treatment progress and attendance. All other communication will require the child's agreement unless evaluator/therapist feels there is a safety concern.

EMAIL, TEXTING & OTHER ELECTRONIC MEDIUMS OF COMMUNICATION

Clinicians are often not immediately available by telephone. Clinicians do not answer phone calls when in session and are otherwise unavailable. At these times, you may leave a message on the main Business Office number. If you wish for a return phone call, please be sure to leave your name and phone number along with a brief message concerning the nature of your call. Non-urgent phone calls are generally returned within 24 hours during normal workdays (Monday through Thursday). In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call **911** to request emergency assistance, go to the nearest emergency room and/or call Macomb County 24 Hour Crisis Line at 586-307-9100 or St. Clair County 24 Hour Crisis Line at 888-225-4447 (refer to the **Emergency Procedures** form available on-line or in the Waiting Room).

Some patients prefer to communicate about appointment times or other administrative issues via email. Email should only be used by your assigned therapist/New Horizons Counseling Center, PLLC to schedule and/or change an appointment, billing, ask non-urgent questions or provide educational material. Although information via computer is encrypted, email transmitted through regular services is not encrypted. This means that a third party may be able to access information in an email and read it since it is transmitted over the internet. In addition, once you receive email, someone may be able to access your email account and read it. This may include your employer if you use a work-related email address. It is your responsibility to ensure the security and confidentiality of sent and received electronic communication on your electronic devices. Email should be considered to be more similar to a "post-card" than to a sealed letter and for that reason, it is discouraged sending any clinical or other sensitive information via email. Please use the telephone for anything urgent or time sensitive as New Horizons Counseling Center, LPPC cannot guarantee that an emergency email will be seen in a timely manner but generally within 48 hours. In addition, electronic communication may be used to change or cancel an appointment; however, the electronic communication must be sent at least 24 hours before the scheduled appointment to avoid the $50 no show/cancellation fee as stated above in paragraph titled Appointments.

With your consent, text messaging and email will only be used by your assigned therapist/New Horizons Counseling Center to schedule and/or change an appointment, billing, ask noon-urgent questions or provide educational material.

Do not use text messaging or email to send sensitive material. New Horizons Counseling Center does not guarantee the privacy or security of information sent via text or email. Do not use these forms of communication if you are concerned with the security of information being shared.

There are numerous limitations to electronic technology and communication: computers can crash, viruses can invade, email accounts can be hacked or freeze up, iPads and tablets and cellular phones can be lost or misplaced, etc. Please keep this in mind if you send sensitive information via electronic mediums.

OTHER RIGHTS

If you are unhappy with any aspect related to treatment or therapist, please share concerns with your therapist. Concerns are taken seriously and handled with care and respect. You may also request to be referred to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin or source of payment. You have the right to ask questions about any aspects of therapy including therapists' qualifications, specific training and experience. You should expect the clinician would not have social or sexual relationships with patients or with former patients.