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| --- |
| DEMOGRAPHIC INFORMATION |
| Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Last) (First ) (Middle) (Nickname)  Sex: 🗖 M 🗖 F D.O.B.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parents/Caregivers Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City/State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_ School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent’s Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parents/Guardian’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| PAYMENTName of Mental Health Insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (look at the back of the insurance card, it may be different from your medical insurance.) Name of the Primary Insured/or Private Pay Responsible person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to Client (circle one): Mother, Father, Sibling, Relative, Legal Guardian, Other: \_\_\_\_\_\_\_\_  Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address (if different from above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Authorization Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| IMPORTANT - Please read the following statements and sign below:  The New Life Family Counseling will file claims to your insurance carrier only if we are a contracted network provider. In the case of the out-of network services, you will pay for the service first, we will provide you with a receipt for your payment so that you may get your own reimbursement from your insurance. **If prior authorization is required for your insurance benefits, it is the responsibility of the Client (or Legal Guardian) to obtain authorization from the insurance company for all visits.** If you have not obtained authorization for this visit, you will be responsible for the entire charge.  I hereby give my permission for New Life Family Counseling to share my personal and medical information for billing purposes. I also give consent to my Mental Health insurance carrier to assign payment to New Life Family Counseling for services provided.  RESPONSIBLE PERSON AGREEMENT: I have read and understand the above policy. I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by New Life Family Counseling, A Professional LCSW Corporation.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature (Client signature if client is the one responsible for payment) Date: |
| OTHER CURRENT MENTAL HEALTH SERVICES |
| 🗖No current services🗖Psychiatric/Medication: Name of doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🗖Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| RELIGION/FAITH |
| Do you attend church? 🗖 Yes 🗖 No  If Yes, how often? 🗖 Occasionally 🗖 Weekly 🗖 More than Once a WeekAre there any recent changes in your faith or church attendance? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| PROBLEM DESCRIPTION |
| **Please circle & describe symptoms to be treated:**  Physical Aggression Runaway Tantrums Lying Depressed Affect  Verbal Aggression Property Destruction Truancy Sexually Acting Out Anxious Affect  Non-Compliance Disruptive Behavior Stealing Self-Injury/Suicidal Toileting Problems  Anger Outbursts Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Yes No**  🗖 🗖 Caused injury (bruising/bleeding) to others in past month?  🗖 🗖 Caused significant property damage (>$25) in past month?  🗖 🗖 Are other people’s safeties at risk due to client’s violence?  🗖 🗖 Arrested or serious criminal behavior in past month?  🗖 🗖 School placement in jeopardy? (suspended, multiple referrals)  🗖 🗖 Home placement at risk?  🗖 🗖 Serious suicidal gestures/attempts in past 6 month?  🗖 🗖 Admitted to a crisis unit in past 6 months? |
| PARENTS & FAMILY INFORMATION: |
| Parents/Legal Guardian’s Marital Status:  🗖 Married 🗖 Separated 🗖 Divorced 🗖 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How long divorced \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of divorces \_\_\_\_\_\_\_ Length of current marriage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Frequency of family moves in the last two years: \_\_\_\_\_\_\_\_\_\_\_ How long at the current address:\_\_\_\_\_\_\_\_\_\_\_   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Please list OTHER children by age:  (Place a check mark by name if from previous marriage or adoption) | | | | | | | NAME | AGE | SEX | EDUCATION LIVING AT HOME | | SPECIAL CONCERNS | |  |  |  |  | |  | |  |  |  |  | |  | |  |  |  |  | |  | | Please list any other person (s) living in your home: | | | | | | | NAME | AGE | SEX | RELATIONSHIP | SPECIAL CONCERNS | | |  |  |  |  |  | | |  |  |  |  |  | | |
|  |
| HEALTH & MEDICAL INFORMATION |
| **CHILD’S HEALTH RATING:** 🗖 Excellent 🗖Good 🗖 Average 🗖 Poor 🗖 Very Poor    Currently under a doctor’s care? 🗖 Yes 🗖 No If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ADDITIONAL BACKGROUND INFORMATION & SPECIFIC CONCERNS |
| Has your child seen a counselor or therapist previously? 🗖 Yes 🗖 No If yes, who and when ?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What is your main concern about your child?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other Specific Concerns:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| CONSENT TO RELEASE INFORMATION |
| Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **I authorize:** New Life Family Counseling  22600 Savi Ranch Parkway, Ste., A42,  Yorba Linda, CA 92887  to release and/or obtain confidential information concerning the above-named client with the following:  Agency/Contact: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Mailing Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  City, State, Zip: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Phone/Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **I authorize:**  Verbal communication regarding ALL client records/information between both parties.  **OR**  Copies of the following documents to be mailed/faxed to the agency listed above  Copies of the following documents to be mailed/faxed to New Life Family Counseling  Limited verbal communication (no copies) related only to the following records(Check which documents are authorized to be released):  Treatment Plan/Reviews  Bio-Psychosocial Evaluation  Progress Notes  Behavioral Assessment  Behavioral Program  Progress Summary  Psychiatric Evaluation  Medication Management  Discharge Summary  Medical History & Physical  Immunization Record  Lab Results  Individual Education Plan (IEP)  Report Cards/Transcripts  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Purpose of Release:**  At the request of the individual  Treatment Coordination  Assessment  Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from New Life Family Counseling. * I authorized the above named agency(s), person, or offices to exchange verbal (telephone) and written information. As specified above for the purpose and treatment period indicated. I hold harmless New Life Family Counseling in regard to the use of information authorized for release of exchange. * I understand that I may revoke this authorization in writing at any time, however I cannot revoke authorization for action that has already been taken. * A copy of this release shall be valid as the original. Original will be retained in medical record.   **THIS CONSENT EXPIRES 1 YEAR FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Client/Legal Guardian Signature Date |
| CANCELLATION / NO SHOW POLICY |
| I agree to attend all scheduled appointments. I understand that failure to cancel an appointment without a twenty-four **(24) hour notice** or not showing up for an appointment **will result in a fifty-dollar ($50.00) fee**. Repeat offenses of this policy may result in permanently being removed from the schedule.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_  Client/Legal Guardian Signature Date |
| CONSENT FOR PSYCHOTHERAPY TREATMENT (INFORMED CONSENT) |
| I hereby consent to enter treatment with New Life Family Counseling. I understand that all information disclosed during the course of therapy will be held in confidence with the exception of intervention with threats of harm to myself or others, allegations of child abuse or neglect and/or court ordered disclosures. I understand that New Life Family Counseling has a legal and ethical obligation to disclose this information and will make every effort to discuss this with me should the need arise. I understand that all information will be held in the strictest confidence and will not be released to any one without my prior specific written permission. (Please refer to HIPAA Notice below)  I understand that I will expect to be an active participant in my treatment. I will commit myself to keeping my appointments as scheduled. I acknowledge that there is never a guarantee in the outcome of my therapy.  I understand that payment arrangements for services are my responsibility. I understand that I will be expected to notify the office of the need to reschedule an appointment at least 24 hours in advance.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_  Client Date  ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_  Legal Guardian Signature Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_  Witness Date  I have Received a copy of the notice of privacy practice.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_  Signature Date |
| NOTICE OF PRIVACY PRACTICES (HIPAA) |
| Notice of Privacy Practices  THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU AND YOUR CHILDREN MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.  (No response is needed.)  **Why you are receiving this notice:**  Federal law requires New Life Family Counseling to:   * Make sure that medical information that identifies you is private * Give you this notice of our legal duties and privacy practices with respect to medical information about you; and * Follow the terms of this Notice, or any amendment to this Notice that is in effect.   **How New Life Family Counseling** **uses and discloses Protected Health Information:**  The most common reason why we use or disclose your information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; conducting evaluation and assessments; conducting observations; designing treatment plans; referring you to another provider for care or getting copies of your health information form another professional that you may have seen. Examples of how we use or disclose your information for payment purposes are: asking you about your health plans or other payers; and preparing or sending bills or claims. “Health care operations” mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your information for health care operations are: financial or billing audits; internal quality assurance; education of staff and other professionals. We routinely use your information for these purposes without any special permission.  **Additional Uses or Disclosures:**  We may also use and disclose your Protected Health Information as permitted by laws for the following purposes:   * When a state or federal law mandates that certain information be reported for a specific purpose * To governmental authorities about victims of suspected abuse, neglect or domestic violence * To other government agencies that provide public benefits for determining eligibility and compliance * For health oversight activities, such as inspections, investigations and audits * To prevent a serious threat to health or safety * Of a “limited data set” for research, public health, or health care operations * Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures * For legal purposes, such as subpoenas or court orders * For law enforcement purposes, such as information pertaining to a victim of a crime; or to report a crime * For specialized government functions, such as intelligence activities; disaster relief activities; or other national security activities authorized by law * For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or devices * Relating to worker’s compensation programs * To “business associates” who provide services for us and who commit to respect the privacy of your information * To your family or other persons who are involved in your care. (You have the right to object to disclosing this information.) * As otherwise required by law.   Other uses or disclosures of your protected health information require your written authorization If you give us your authorization you may cancel it by writing to our Privacy Officer at the address listed below. If you cannot give your authorization due to an emergency, we may release your health information if it is in your best interest.  **Your Protected Health Information Rights:**  You have the following rights with respect to your protected health information:   * To see or obtain a copy of your health information maintained by New Life Family Counseling. We may not be able to provide health information that includes psychotherapy notes, is part of a legal case, or is otherwise excluded from disclosure by laws. We may charge a copying fee. To inspect and/or receive a copy of your medical information, you must submit your request in writing to New Life Family Counseling. * To request a list of where we have sent your health information. The list may not include disclosures authorized by you; disclosures for treatment, payment, and health care operations; or other disclosures permitted by law. There may be a charge for the cost of compiling the information. * To request that we contact you at a different address or phone number, if contacting you about your health information at your present location would endanger you. * To request that we limit the use and disclosure of your health information. (Based on statutory guidelines, New Life Family Counseling may not be required to agree to your request.) * To request another paper copy of this notice.   **How to exercise your rights regarding your Protected Health Information disclosures:**  If you have any question, or wish to make a request regarding your Protected Health Information, or would like another paper copy of this notice, please contact our privacy officer at the address below.  Privacy Officer Secretary of Health and Human Services  New Life Family Counseling 200 Independence Avenue, SW  22600 Savi Ranch Parkway Washington D.C. 20201  Yorba Linda, CA 92887 |