|  |  |
| --- | --- |
| Insert date | Choose name |

**NEW HOPE COMMUNITY SERVICES, LLC**

### SERVICE INTAKE FORM

Please complete the information requested based on the individual receiving services.

|  |  |
| --- | --- |
| Intake Date | Have you been treated here before? Yes No |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: |  |  |  |  |
|  | First | Middle | Last | Maiden |
| Address: |  |  |  |  |
|  | Street |  |  | Apt # |
| City |  | State |  | Zip |
| Home Telephone # |  ( )  | Daytime # |  ( )  |
| Cell Phone # |  ( )  |  |  |
| Can we leave a message concerning your appointments?  | Yes No Phone # ( ) -  |
| Would you prefer email or text message notifications?  | Text Email:  |
| Date of Birth: |  Age:  |  | GENDER: M F ETHNICITY:  |

:

|  |  |
| --- | --- |
| Place of Employment: | SS#: |
|  |  |
| If Sliding Scale: |  | Annual House Hold Income: |  | ***For Office Use Only:*** |
|  |  |  |  | **SFS $50 $75 $100** |
| If filing Insurance: |  |  |  |  |
| **PRIMARY INSURANCE** |
| Name of Insured: |  | SS# |  | Date of Birth: |
| Type of Insurance |  |  |  |  |
| Subscriber ID# |  | Group ID# |  |  |
| Current Primary Care Physician: | Phone: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **MARITAL STATUS** | **MILITARY** Yes No |  |  | **EDUCATIONAL STATUS** |
| Single | Active Duty? Yes N | o |  | In School, grade |
| Married | Combat Exp? Yes No |  |  | Some School |
| Separated | Branch: |  |  |  | High School Grad |
| Divorced | Type of Discharge: |  |  | GED |
| Living With | Honorable |  |  | Some College |
| Widowed | Dishonorable |  |  | Associate’s Degree |
| Other | Medical |  |  | Bachelor’s Degree |
|  |  |  |  |  | Graduate Degree |
| **REFERRAL REASON** |  |  |  |  | **EMPLOYMENT STATUS** |
| Addiction | Neglect |  |  | Employed Full-Time |
| Anger | Parenting Skills |  |  | Employed Part-Time |
| Anxiety | Pressure/Stress |  |  | Student |
| Depression | Pre-Marital Counseling | Job Training Program |
| Drug/Alcohol Problems | PTSD |  |  | Laid-Off |
| Employment Problems | School Problems |  |  | Terminated |
| Eating Disorder | Self Esteem Problems | Quit |
| Home/Family Problems | Sexual Abuse |  |  | Retired |
| Legal Problems | Self |  |  |  | Unemployment |
| Life Changes | Sexual Dysfunction | Other: (please list) |
| Marital Problems | Suicide Issue |  |  |  |
| Person to Contact in Case of Emergency: |
| Relationship |  | Phone # |  |  |  |
| Briefly described the circumstances that have brought you to counseling |
|  |
| What do you hope to gain from counseling? |
|  |
| **MARITAL HISTORY** |  |  |  |  |  |
| Total Number of Marriages: | Time in Current Marriage: |  |
| **PERSONAL HISTORY** |  |  |  |  |  |
| Have you ever experience physical abuse? | Yes No | If yes, please give age(s) andcircumstances |
|  |  |  |
| Have you ever experience sexual abuse? | Yes No | If yes, please give age(s) and circumstances |
|  |  |  |
| Please list your hobbies and leisure activities: |  |  |

|  |  |  |
| --- | --- | --- |
| **LEGAL HISTORY** |  |  |
| Have you been or are you now involved in any activecases (traffic, civil, criminal) as a juvenile and/or adult? | Yes No | If yes, please give age(s) and circumstances |
|  |  |  |
| Are you currently on probation or parole? | Yes No | If yes, please provide probation officer’s contact |
|  |  |  |
| Please list your charges, approximate dates (or age), and current status: |  |

|  |  |  |
| --- | --- | --- |
| **EDUCATIONAL HISTORY** |  |  |
| Graduate of High School? | Yes No | If no, please indicate departure year (age) |
|  |  |  |
| College Graduate? | Yes No | If no please indicate # of years attended |
|  |  |  |
| Other training – skills sets |  |  |

|  |  |  |
| --- | --- | --- |
| **EMPLOYMENT HISTORY** |  |  |
| Currently Employed? | Yes No | If yes, please give location / years |

|  |
| --- |
| **HEALTH HISTORY** |
| Are you currently taking prescription medication? If so, please list them and why you are taking them. |
|  |
| SURGERIES |
| List surgeries and dates: |

|  |
| --- |
| ACCIDENTS |
| List any accidents that resulted in serious or disabling injuries: |
|  |
| PAST COUNSELING/TREATMENT |
| List any prior counseling and/or treatment programs participated in |
|  |
| **PHYSICAL LIMITATIONS OR DISABILITIES** |
| Please list any physical limitations or handicaps: |
|  |
| Are you experiencing any sleeping difficulties? If so, please explain: |
|  |
| Do you have any problems related to eating? Is so, please explain: |
|  |
| How many pregnancies have you had? Miscarriages? Abortions? |
|  |
| Please describe any other physical conditions or complaints not mentioned above: |
|  |
| **CURRENT FAMILY** |
| List all persons currently living in household: |

|  |  |  |  |
| --- | --- | --- | --- |
| **FAMILY OF ORIGIN** |  |  |  |
| Mother: |  |  | Occupation: |
| Mother deceased? | Yes No | If yes, when? | How? |
| Father: |  |  | Occupation: |
| Father deceased? | Yes No | If yes, when? | How? |
| Parents Married? | Yes No | Divorced? | Yes No |
| Describe briefly your relationship(s) w/key members of your family: |
|  |
| **SUBSTANCE USE** |  |  |  |
| Please list all drugs (alcohol included) that you have taken in the last year. Include any prescription medications you have taken(whether prescribed or not). |
| Substance |  | Frequency | Last Used |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Please list any family members (including self) that have ever had a history of addiction or substance abuse or arrested while drinking or using drugs: |
|  |
| **SPIRITUAL VALUES** |  |  |  |
| How has your church, your faith, religion, belief system influenced your current situation? |

**NEW HOPE COMMUNITY SERVICES, LLC**

**PATIENT HEALTH QUESTIONNAIRE (PHQ)**

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question as best you can unless you are requested to skip over a question.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **1. During the *last 4 weeks*, how much have you been bothered by any of the following****problems?** | **Not bothered****at all** | **Bothered some** | **Bothered a little** | **Bothered a lot** |
| a. Stomach pain |  |  |  |  |
| b. Back pain |  |  |  |  |
| c. Pain in your arms, legs, or joints (knees, hips,etc.) |  |  |  |  |
| d. Menstrual cramps or other problems withperiods |  |  |  |  |
| e. Pain or problems during sexual intercourse |  |  |  |  |  |  |  |  |
| f. Headaches |  |  |  |  |  |  |  |  |
| g. Chest pain |  |  |  |  |
| h. Dizziness |  |  |  |  |
| i. Fainting spells |  |  |  |  |
| j. Feeling your heart pound or race |  |  |  |  |
| k. Shortness of breath |  |  |  |  |
| l. Constipation, loose bowels, or diarrhea |  |  |  |  |
| m. Nausea, gas, or indigestion |  |  |  |  |
| **FOR OFFICE CODING: 300.82 (F45.1) if at least 3 of #1a-m are “a lot” and lack an adequate biol explanation** |
| **2. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?** | **Not bothered at all** | **Bothered several days** | **Bothered more than****half the days** | **Bothered nearly every day** |
| a. Little interest or pleasure in doing things |  |  |  |  |
| b. Feeling down, depressed, or hopeless |  |  |  |  |
| c. Trouble falling or staying asleep, or sleepingtoo much |  |  |  |  |
| d. Feeling tired or having little energy |  |  |  |  |
| e. Poor appetite or overeating |  |  |  |  |
| f. Feeling bad about yourself – or that you are afailure or have let yourself or your family down |  |  |  |  |
| g. Trouble concentrating on things, such asreading the newspaper or watching television |  |  |  |  |
| h. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have beenmoving around a lot more than usual |  |  |  |  |
| i. Thoughts that you would be better off dead orof hurting yourself in some way |  |  |  |  |
| **FOR OFFICE CODING: 296.21 if at least 4**  **in x3/4 – Add score for severity – add up all**  **- 0/1/2/3 – 1-4 Minimal/5-9 Mild/10-14 Moderate/15-19 Mod Sev****/ 20-27 Severe 296.23 if #2a or b and 5 or more of #2c-i are at least “more than half the days” (count #2i if present at all)****311 if #2a or b and 2, 3 or 4 of #2a-i are at least “more than half the days” (count #2i if present at all) (REPEAT PHQ-9 – every 2 weeks for status)** |

|  |  |  |  |
| --- | --- | --- | --- |
| **3. Questions about anxiety** | **NO** | **YES** |  |
| a. In the last 4 weeks, an anxiety attack – sfeeling fear or panic | have you had uddenly? |  |  |
| **If you checked “NO”, go to question #5.** |  |  |
| b. | Has this ever happe | ned before? |  |  |  |
| c. Do some of these at suddenly out of the situations where yoto be nervous or un | tacks come blue that is, in u don’t expectcomfortable? |  |  |
| d. Do these attacks bo or are you worried aanother attack? | her you a lot bout having |  |  |
| **4. Think about the last****attack.** | **bad anxiety** | **NO** | **YES** |
| a. Were you short of b | reath? |  |  |
| b. | Did your heart race,skip? | pound, or |  |  |
| c. Did you have chestpressure? | pain or |  |  |
| d. | Did you sweat? |  |  |  |
| e. Did you feel as if yochoking? | u were |  |  |
| f. Did you have hot fla | shes or chills? |  |  |
| g. Did you have nause stomach, or the feelwere going to have | a or an upset ing that youdiarrhea? |  |  |
| h. | Did you feel dizzy, ufaint? | nsteady, or |  |  |
| i. Did you have tinglinin parts of your bod | g or numbnessy? |  |  |
| j. Did you tremble or s | hake? |  |  |
| k. Were you afraid you | were dying? |  |  |
| **5. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?** | **Not bothered at all** | **Bothered several days** | **Bothered more than half the days** | **Bothered nearly every day** |
| a. Feeling nervous, anxious, on edge, or worrying a lot about differentthings. |  |  |  |  |
| **If you checked “not bothered****at all”, go to question #6.** |  |
| b. Feeling restless so that it is hardto sit still |  |  |  |  |
| c. Getting tired very easily |  |  |  |  |
| d. Muscle tension, aches, orsoreness |  |  |  |  |
| e. Trouble falling asleep or stayingasleep |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **5. Over the *last 2 weeks*, how often have you been bothered by any of****the following problems?** | **Not bothered****at all** | **Bothered several****days** | **Bothered more than****half the days** | **Bothered nearly every day** |
| f. Trouble concentrating on things, such as reading the newspaper orwatching television |  |  |  |  |
| g. Becoming easily annoyed orirritable |  |  |  |  |
| **FOR OFFICE CODING: 300.01 if #3a-d are all “yes” and 4 or more of #4 a-k are “Yes” Other 300.02 if #5a and answers to 3 or more of #5b-g are “more than half”** |
| **6. Questions about eating** | **NO** | **YES** |  |
| a. Do you often feel that you can’t control what or how much youeat? |  |  |
| b. Do you often eat, within any 2- hour period, what most people would regard as an unusuallylarge amount of food? |  |  |
| **If you checked “No” to either****#6a or 6b, go to question #9.** |  |
| c. Has this been as often, onaverage, as twice a week for the last 3 months? |  |  |  |
| **7. In the *last 3 months* have you*****often* done any of the following in order to avoid gaining weight?** | **NO** | **YES** |
| a. Made yourself vomit? |  |  |
| b. Took more than twice therecommended dose of laxatives? |  |  |
| c. Fasted – not eaten anything at allfor at least 24 hours? |  |  |
| d. Exercised for more than an hourspecifically to avoid gaining weight after binge eating? |  |  |
|  | **NO** | **YES** |
| **8. If you checked “Yes” to any of****these ways of avoiding gaining weight, were any as often, on average, as twice a week?** |  |  |
| **FOR OFFICE CODING: 307.51 if #6a, b and c and #8 are all “Yes”; 307.51 is the same but #8 either “No” or left blank** |
|  | **NO** | **YES** |  |  |
| **9. Do you drink alcohol (including****beer or wine)?** |  |  |  |  |
| **If you checked “NO”,****go to question # 11.** |
| **10. Have any of the following happened to you MORE THAN****ONCE IN THE LAST 6 MONTHS?** | **NO** | **YES** |  |
| a. You drank alcohol even though a doctor or other healthcare worker suggested that you stop or cutdown because of your health. |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **NO** | **YES** |  |
| b. You drank alcohol, were high fromalcohol, or hung over while you were working, going to school, or taking care of children or otherresponsibilities. |  |  |
| c. You missed or were late for work,school, or other activities because you were drinking or hung over. |  |  |
| d. You had a problem getting alongwith other people while you were drinking |  |  |
| e. You drove a car after havingseveral drinks or after drinking toomuch |  |  |
| **FOR OFFICE CODING: 305.00 if any of #10a-e are “YES” – notate severity on DX** |
|  | **Not Difficult****at all** | **Somewhat****Difficult** | **Very****Difficult** | **Extremely****Difficult** |
| **11. If you checked off *any* problems on this questionnaire, how *difficult* have these problems made it for you to do your work, take care of things at home, or****get along with other people?** |  |  |  |  |
|  |  |  |  |  |
| **12. During *the last 4 weeks*, how much have you been bothered by****any of the following problems?** | **Not bothered****at all** | **Bothered several****days** | **Bothered more than****half the days** | **Bothered nearly every day** |
| a. Worrying about your health. |  |  |  |  |
| b. Your weight or how you look. |  |  |  |  |
| c. Little or no sexual desire orpleasure during sex. |  |  |  |  |
| d. Difficulties with husband/wife, partner/lover orboyfriend/girlfriend. |  |  |  |  |
| e. The stress of taking care of children, parents, or other familymembers. |  |  |  |  |
| f. Stress at work or outside of thehome or at school. |  |  |  |  |
| g. Financial problems or worries. |  |  |  |  |
| h. Having no one to turn to whenyou have a problem |  |  |  |  |
| i. Something bad that happenedrecently. |  |  |  |  |
| j. Thinking or dreaming about something terrible that happened to you in the past – like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexualact. |  |  |  |  |

|  |
| --- |
|  |
|  | **NO** | **YES** |  |
| **13. In the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have****unwanted sex?** |  |  |
| **14. What is the most stressful thing****in your life right now?** |  |
|  |
|  | **NO** | **YES** |  |
| **15. Are you taking any medicine for****anxiety, depression, or stress?** |  |  |  |
| **16. FOR WOMEN ONLY: Questions about menstruation, pregnancy,****and childbirth.** |  |
| a. Which best describes your menstru | al periods? |  |  |  |
| Periods are unchangedNo periods because pregnant or r Periods have become irregular orfrequency, duration, or amount.No periods for at least a year.Having no periods because takingreplacement (estrogen) therapy or oral | ecently gave birth. changed inhormone contraceptives. |  |  |  |
|  |
|  | **NO** | **YES** |  |
| b. During the week before your period starts, do you have a serious problem with your mood – like depression, anxiety,irritability, anger or mood? |  |  |
| **IF YES:** Do these problems go away bythe end of your period? |  |  |
| c. Have you given birth within thelast 6 months? |  |  |
| d. Have you had a miscarriage withinthe last 6 months? |  |  |
| e. Are you having difficulty gettingpregnant? |  |  |
| Adapted from the PRIME-MD Patient Health Questionnaire-Developed by Dr. Robert Spitzer, Janet Williams, Kurt Kroenke, and colleagues. |
| **17. Which ONE of the following statements BEST characterizes you?** |  |  |
| As far as I’m concerned, I do not have any problems that I need to change. |
| I am aware of some problems and am considering beginning to work on them. |
| I have worked on problems unsuccessfully but intend to continue trying. |
| I am currently taking steps to overcome the problems that have been bothering me. |
| I have already overcome some problems and want help now to avoid backsliding. |
| Adapted from G. Ilaga (2009) from the Stages of Change/Transtheoretical Model (TIM), developed by Prochaska & DiClemente (1982). |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**NEW HOPE COMMUNITY SERVICES, LLC OUTPATIENT SERVICES CONTRACT STATEMENT OF PROFESSIONAL DISCLOSURE**

Welcome to New Hope Community Service Center (NHCS). This document contains important information about our professional services and business policies. Please read it carefully and write down any questions you may have so that we may promptly discuss them with you. When you sign this document, it will represent an agreement between you and NHCS.

GENERAL INFORMATION

At NHCS, we have a variety of mental health and substance abuse professionals to serve you. Among them are Licensed Professional Clinical Counselors (LPCCs), Licensed Professional Counselor Associates (LPCAs), Professional Counselor Interns (Master Level Graduate Students), Certified Alcohol and Drug Counselors (CADCs), and CADC Interns. Under the care of our medical licensed staff (Medical Doctors – M.D.), we deliver you the best care and service we can. Each licensed clinician holds a Master’s degree or PhD and has gone through rigorous education, training, and supervision to become licensed by the state. “Interns” are unlicensed and uncertified individuals who are under the guidance of a licensed professional supervisor. Interns have Master’s degrees and are practicing under supervision for licensure or are graduate students who have completed the bulk of their education and are now gaining the necessary clinical experience to graduate. Your therapist will inform you of the level of their training and answer any questions you may have about their qualifications.

COUNSELING SERVICES

Psychotherapy varies depending on personalities of the therapist and the consumer (you) as well as what problems have brought you here. There are different methods we may use to deal with specific concerns. In order for the therapy to be most successful, you will work on things we talk about during sessions and at home.

Psychotherapy has benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. But there are no guarantees to what you will experience.

CONFIDENTIALITY

The laws and standards of the mental health profession require that clinicians keep treatment records. In general, the law protects the privacy of all communications between a consumer and a therapist, and your information may only be released with your written permission. But there are a few exceptions:

In most legal proceedings, you have the right to prevent disclosure of information about your treatment. In some cases, specifically involving children, a judge may order a therapist’s records or testimony to question your emotional condition. There are some situations where the mental health professional is legally and ethically bound to take action to protect you or others from harm, even if that means revealing some information about treatment. For example, if the clinician believes that a child, elderly person, or disabled person is being abused, they may be required to file a report with appropriate state agency(ies).

If a therapist believes that the consumer constitutes a danger to him/herself or to others, they are required to take protective action. These actions may include helping the consumer make a safety plan, notifying potential victims, contacting police, or seeking hospitalization for the consumer.

These situations rarely occur in our practice. If such a situation does arise, we will make every effort to fully discuss it with you before taking action.

### We may also disclose to insurance company information they need to insure reimbursement – like your diagnosis.

MINORS: if you are under the age of eighteen, please be aware that the laws may provide your parents with the right to examine your records.

TRAINING FACILITY

As a training facility, we routinely consult with our interns and other licensed professionals about cases. During consultation, we make every effort to maintain confidentiality of the consumer. The consultants, interns, and supervisors are also legally bound to keep information confidential. The process of training and supervision is fundamental to the work we do here at NHCS, so we will routinely use live observation, “co-therapy” with a senior therapist and video recording during therapy sessions. All the rules concerning confidentiality apply to live and taped observations, and any recordings made will be treated with the utmost respect and care as your written records. You may choose to “opt-out” of the observation process. However, this may preclude you from participating in our reduced- fee services, which are offered by our interns.

It is important that you discuss any questions or concerns that you have regarding confidentiality with your therapist. We will be happy to discuss these issues with you if you have specific questions. While we provide you with general legal and ethical guidelines which govern our practice and those that operate under our service, we cannot provide you with legal advice.

The fee schedule has been given to you for review. All clients have the option of being billed according to the sliding fee scale which is determined by your family income and family size. We also accept health insurance reimbursement.

However, it is the consumer’s responsibility to ensure that your service is covered by your insurance. We will attempt to provide you with the most accurate data on what insurance programs are accepted and rate of reimbursement. If you would like us to bill your insurance company on your behalf, you will be billed according to the schedule of reasonable and customary fees. If there is a deductible that must be met, you will be responsible for paying the full amount of the reasonable and customary fee until your deductible is met. After meeting the deductible, you will be responsible for meeting the co-pay each visit. If your insurance company denies services of coverage for any reason, it will be your responsibility to pay the reimbursable fee based on current service rates. Submitting for insurance reimbursement requires your authorization to release the protected health information necessary to process the claim, including your mental health diagnosis. Your authorization is also necessary so that we may receive payment directly from your carrier. If we are assisting you in filing your insurance, please initial the following statements:

|  |  |
| --- | --- |
|   | I authorize the release of any medical or other protected health information necessary to process the claim. Ialso request payment of government benefits either to myself or to the party who accepts assignment as indicated on the claim. |
|  | I authorize payment of medical benefits to the physician or supplier for services described on the claim. |
|   | I agree to inform NHCS of any change in my financial status or special arrangements that have been made to cover the cost of my services (e.g. assistance provided by your church or other resources). |
|   | I understand, should my insurance company, for any reason, decide NOT to cover my benefits, I amresponsible for any and all charges incurred to date. |

PROFESSIONAL AND OTHER FEES

Your hourly fee is $100.00. In addition to appointments, we charge this amount for other professional services you may require. “Other services” include report writing, telephone consultations, telephone conversations with you lasting longer than 15 minutes with therapist, attendance at meetings with other professionals you have authorized, preparation of records and/or treatment summaries, and the time spent performing any other professional service that you may request. If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time even if we are called to testify by another party on your behalf. Because of the difficulty of legal involvement, we charge a flat fee of $600, plus $100 per hour for preparation and attendance at any legal proceeding.

BILLING AND PAYMENT

You will be expected to pay for each session at the time of your appointment, unless we agree otherwise. Payment schedules for other professional services will be agreed upon prior to performance of said services. In circumstances of unusual financial hardship, we may be willing to negotiate a fee adjustment or installment plan.

CANCELLATIONS AND NO-SHOWS

Our schedules are very busy. Therefore, in order to remain accessible to people as possible, the following guidelines have been established:

* NHCS will charge for mental health and counseling appointments that have not been canceled within **24 HOURS PRIOR** to scheduled appointment. Exceptions to this policy will be made only if proved an emergency.
* The client will be billed $100 in event of no-show or missed appointment (no portion of the fee will be billed to your insurance carrier or other third party payer).
* Front desk personnel will be happy to answer your questions but **DO NOT** have the AUTHORITY to change this policy.

APPOINTMENT REMINDER

NHCS will call, email, or text the consumer the day before to confirm your appointment. NHCS will contact the phone number or email that is provided on the first page of the intake form specified by the consumer. If the consumer does not wish to be reminded of the appointment, please confirm with your therapist.

PHONE CALLS

Telephone appointments may be set at the discretion of the counselors and will be billed in the same manner as in- person appointments with the exception that insurance cannot be billed.

In general, the therapists have very limited availability outside of scheduled appointments and after-hour appointments are scheduled on an “as-needed” event. Therefore, if services are needed after hours, consumers are encouraged to visit their local emergency rooms or phone (877) 852-1523 (Comprehend Crisis Hotline) or emergency services (911) if a need arises. If the counselor is available, the consumer will be billed for any phone call lasting longer than 10-minutes. The phone calls will be billed in the same manner of in-person appointments with the exception that insurance cannot be billed.

NON-DISCRIMINATION POLICY STATEMENT

It is the policy of NHCS to provide services to all people without regard to race, color, national origin, religion, sexual orientation, age, or disability. No person shall be excluded from participation in, or denied the benefits of any service, or be subjected to discrimination because of race, color, national origin, religion, sexual orientation, age, or disability.

COMPLAINT PROCEDURE

Any grievances must be made in writing to NHCS’s Compliancy Officer –

Ms. Heather Elliott, BA Compliancy Officer, NHCS 901 US HWY 68, Ste 900

Maysville, Kentucky 41056

The complaint must include your name, address, telephone number, and a brief description of what occurred which lead you to believe you were discriminated against. In this way the appropriate person may respond to your complaint.

You may also file a complaint against the establishment by contacting:

Office of the Ombudsman Cabinet of Family Health Services 275 East Main Street, 1E-B Frankfort, Kentucky 40621

You will not be intimidated, harassed, threatened or suffer penalty because you filed a complaint. Any penalty or reprisal against you or other involved person(s) is prohibited by law.

CONSENT

I voluntarily consent to receive therapeutic services through NHCS.

I understand that I have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued. Furthermore, if I decide not to receive therapeutic assistance from NHCS, referrals to other qualified professionals can be provided.

If I have any questions and/or concerns now or in the future about the limitations of confidentiality, qualifications of my therapist, the potential risks of therapy, or anything else related to therapy, I understand that I should consult my therapist.

By signing this form, I am granting consent to NHCS to use and disclose my protected health information, such as my name, address, phone number, for the purpose of treatment, payment and agency operations. NHCS’ Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information.

You have legal right to review our Notice of Privacy Practices before signing this consent and we encourage you to read it in full. You have a right to request us to restrict how we use your and disclose your protected health information for the purposes of treatment, payment or agency operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

I certify that this form has been fully explained to me, that I have read it, or had it read to me, and that I understand its contents.

|  |  |  |
| --- | --- | --- |
| Client Signature |  | Date |
| Client Signature |  | Date |
| Witness Signature |  | Date |
| Therapist Signature |  | Date |

|  |  |  |
| --- | --- | --- |
| ***For Office Use Only:*** |  | Diagnosis Code:  |
| Auth Needed Yes No | Date Auth Received: |  |
| **Billing Code(s):** |  | Auth #  |  |
| 99203/5 | 90832-30 | 90849-F3 | Auth Expires: |  |
| 99212/15 | 90834-45 | 90853-G | Insurance Card Copied |  |
| 99241/45 | 90837-60 | 90885-RRvw | DL/ID Copied |  |
| 90791-Dx | 90839-CR |  | **\*\*codes not listed see billing manual codex** |
| 90792-WD | 90840-CR2 |  | MM-Medication Mgmt |  |
| 96102-MMPI | 90846-F | 90887-Intx | ND-no doc WD-w/doc |  |
| 90785-PT | 90847-F2 | 90899-Unlst | CR-Crisis / H-Home Visit | Counselor: |



# OUTPATIENT SERVICES AGREEMENT

Welcome to New Hope Community Services. This document contains important information about New Hope services and business policies. Please review it CAREFULLY and discuss any questions you may have with reception.

**Appointments and Professional Fees:** Sessions are typically 45 minutes in length and can be scheduled by phone or in person. Standard charges are as follows:

|  |  |
| --- | --- |
| Initial Appointment-Intake | $150 – per event |
| Individual, Family, Couples Therapy | $100 – per session |
| Group Psychotherapy (Regular) | $25 – Event |
| Intensive Outpatient Group | $45 - Event |
| Psychological Testing | $375 / Full Battery |
|  | $120 / Hour Partial |
| DUI Assessment | $50 |
| DUI Education | $250 |
| DUI Treatment | $25 - Event |
| Psychoeducation (Parenting, AngerManagement, DVO, LifeSkills) | $275 - Course |
| Additional Professional Services(report writing, letter writing, completion of forms, telephone calls, attendance at meetings) | $125 – per hour |
| Forensic Services (preparation andattendance at legal proceedings, even if called to testify by/for another party) | $125 – per hour |
| Missed Appointments (for **ANY** reasonother than weather) | $100 |
| Late Cancellations (For **ANY** reason-less than 24 hour notice) | $100 |
| (cannot be billed to insurance company if you miss –Patient will be responsible for FULL AMOUNT) |

## Initial

**PAYMENT AND/OR ALL CO-PAYS ARE REQUIRED AT TIME OF SERVICE IN ALL CIRCUMSTANCES REGARDLESS OF WHO ATTENDS THE SESSION(S).**

Most insurance companies require you to authorize New Hope to provide them with a clinical diagnosis from the Diagnostic and Statistical Manual of Mental Disorders. We may have to pride additional clinical information such as treatment plans or summaries, or even copies of the entire record. New Hope has NO CONTROL over what they do with this information once it is in their hands. In some cases, they may share the information with a national medical information database.

Note: Your appointment times are **SPECIFICALLY RESERVED** for **YOU**. Therefore, you **MUST** notify the office **24 hours in advance** if you need to cancel or reschedule. It typically requires that amount of time to attempt to fill your missed appointment slot with another patient.

**PLEASE NOTE:** If your account has not been paid for more than **60** days and arrangements for payment have not been made, New Hope will use all available legal means to secure payment. This may include hiring a collection agency or going through small claims court. You will be responsible for any fees incurred by said collection agency or court fees as assessed.

CONTACTING OFFICE PERSONNEL: New Hope offices are typically open for BUSINESS OPERATIONS from 8:30 AM to 5:00 PM Monday through Friday. The majority of your phone calls will be returned on the same day that you make it, with the exception of weekends and holidays. However, we cannot be responsible for electronic glitches or answering service mistakes that do not record nor deliver your message to us. If you

have not heard back from us within 24 hours, PLEASE return your call. After hours, you will receive a message instructing you with directives of what to do in case we are not available. If you have a true clinical emergency, please go to your nearest emergency room support center and let them know you are under the care of New Hope. All phone calls that are greater than 5 minutes will be charged at the hourly rate prorated in 15-minute increments.

RECORDS: You are entitled to a copy of your records unless we feel that seeing them would be emotionally damaging. In this case, we will send them to a mental health professional of your choosing for you to review them together. We may also decide to review them with you before we distribute them outside of our agency.

*Your signature below indicates that you have read the documents, understand them, and agree to abide by their terms during this professional relationship.*

## Signature Date

Witness Date

**NHCS Electronic Communication Policy**

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, we have implemented the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, may put your privacy at risk and can be inconsistent with Kentucky/Ohio law and with the standards of ethical practice. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and Kentucky/Ohio law.

If you have any questions about this policy, please feel free to ask for clarification.

# Email Communications

We use email communication and text messaging only with your permission and only for administrative purposes. That means that email exchanges and text messages with our office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email us about clinical matters because email is not a secure way to contact us. If you need to discuss a clinical matter with any member of NHCS staff, please feel free to call the office so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

# Text Messaging

Because text messaging is a very unsecure and impersonal mode of communication, we do not text message nor do we respond to text messages from anyone in treatment at NHCS. So, please do not text message any NHCS employees.

# Social Media

We do not communicate with, or contact, any of our patients through social media platforms like Twitter and Facebook. In addition, if we discover that we have accidentally established an online relationship with you, we will immediately cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

NHCS participates on various social networks. If you have an online presence, there is a possibility that you may encounter an NHCS employee by accident. If that occurs, please discuss it with us during our time together. We believe that any communications with patients online have a high potential to compromise the professional relationship. In addition, please do not try to contact any NHCS employee in this way. We will not respond and will terminate any online contact no matter how accidental.

Social media is a 24/7 medium; however, our monitoring capabilities are not. If you are experiencing an emergency please call the National 24/7 Crisis Call Center at 1-755-784-8090, visit your local ER, or simply dial 911.

# Websites

NHCS has a website that you are free to access. We use it for professional reasons to provide information to others about our practice. You are welcome to access and review the information that we have on our website and, if you have any questions about it, we can certainly discuss it during your therapy sessions.

Our website is online 24/7; however, our monitoring capabilities are not. If you are experiencing an emergency please call the National 24/7 Crisis Call Center at 1-755-784-8090, visit your local ER, or simply dial 911.

# Web Searches

NHCS will not use web searches to gather information about you without your permission. We believe that this violates your privacy rights; however, we understand that you might choose to gather information about us in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about any NHCS employees through web searches, or in any other fashion for that matter, please discuss it with Administration during your time here so that we can deal with it and its potential impact on your treatment.

Recently it has become fashionable for patients to review their health care providers on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of NHCS employees or any professional with whom you are working, please share it with us so we can discuss it and its potential impact on your therapy. Please do not rate our work with you while we are in treatment together on any of these websites. This is because it has a significant potential to damage our ability to work within our community.

### SIGNATURE OF PATIENT DATE

**WITNESS SIGNATURE DATE**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

|  |
| --- |
| **Office Use Only:** |
| Records Released by: | Choose an item. |
| Date Released: | Choose Date |

|  |  |  |
| --- | --- | --- |
| Court | Choose an item. | KAP |
| Physicians | Choose an item. | DBHS |
| KY Dept of Transportation | Choose an item. |
| Commonwealth of KY Choose an item. | OTHER: |
| I herby authorize NHCS to request information **FROM** ABOVE SELECTED ENTITIES. |
| I herby authorize NHCS to provide information **TO** ABOVE SELECTED ENTITIES. |
| **REGARDING:** |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name:  |  |  |  |
| First | Middle | Last | Maiden-Other Names Used |
| Address:  |  |  |  |
| Street |  |  | Apt # |
| City | State |  | Zip |
| Date of Birth:  | Age:  |  | GENDER: M F SS#:  |
| **RECORDS TO RELEASE:** | Dates of Treatment:  |
| Consultative Report |  |  |  |
| Progress Notes |  | Alcohol / Drug Treatment / Evaluation |
| Entire Record |  | Anger Management Evaluation |
| Pharmacology Report |  | DUI Compliant / Non-Compliant Report |
| Psychiatric / Psychological Evaluation |  |  Other:  |
| **Purpose of Release:** |  |  |  |
| Continuity of Care | Transfer of Care Insurance (Billing or Approval)  Personal Request |
| Court Order | OTHER:  |

**This authorization expires on the following date, event or condition:**

If there is no date, event or condition specified, authorization will expire in one year.

**STATEMENT OF AUTHORIZATION**

* I understand that, except for research-related treatment, NHCS will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
* Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving WRITTEN notification to NHCS (Medical Records). A photocopy/fax of this authorization will be treated as the original.
* I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, the facility, their employees and my physician(s) cannot prevent the re-disclosure of that information. I herby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

|  |  |  |
| --- | --- | --- |
| Signature of Patient/Legal Guardian |  | Date |
| Relationship to Patient |  |  |
| Witness Signature |  | Date |

### NHCSPageLogo.jpgAUTHORIZATION FOR RELEASE OF INFORMATION

|  |
| --- |
| **Office Use Only:** |
| Records Released by: | Choose an item. |
| Date Released: | Choose Date |

|  |  |  |
| --- | --- | --- |
| Court | Choose an item. | KAP |
| Physicians | Choose an item. | DBHS |
| KY Dept of Transportation | Choose an item. |
| Commonwealth of KY Choose an item. | OTHER: |
| I herby authorize NHCS to request information **FROM** ABOVE SELECTED ENTITIES. |
| I herby authorize NHCS to provide information **TO** ABOVE SELECTED ENTITIES. |
| **REGARDING:** |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name:  |  |  |  |
| First | Middle | Last | Maiden-Other Names Used |
| Address:  |  |  |  |
| Street |  |  | Apt # |
| City | State |  | Zip |
| Date of Birth:  | Age:  |  | GENDER: M F SS#:  |
| **RECORDS TO RELEASE:** | Dates of Treatment:  |
| Consultative Report |  |  |  |
| Progress Notes |  | Alcohol / Drug Treatment / Evaluation |
| Entire Record |  | Anger Management Evaluation |
| Pharmacology Report |  | DUI Compliant / Non-Compliant Report |
| Psychiatric / Psychological Evaluation |  |  Other:  |
| **Purpose of Release:** |  |  |  |
| Continuity of Care | Transfer of Care Insurance (Billing or Approval)  Personal Request |
| Court Order | OTHER:  |

**This authorization expires on the following date, event or condition:**

If there is no date, event or condition specified, authorization will expire in one year.

**STATEMENT OF AUTHORIZATION**

* I understand that, except for research-related treatment, NHCS will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
* Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving WRITTEN notification to NHCS (Medical Records). A photocopy/fax of this authorization will be treated as the original.
* I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, the facility, their employees and my physician(s) cannot prevent the re-disclosure of that information. I herby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

|  |  |  |
| --- | --- | --- |
| Signature of Patient/Legal Guardian |  | Date |
| Relationship to Patient |  |  |
| Witness Signature |  | Date |

**CONFIRMATION AND ACCEPTANCE OF DUI ASSESSMENT, FREEDOM OF CHOICE STATEMENT**

**AND FEE AGREEMENT**

As a result of my conviction for Driving Under the Influence (DUI), I understand that I am required by KRS189A to receive a DUI assessment and to complete a program at the level of care identified by my assessment.

**FREEDOM OF CHOICE**

I understand that I may select any certified DUI agency to provide me with my DUI assessment. I have freely chosen

New Hope Community Services

to conduct my DUI assessment at a cost of Intl

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_.

$50

I understand that once my assessment is completed I may choose to attend a program at the level of care identified during my assessment at a certified DUI agency. I have freely chosen as the agency to provide my program.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

New Hope Community Services

 Intl

### CONFIRMATION/ACCEPTANCE OF ASSESSMENT

I confirm that I have participated in and received the results of my DUI assessment and I have been identified as needing the following level of care:

20-Hour Education Outpatient Treatment

Intensive Outpatient Treatment Residential/Inpatient Treatment Detoxification

 Intl

FEE AGREEMENT

The requirements and fees for completion of this program have been explained to me in detail and I agree to pay ALL fees and to attend ALL required sessions. I understand that in accordance with KRS189A, non-payment of fees for this program will result in a report of non-compliance being sent to the court and may result in a bench warrant being issued by the court for my arrest.

 Intl

I also understand that if I fail to accurately disclose all of my outstanding DUI arrests and/or convictions thte program I complete may not meet the requirements for reinstatement of my driver’s license.

 Intl

I have read and fully understand the statements initiated above and I have discussed my assessment and recommended program with a certified DUI assessor.

Signature of Client Date

# EDUCATION AGREEMENT

As a result of your Driving Under the Influence (DUI) assessment, it has been determined that you need an education program to complete the requirements for your DUI conviction. Please read the following information and sign the form signifying your agreement to participate in and complete this education program.

**I have chosen to provide the education program required to comply with my assessment.**

**I understand that this program will cost me . The education classes will meet at the following times:**

**DATE ATTENDED**

**DAY/DATE: \_ TIME: TO \_**

**DAY/DATE: \_ TIME: TO \_**

**DAY/DATE: TIME: TO \_**

**DAY/DATE: \_ TIME: TO \_**

**DAY/DATE: \_ TIME: TO \_**

**DAY/DATE: \_ TIME: TO \_**

**DAY/DATE: \_ TIME: TO \_**

**DAY/DATE: \_ TIME: TO \_**

**DAY/DATE: \_ TIME: TO \_**

**DAY/DATE: \_ TIME: TO**

**DAY/DATE: \_ TIME: TO \_**

**If it is necessary for me to miss a session, I understand that it is my responsibility to contact this agency to notify them of my absence and to make arrangements to complete the missed session in the future. I understand that missing a session may delay the completion of my education program. I understand that failure to complete the program or pay the fees associated with the program may result in a report of non-compliance being sent to the court.**

**SIGNATURE OF CLIENT DATE**

**SIGNATURE OF CERTIFIED DUI ASSESSOR DATE**

# EDUCATION/TREATMENT AGREEMENT

**CLIENT NAME: CLIENT ID/SS#: AGENCY NAME:**

## You have selected the above agency to provide services at the level of care identified by your assessment. The following provides you with a schedule of times and fees for that services.

 **\_ 20-HOUR EDUCATION**

**Fee for this service:**

**Days of the week and times of sessions:**

**DAY TIME**

 **\_ \_**

 **\_ \_**

 **\_ \_**

 **\_ GROUP OUTPATIENT TREATMENT**

**Fee for this service: \_ Day of the week and time of session:**

**DAY TIME**

 **\_ \_**

 **\_ INDIVIDUAL OUTPATIENT TREATMENT**

**Fee for this service: \_ Day of the week and time of session:**

**DAY TIME**

 **\_ \_**

 **\_ INTENSIVE OUTPATIENT TREATMENT**

**Fee for this service:**

**Days of the week and times of sessions:**

**DAY TIME**

 **\_ \_**

 **\_ \_**

 **\_ \_**

 **\_ RESIDENTIAL/INPATIENT TREATMENT**

**Fee for this service:**

**Scheduled date of admission to program:**

## I fully understand the schedule of services and fees required for my participation in the identified program. I agree to pay all fees in full and maintain regular attendance until the completion of my program. I understand that failure to complete the program or pay the fees assigned will result in a report of non-compliance being sent to the court by this agency and may result in a bench warrant being issued by the court.

**SIGNATURE OF CLIENT DATE**

**SIGNATURE OF AGENCY REPRESENTATIVE DATE**

