NEW LEAF COUNSELING

NEW CLIENT INTAKE FORM

Thank you for choosing New Leaf Counseling and supporting an Antioch local small business. We look forward to providing you with excellent and efficient counseling services. Please take a few minutes to answer the following questions to the best of your abilities. This information is held to the same standards of confidentiality as our therapy.

SECTION 1: PERSONAL INFORMATION

Client Name:_____
(Last) (First) (Middle Initial)

Birth date: _____/_____/_____ **Age:**_____ **Gender:**_____

Marital status: Never married Partnered Married Separated Divorced Widowed

Current Address: _____
(Street)

_____
(City) (State) (Zip)

Home/Cell Phone:_____ May we leave a message? Yes No / Or Text? Yes No

Email:_____ May we email you?* Yes No
*NOTE: Emails are not confidential

Emergency Contact: _____ **Telephone number:** _____

Relationship: _____

SECTION 2: GENERAL HEALTH INFORMATION (Optional)

Quick Check - Check the issues below that apply to you.

Depressed Mood	Panic Attacks	Memory Lapse	Relationship Problems	Mood Swings
Phobias	Procrastination	Hallucinations	Attention & Focus Issues	Repetitive Behaviors
Sleep Disturbance	Eating Difficulties	Suicidal Thoughts	Anxiety	Body Complaints
Anger Issues	Excessive Worry	Alcohol Abuse	Drug Abuse	Traumatic Event

◆ Have you felt depressed recently? Yes No If yes, for how long?_____

◆ Have you had any suicidal thoughts recently? Yes No If yes, how often? Frequently Sometimes Rarely

◆ Have you ever had suicidal thoughts in your past? Yes No If yes, how long ago?_____
How often did you have these thoughts? Frequently Sometimes Rarely

◆ Are you currently taking any psychiatric prescription medication? Yes No
If Yes, please list:_____

◆ If No, Have you been prescribed psychiatric prescription medication in the past? Yes No
If yes, please list:_____

◆ Have you been psychiatrically hospitalized in the past? Yes No
If yes, please list dates and locations:_____

◆ Are you having any problems with your sleep habits? Yes No If yes, circle those that apply:

Sleep Too Much Sleep Too Little Poor Quality Disturbing Dreams Other:_____

◆ Are there any changes/difficulties with your eating habits? Yes No If yes, circle those that apply:

Eating Less Eating More Binge Eating Other:_____

◆ Do you consume alcohol regularly? Yes No

In one month, how many times do you have four or more drinks in a 24-hour period?_____

◆ How often do you engage in recreational drug use? Daily Weekly Monthly Rarely Never

What kinds of recreational drugs do you use: _____

◆ Are you currently in a romantic relationship? Yes No If yes, how long have you been in this relationship?_____

On a scale from 1-10 (10 being great), how would you rate the quality of your relationship? _____

◆ In the last year, have you had any major life changes (e.g. new job, moving, illness, relationship change, etc.)?

_____

_____

◆ Is there any other information that you would like to share?

_____

FAMILY MENTAL HEALTH HISTORY

The following is to provide information about your family history.
Please mark each as yes or no. If yes, please indicate the family member affected.

Depression Yes No _____

Suicide Yes No _____

Anxiety Disorders Yes No _____

Bipolar Disorder Yes No _____

Panic Attacks Yes No _____

Alcohol/Substance Abuse Yes No _____

Eating Disorder Yes No _____

Trauma History Yes No _____

Domestic Violence Yes No _____

Sexual Abuse Yes No _____

Obesity Yes No _____

Obsessive Compulsive Behavior Yes No _____

Schizophrenia Yes No _____

OCCUPATIONAL INFORMATION

Are you currently employed? Yes No
If yes, who is your employer?_____

What is your position?_____

Are you happy in your current position? Yes No

Does your work make you stressed? Yes No

If yes, what are your work-related stressors?_____

SECTION 3: INFORMED CONSENT TO TREATMENT (In-Person / TeleHealth / Child Services)

New Leaf Counseling provides outpatient-counseling services to individuals, families and groups including children, adolescents and adults. In your initial visit your therapist will gather information as to your goals in coming to therapy. Therapy is a unique process for each individual and honesty between you and your therapist about what you are experiencing is key to your emotional growth and change. Our goal is to provide and maintain a positive clinician-client relationship.

Part A: Crisis and Emergencies

We **DO NOT** offer crisis or emergency services. If you feel you are in a crisis you are advised to go to your closest hospital emergency room or call 911. Our therapists are available by phone and email though we cannot guarantee that you would receive a timely response back from your therapist during a crisis.

By initialing below you attest that you are aware that New Leaf Counseling does not offer crisis or emergency assistance. You are also aware that you may experience some uncomfortable emotions while working towards your goals in therapy and will discuss any concerns about your therapy process with your therapist.

Client Initials _____
(or parent / legal guardian)

Part B: Confidentiality

In order to protect you and to offer you the most professional of services, we abide by strict legal and ethical guidelines. Any information you share with us in session, in paperwork, emails, texts or phone calls will not be shared with anyone unless you have given us written permission to do so.

The only exception to this rule is if your therapist feels you have become a danger to yourself or others, we have been made aware of any abuse, real or alleged, to children, elderly or incapacitated people (we are mandated reporters and required by the State of Illinois to report these allegations), or if we have been issued a subpoena accompanied by a court order to produce records.

If your therapist receives clinical supervision he/she will inform you of such an arrangement and explain the process of supervision to you. If you are here with family, your therapist will discuss limits of confidentiality.

By initialing below you attest that you have been made aware of and understand the confidentiality process at New Leaf Counseling.

Client Initials _____
(or parent / legal guardian)

Part C: Appointments

Appointments will be scheduled between the therapist and the client. If you need to cancel your appointment for any reason, except for extreme circumstances or emergencies, you are required to give no less than a 24-hour notice to your therapist. Should your appointment be on a Monday, notice would need to be given the prior Friday by noon to avoid the late cancellation fee.

Appointments canceled with less than 24-hour notice or appointments missed will be billed per the New Leaf Counseling Financial Policy. This fee will not be covered by your insurance and it must be paid prior to resuming sessions with your therapist. All co-pays, deductibles or arranged fees are due at the beginning of each appointment.

Regular appointments are paramount to positive behavioral change. Repeated missed or rescheduled appointments will result in termination of services. Three subsequent missed appointments will result in automatic termination of services.

By initialing below you attest that you are aware of the cancellation policy and fees. You are also aware that any co-pays, deductibles or arranged fees are due at the beginning of each appointment.

Client Initials _____
(or parent / legal guardian)

Part D: Electronic Communication

Often, we will communicate through texting and email. By initialing below you are attesting that you recognize that electronic communication is not completely secure. You agree to not hold New Leaf Counseling responsible for any information that may be stolen. Your initials below attest that if you, the client, choose to communicate with your therapist or New Leaf Counseling through any form of electronic communication you will assume all risks associated with your chosen form of communication. Furthermore, texting, emailing, and phone calls between the Clinician and Client are only to be used for rudimentary information gathering and confirmation of appointments, nothing more.

Client Initials _____
(or parent / legal guardian)

Part E: Parenting Arrangements (Skip to "Part:I" if client is over 18 yrs old)

In order to protect you and to offer you the most professional of services, we abide by strict legal and ethical guidelines.

Please provide your child's counselor a copy of the current parenting agreement if applicable. This will ensure New Leaf Counseling is following agreed upon or court enforced; discussion of child's case between the two parents, understanding of co-parenting duties and schedules, co-parenting billing/payment, as well as coordination of services between parents/guardians.

By initialing below you attest that you have been made aware of and understand the Parenting Arrangements process at New Leaf Counseling.

Client Initials _____
(or parent / legal guardian)

Part F: Office Behavioral Guidelines

The counselor will set rudimentary rules for behavior in the office during sessions that include but are not limited to;

- Remaining in the assigned treatment room during session
- Using/playing only with counselor provided materials/toys
- Following counselor's further instruction as necessary

At the end of the session, the counselor will lead the child to the waiting room for pickup by the parent(s)/guardian(s). Counselors will not be responsible for taking the child to the parent(s)/guardian(s) car or outside of the waiting room. If the child is unable to leave the treatment room, the parent(s)/guardian(s) will be advised to come into the treatment room to pick up their child.

By initialing below you attest that you are aware of the Office Behavioral Guidelines policy.

Client Initials _____
(or parent / legal guardian)

Part G: Family Involvement

Regular appointments are paramount to positive behavioral change. A change in a child's behavior is many times tied to the family system, family behavior and family rules in place within the home.

New Leaf Counseling Counselors may ask that one or both parents(s)/guardians(s) be available for their own individual or family sessions as part of the overall treatment.

By initialing below you attest that you have been made aware of New Leaf Counseling Family Involvement guidelines.

Client Initials _____
(or parent / legal guardian)

Part H: Child and Teen Confidentiality

New Leaf Counseling Counselors will explain to the child, based on age appropriateness, that information shared by the child during the session is confidential and private between the child and counselor.

There is an ebb and flow to therapy with a child and their family; the counselor will speak with the child prior to sharing information with the parents(s)/guardian(s). In cases of self harm, suicidal ideation or any other danger to the child the counselor will speak with the parent(s)/guardian(s) without consent of the child.

Depending on the child's age, maturity and family situation, in some cases under the Illinois law (410 ILCS 210), minors 12 and older may receive outpatient counseling without the consent of their parents, up to five visits of 45 minutes each. The minor's parents shall not be informed without the consent of the minor unless the facility director believes such disclosure is necessary (405 ILCS 5/3-501).

Regarding Mental Health Treatment Outside of New Leaf Counseling:

MENTAL HEALTH TREATMENT – VOLUNTARY INPATIENT: Any minor 16 years or older may be admitted to a mental health facility as a voluntary patient if the minor herself executes the application. The minor's parent or guardian shall be immediately informed of the admission (405 ILCS 5/3-502).

SUBSTANCE ABUSE TREATMENT: Minors 12 years of age or older who may be determined to be an addict, an alcoholic or an intoxicated person or who may have a family member who abuses drugs or alcohol, may give consent to medical care or counseling related to diagnosis or treatment. The consent of the parent, parents or legal guardian shall not be necessary to authorize medical care or counseling (410 ILCS 210/4.).

By signing below you attest that you have been made aware of New Leaf Counseling's Child and Teen Confidentiality Guidelines.

Child/Teen Signature (12 years or older): _____ Date: _____

Parent Signature:_____ Date: _____

Part I: Telehealth Consent (Skip to "Part:K" if you do not wish to give TeleHealth Consent)

Telehealth allows New Leaf Counseling's counselors to diagnose, consult, treat and educate using interactive audio, video or data communication regarding treatment.

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Information disclosed during the course of therapy, therefore, is generally* confidential.

*There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person.
I also understand that if I am in a mental or emotional condition and am a danger to myself or others, my counselor has the right to break confidentiality to prevent the threatened danger.

Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent. I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured. I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my counselor to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons.

In addition, I understand that Telehealth treatment is different from in-person therapy and that if my counselor believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a counselor in my geographic area that can provide such services.

In the beginning of our Telehealth session, I will provide my counselor with an address location of where I am located in the event emergency services will need to be notified on my behalf, as well as, confirmation that I am in a confidential location (private space in my household, place of business, or public area) and am comfortable having psychotherapy services via Telehealth.

Confirm with your insurance company that the Tele-Sessions will be reimbursed; if they are not reimbursed by your policy, you are responsible for full payment.

By initialing below you attest that you have been made aware of New Leaf Counseling TeleHealth Consent guidelines.

Client Initials _____
(or parent / legal guardian)

Part J: Informed Consent Checklist for Telehealth Services

Before starting each video-conferencing service, we will discuss and agree to the following:

- There are potential benefits and risks of Telehealth(e.g., limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for Telehealth services, and nobody will record the session without permission from the other person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the professional counselor and/or practicum or internship student counselor-in-training will explain how to use it.
- It is essential to be in a quiet, private space that is free of distractions (including a cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is essential to be on time. If you need to cancel or change your tele-appointment, you must notify the counselor in advance by phone, text, or email.
- We need a back-up plan (e.g., a phone number where you can be reached) to restart the session or to reschedule it in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in Telehealth sessions.

I have read and understand the information provided above. I have the right to discuss any of this information with my counselor and any questions I may have regarding my treatment. I understand that I can withdraw my consent to Telehealth communications by providing written notification to New Leaf Counseling. My signature below indicates that I have read this Agreement and agree to its terms.

Client Signature: _____ **Date:** _____
(or parent / legal guardian)

Part K: Consent to Treatment

I acknowledge that I have been given the Notice of Privacy Practices and have had it explained to me. I understand that the therapist and organization is available to provide Outpatient Counseling Services to address a variety of concerns to Individuals, Couples, Families and Groups. I understand that Outpatient Counseling Services may be an important factor in the development and growth of an individual as well as may present some risks; at times, the counseling process may intensify some symptoms. There is no guarantee for services provided, as behavioral changes ultimately happen within the client over time.

I am aware that I may stop my treatment with the therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I agree to attend all scheduled appointments. I am aware that I must call to cancel an appointment at least twenty-four (24) hours before the time of the appointment. If I do not contact the therapist twenty-four (24) hours prior to the scheduled appointment, or fail to attend the scheduled appointment, **I agree to pay a fee as outlined in the New Leaf Counseling Financial Agreement Policy.**

I understand that an agent of my insurance company, any other third-party payer, or credit card/financial institution may be given information about the type(s), cost(s), date(s) and providers of any services or treatments I receive. I authorize the release of necessary information to my insurance company/EAP, third-party payer, or credit card/financial institution (in the event of a disputed charge) so that New Leaf Counseling may pursue payment for services rendered to me.

Client Signature: _____ **Date:** _____
(or parent / legal guardian)

SECTION 4: FINANCIAL AGREEMENT

To prevent misunderstanding between patients and our practice, the clinician's at New Leaf Counseling, LLC adhere to the following client financial policy. Your complete understanding of your financial responsibilities is an essential element of the physician-patient relationship and continued medical management. Please read page 2 (Understanding Mental Health Expenses) carefully and if you have any questions, please do not hesitate to ask a member of our staff.

Understanding Mental Health Expenses

When both you and your health insurance company pay for your health care expenses, it's called cost sharing. Deductibles, coinsurance and copays are all examples of cost sharing. Understanding how they work will help you know how much you'll pay.

Deductible: A deductible is the amount you pay for health care services before your health insurance begins to pay. How it works: If your plan's deductible is $1,500, you'll pay 100 percent of eligible health care expenses until the bills total $1,500. After that, you share the cost with your plan by paying coinsurance

Coinsurance: Coinsurance is your share of the costs of a health care service. It's usually figured as a percentage of the amount we allow to be charged for services. You start paying coinsurance after you've paid your plan's deductible.

> **How it works:** You've paid $1,500 in health care expenses and met your deductible. When you go to the doctor, instead of paying all costs, you and your plan share the cost. For example, your plan pays 80 percent. The 20 percent you pay is your coinsurance.

Copay: A copay is a fixed amount you pay for a health care service, usually when you receive the service. The amount can vary by the type of service.

> **How it works:** Your plan determines what your copay is for different types of services, and when you have one. You may have a copay before you've finished paying toward your deductible. You may also have a copay after you pay your deductible, and when you owe coinsurance.

Your Insurance ID card may list copays/coinsurance/deductibles for some visits. You can also create an online account with your insurance carrier or contact your employer Human Resources representative to further help define what your benefits are.

How We Work Together

Full payment is due at the time of service for all copays, payment towards deductibles, and coinsurance. For your convenience we accept cash, personal check, credit/debit cards (Visa, MasterCard, American Express, Discover). New Leaf Counseling, LLC is required to collect these based on your benefits contract and New Leaf Counseling, LLC's contractual agreement with your insurance carrier. New Leaf Counseling, LLC must collect copays or coinsurance at the time of service and is required to report to the carrier any enrollees failing to pay the copay. A valid credit card number will be kept on file during your treatment at New Leaf Counseling, LLC.

All clients are required to have a credit card on file with New Leaf Counseling, LLC. All accounts that have not received payment towards a balance within 90 days will have the credit card on file charged for the balance amount. Any fees associated with checks returned to New Leaf Counseling by your bank for insufficient funds will be billed to the client and an alternate method of payment will be required.

It is your responsibility to provide New Leaf Counseling, LLC with current, accurate insurance information and to notify New Leaf Counseling, LLC of any changes in this information. A valid insurance card(s), picture ID, and date of birth of the adult insured (policyholder and guarantor of bill) must be presented prior to the time of service.

It is the patient's responsibility to obtain insurance carrier coverage limitations. These include prior authorization, referral requirements, and member out-of-pocket financial requirements (copay, deductible, coinsurance). The amount of your copay may differ for your provider at New Leaf Counseling, LLC than for your primary care. If your insurance company denies a claim filed on your behalf, you are responsible to pay New Leaf Counseling, LLC for the difference between the standard rate and the amount previously paid as copay unless approved by New Leaf Counseling, LLC.

If New Leaf Counseling, LLC does not participate with your insurance, you are expected to pay in full for our services at the time of visit. New Leaf Counseling, LLC may provide assistance in submitting the charges to your insurance company; however payment is expected up front.

If you do not have medical insurance, payment in full for services is required at the time of the visit.

By initialing below you attest that you have read all of the above Financial Agreement Policy.

Client Initials _____
(or parent / legal guardian)

Additional Charges NOT Covered by Insurance:

- Medical Letters Requests $150 per hour, after written consent provided.
- Case Management $130.00 (prorated per 15 min.). Case Management includes indirect services we provide outside our session times such as writing letters, consultations made at your request (for which a written authorization for disclosure of confidential information is required), coordinating adjunct and Court Advocacy services, and completing forms or reports. On occasion you may request that we testify or be present in court proceedings on your behalf of subpoena from the court the time billed will begin from our arrival at the courthouse to completion of testimony.
- Late cancellation/Missed Appointment – fewer than 24 hours prior to appointment $150.00.

By signing this form you are authorizing:

- Coinsurance Charges
- Copay Charges
- Late Cancellation/Missed Appointment Charges
- Past-Due Accounts – over 90 days – will have the credit card on file charged for the balance amount.
- In the event of a dispute of charges, New Leaf Counseling LLC may share dates of service, service description, and any other signed paperwork with your financial institution to resolve the matter.

I understand New Leaf Counseling, LLC Financial Agreement, and hereby agree to all within it:

Client Signature: _____ **Date:** _____
(or parent / legal guardian)

SECTION 5: INSURANCE INFORMATION

Name of Primary Insurance Company: _____

Insurance ID #: _____ Group#: _____

Subscriber/Policy Holder's Name: _____

Subscriber/Policy Holder's Date of Birth: _____/_____/_____
(Month) (Day) (Year)

SECTION 6: CREDIT CARD INFORMATION

Card Holders Name: _____

Credit Card Number: _____

Expiration Date: _____

Security Code (3 digits on the back of card): _____

Billing Address: _____ Billing Zip Code: _____

I agree to have my credit card charged for each visit: YES NO

Cardholders' Signature: _____ **Date:** _____