NEW LEAF COUNSELING

Informed Consent to Treatment

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 to each individual of honesty between you and your therapist about what you are experiencing is key to your emotional growth and change.

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.

Initials: _____ **Therapist Initials: _____**

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.

Initials: _____ **Therapist Initials: _____**

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.

Initials: _____ **Therapist Initials: _____**

Financial Policy Agreement

Payment in full is due at the beginning of each session. New Leaf Counseling requires all clients to have a credit card on file. New Leaf Counseling accepts checks, cash and credit card (VISA, MasterCard and Discover only). You are responsible for all charges for professional services rendered on behalf of the identified client. This includes psychotherapy, receipt of faxes, telephone or email contact with the client or professionals involved with the client, letters and reports, any collection or attorney fees or court costs associated with the use of outside agencies required for collection of your account. Phone therapy and reports are not covered by insurance. This pertains to any call other than confirming or canceling an appointment.

All clients are required to have a credit card on file with New Leaf Counseling. 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 by checks returned to New Leaf Counseling by your financial institution for insufficient funds will be billed to the client and an alternate method of payment will be required.

By initialing below you attest that you have been made aware of New Leaf Counseling's fees for services rendered and acknowledge that you will be responsible for any balance past 90 days from the date of service.

Initials: _____ **Therapist Initials:_____**

Insurance

You are required to obtain verification of your insurance benefits prior to beginning treatment at New Leaf Counseling. As a courtesy we will verify insurance benefits when provided information prior to the first session. As a courtesy to you, if we are in-network we will bill for services rendered at New Leaf Counseling for your session. Insurance policies are an arrangement between you, and your insurance provider. You are responsible for all expenses not paid by the insurance provider.

By initialing below you agree that you are aware you are required to verify your insurance benefits prior to starting treatment at New Leaf Counseling. You have also been made aware that you are responsible for all expenses not paid by the insurance provider.

Initials: _____ **Therapist Initials:_____**

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.

Initials: _____ **Therapist Initials: _____**

Consent to Treatment

I acknowledge that I have been given the Notice of Privacy Practices and have had explained to me and understand that this 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 this 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 Policy I have signed.***

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 _____

Parent Signature _____

Date _____