Client Intake Form

Client's full name: ____

Preferred name: ____

If client is a minor, who is legal guardian? _________________________________

Parents' full name ***(if client is a minor):*** ____________________________________

Client's Date of Birth: __________________

You can choose to disclose or to not disclose these questions inside this box:

Ethnicity: American Indian or Alaska Native | Asian | Black or African American | Hispanic or Latino | Native Hawaiian or Other Pacific Islander | White

Gender Identity (please circle):

Male *Female* *Transgender Male/Trans Man/FTM*

Transgender Female/Trans Woman/MTF *Non-Binary*

Genderqueer, neither exclusively male or female

Additional gender category, or other please specify: _________________________

Sexual Orientation (please circle):

Lesbian, gay, or homosexual *Straight or heterosexual* *Bisexual*

Unknown *Something else, please describe:* ________________

Sexo Administrativo: Male Female Unknown

Client Address: ____

City/ State/ Zip Code: ____

Home Phone: __________________ **Cell:** _______________ **Work:** ________________

Email Address: ____

Can we leave a voice message or text for the numbers listed above? ____Yes ___No

Emergency Contact: The person listed is authorized to be contacted for emergencies only.

Name: ____________________________________Phone: ________________________

Relationship: ____________________

Contacts: The person(s) listed are authorized to discuss my treatment, appointments, or to coordinate care.

1) Name: ____________________________________Phone: ________________________

   Relationship: ____________________

2) Name: ____________________________________Phone: ________________________

   Relationship: ____________________

____________________________________ ________________________

Signature of Client or Responsible Party ***Date***

New Harvest
Therapy Services

Medications Log

Name:	**Date of Birth:**
Medication:	
Dose/Directions:	
Prescribed By Dr.:	
Medication:	
Dose/Directions:	
Prescribed By Dr.:	
Medication:	
Dose/Directions:	
Prescribed By Dr.:	
Medication:	
Dose/Directions:	
Prescribed By Dr.:	
Medication:	
Dose/Directions:	
Prescribed By Dr.:	
Medication:	
Dose/Directions:	
Prescribed By Dr.:	
Medication:	
Dose/Directions:	
Prescribed By Dr.:	

Consent and Services Agreement

CONFIDENTIALITY: Confidential mental health information is protected except for conditions outlined in the Privacy Policy provided by New Harvest Therapy Services and written to comply with HIPPA and Indiana State Regulations. However, I understand if I or a minor (whom I have legal guardianship) discloses information related to suspected threats of physical harm of self or others, occurrence of child, elder, or dependent adult abuse, or if commanded by court order; New Harvest Therapy Services will be required to disclose such information to appropriate authorities or parties mandated by law. Treatment records, reports and results of psychological testing are confidential and can be released only with a written consent authorizing such release. In the case of children, only the legal custodial parent will have access to information from therapy sessions and/or case records, unless otherwise ordered by a court.

PRIVACY PRACTICES -Your signature confirms that you have received/read a copy. Upon review if you have any questions and/or choose to revoke consents, please notify your therapist immediately.

RELEASE OF INFORMATION : I give permission to New Harvest Therapy Services Staff to have access to my private records and/or information to conduct the normal business of the agency. This will include clinical review of my record, filing insurance or payment arrangements, and other internal duties such as monitoring and quality assurance. The staff is required to follow all the rules of confidentiality and is required to keep information private.

CONSENT/AUTHORIZATION FOR MENTAL HEALTH SERVICES:

I authorize/consent to the provision of Mental Health Services by the professional staff of New Harvest Therapy Services, Inc. The primary mode of service is psychotherapy with case management features. This model of treatment includes a Mental Health diagnosis, outcome treatment plans, and progress notes retained in a record of my visits and outreach efforts made on my behalf. While every effort is made to resolve the issues and what I identify as a problem in my life, there is no guarantee the issue will be resolved. The goal of service is to help me to deal with the issue to the best of my ability. I understand that I am consenting and agreeing only to those mental health services the above name provider is qualified to provide within:

- The scope of the provider's license, certification, and training, or
- The scope of license, certification, and training of those mental health providers directly supervising the services received by the above named.
- Therapy Session for family, couples, or individuals are 53 minutes in length. If you are more than 15 minutes late to your appointment, we will need to reschedule your session.

I have been informed as to the procedures involved, alternative choices and any possible significant risks associated with the treatment process.

____________________________________ ________________________

Signature of Client or Responsible Party *Date*

OFFICE POLICIES

Conflict Resolution: New Harvest Therapy Services works hard to make sure you have a positive therapy experience. However, if a conflict occurs, it is agreed that any disputes shall be negotiated directly between the parties. If these negotiations are not satisfactory, then the parties agree to mediate any differences with a mutually acceptable third-party mediator. If these are unsatisfactory, then the parties shall move to arbitration, and then binding arbitration, choosing an arbitrator mutually agreeable to both. Litigation shall be considered only if and after all of these methods of resolution are given a good faith effort and are satisfactory.

Office Financial Policy**:** I understand charges are based on a clinical hour defined by insurance carriers. I understand a **$30.00 fee** is applied for failed appointment **without 24-hour notice of cancellation**. This charge is not paid by the insurance.

Other services including phone calls, review of records, consultation service with other providers, and any other professional services, either requested by the client or necessary for treatment but outside of the clinical face-to-face setting, are usually the responsibility of the client. **If I request completion of any forms, letters, or any other professional services outside of the therapy session, I may be charged $5 per page per form or letter and this is the responsibility of the client and will not be covered by insurance benefits.**

I hereby *authorize payment of insurance benefits to this office for services* rendered to me and/or my dependents. I authorize release of any medical/psychological information necessary to process claims and/or comply with record keeping requirements.

In cases where prior authorization is required after the initial allotted visits, I will be responsible for additional session if my insurance company denies the claims.

I understand ***I am financially responsible to this office for all copayments and charges not covered by the assignment of benefits above.*** It is the office policy to collect at each visit the amount not covered by insurance directly from the client/responsible party. When the client is a minor, copayment will be collected from the person scheduling the appointments, as it is that person's responsibility to make arrangements with the responsible party for timely payments.

I authorize the release of name, address, telephone number, and outstanding balance in collection matters.

In order to avoid the $30.00 charge at the time of a missed appointment, a 24-hour cancelation notification will be required.

Payment Authorization: I understand that charges are based on a clinical hour of 53 minutes. I understand I am financially responsible to this office for charges. ***Payment is expected at the time services are rendered.*** The practice may utilize my payment methods on file for any balances, including late cancellation and no-show fees, without additional authorization. I authorize the release of name, address, telephone number, and outstanding balance in collection matters.

Name on Card: ______________________________________

Credit Card # ____

Expiry Date: ____

CV Code: ____

___________________________________ ________________
Signature of Responsible Party *Date*

Cancellation and Missed Appointment Notice: CONTINUITY OF CARE IS AN IMPORTANT ASPECT OF PROVIDING MENTAL HEALTH THERAPY. Frequent cancellations and/or failure to show for session may cause long periods between therapy sessions and impact the effectiveness of your treatment. We strive to provide quality care, but your cooperation in keeping your appointments is of the utmost importance. We would like to take this opportunity to inform our clients regarding the office policy on cancellations (contacting the office prior to your appointment time) and no-shows (failing to notify the office prior to your appointment time).

- If you are unable to keep your appointment and wish to cancel, PLEASE contact the office. We appreciate at least a *24 hours' notice*, but please call even if it is a couple of hours before your scheduled appointment. This allows us enough time to schedule a client who may be waiting for an appointment.
- We attempt to contact our clients who have no-showed for an appointment. However, if *you no-show and we are unable to contact you, your next scheduled appointment may be given to another client as needed.*
- If during the course of treatment, you *no-show or fail to give 24 hours notice for two appointments*, your session slot will be made available to other clients. As frequent failure to attend therapy impacts the effectiveness of treatment, *our policy is to wait 30 days before re-scheduling,* allowing you time to prioritize your schedule for therapy. After 30 days, please call at any time if you're interested in making another appointment. We will do our best to accommodate your needs at that time.

***Legal Appearances/Documentation*:** New Harvest Therapy Services does not provide documentation, letters, clinical reports, or consultations to legal entities unless required by law (subpoena). New Harvest Therapy Services will not appear in court for any legal proceeding unless required by law.

If New Harvest Therapy Services is subpoenaed or required to give testimony or documentation for legal proceedings, the charge is $150.00 per hour billed directly to the client. This includes travel time to court and any other requests made by the client outside of therapy sessions.

Client Email/Texting Consent: The transmission of client information by email and/or texting has several risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

- Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients
- Email and text senders can easily misaddress an email or text and send the information to an undesired recipient
- Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his/her copy
- Employers and online services have a right to inspect emails sent through their company systems
- Emails and texts can be intercepted, altered, forwarded, or used without authorization or detection
- Emails and texts can be used as evidence in court
- Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party

Conditions for the use of emails and texts: Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of emails and texts, as well as information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by therapist's intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

- Email and texting *is not appropriate for urgent or emergency situations*. Provider cannot guarantee that any email and/or text will be read and responded to within any particular period of time.
- *Emails and texts should be concise.* The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations
- All emails will usually be printed and filed into the client's record. Texts may be printed and filed as well
- Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law
- Clients/parents/legal guardians *should not use emails or texts for communication of sensitive medical information*
- Provider is not liable for breaches of confidentiality caused by the client or any third party
- It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted

Please provide your email if you would like to consent to communication with New Harvest Therapy via email and text: ____

Email Reminders: New Harvest Therapy Services provides email reminders of appointments. These email reminders are a courtesy, clients are 100% responsible for making appointments. If you would prefer **NOT** to receive an email reminder of your appointment. Please check ______I would like to **opt out** of email reminders.

CONSENT: I have reviewed and understand the consent for treatment, New Harvest Therapy Services financial policies, and other information. I understand I am financially responsible for any charges not covered by insurance, copayments, and coinsurances at the time services are rendered.

____________________________________ ________________________

Signature of Client or Responsible Party *Date*

IF CLIENT IS A MINOR OR HAS A GUARDIAN:

Consent for Services to a Minor

I, ____ (*print name*) am authorized to consent for

treatment of ___________________________________(*child's name*)

born on ________________. I give my consent for the provision of services for therapy with New

Harvest Therapy Services, Inc.

____ ______________

Signature of Parent/Legal Guardian Date

NOTICE OF PRIVACY PRACTICES

Client Copy

This notice describes how medical/mental health information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Information is released in accordance with state and federal laws and the ethics of the counseling/psychological profession. This notice describes policies related to the use and disclosure of client's healthcare information.

> "Use and disclosure of protected health information for the purpose of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes."

Treatment - Use and disclose health information to: Provide, manage, or coordinate care with consultants and referral sources.

Payment - Use and disclose health information to verify insurance and coverage, process claims and collect fees.

Healthcare Operations - Use and disclose health information for review of treatment procedures, review of business activities, Certifications, Staff Training, and Compliance and licensing activities.

Other uses and disclosure without your consent-Mandated reporting, Emergencies, Criminal damage, Appointment scheduling, Treatment alternatives and As required by law.

Client Rights:

- Right to request where we contact you
- Right to receive changes in policy
- Right to release your medical records
  - Written Authorization
  - Right to revoke authorization
  - Revocation is not valid to the extent you have acted in reliance on such previous authorizations
- Right to inspect and copy your medical billing records
  - Therapist may deny this request
  - Charges for copying, mailing, etc.
- Right to add information or amend your record
  - May request to amend record
  - May deny request (if denied, right to file disagreement statement and statement will be filed in your record
  - Amendment request must be in writing
- Right to Accounting of disclosures
  - Disclosure for treatment, payment of healthcare operations
  - Disclosures pursuant to a signed release
  - Disclosure made to client
  - Disclosures for national security or law enforcement
- Right to request restrictions on uses and disclosures of your healthcare information
  - Must be in writing
  - You are not obligated to agree
- Right to Complain
  - Please contact therapist
  - If not satisfied, right to complain to the U. S. Dept. of Health and Human Services
  - No retaliation