Counseling Services Application **New Hope Counseling Services, PLLC**

Personal Information ☐ **Check if Child Under 18** ☐ **Check if Student**

First Name	Middle Initial	Last Name	Today's Date

Mailing Street Address	City	State	Zip	Birth Date

Preferred Phone #	Secondary Phone: ☐ Business ☐ Home ☐ Cell	e-Mail Address

Gender ☐ Male ☐ Female	Work: ☐ Full ☐ Part-time Profession:	Employer Name	SSN (for insurance purposes)

List Present or Previous Health Problems	List Any Past or Present Medications Previous mental health counseling? ☐ Yes ☐ No

Marital Status: ***S M W SEP D*** ☐ **Spouse Information** ☐ **Parent Information if Child**

First Name	Middle Initial	Last Name	Marriage Date

Mailing Street Address ☐ (Check is Same as Above)	City	State	Zip	Birth Date

Preferred Phone #	Secondary Phone: ☐ Business ☐ Home ☐ Cell	e-Mail Address

Gender ☐ Male ☐ Female	Work: ☐ Full ☐ Part-time Profession:	Employer Name	SSN (for insurance purposes)

List Present or Previous Health Problems	List Any Past or Present Medications Previous mental health counseling? ☐ Yes ☐ No

Children Information (List All Children)

Name	Birth Date	Lives With You?	Name	Birth Date	Lives With You?

Other Information (PLEASE CHECK ALL THAT APPLY)

☐ History of grief/loss
☐ Problems at work/school
☐ Isolation issues or fears/phobias
☐ Concentration or attention problems
☐ Current/past substance abuse
☐ Severe mood swings or irritability
☐ Subtance abuse in family
☐ Sexual abuse
☐ Traumatic events
☐ Financial stress
☐ Social skill deficits
☐ Impulsive behavior
☐ Legal involvement
☐ Mood symptoms
☐ Anxiety symptoms or compulsive behavior
☐ Behavioral problems/aggression
☐ Marital conflict
☐ Other: _____

What do you hope to change or accomplish by seeking help at this time? (Use the back of form if more room is needed).	List any agencies or other professionals who have provided you counseling services in the past and any previous mental health diagnoses, if applicable.

Signature	Signature

Mental Health INSURANCE INFORMATION

New Hope Counseling Services, PLLC

(If you are self-pay, you may skip this page)

Please Complete All Information That is Applicable

Do You Want New Hope Counseling Services to Make Claims to Your Primary Insurance? ☐ Yes ☐ No

Primary Health Insurance					Member #	Subscriber/Insured Name
Mental Health Benefits? ☐ Yes ☐ No	# of Visits Authorized	Begin Date	End Date	Authorization #	Representative Name	Date of Call
Secondary Health Insurance					Member #	Subscriber/Insured Name
Mental Health Benefits? ☐ Yes ☐ No	# of Visits Authorized	Begin Date	End Date	Authorization #	Representative Name	Date of Call

Other Health Insurance (attach details) **Address** **Phone**

Other Third Party Payer (attach details) **Address** **Phone**

Referred By (name of physician, friend, pastor, bishop, etc.)	Is client's condition related to employment, auto accident, or other accident or event?

Medicare / Medicaid Clients

Insurance Company					**Health Insurance #**	
# of Visits Possible	# of Visits Authorized	Begin Date	End Date	Authorization #	Representative Name	Date of Call

EAP (Employment Assistance Program)	**Phone**	**Employer**

Counseling Description of Services New Hope Counseling, PLLC

Goals and Outcomes: Thank you for choosing New Hope Counseling for your care and I look forward to helping you meet your goals. Your goals are more likely to be met when you understand the nature and limitations of counseling. Generally, counseling is most useful in helping individuals help themselves or improve their relationships by changing, feelings, thoughts, and /or behaviors. You determine the nature and amount of change you wish to make.

Benefits and Risks Most people experience improvement or resolution to the concerns that brought them to counseling, but of course, there are no guarantees: and there are some risks. For example, counseling could open up new levels of awareness that may cause discomfort.

Length of Therapy Many counseling issues can be resolved in 12 or fewer sessions, however some issues require more extensive care. Insurance companies require medical necessity for counseling so your progress will be evaluated throughout treatment and appropriate referrals for continued care after service termination may be discussed. If two months have passed since your last appointment or contact with me your case will be closed. If you choose to return to services at any time in the future your case can easily be reopened and you will be asked to update your information

Confidentiality: I understand that the information you share in counseling is personal. I will not release confidential information without a written release of information form unless such release is authorized or required by law. Your information is protected but there are certain situations which I am required by law to disclose the information. For example, I am a mandatory reporter of child abuse/ neglect and intent to harm yourself or others. By signing this description of Services you acknowledge receipt of ***New Hope Notice of Privacy Practices.*** This document describes your rights and my obligation regarding the use of your private health information. Please be aware that insurance companies require a mental health diagnosis and other identifying information, including but not limited to, date of birth social security number and address.

Payment for Services: The fee for the initial 45 minute assessment is billed to insurance for $150. Subsequent 45 minute sessions are billed at $85.00. Please call your insurance company in advance (benefits number or web site listed on your health insurance card) for information about your mental health coverage including if visits require pre- authorization, if there are a limit to the number of visits and what your copay (your part of the fee) will be. Please be prepared to pay your copay at each visit. I accept cash credit or checks for payment. If you do not have a mental health diagnosis or you are participating in life coaching sessions insurance will not cover services and you may choose to pay a discounted self pay fee. Consultation outside of the office is billed at $85.00 per hour including travel time and is not covered by insurance. Returned check fee is $40.

Appointment Cancellation: On occasion a situation may arise which prevents you from keeping a scheduled counseling appointment and I understand. As a courtesy please notify me at least 24 hours in advance of your appointment if you cannot keep it so I can offer it to another client. Except in emergency situations, you may be personally charged a ***$30 cancellation/ no show fee*** to offset the lost appointment time. Insurance companies will not cover a no show fee.

Emergency Phone Contact: Your phone calls are received 24 hours a day by a confidential voicemail system. Please leave a message and I will make every effort to return your calls as soon as possible. I do not charge for brief phone calls but do charge for ongoing or lengthy phone communication. Please leave a message marked urgent if you are in crisis and call 911 if you are in imminent danger of harming yourself or others.

I have read the above information, and understand that I am encouraged to ask questions and give input regarding the counseling process at any time. If there is anything in this form that I do not understand it is my responsibility to seek clarification.

Do you want New Hope Counseling to file claims to your primary insurance company _____ (Yes/No/ EAP only)

It is my understanding that my copay or fee for each session is $_____

Signature (s):_____ Date:_____

Consent for Release/Exchange of Health Information (OPTIONAL)

New Hope Counseling Services, PLLC
10134 West Broad Street
Glen Allen, VA 23060

I _____, hereby authorize New Hope Counseling Services to:

Please initial below all that apply:

_____ Exchange information with _____ Release information to _____Obtain information from

Name of person/agency and address and phone number:_____

_____

For the purpose of **coordination of care and treatment** and (add any other purposes)

Information to be released /exchanged (please initial all that you authorize):

_____ Summary of treatment / verification of mental health treatment
_____ Mental health treatment plans and/or progress notes
_____ Information concerning past or present substance abuse
_____ Information for billing

I understand that:

- I may inspect or copy the protected health information to be disclosed.
- Information used or disclosed pursuant to this authorization may be subject to secondary disclosure by the recipient, for which New Hope Counseling Services will not be held responsible.
- I may refuse to sign this authorization and that you will not condition treatment upon that decision.
- That my records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent except that release which is provided for or required within Federal and State laws and regulations
- I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance on it (ie. Records released after consent given and prior to consent being revoked).
- This consent will expire one year from the date signed or with written cancellation or on _____ (Expiration date or event such as termination of treatment.)

_____ _____ _____
Client's Name (PLEASE PRINT) Signature Date

_____ _____
Client's Date of Birth Client's Social Security Number

_____ _____
Client's and/or Legal Guardian's Signature Witness signature

_____ _____ _____
Spouse (PLEASE PRINT) Signature Date

_____ _____
Spouse Date of Birth Spouse Social Security Number

***CANCELLATION OF CONSENT**

The person who signed this authorization may cancel this consent at any time. A written notice may also serve as a notice of cancellation. Cancellation of consent will not apply if received after information has been released. I cancel this consent on

(Date) _____ (Signature) _____

NOTICE OF PRIVACY PRACTICES

(Medical)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us, in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.
As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we many use and disclose your health information.
We may use and disclose your medical records only for each of the following purposes: Treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a counseling session.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of March 23, 2009 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll-free: 1-877-696-6775

Client signature:_____ Date:_____

Spouse or significant other signature:_____ Date:_____