Welcome to New Horizon Counseling Services

Client Information and Informed Consent for Services

Welcome and thank you for choosing New Horizon for your counseling services. Today's appointment will take approximately 60 minutes after you have completed the forms. We realize that beginning a process of counseling may be a major decision, and that you may have many questions. This document is intended to inform you of our policies, your rights, and state and federal laws. If you have any questions or concerns, please ask and we will try our best to give you all the information you need. When you sign this document, it will represent an agreement between you and New Horizon Counseling Center.

Our Counseling Center

New Horizon is dedicated to providing the highest quality in our respective areas of expertise to our community. Our mission is to promote a positive emotional and psychological lifestyle for our clients through counseling and psychotherapy services.

Our Therapists

Our therapists are graduates from a major accredited University, holding a Master's degree in Counseling or higher. Each therapist is licensed through their respective Texas State Board. Those that are interns are in the process of completing 3,000 supervised hours; they are under supervision to ensure that you will receive the highest excellence of service. New Horizon carefully selects interns based on their knowledge, character, ethics, experience, and passion to help. If you have any questions regarding any intern, ask to speak with the Director of New Horizon Counseling, Jaime Corona, MA, LPC-S or of New Horizon Counseling-NRH, Ashley Knight, MA, LPC, LMFT.

If you have any complaints, you may contact the Complaints Management and Investigative Section.
PO Box 141369, Austin, Texas 78714-1369
Website: http://www.dshs.state.tx.us/
Telephone: 1-800-942-5540

Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and the client as well as the particular problems you bring forward. There are many different methods your therapist may use to deal with the problems that you hope to resolve. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have 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. Psychotherapy has also shown to have great benefits for people who go through the process. Therapy often leads to an improved relationship, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

The first few sessions will involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your therapist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about procedures, they should be discussed whenever they arise. If your doubts persist, your therapist will be happy to help you set up a meeting with another mental health professional for a second opinion.

Sessions

Normally an evaluation will be conducted that will last at least two sessions. During this time, you and the therapist both decide whether your therapist is the best person to provide the services you need in order to meet your treatment goals. If psychotherapy has begun, we will usually schedule one 4560 minute session per week or as needed. Once an appointment is scheduled, you will be expected to pay for it unless you provide a 24-hour advance notice of cancellation or reschedule (unless we agree that you were unable to attend due to circumstances beyond your control.)

Confidentiality & Limitations

All communication with your counselor is confidential and will not, except under circumstances explained below, be disclosed to anyone outside of New Horizon unless you give written authorization to release information. You will need to sign a Release of Information Form if you wish to have New Horizon staff communicate information to anyone other than those specified below (see Consent for Limited Release of Information).

A record is kept of your work with us. It contains information you have provided to us in writing as well as counseling notes of your sessions. The record remains at New Horizon for a period of seven years following your last visit; at that time, it is destroyed. **Your record never leaves the Counseling Center.**

It is important that you understand that all identifying information about your therapeutic treatment is kept confidential. Information solicited by phone, written, or in person about clients will not be provided. You will need to sign our Consent to Release Information Form before any information is provided to a third party outside our office. This condition applies also in cases where coordination of treatment is necessary with another health professional (physician/psychiatrist). However, there are exceptions and/or limitations to confidentiality, including:

- In cases of immediate risk/threat of suicide or homicide on the part of the client.
- In cases of child or elderly sexual abuse or neglect
- In cases required by law.

Patient's Name: _____ Date: _____

Emergency Situations

We are usually available Monday through Friday from 9:00 am to 7:00pm. If we are not able to answer the phone, you can leave a message in our voicemail with your name and phone number where we can reach you. We will make every effort to return your call on the same day you made it, with the exception of weekends and holidays. If you are not able to reach us and feel that you can't wait for us to return your call, contact your family physician or the nearest emergency room and ask for the clinician/psychologist/psychiatrist on call. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

Requested Services (please check all that may apply)

Individual Counseling: ____ Marriage/Couples Counseling:____ Family Counseling:____ EAP:____

Please note all indicated below will have certain requirements, restrictions and fee agreement:

Immigration Assessments: ____ Disability Assessments: ____

Other Documentation (please specify type): _____

Payment Method for Professional Fees

NHCC NRH only accepts private pay and primary insurance. We will provide a receipt to you for any additional charges for reimbursement to your second insurance provider.

Insurance:_____ Member ID #: _____

Primary Insurance Holder: _____ Group ID#_____

DOB of Primary Insurance Holder_____/_____/_____ Relationship to Client: _____

EAP Provider:_____ Contact#_____

EAP Authorization Number:_____ Number of EAP sessions:_____ Eff Date:_____

The following is a fee agreement between NHCC & _____.
Client Name and Insurance name if applicable

I have received a copy of the HIPAA Notice of Privacy Practices and fully understand how my personal health information will be used and disclosed.

_____
Initials

CONSENT TO TREATMENT

By signing this Client Information and Consent Form as the client or Guardian of said client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

_____ _____

Signature – Client / Parent or Guardian **Date**

_____ _____

Signature – Therapist **Date**

DO NOT FILL BELOW LINE- STAFF ONLY

Attending Support Staff: _____

Uploaded by: _____ Date: _____

FINANCIAL POLICY- NEW HORIZON COUNSELING CENTER NRH

Below are the terms of agreement regarding payment for sessions at New Horizon Counseling Center-NRH

1. I understand New Horizon **accepts only the primary insurance** and any additional insurances will be my responsibility. I will be provided a receipt to seek reimbursement from any additional payers.
2. I understand for payment of services a credit card is required to be kept on file and authorized for charges to pay for your therapy fees, including but not limited to sessions, no shows/cancels, documentation, consultations. A charge will be made at the time of the appointment.
3. I understand that my appointment time is reserved exclusively for me and if I fail to show or don't cancel/reschedule my appointment with at least a **24hr advance notice**, I will be responsible for a **$50 No Show/Late Cancel fee**. Fees will be charged at the time of the missed appointment with a credit card you provide to be kept on file.
4. Session fees are based on a clinical hour, which is defined by insurance providers as 45-60 minutes direct with the counselor or professional.
5. I understand that if I am late to a session, that **session will end at the time originally scheduled**. It is my responsibility to arrive on time.
6. Services including phone calls, emails, record reviews, and professional consults at times other than the scheduled therapy session are the patient's responsibility. These services will be billed per quarter hour.
7. I authorize my health insurance to provide payment of benefits to New Horizon Counseling Center- NRH.
8. I understand records of my treatment may be shared with my insurance company when necessary to process claims.
9. I will be expected to pay my rate indicated on my financial agreement for each session at the beginning of my session. All balances incurred between sessions will be due prior to my next session.
10. Appointments will be rescheduled if a prior balance remains and client is not in crisis. Therapy will be discontinued for balances 45 days past due after all reasonable efforts to collect payment and/or enter a mutually agreed upon financial resolution. For additional details please discuss with office manager.
11. I understand that in the event my insurance provider does not pay for any session(s), I will be fully responsible for the entire amount billed to the insurance provider.
12. I understand that in the event my insurance coverage changes, I will be informed by NHCC and responsible for the new client responsible amount indicated by the insurance provider **effective from the date the insurance changed.**
13. I understand that NHCC-NRH reserves the right to change and update the fee agreement at any time.

I have reviewed this document and understand the contingencies stated above.

_____
Printed Client name

_____
Printed Guardian/Payee name

_____ _____
Signature Date

NEW HORIZON COUNSELING CENTER- NRH
5424 RUFE SNOW DRIVE, SUITE 304, NRH, TX 76180

Financial Agreement and Authorization for Recurring Credit Card Charges

Name of Client_____

I agree to pay the below fees for services rendered at the time of services with the card supplied or other form of payment. I understand that this authorization will remain in effect during the duration of counseling. I understand my fee agreement will be updated when payment sources change, including but not limited to change in deductible, insurance type or rate, or NHCC-NRH fee schedule. These charges may include:

- Co-pay and/or co-insurance for session (Intake/Follow-up)
  - Pre-deductible: $_____/_____ Post-deductible $_____/_____ OOP met $_____/_____ Self-Pay $_____
- Charge for no show or cancellation without 24 hours' notice: $50.00
- Emotional Support Animal Documentation Housing $99.00 Airline $99.00 Housing and Airline $149.00
- Disability Documentation/ Requested Paperwork: $30.00 minimum for 30 minutes, $15.00 for each additional 15 minutes
- Additional documents preparation charges are time based. Minimum fee must be paid before paperwork can be completed. Total remaining balance must be paid prior to releasing paperwork.
- Request for records include a charge based upon length of time to complete, delivery methods and number of pages. A separate form will be provided with payment details.
- Phone consultations outside of your normal therapy session are charged beyond 15 minutes at $15 per 15 minutes.

Signature of Client/Guardian: _____ Date:_____

For payment of services a credit card is required to be kept on file and authorized for charges to pay for your therapy fees. You will be charged the day of your therapy appointment unless other arrangements have been made for sessions. You may pay in person with an alternative method at the time of appointment, however, a card will still be required for late cancels or no show fee's**. A no show/late cancellation fee of $50 will be charged at the time of the missed appointment.** Overdue balances or denied payments, must be paid prior to your next session. The charge will be made under the name New Horizon Counseling Center. You agree that **no prior notification is necessary** unless the amount billed each time exceeds the preset fee amount in which case you will receive notification in advance.

Account Type: □ Visa □ MasterCard □ American Express □ Discover Card Number _____-_____-_____-_____

Cardholder Name _____

Expiration Date _____ CVV _____ Billing Address_____

I authorize New Horizon Counseling Center-NRH to charge this credit card for professional services and associated charges as agreed below. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify this practice in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date.

Signature of Authorized Credit Card User: _____ Date: _____

NEW HORIZON COUNSELING CENTER NRH – Adult Intake

Name_____Date_____

Address_____ Apt _____

City _____ State _____ Zip Code _____

E-mail _____ OK to contact? ☐YES ☐NO

Phone _____ OK to contact? ☐ YES ☐ NO Is this a cell phone? ☐ YES ☐ NO

Date of Birth _____/_____/_____ Age _____ Social Security #: _____-_____-_____

Employer _____ Occupation _____

Number of different jobs in past 3 years: _____ Last Grade / School Completed_____

Gender: ☐ Male ☐ Female Ethnicity: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If married, separated, divorced, or widowed, how long: _____

Name of Spouse/Partner_____ Date of Birth ___/___/_____ Do you have children: ☐ Yes ☐ No If yes, how many children? _____

Name of Children/Others in Household	Relationship	Date of Birth	Age	Lives with You?
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No

Physician Name _____ Date of last physical: ____/____/_____

Any health issues: _____

_____

Current Medications:

Name: _____Dose:_____Eff Date:_____

Reason Prescribed: _____

Name: _____Dose:_____Eff Date:_____

Reason Prescribed: _____

Name: _____Dose:_____Eff Date:_____

Reason Prescribed: _____

Name: _____Dose:_____Eff Date:_____

Reason Prescribed: _____

In Case of Emergency:

I authorize to contact _____ Relationship_____

Phone Number _____ Alternate Phone Number: _____

How did you hear about us? ☐ Friend/Family ☐ Former/Current Client ☐ Psychology Today

☐Therapy Tribe ☐ Our Website ☐ Goodtherapy.com ☐ Counsel-search.com

☐Other:_____

NHCC ASSESMENT and HISTORY INFORMATION

This information will help you and your therapist begin to clarify your therapy goals.

Patient Name: _____ Date: _____

□ Yes □ No Have you ever been treated by a psychiatrist?

□ Yes □ No Have you ever been hospitalized for mental or chemical dependency treatment?

□ Yes □ No Have you seen another therapist in the past 24 months?

If yes, who did you see? _____

□ Yes □ No Have you ever attempted suicide? If yes, when? _____

□ Yes □ No Any mental health problems in father's/mother's family? If yes, please indicate who and what diagnosis? _____

_____

Briefly describe your reasons for seeking counseling services: _____

_____

_____

What kind of things have you tried so far to handle this situation? _____

_____

_____

Please place a number that best corresponds to the issue listed below: (past or present issues may be indicated)

NEVER RARELY SOMETIMES OFTEN ALWAYS

0 1 2 3 4 5 6 7 8 9 10

____Abuse – physical	____Abuse – sexual	____Abuse – emotional
____Abuse – neglect	____Aggression, violence	____Alcohol use
____Anger, hostility, irritable	____Anxiety, nervousness	____Attention, distraction
____Career concerns, goals, choices	____Co-dependence	____Confusion
____Compulsions	____Cruelty to animals	____Crying, sadness
____Custody of children	____Decision-making, indecision	____Delusions (false ideas)
____Depression	____Divorce/separation (parental)	____Drug Abuse (prescribed)
____Drug Use (illegal)	____Eating problems	____Financial
____Gambling	____Grieving	____Goals
____Guilt	____Headaches	____Impulsiveness
____Judgmental	____Loss of control	____Marital/Partner
____Memory problems	____Menstrual, PMS, menopause	____Mood swings
____Obsession/compulsion	____Panic/Anxiety attacks	____Parenting
____PTSD	____School problems	____Self-esteem
____Sexual issues	____Sleep problems	____Stress
____Suicidal thoughts	____Tobacco use	____Temper/low tolerance
____Thought disorganization	____Work problems	____Other:_____

NHCC ASSESMENT and HISTORY INFORMATION Cont.

Patient Name: _____ Date: _____

In the past 36 months has there been a death of a family member or someone close to you?

□Yes □ No If yes, who? _____ When: _____

_____ _____

Prior to the 36 months, has there been a death of someone that was close to you?

□Yes □ No If yes, who? _____ When: _____

_____ _____

Please rate below on a scale of 0 to 10, 0 = not at all, and a 10 = very much so:

_____ I was very close and had a good relationship with my father.

_____ I was very close and had a good relationship with my mother.

_____ I was very close and had a good relationship with my siblings.

_____ I have several good friends.

_____ I often have nightmares.

_____ I enjoy spending time alone.

_____ I have a tendency of agreeing with other people to avoid confrontations.

_____ I don't like being around other people, I want to be alone.

_____ I like myself.

_____ I have a healthy interest in sex.

_____ I sometimes am confused with my identity.

_____ I put the needs and wishes of others first before myself even if I am not comfortable with it.

_____ I think I am responsible for the way others feel and their behaviors

_____ I drink alcoholic beverages at least 3 times per week.

_____ I have a problem saying "no"

_____ Others can make me mad, frustrated, disappointed, or sad easily.

Fears or concerns of counseling: _____

_____

_____

Goal or expectation of counseling: _____

_____

_____

_____