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

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 – Child Intake

Child's Name: ____ Date: ________________

Child's Address: ____ Apt: _________________

City: ____ State: __________________ Zip Code: ______________

Child's Ethnicity: _____________________________ ☐ Male ☐ Female DOB: _____/_____/________ Age ______

Social Security #: _______-______-__________

Father's Name: ____ DOB: _____/_____/________ Age ______

E-mail: ____ OK to contact? ☐YES ☐NO

Phone: __________________________ OK to contact? ☐ YES ☐ NO Is this number a cell phone? ☐ YES ☐ NO

Father's Employer: ______________________________________ Occupation: _____________________________

Social Security #: _______-______-__________

Mother's Name: ____ DOB: _____/_____/________ Age ______

E-mail: ____ OK to contact? ☐YES ☐NO

Phone: __________________________ OK to contact? ☐ YES ☐ NO Is this number a cell phone? ☐ YES ☐ NO

Mother's Employer: _____________________________________ Occupation: ______________________________

Social Security #: _______-______-__________

Does child live with both biological parents? Y - N

Legal Guardian's Name (if different from mother & father): ____

Legal Guardian's DOB: ______/______/_____________

E-mail ____ OK to contact? ☐YES ☐NO

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

Employer: ____ Occupation: _____________________________

Social Security #: _______-______-__________

Child's School: ____ Grade: ________________

Was child referred to counseling? Y - N If Yes, by whom?____

Names and ages of others living in your home:

Name: Age : Relationship:

____

____

____

____

____

____

____

____

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

Patient's Name: ________________________________ **Date:** ______________________

☐ YES ☐ NO Has child ever been treated by a psychiatrist? Who? When?
____

☐ YES ☐ NO Has child ever been treated by a counselor? Who? When?
____

Patient's Physician: ____

Date of last visit: ____________ Reason for visit: ______________________________________

Current Medications:

Name: ______________________________________Dose: __________________Eff Date:_____________________

Reason Prescribed: ____

Name: ______________________________________Dose: __________________Eff Date:_____________________

Reason Prescribed: ____

Name: ______________________________________Dose: __________________Eff Date:_____________________

Reason Prescribed: ____

☐ YES ☐ NO Has child been diagnosed with developmental problems?

☐ YES ☐ NO Any speech impairment problems?

☐ YES ☐ NO Has child been exposed to trauma?

☐ YES ☐ NO Any mental health problems in father's/mother's family?

If yes, please indicate who and what diagnosis? ____
____

☐ YES ☐ NO Any complications during pregnancy with child?

☐ YES ☐ NO Any complications at birth of child?

Briefly describe your reasons for seeking counseling services:
____
____
____
____

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

NHCC ASSESMENT and HISTORY INFORMATION Cont.

Patient's Name: ________________________________ **Date:** ______________________

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 – neglect
____Anxiety, nervousness
____Compulsions
____Decision-making, indecision
____Divorce, separation
____Guilt
____Irritable
____Loss of control
____Obsession/compulsion
____Self-esteem
____Substance Abuse
____Thought disorganization

____Abuse – sexual
____Aggression, violence
____Attention, distraction
____Cruelty to animals
____Delusions (false ideas)
____Eating problems
____Headaches
____Judgment (sense of)
____Memory problems
____Panic/Anxiety attacks
____Sleep problems
____Suicidal thoughts
____Bed wetting

____Abuse – emotional
____Anger, hostility
____Confusion
____Crying, sadness
____Depression
____Grieving
____Impulsiveness
____Judgmental
____Mood swings
____School problems
____Stress
____Temper/low tolerance
____Other ______________

In the past 36 months, has there been a death of a family member or someone close to child?
☐ YES ☐ NO If yes, who? ____
When: ________________________________

Prior to the 36 months, has there been a death of someone that was close to child?
☐ YES ☐ NO If yes, who? ____
When: ________________________________

Please rate below on a scale of 1 through 10, 0 = not at all, and a 10 = very much so:
_____ Child is very close and has a good relationship with siblings.
_____ Child has several close friends
_____ Child often has nightmares.
_____ Child prefers to spend time alone.
_____ Child does not make eye contact when spoken to.
_____ Child does not like being around other people.
_____ Child likes self.

Patient's Name: ________________________________ Date: ______________________

CONFIRMATION OF RIGHT TO CONSENT TO SERVICES

I, ____________________________________ hereby confirm and verify that I hold and maintain the right to consent to the provision of psychological counseling for the following child:

Child's name: _____________________________Date of Birth: ____/____/______

______ I have supplied available documentation certifying my ability to consent to counseling, including but not limited to- custody agreement and/or divorce decree. I understand that without proper documentation my child will not be seen.

Initials

________ I declare that **no documentation exists** that pertains to child custody or care.

Initials

____

Parent / Guardian Signature Date

CONSENT TO SERVICES

This is to certify that I, _____________________________________ give permission for the above named child to receive counseling from New Horizon Counseling Center.

_______________________________________ _____________________________________

Parent / Guardian Signature Date Therapist Signature Date