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. Session fees are based on a clinical hour, which is defined by insurance providers as 45-50 minutes direct with the counselor or professional.

2. If I, the patient, fail to appear for an appointment without a 24-hour notice of cancellation, appointment fees will be charged and I will be responsible for payment.

3. 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.

4. 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 of an hour.

5. I authorize my health insurance to provide payment of benefits New Horizon Counseling Center- NRH.

6. I understand records of my treatment may be shared with my insurance company when necessary to process claims.

7. I understand I am responsible for payment if my insurance company declines payment.

8. 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.

9. 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.

10. 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.

11. I understand that my appointment time is reserved exclusively for me and if I don't cancel or reschedule my appointment with at least a 24hr advance notice, I will be responsible for a $50 fee.

12. 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 name

_____ _____

Signature Date

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NEW HORIZON COUNSELING CENTER- NRH

Financial Agreement and Authorization for Recurring Credit Card Charges

For your convenience, you may authorize recurring charges to your credit card to pay for your therapy sessions. You will be charged the day of your therapy appointment unless other arrangements have been made for sessions. A no show/late cancellation fee will be charged at the time of the missed appointment. Balances must be paid prior to each 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.

Name of Client_____

Account Type: □ Visa □ MasterCard □ American Express □ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

Billing Address_____

CVV (3-digit number on back of Visa, MasterCard, or Discover; 4 digits on front of AmEx) _____

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:_____

I authorize New Horizon Counseling Center-NRH to charge this credit card for professional services and associated charges as agreed below. 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: $_____

Self-pay for session or payment for session not covered due to deductible: $_____

Charge for cancellation without 24 hours' notice: $50.00

Other charges [specify]: _____ $_____

_____ $_____

I agree to pay the above 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.

Signature of Client/Guardian: _____Date:_____

Child Registration

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 – sexual	____Abuse – emotional
____Abuse – neglect	____Aggression, violence	____Anger, hostility
____Anxiety, nervousness	____Attention, distraction	____Confusion
____Compulsions	____Cruelty to animals	____Crying, sadness
____Decision-making, indecision	____Delusions (false ideas)	____Depression
____Divorce, separation	____Eating problems	____Grieving
____Guilt	____Headaches	____Impulsiveness
____Irritable	____Judgment (sense of)	____Judgmental
____Loss of control	____Memory problems	____Mood swings
____Obsession/compulsion	____Panic/Anxiety attacks	____School problems
____Self-esteem	____Sleep problems	____Stress
____Substance Abuse	____Suicidal thoughts	____Temper/low tolerance
____Thought disorganization	____Bed wetting	____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 services, including but not limited to- custody agreement and/or divorce decree. I understand that without proper documentation my child will not be seen.

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

_____

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