***New Leaf Counseling Services***

3 Oak Drive, Suite B, Maryville, IL 62062

Phone: 618-980-2358, Fax: 309-323-0475, [NewLeafCounsel@gmail.com](mailto:NewLeafCounsel@gmail.com)

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**Client Record**

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Preferred Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_ Age\_\_\_

Main phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ please circle one: home cell ***ok to leave a message? Y N***

Alternative phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ please circle one: home cell work ***message? Y N***

Home address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1st Emergency Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2nd Emergency Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer/School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Previous experience with counseling?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information:**

Primary Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Phone: \_\_\_\_\_\_\_\_

Member ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Address (if other than client): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

**Insurance and Non-payment privacy policies. Please Read and Sign Below:**

I hereby authorize the counselor and New Leaf Counseling Services, LLC to release to any party responsible for payment any information acquired in the course of therapeutic examination or treatment. A photocopy of this authorization shall be considered as effective and valid as the original. This release shall be valid for 1 year. I authorize any holder of clinical information about me to release to the health care financing administration and its agents any information needed to determine these benefits payable for related services. I hereby authorize the counselor to receive direct payment for the amount due me in my pending claim for therapeutic services rendered.

I understand that I am financially responsible for charges not covered by a third party/insurance plan. If charges for services are unpaid after 3 months and 2 or more mailed statements, the charges might be submitted to a collections agency. No medical or therapeutic information will be shared with the collections agency, only dates of service(s) and unpaid fees. Prior to submission of unpaid bills to any collection agency, the responsible party will be notified through the U.S. Post Office of intention to do so and given a final opportunity to make payment.

**Signature of Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Signature of Parent/Guardian if needed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

Party Responsible for payment if other than client:Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_ Relationship to client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

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Phone: 618-980-2358, Fax: 309-323-0475, [NewLeafCounsel@gmail.com](mailto:NewLeafCounsel@gmail.com)

**Consent to Treatment and Privacy Practices**

**This notice is required by the federal government under the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of Protected Health Information (PHI) used for the purpose of treatment, payment and other health care operations. This notice describes how your information may be used and disclosed and how you can access this information. The practice is required to obtain your signature indicating that you have received this notice.**

Welcome to New Leaf Counseling Services LLC. Before beginning therapy, it is important that you understand the following points:

1. *Your therapist does not provide emergency services, so if there is an emergency while she is unavailable, please call your physician, go to the emergency room, or call 911 or someone who can protect you. If you need to contact your therapist, know that neither phone nor email is consistently monitored, especially during standard non-business hours, and a reply will not be immediate.*
2. Payment is expected at each session, unless previous arrangements have been made. Payment can be made with cash, check or most credit/debit cards (any which can be processed through the Square system). Returned checks will incur a minimum fee of $35, plus the original amount of the check.
3. **Please provide notice of intent to cancel an appointment as soon as possible. By notifying the office before Noon of the previous business day of your scheduled appointment you will be able to avoid a fee charged to your account. (The fee will be $75 for a Failure to Show, $60 for a Late Cancel.) When canceling an extended hour RRT session, please give 2 business days’ notice. ($125 for a late cancel, $250 for a Failure to Show).**
4. Your decision to receive services is voluntary even though you may have received a referral.
5. If you are using insurance, the office will work with your insurance company to the fullest extent possible, but ultimately you are responsible for the total balance of your unpaid account.
6. Confidentiality is of the utmost importance. Health Insurance Portability and Accountability Act (HIPAA) requirements are strictly maintained. Information will only be disclosed with your specific written consent, except in the following circumstances. Your therapist may disclose information about you if any of the following conditions apply:
7. You are a danger to yourself or others.
8. You are seeking treatment to avoid detection or apprehension.
9. You are under the age of 16 and are a victim of a crime.
10. Information comes to light in the session which would require the therapist to make a report to the Child Abuse Hotline or the Senior Abuse Hotline in order to comply with Illinois Mandated Reporter requirements.
11. You die and information is required regarding a will or deed.
12. You file suit against Jean McGurk O’Brien or New Leaf Counseling Services LLC; if you claim mental damages in a lawsuit; or if necessary to defend against charges brought before or by the Illinois Department of Financial and Professional Regulation, or other professional certification, licensing or regulation agency.
13. Your therapist receives a subpoena and is required by law to yield information.
14. Your sessions may be recorded to enable your therapist to clinically review the session. The recording or a transcript of the recording might be used for clinical evaluation or training of other healthcare professionals learning from the therapist. At the beginning of any session which is being recorded verbal acknowledgement of the recording will be made to ensure your awareness and consent.
15. If you use location-based services on your mobile phone, be aware of the privacy issues related to using these services. New Leaf Counseling Services, LLC does not intentionally place itself as a check-in location on any site or application, however, if you have GPS tracking enabled on your device, it is possible that this or the other counseling offices within this suite have been registered at one or more of these tracking systems. Additionally, others may surmise that you are a therapy client due to regular check-ins at this location. Please be aware of this privacy risk if you are intentionally “checking in” from this office or if you have a passive LBS app enabled on your phone.

**Consent to Treatment and Privacy Practices (continued)**

1. Regarding email and texting: Please do not email/text content related to your therapy sessions, as these electronic services do not meet HIPAA security or confidential standards. If you choose to communicate by email or text, be aware that all emails are retained in the logs of your and my Internet service providers, and texts are retained in the phones. While it is unlikely that someone will be looking at these logs, they are available to be read by the system administrator(s) of the Internet service provider, or may be casually read by anyone holding your phone. You should also know that any emails I receive from you and any responses that I send to you may become a part of your legal record.
2. Internetbusiness review sights might list this practice (ie: Yelp, Healthgrades, Bing, etc.). Some of these sites include forums in which users rate their providers and add reviews. If you should find my listing on any of the sites, please know that my listing is NOT a request for a testimonial, rating or endorsement from you as my client. Of course, you have a right to express yourself on any site you wish, but due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. Please also be aware that using these sites to indirectly communicate with me will not be effective as I very likely will not ever see your message/comments/review. At anytime it would be preferable for you to bring your feelings and reactions directly to me during the course of our work together, even if you decide that we are not a good fit. Please keep in mind that you may be sharing personally revealing information in a public forum.
3. If you feel that your therapist has done something harmful or unethical and you do not feel comfortable discussing it with her, you can always contact New Leaf Counseling Services, or Illinois Department of Financial and Professional Licensure at: 320 West Washington Street, Springfield, Illinois 62786, 217-785 – 0820 or **Toll Free:** 1-888-4REGUL8 (1-888-473-4858)
4. Mental Health Services Benefits and Risks: While it may not be easy to seek help from a mental health professional, I hope that this experience will assist you in understanding your situation or problem and moving towards a resolution of this issue. A therapist has professional training and knowledge of human development and behavior and will make observations about your situation and will assist you in finding options for resolution of your issue(s). The therapist may utilize various therapeutic approaches in order to assist you in resolving your problem(s). You should be aware that entering into psychotherapy is a risk. Psychotherapy sessions can be difficult or emotionally painful at times. Often times, you may learn new information about yourself that you may not like. Often personal growth cannot occur until you are able to confront your issues and experience the associated feelings. These feelings may include pain, sadness, anger or shame. The success of our work depends on quality effort of both therapist and client and the realization that you are ultimately in control of and responsible for the changes that result from psychotherapy. Specifically, one risk of psychotherapy is encountering (positive or negative) reactions from significant others to your new lifestyle choices/changes. Any identified relationship goals when working with a couple are necessarily successful based on many circumstances, many or most of these are outside the purview of your Psychotherapist. Be aware that “success” is not guaranteed, although our work together will be in every way possible directed towards addressing and relieving your issues.
5. Goals, Purposes, and Techniques of Therapy: Psychotherapy may be one way to effectively treat your problem. There may be alternative ways to treat you problem. It is important for you to discuss any concerns you have regarding my treatment recommendations. I encourage you to provide input into setting goals for therapy and the therapeutic techniques used for treatment. As therapy progresses, these goals and techniques may change. My theoretical orientation is Rapid Resolution Therapy®. However, there are many different ways to go about clearing a trauma and if RRT® is not the form of therapy that you are comfortable with a referral will be made available to you with another area therapist that may be more to your liking.
6. Relationship: Your relationship with your therapist is a professional relationship. In order to preserve this relationship I cannot have any other type of relationship with you. Any personal or business relationships with you will undermine the effectiveness of the therapeutic relationship and therefore is strictly prohibited. I am committed to your mental health, but am not in the position to become socially or personally involved with you. Please note that I cannot accept any gifts.
7. Sessions may use Telehealth, which is generally covered by insurance plans, you may contact your insurance company to confirm services. Telehealth sessions will be conducted using a HIPAA secure platform. If participating in a Telehealth session, please try to be in a setting which will give you privacy for our conversation. It is useful to use earbuds/head phones with a microphone if you have them available to improve sound quality and audio privacy. If session is interrupted by a faulty connection please immediately reinitiate the contact, if that is not effective the therapist will call you so that we may finish our conversation.

**Consent to Treatment and Privacy Practices (continued)**

1. Client Rights and Responsibilities
2. To ask any question regarding your treatment which you may have.
3. To end therapy at any time.
4. To receive respectful treatment that will be helpful and will treat you with dignity.
5. To have a safe environment.
6. To ask for what you want and need, and to express any concerns you have about treatment or services.
7. To work together to develop the most helpful treatment possible for you.
8. Right to inspect and/or obtain a copy of your written records (audio recording is excluded) for as long as they are retained in accordance with federal, state or local laws. At your request, the process will be discussed.
9. Right to an accounting of disclosures of PHI that were made without your authorization (those in section 6 of Consent to Treatment and Privacy Practice above).
10. You have a right to notice of any changes of the Consent to Treatment and Privacy Practices which are made during the course of your services. If you are no longer in treatment, you may at anytime request a copy of the effective Consent to Treatment and Privacy Practices.
11. You have a right to a paper copy of these notices, if you would like a copy please ask your therapist.

I here acknowledge that I have received and have been given an opportunity to read a copy of New Leaf Counseling Services, LLC’s Consent to Treatment and Privacy Practices. I understand that if I have any questions regarding the Consent to Treatment and Privacy Practice notice or if I have any questions regarding treatment, privacy or services, I can ask my Therapist or contact New Leaf Counseling Services at 618-980-2358. I voluntarily agree to receive mental health services through New Leaf Counseling Services, LLC and acknowledge that I may discontinue care, treatment or services at any time.

**My signature indicates that I consent to treatment and agree to all the term and information contained in this document. I have been given opportunity to ask questions and seek clarification of this document. I understand my rights related to my protected health information. I acknowledge that I have been given the choice to receive a copy of this Consent to Treatment and Privacy Practices notice, and I accept my Rights and Responsibilities.**

**Client Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_

*As necessary: Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***For your information:***

***Price list – charges submitted to insurance and private pay***

*90791 Diagnostic Evaluation $175*

*90834 Individual Psychotherapy/45min $145*

*90837 Individual Psychotherapy/60min $175*

*90847 Family Therapy/ Conjoint Therapy $175*

*90846 Family Therapy without patient $175*

*90833 Psychotherapy additional 30 mins +$85*

*+99050 Evenings or weekends +$20*

*RRT Rapid Resolution Therapy $500*

*RRT fup Rapid Resolution Therapy follow up $200*

*--------------------------------------------------------------------*

*99003 No Show $75*

*99003 Late Cancel Charge $60*

*03/30/2020*