



## **Introduction to New Leaf Resources**

We want you to be an informed participant in the care you receive at New Leaf Resources. Below you will find a copy of our Mission Statement and our Philosophy Statement. You will also find a description of the therapeutic process. We trust that this information will help you understand how we function and what you can expect from your participation in therapy at New Leaf Resources.

### **NEW LEAF RESOURCES MISSION STATEMENT**

We are a specialized Christian ministry which promotes healthy living and intervenes in the cycle of addiction, compulsion and dysfunctional relationships. We provide education, prevention, intervention, referral, counseling and consultation services to individuals, families, organizations and communities.

### **NEW LEAF RESOURCES STATEMENT OF PHILOSOPHY**

We believe that all people are created in God's image and have immeasurable value, regardless of their life circumstances. As an organization and as individuals, we openly acknowledge our own brokenness and dependence on God's healing grace and love in our lives. We believe that God works compassionately in the lives of people, calling and equipping us to participate in this ministry. There is a grace at work, the movement of God's redemptive activity which calls upon the gifts, skills, training and experience of the staff to encourage, promote and facilitate this process of healing in our broken world. We seek to bring Christ-like care, restoration and hope in a manner which is sensitive to the complexity of the human condition, which includes the mental, emotional, physiological, social and spiritual dimensions.

We believe that ministry grows out of community. The quality of our staff life and the health of our organizational functioning are directly correlated with the quality of care we have to offer. In this ministry we seek to proclaim and embody God's forgiving and reconciling love. It is our goal that God's ministry of grace and love be reflected in our self-care, our communal life, and in the lives of those we serve.

### **The Therapeutic Process:**

People enter therapy for a variety of reasons, hoping to grow and heal. We congratulate you for having the courage to take this step. If you ever have questions about your therapy work at New Leaf, please feel free to discuss this with your therapist or Executive Director. We will be happy to respond to your concerns.

When you enter therapy at New Leaf, your therapist will initially spend time with you exploring the issues you brought to therapy. Together you will set goals that you wish to achieve in your work. Periodically you will review your progress in therapy. The length of therapy will vary depending on the concerns you bring to therapy and the issues that may come up for you while in therapy.

The changes that you seek can be difficult and painful at times. Therapy can stir up intense feelings like fear, anger, guilt, loneliness, abandonment, depression etc. In the process of therapy you may make changes in yourself and your relationships that you never anticipated. Personal growth is seldom easy. Please talk to your therapist about these matters or concerns.

If you ever have questions regarding your therapy, fees, billing, insurance, scheduling, etc., feel free to talk to your therapist or the appropriate administrative staff.



## **Privacy Notice of New Leaf Resources (NLR)**

This notice is in effect as of April 14, 2003

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION  
ABOUT YOU MAY BE USED AND DISCLOSED  
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW CAREFULLY**

### **1. Statement of Our Duties**

We are required by law to maintain the privacy of your personal health information and to provide you with this notice of our privacy practices and legal duties. We are required to follow the terms of this notice. We reserve the right to change the terms of this notice based on NLR's needs and changes in the state and federal law. If we change this notice, we will provide you with a revised notice in writing.

### **2. Statement of Your Rights**

You have the right to know how we may use or disclose your Protected Health Information (PHI). In addition, you have the following rights:

- The right to request that we place additional restrictions on our uses and disclosures of your PHI. However, we are not obligated to agree to impose any such additional restrictions. If we do agree, we will then abide by our agreement.  
(Except in case of emergencies or as required by law)
- The right to inspect and to receive a copy of the protected health information that we maintain in our files about you. Recipient will be charged a fee for copying and postage of PHI.
- The right to have us correct or amend any information that you believe is incorrect or incomplete.
- The right to receive an accounting of the disclosures of your PHI that we make for purposes other than activities related to your treatment, our payment functions, or other health care operations. Disclosures to you or authorized by you are also excluded.
- The right to receive confidential communications at alternate locations.  
(e.g., alternate address or telephone number)
- The right to release your records to others, for any purpose you choose. Such a request must be in writing and may be revoked at any time in writing.
- The right to obtain a paper copy of this notice from us on request if you first receive this notice electronically.

**NOTE: To exercise any of these rights, please contact our privacy officer at the address provided in section 4 of this notice. All requests must be submitted in writing. If we deny your request, we will tell you the basis for our decision, and whether you have the right to further review.**

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### 3. Use and Disclosure of Protected Health Information (PHI)

NLR adheres to Illinois and Federal Law that requires written authorization in order to disclose any PHI outside of NLR. However, we are allowed to use or disclose your PHI in the following situations without your consent:

- *Treatment.* We may use or disclose your health information to provide, coordinate, or manage your treatment, including others outside our practice with whom we are consulting or to whom we are referring you.
- *Payment.* Information will be used to obtain and facilitate payment for treatment and services provided. This will include verification of benefit eligibility and coverage, determination of payment status, utilization review, and/or collecting unpaid balances.
- *Healthcare Operations.* We may also use or disclose your protected health information to perform administrative, financial, legal and quality improvement activities necessary to run the business and support the core functions of treatment and payment.
- *Emergencies.* Sufficient information may be shared to address an immediate emergency you may be facing.
- *Judicial Proceedings.* We may disclose your PHI in a judicial proceeding in response to a court order.
- *Serious Threat to Safety.* We may disclose information if we believe it is necessary to prevent or lessen a serious threat to a person's health or safety.
- *Abuse and Neglect.* We are required by law to share with authorities in cases where we suspect child, elder or institutional abuse or neglect.
- *Government Requirements.* We may disclose information to a health oversight agency for activities authorized by law such as audits, investigations, inspections and licensure. We are also required to share information, if requested, with the Department of Health and Human Services to determine our compliance with federal laws related to health care.
- *Criminal Activity or Danger to Others.* If a crime is committed on our premises or against our personnel, we may share information with law enforcement to apprehend the criminal.
- *Others involved in your healthcare.* Unless you object, we may disclose to a family member or other close person you identify, PHI that directly relates to their involvement in your care. If you object, we may still disclose information if we believe, in our professional judgment, that it is in your best interest.

### 4. Contact Person for Complaints or Further Information

To request more information about this notice, you may contact the person listed below. You may complain either directly to us or to the Secretary of Health and Human Services if you believe that we have not properly protected your health information. You will not be retaliated against in any way for filing a complaint. To file a complaint with us, you may submit one in writing that includes as many details as possible to:

Privacy Officer  
S. Terry Top, Executive Director  
New Leaf Resources  
2325 - 177<sup>th</sup> Street  
Lansing, IL 60438  
(708) 895-7310

Region V, Office of Civil Rights  
U.S. Department of Health & Human Services  
233 North Michigan Ave., Suite 240  
Chicago, IL 60601  
(312) 886-2359  
Fax: (312) 886-1807

### 5. Our practices regarding confidentiality and security

We restrict access to your protected health information to those employees who need to know this information in order to provide services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your private information.



Client Data Sheet – Youth

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sex:  M  F

Address: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_

Social Security # \_\_\_\_\_

School: \_\_\_\_\_

Grade: \_\_\_\_\_

Teacher: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Home # (if different): (\_\_\_\_\_) \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_

Cell: (\_\_\_\_\_) \_\_\_\_\_

Highest Level of Education: \_\_\_\_\_

Employer: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Home # (if different): (\_\_\_\_\_) \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_

Cell: (\_\_\_\_\_) \_\_\_\_\_

Highest Level of Education: \_\_\_\_\_

Employer: \_\_\_\_\_

Religion: \_\_\_\_\_

Please list any medical problems: \_\_\_\_\_

\_\_\_\_\_

Medications currently taking: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

**How did you hear about New Leaf Resources?** \_\_\_\_\_

**Previous Counseling or Therapy** (with whom and when): \_\_\_\_\_

Reason: \_\_\_\_\_

**What are the issues or concerns you would like addressed:** \_\_\_\_\_

**Is there any other information that would be important for your therapist to know?**

**List the members in your immediate family, and all others living in your home:**

Name	Age	Relationship	Living with you
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Has anyone else in the family received counseling services?** \_\_\_\_\_

**Does anyone in the family have a problem with drugs or alcohol currently or in the past?**



**Client Billing Information**  
**Client Information**

Name \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home # (\_\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_\_) \_\_\_\_\_  
Cell (\_\_\_\_\_) \_\_\_\_\_ E-Mail \_\_\_\_\_  
Date of Birth \_\_\_\_\_  M  F  
Marital Status \_\_\_\_\_ Social Security # \_\_\_\_\_  
Employer or School \_\_\_\_\_  
Employment Status \_\_\_\_\_  
New Leaf Office Location  Lansing  Downers Grove  Crown Point  
*Would you like to receive New Leaf Resources quarterly Newsletter & Updates?*  Mail  E-mail

**Insured Information**

Client Relationship to Insured:  Self  Spouse  Child/Other \_\_\_\_\_  
*If client relationship to insured is other than "Self" please complete the following:*

Insured's Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home # (\_\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_\_) \_\_\_\_\_  
Cell (\_\_\_\_\_) \_\_\_\_\_  
Date of Birth \_\_\_\_\_  M  F  
Marital Status \_\_\_\_\_ Social Security # \_\_\_\_\_  
Employer or School \_\_\_\_\_  
Employment Status \_\_\_\_\_

**Billing Information (If responsible party is other than the client)**

Insured's Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home # (\_\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_\_) \_\_\_\_\_  
Cell (\_\_\_\_\_) \_\_\_\_\_  
Date of Birth \_\_\_\_\_  M  F  
Marital Status \_\_\_\_\_ Social Security # \_\_\_\_\_  
Employer or School \_\_\_\_\_  
Employment Status \_\_\_\_\_

**ATTENTION THERAPIST**  
**PLEASE ATTACH A COPY OF THE INSURANCE CARD**  
**AND/OR FILL OUT THE FOLLOWING INFORMATION.**  
**Thank You**

**Insurance Company Information**

Insurance Company \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number/s \_\_\_\_\_  
Plan Name: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**If client is covered by more than one insurance,  
please include that information below,  
including information regarding the insured,  
if the insured is not the client.**

**Secondary Coverage**

Insurance Company \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number/s \_\_\_\_\_  
Plan Name: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Secondary Insured Information**

Client Relationship to Insured:  Self       Spouse       Child/Other \_\_\_\_\_  
*If client relationship to insured is other than "Self" please complete the following:*

Insured's Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home # (\_\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_\_) \_\_\_\_\_  
Cell (\_\_\_\_\_) \_\_\_\_\_  
Date of Birth \_\_\_\_\_  M     F  
Marital Status \_\_\_\_\_ Social Security # \_\_\_\_\_  
Employer or School \_\_\_\_\_  
Employment Status \_\_\_\_\_



## Client Commitment

(Effective September 7, 2010)

- The fee for the initial assessment session is \$200 per hour.
- The fee for subsequent individual, play therapy, or family therapy when a client is not present (i.e. a child's counselor meeting with parents) sessions is \$125 per hour, and the fee for subsequent family therapy sessions (includes family meetings, couples counseling, etc.), is \$150 per hour.
- Group therapy sessions will be billed at \$50 per person per hour.

**Please place an "X" by the pre-approved commitment option below.**

1. \_\_\_\_\_ I am able to pay the full fee listed above out of pocket.
2. \_\_\_\_\_ I will be filing insurance. By law, New Leaf Resources will bill my insurance at the full fee listed above. Until New Leaf establishes that the portion of my fees that I am responsible for is less than this amount, **I will pay \$75 for each session at the time of service.** After my exact coverage has been determined, I will pay my co-payment and/or deductible at each session.
3. \_\_\_\_\_ I will be filing insurance. By law, New Leaf Resources will bill my insurance at the full fee listed above. However, I cannot afford to pay the fee established by my insurance coverage. I have spoken with the office staff and they agreed to provide me with financial assistance toward the cost of my therapy sessions.
4. \_\_\_\_\_ I do not have insurance coverage and I cannot afford to pay the full fee listed above. I have spoken with the office staff and they agreed to provide me with financial assistance toward the cost of my therapy sessions.

*New Leaf Resources is able to offer limited financial assistance from the  
"Marty Doot Client Assistance Fund."*

*Contributions to the fund are received from individuals, churches and businesses that support the ministry.*

As a client of New Leaf Resources, I am aware that my responsibilities include:

- An honest assessment of my ability to pay.
- Promptly notifying New Leaf Resources of any life changes that would result in an adjustment of the amount of help I am receiving from the "Marty Doot Client Assistance Fund."
- Paying my fee promptly.
- **Being charged and being responsible to pay a \$75 fee when...**
  - **I fail to give a 24 hour notice when canceling an appointment**
  - **I do not show up for a scheduled appointment**

**I understand New Leaf Resources reserves the right to pursue collection of delinquent accounts.**

**I understand that in the event my account is sent to collections,**

**I will be responsible for all collection costs and legal fees.**

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



## Consent for Treatment of a Minor

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

I, \_\_\_\_\_ do hereby authorize New Leaf Resources to provide counseling/treatment to \_\_\_\_\_. I give this consent as the client's custodial parent or legal representative.

I understand that the therapist is able to share with me the following information without authorization from the client:

- Current mental condition/status
- Diagnosis
- Treatment needs/recommendations
- Times and Dates of Service
- Billing/Insurance/Payment information

Clients under age 12, the parent or legal representative has the right to all treatment information.

Clients aged 12-18, the parent or legal guardian has the right to access only the information listed above, unless the client signs an authorization specifically releasing more information.

I also understand I may revoke this consent at any time by giving written notice to the therapist.

\_\_\_\_\_  
Printed Name of Custodial Parent or Legal Representative

\_\_\_\_\_  
Signature of Custodial Parent or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Witness

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date



## Consent and Agreement for Treatment Consent to Use and Disclose Your Health Information

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment, or for other business or government functions.

***The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read the Privacy Notice before you sign this Consent form.***

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment, or administrative purposes. Any request to do so must be made in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we will then comply with your wish.

### **Informed Consent**

Informed Consent is an interactive process between client and therapist involving your right to have the following information explained to you:

- your condition or diagnosis
- the nature and purpose of treatment
- the likelihood of success
- the risks and potential consequences of treatment, including refusing treatment, and the consequences of doing so
- the alternatives to treatment, including refusing treatment, and the potential consequences of doing so
- the right to include or exclude your family or significant other/s in treatment, to the extent permitted by the law

### **By signing this form, I am indicating:**

- I have read, understand, and agree to the terms of the **Consent and Agreement for Treatment** as outlined above, except as otherwise noted in writing.
- I have been given the opportunity to review and receive a copy of the **Notice of Privacy Practices** of New Leaf Resources.
- As a consenting adult, I agree to permit the staff at New Leaf Resources to provide me with treatment services.
- I understand that I have the right to discontinue treatment at any time.

**Note: If you do not sign this consent form, we will not be able to treat you. After you have signed this consent, you have the right to revoke it, in writing, and we will comply with your wishes from that time forward.**

\_\_\_\_\_  
Printed Name of Client/s

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Client or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Client (if Legal Representative)

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date