new leaf resources
hope. help. healing.
www.newleafresources.org

Welcome to New Leaf Resources!

The staff at New Leaf Resources are committed to instilling *hope*, providing *help*, and promoting *healing*. Personal growth and change may be difficult at times. Your therapist will provide a safe and supportive environment and will walk beside you on your journey towards healing.

New Client Paperwork

Please complete these forms and give the packet to your therapist at your first appointment.

1. Client Information (2 pages)
2. Client Commitment (1 page)
3. Client Data Sheet (5 pages)
4. Client Consent (1 page)

COUPLES: Each of you will need to fill out this information.

Privacy Notice Information

The Privacy Notice of New Leaf Resources is available online at www.newleafresources.org and available at each of the NLR offices by request.

new leaf resources
hope. help. healing.
www.newleafresources.org

CLIENT INFORMATION

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Primary Phone Number _____ Is it okay to leave a message? Yes ○ No ○ Text? Yes ○ No ○

Social Security Number _____ Gender: Email: _____

How did you hear about New Leaf Resources? _____ Church Affiliation (if any) _____

IF CLIENT IS A MINOR:

Your Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Primary Phone Number _____ Is it okay to leave a message? Yes ○ No ○ Text? Yes ○ No ○

Are you the parent/legal guardian of this minor? Yes ○ No ○

IF YOU ARE ATTENDING SESSIONS WITH SOMEONE ELSE:

Their Name _____ Date of Birth _____

BILLING INFORMATION

(Fill this out if the information is <u>different</u> than the client information)

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Primary Phone Number _____ Secondary Phone Number _____

Social Security Number _____ Gender M ○ F ○

Relationship to Client _____

**New Leaf Resources will send unpaid balances to a collection agency if payment arrangements are not initiated by the responsible party.*

new leaf resources
hope. help. healing.
708-895-7310

INSURANCE INFORMATION

(If primary insured is the client—skip to the Primary Insurance Carrier Info)

Name of Primary Insured_____ Date of Birth _____

Address _____ City _____State _____ Zip _____

Primary Phone Number _____ Gender M ○ F ○

PRIMARY INSURANCE CARRIER

Insurance Company Name _____ Phone Number _____

ID Number _____ Group Number _____

SECONDARY INSURANCE CARRIER

At this time New Leaf Resources will not be filing secondary insurance for our clients. We apologize for the inconvenience.

ASSIGNMENT & RELEASE

I select New Leaf Resources (NLR) as my provider of choice. I hereby authorize payment for services directly to NLR. I represent that I have insurance coverage and do hereby authorize NLR to release and obtain all information necessary to secure payment of said benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I acknowledge that NLR has made available to me the Privacy Notice of New Leaf Resources online at www.newleafresources.org and in handout form at each of the NLR offices.

_____ _____

Signature of Client or Parent/Legal Guardian Printed Name

_____ _____

Date Relationship to Client

new leaf resources
hope. help. healing.
www.newleafresources.org

FORM #2

CLIENT COMMITMENT

Thank you for choosing NLR as your counseling services provider. We are committed to helping you reach your goals. We ask that you commit yourself to the timely payment of your agreed upon portion of the charge.

FEES

Initial Assessment	$170
Session (1 hour)	$140
Session (45 minutes)	$105
Group Therapy Session (1 hour)	$50/person
Late Cancellation Fee/No Show Fee	$50
Testing	Varies depending on tests administered
Returned Check	$25

We accept cash, checks, VISA, MASTERCARD, AMERICAN EXPRESS and DISCOVER.

PAYMENT POLICY AGREEMENT (initial each section)

_____ 1. Insurance co-payments are due at time of service.

_____ 2. Payment is due upon receiving your monthly statement in the mail.

_____ 3. I understand that all charges are my responsibility to pay. If I have insurance, I realize that insurance payments do not always cover all fees and that I am responsible for any part not covered.

_____ 4. I understand that appointments not cancelled within 24 hours will be charged a $50 fee.

_____ 5. I understand that if I do not show up for my scheduled appointment I will be charged a $50 fee.

_____ 6. I agree that if any portion of my account balance is over ninety (90) days, it will be considered delinquent for the purposes of collection.

_____ 7. If any portion of my account becomes delinquent (as defined in section 6) and it becomes necessary to institute legal proceedings to collect payment, I further agree to pay the attorney fees incurred through litigation and/or other efforts undertaken to collect such delinquent sums.

I have read and I understand the above policies and agree to abide by them. By signing this commitment form I am agreeing to be the person financially responsible for this client account.

Print Name _____ Signature_____

Name of Client (if different than above) _____ Date _____

Date: _____

ADULT CLIENT DATA SHEET

(for therapist records only)

Personal Information

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact numbers therapist can call:	Approval to leave a message:	Text:
Cell: _____	Yes ○ No ○	Yes ○ No ○
Other: _____	Yes ○ No ○	
Email: _____	Yes ○ No ○	○ ○

In case of emergency who should be contacted? _____

Primary # _____ Secondary # _____

Marital Status: Single☐ Married☐ Divorced☐ Widowed☐ Living with Partner☐

If applicable, is this your first marriage? Yes ☐ No ☐

Name of Spouse/Partner: _____ Date of Current Marriage: _____

Please list the names and ages of your children:

Name	Biological/Stepchildren	Age	Currently living with you?
_____	B ☐ S ☐	_____	Yes ☐ No ☐
_____	B ☐ S ☐	_____	Yes ☐ No ☐
_____	B ☐ S ☐	_____	Yes ☐ No ☐
_____	B ☐ S ☐	_____	Yes ☐ No ☐
_____	B ☐ S ☐	_____	Yes ☐ No ☐

Please list any other persons living with you: _____

Current/Past Military History:

Are you currently serving or have you served in the military? Yes ☐ No ☐

If Yes, please explain (when/how long/branch) _____

Education/Employment Information:

Highest (or current) Grade Level Achieved: _____

Current Employer: _____ Title: _____

Employment Status: ☐Full Time ☐Part Time ☐Unemployed ☐Retired

☐Home Maker ☐Student

Spirituality:

Any past or current spiritual/religious beliefs, practices, or affiliations?

_____

_____

Physical Health/Concerns

Describe any major health problems/surgeries/hospitalizations for any physical or emotional problem that you *have had* or *are currently* being treated: _____

_____

What medications are you currently taking (prescription/OTC/Supplements):

Name	Dose/Frequency	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(If more space needed, please continue on back)

Name of Physician(s): _____

Recent/Present Physical Concerns (please check all of the symptoms below that apply to you):

☐ Stomach Aches	☐ Headaches	☐ Backaches	☐ Eating Difficulties
☐ Sexual Difficulties	☐ Grinding Teeth	☐ Sinus Problems	☐ G.I Issues
☐ High Blood Pressure	☐ Blackouts	☐ Cancer	☐ Sleep difficulties
☐ Decreased Energy	☐ Ulcers	☐ Chronic Pain	☐ Migraine Headaches

Are there other concerns (not listed above) that you want to discuss? _____

_____

Substance Use

Do you use chewing tobacco? ☐ Yes ☐ No Frequency: _____

Do you smoke? ☐ Yes ☐ No Frequency: _____

Do you drink alcohol? ☐ Yes ☐ No Frequency: _____

Do you use drugs? ☐ Yes ☐ No Frequency: _____

Do you use caffeinated beverages? ☐ Yes ☐ No Frequency: _____

Do you use marijuana? ☐ Yes ☐ No Frequency: _____

Please list any other substances you *have used* or are *currently* using: _____

_____

Have you ever felt you should cut down on your drinking/drug use? Yes ☐ No ☐

Have people annoyed you by criticizing your drinking/drug use? Yes ☐ No ☐

Have you ever felt bad or guilty about your drinking/drug use? Yes ☐ No ☐

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? Yes ☐ No ☐

Emotional Concerns

Recent/Present Emotional Concerns (please check all of the symptoms below that apply to you):

☐ Loss of Interest	☐ Difficulty Remembering	☐ Avoid Going Places
☐ Guilt	☐ Confusion	☐ Avoid Being With Others
☐ Concentration Difficulty	☐ Difficulty Making Decisions	☐ Checking Things Repeatedly
☐ Loss of Appetite	☐ Pornography	☐ Intense Fear
☐ Thoughts of Self-Harm	☐ Taking Risks	☐ Concerns with alcohol
☐ Thoughts of Harming Others	☐ Racing Thoughts	☐ Concerns with Drug Use
☐ Depression	☐ Hearing Voices	☐ Excessive Technology Use
☐ Feelings of Hopelessness	☐ Seeing Things	☐ Work Problems
☐ Episodes of Crying	☐ Anxiety	☐ Financial Problems
☐ Moody	☐ Panic Attacks	☐ Learning Problems
☐ Feeling Empty Inside	☐ Anger	☐ Relationship Problems
☐ Afraid of Rejection	☐ Worry	☐ Easily Irritated

Are there other concerns (not listed above) that you want to discuss? _____

_____

Have you had a history of trauma, abuse, or neglect? Yes ☐ No ☐

If Yes, what types of abuse or trauma have you experienced?

___ Physical ___ Sexual ___ Emotional ___ Neglect ___ Verbal

___ Natural Disaster ___ Spiritual ___ Domestic Violence ___ Health

If other, please explain: _____

Have you had any major losses in your life? Yes ☐ No ☐

If yes, please explain: _____

Major stressors in the past year: Yes ☐ No ☐

☐ Financial ☐ Children ☐ Relationships ☐ Employment

☐ Legal Issues ☐ School ☐ Caregiving ☐ Other

Please Explain: _____

_____

Have you previously attended Counseling/Therapy (group or individual): Yes ☐ No ☐

Was it helpful? _____

_____

Are there any family members, relatives, or friends currently receiving counseling at New Leaf Resources?

Yes ☐ No ☐ Who? _____

What are your major **strengths:** _____

Who can you count on for **support/resources:** _____

What is your reason for seeking counseling at this time?

new leaf resources
hope. help. healing.
www.newleafresources.org

FORM #4

Consent & Agreement for Treatment - Adult

CONSENT TO COLLECT, CREATE, USE, MAINTAIN AND DISCLOSE YOUR HEALTH INFORMATION

(A separate form must be completed for each adult participating in treatment)

When we examine, diagnose, treat or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. This information may include your health records, health history, symptoms, examination and test results, diagnosis, treatment plans, and billing and health insurance information. 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 (such as supervision) or required government functions (such as reporting abuse).

The New Leaf Resources (NLR) Privacy Practice Notice explains in more detail your rights and how we can use and share your information. The NLR Privacy Practice Notice is available online at www.newleafresources.org and available at each of the NLR offices by request.

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 & Agreement for Treatment as outlined above, except as otherwise noted in writing.
- I have been given the opportunity to review and have access to a copy of the NLR Privacy Practice Notice. NLR reserves the right to change its notice and practices at any time, if it sends a copy of the revised notice to the address that I have provided.
- As a consenting adult, I agree to permit the staff at NLR to provide me with treatment services.
- I understand that I have the right to request restrictions on the use or disclosure of my information. I understand that NLR is not required to agree to those restrictions, but if it does, it must honor the restriction unless I revoke the request or it notifies me that it is no longer going to honor the request. NLR has a form available for me to complete if I wish to request a restriction.
- I understand that I have the right to discontinue treatment at any time.
- **If I do not sign this consent form, New Leaf Resources will not be able to treat me.**

Printed Name of Client	Date of Birth
Signature of Client	Date
Signature of Witness	Date