New Hope
Counseling

A warm welcome to all new clients!

I am excited that you have chosen New Hope Counseling. My name is Patricia Reed MA, MFT 33142 and my goal is to help you experience happiness, peace, and sense of purpose. With my expertise and your commitment to making improvements in your personal, work, and family relationships you may indeed find "new hope."

To get started complete the included forms and bring them with you to our first session. The information you provide is held to the same standards of confidentiality as your therapy. Please ask me if you have any questions about information provided in this packet, if you need clarification of office policy at any time, or have any therapeutic treatment issue.

I look forward to meeting you!

Truly,

Patricia Reed MA, MFT 33142
Founder & Director, New Hope Counseling

New Hope Counseling

Patricia Reed, MA, MFT 33142
500 E. Calaveras Blvd. Suite 317
Milpitas, CA 95035
Phone: 408 – 262 – 4870
Email: Info@NewHopeCounseling.Org

Patient Information

Please complete to the best of your ability

DATE: / /

Client Information: Self: ☐ Couple: ☐ Child: ☐ Family: ☐

Patient's Name:

Birthdate (M/D/Y): / / Social Security Number: - -

Street Address:

City: State: Zip Code:

Members of Household:

Name: Age: Relationship:

Name: Age: Relationship:

Name: Age: Relationship:

Name: Age: Relationship:

Name: Age: Relationship:

Client Contact Information:

Primary Contact Number: ( ) - - Secondary Contact Number: ( ) - -

Emergency Contact: Phone: ( ) - -

Email:

Is it ok to contact you via Phone? ☐ Yes ☐ No Text? ☐ Yes ☐ No Email? ☐ Yes ☐ No

Special Instructions (i.e., best time to call):

Insurance Information: (please complete with Primary Insured's information)

Name (if different from Patient):

Birthdate (M/D/Y): / / Social Security Number: - -

Primary Insured's Relationship to Client:

Employer:

Insurance Company: Phone: ( ) - -

Insurance ID Number: Group Number: Pre – Authorization:

Are you responsible for Copay? Yes: ☐ No: ☐ If yes, amount: $

Are you receiving Employee Assistance Benefits? Yes: ☐ No: ☐ If yes, sessions:

Client Consent:

I consent to assessment, treatment, and/or diagnostic procedures for myself or for my family member. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I authorize the release and exchange of information between my therapist and the referral source and other co-treating providers for the purpose of treatment, payment, and Health Care Operations. I also authorize the release of information to my health plan for claims or other health plan purposes.

Signature Patient/Legal Representative: Date (M/D/Y): / /

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Patient Health History

Please complete to the best of your ability

Patient Name: _____

Name of person completing form (if different from patient): _____

Physician information

Name: _____ Phone: ( ) - -

Street Address: _____

City: _____ State: _____ Zip Code: _____

Last Exam: / / Medical Concerns:

_____

Counseling History

Have you ever been to counseling before? Yes: ☐ No: ☐ If yes, when was the last session? / /

Why did you seek counseling previously? _____

Please provide a brief summary of why you are seeking counseling today? _____

_____

_____

_____

Optional Health Information

You are not required to provide the information requested below the dotted line

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Please rate the severity of the following symptoms over the last month according to the following rating scale:

(0) No difficulty (1) Mild (2) Moderate (3) Severe

Decreased appetite	Nightmares	Self-injurious behavior
Increased appetite/eating more	Hypervigilance	Opposition
Bingeing and/or purging	Obsessive thoughts	Anger outbursts
Weight change? +: ☐ - :☐ Lbs:	Compulsions	Thoughts of suicide
Depressed mood	Spending sprees	Irritability
Decreased energy/fatigue	Racing thoughts	Thoughts of harming others
Sleep change? +: ☐ - :☐ Hrs:	Rapid heart beat	Impulsivity
Trouble breathing	Sweating	Hyperactivity
Phobia	Decreased sexual desire	Anxiety/Nervousness
Police/Probation involvement	Difficulty with sexual functioning	Worry/Fear
Stealing	Loss of interest in activities	Flashbacks of traumatic event
Lying	Crying	
Truancy	Feelings of hopelessness	
Feelings of helplessness	Violent behavior	
Decreased attention span	Destruction of property	
Inattentive/Distractible	Harming animals	
Memory problems	Fire setting	

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Fee Agreement

Please complete to the best of your ability

Fees Initial: _____

Fees are (*please select your session type*): ☐ $140 for a Traditional 50 minute session, ☐ $160 for an Extended 70 minute session, and ☐ $200 for an Intensive 90 minute session. Letter writing, consultations with other professionals, telephone conversations, reading records or reports, travel time, longer sessions, etc. will be bill at the same rate as your therapy sessions. Returned checks are subject to a $20 fee. This agreement supersedes all previously agreed to financial agreements and is effective as of the date signed.

Insurance Initial: _____

Patients who carry insurance, EAP, or Victim Witness should remember that professional services are rendered and charged to the patient and not to the insurance company. Not all issues/problems/conditions dealt with in therapy are covered by insurance. It is your responsibility to verify the specifics of your coverage. If you are using insurance, I will submit claims for you. You are responsible for any applicable deductibles and copays at the beginning of each session. You understand that insurance is billed as a courtesy to you and that you are responsible for full payment if the insurance company denies the claim.

Payments Initial: _____

Fees are payable at the beginning of each session so as not to interrupt our work as the session ends. If for any reason, you find that you are unable to continue paying for your therapy, you should inform your therapist. She will help you consider any options that may be available to you at that time. If your account is overdue (unpaid) and there is no written agreement on a payment plan, I can use legal or other means (court, collection agencies, etc.) to obtain payment.

Cancellation Initial: _____

The scheduling of an appointment involves the reservation of time specifically for you. In the event of a "No Show" or failure to give a full 24-hour notice of a cancellation, you will be charged the full session fee for all late cancellations and missed appointments. Please be aware that insurance companies will not cover cancellation charges. Patients are required to provide a credit card number which will be charged the full session fee in the event of a "no show" or failure to give a full 24-hour notice of cancellation.

Credit Card Authorization Initial: _____

I, _____, authorize New Hope Counseling/Patricia Reed to charge the full session fee to the credit card indicated below in the event that I (or the patient, if services are being paid for by parent or other representative) fail to give 24 – hour notice of cancellation of a scheduled appointment. I further authorize New Hope Counseling/Patricia Reed to charge my credit card for any unpaid balances for services rendered that remain on the account.

Card Type: ☐ Visa ☐ Mastercard

Card Number: - - - Exp. Date: / CVV Code: _____

Name as printed on card: _____ Billing Zip Code: _____

Authorized cardholder signature: _____ Date (M/D/Y): / /

I have read the above fee agreement document carefully. I understand it fully and agree to all of its terms and conditions.

Signature Patient/Legal Representative: _____ Date (M/D/Y): / /

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Office Policies

Please review, initial, print, sign and return to counselor

Phone & Emergency Contact Initial:

If you need to contact me, do not hesitate to call me direct at (408) 262 - 4870. If I am not available, you can leave a message on my voicemail and I will usually return the call that day. I do not return calls after 6:00pm or on weekends. You will be charged for phone calls if we have a conversation of an information-exchanging or problem-solving nature that lasts more than 10 minutes. If you cannot reach me in an emergency, you can find help at *Emergency Psychiatric Services* (408) 885 – 6100 or for your local *Police* Dial 911.

Confidentiality Initial:

All information disclosed within sessions or consultations is held strictly confidential and may not be revealed to anyone without a written release of information, except where disclosure is permitted or required by law. Disclosure is required in the following circumstances: 1) When there is a reasonable suspicion of child abuse or neglect, or abuse to a dependent or elder adult, 2) When the patient presents an imminent danger to self or others, or 3) If a judge determines that our discussions are not confidential, a judge may request specific information. ****If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. However, it is important that you know that your therapist utilizes a "no secrets" policy when conducting family or marital/couples therapy. This means that if you participate in family, and/or marital/couples therapy your therapist is permitted to use information obtained in an individual session, when working with other members of your family. Please feel free to ask your therapist about the "no secrets" policy and how it may apply to you*

Cancellation of Appointment Initial:

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Payment of Fees Initial:

Payment, including copayment, is due each session. Please prepare your payments prior to your session in respect for counselors scheduled time. All charges for therapy are client's responsibility. I will attempt to bill your insurer based on the information you provide, however, if your insurer does not pay for any reason, you will be billed. Payment must be received within 60 days of receipt of bill. Please request receipt at time of payment. Receipts will be issued via email or standard mail (as requested) within 10 business days.

Therapy Process & Termination Initial:

The length of your treatment and the timing of the eventual termination of treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If your therapist determines that you are not benefiting from treatment, they may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include referral, changing your treatment plan, or terminating your therapy. Counselor does not perform custody evaluations, does not make recommendations regarding custody, and does not prescribe medication or make recommendations about medication.

Signature Patient/Legal Representative: _____ Date (M/D/Y): / /

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Please retain this copy for your records

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Signature Patient/Legal Representative: _____ Date (M/D/Y): / /

HIPAA Notice of Privacy Practices

Patricia Reed, MA, MFT 33142 ▪ New Hope Counseling 500 E. Calaveras Blvd Ste. 317, Milpitas, CA 95035

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice. However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website (if applicable). You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website, which is located at (www.newhopecounseling.org).

III. HOW I MAY USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

1. For Treatment. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you're being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate your care.
2. To Obtain Payment for Treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
3. For Health Care Operations. I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure I'm complying with applicable laws.
4. Other Disclosures. I may also disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Uses and Disclosures Do Not Require Your Consent. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When disclosure is required by federal, state or local law; judicial or administrative proceedings; or, law enforcement. For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
2. For public health activities. For example, I may have to report information about you to the county coroner.
3. For health oversight activities. For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
4. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.
5. To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, I may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
6. For specific government functions. I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
7. For workers' compensation purposes. I may provide PHI in order to comply with workers' compensation laws.
8. Appointment reminders and health related benefits or services. I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to Family, Friends, or Others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

B. The Right to Choose How I Send PHI to You. You have the right to ask that I send information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, email instead of regular mail) I must agree to your request so long as I can easily provide the PHI to you in the format you requested.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Get a List of the Disclosures I Have Made. You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2002.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you $20.00 for each additional request.

E. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by email. You have the right to get a copy of this notice by email. Even if you have agreed to receive notice via email, you also have the right to request a paper copy of it.

V HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section Vl below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Patricia Reed, MA, MFT 33142, New Hope Counseling, 500 E. Calaveras Ste 317, Milpitas, CA 95035; (408) 263 – 4870; or Patricia@NewHopeCounseling.Org

VII EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003 and was updated January 1, 2014

Acknowledgment of receipt of New Client Packet:

Patricia Reed, MA, MFT 33142 ▪ New Hope Counseling 500 E. Calaveras Blvd Ste. 317, Milpitas, CA 95035

Please address any questions or concerns with counselor prior to signing this form

I, _____, have read all of the materials included in this "New Client Packet" carefully. Including all disclosures within Patient Information, Patient Health History, Fee Agreement, Office Policies and the HIPAA Notice of Privacy Practices. I understand its contents and agree to the services, policies, and practices as explained.

In addition, I acknowledge receipt of New Hope Counseling's "Notice of Privacy Practices" as required by HIPAA.

Signature Patient/Legal Representative: _____ Date (M/D/Y): / /

For Office Use Only

Do not write below the dotted line

I attempted to obtain written acknowledgement of receipt of the "New Client Packet" which included Patient Information, Patient Health History, Fee Agreement, Office Policies and the HIPAA Notice of Privacy Practices. Acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgment
- ☐ Emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please specify in the space provided below):

_____

_____

_____

*This form will be retained in your records.