Client Information

Client Name: _____ **Client Date of Birth:**_____

Parent(s) Name (if a minor): _____

Client Address: (Street) _____

(City)_____ **(State)** _____ **(Zip)** _____

Phone Numbers: (**Please mark the box if okay to leave message.**)

(H) (___) _____ - _____ ☐ (C) (___) _____ - _____ ☐ Please check if text is okay: ☐

(W) (___) _____ - _____ ☐ E-mail:_____ ☐

How did you hear about New Heights Counseling? _____

What has brought you in to see us?

_____

_____

_____

_____

Prior mental health services:

1. _____
   a. **Dates:** _____
   b. **Outcome:** _____
2. _____
   a. **Dates:** _____
   b. **Outcome:** _____
3. _____
   a. **Dates:** _____
   b. **Outcomes:** _____

<u>Emergency Contact Information</u>:

I hereby authorize New Heights Counseling to call, if necessary, the following Emergency Contact:

Name: _____ **Relationship:** _____ **Phone Number:** (____)____-_____

Insurance Information

CLIENT'S INFORMATION:

NAME:_____DOB:_____Gender:_____

PRIMARY SUBSCRIBER/CARD HOLDER'S NAME:_____

Date of Birth:_____ **Social Security #:**_____(only for Tricare and AT&T Value Options)

Place of Employment: _____

Primary Insurance: _____

Authorization Number (if applicable for EAP):_____

Number of Authorized Sessions_____

SECONDARY SUBSCRIBER/CARD HOLDER'S NAME:_____

Date of Birth:_____ **Social Security #:**_____(only for Tricare and AT&T Value Options)

Place of Employment:_____

Secondary Insurance (if applicable):_____

Authorization Number (if applicable for EAP):_____

Please provide any additional information needed:

I HEREBY AUTHORIZE New Heights Counseling Resources, Inc., to bill my insurance company(ies) directly to accept payment for services on my behalf. I agree to pay any co-payments at the time of service.

Signature: _____ (Parent/Guardian's Signature if Client is a minor) **Date:**_____

New Heights
Counseling Resources, Inc.

Health History

Client's Name: _____

Ethnicity and/or Race: _____ **Gender:** _____

Have you or anyone in your family had any of the following problems?
(If Yes, please list the relationship to client: X=Self, M=Mother, F=Father, B=Brother, S=Sister, GM=Grandmother, GF=Grandfather, A=Aunt, U=Uncle):

ADD	_____	Drug Use	_____	Migraines	_____
Alcoholism	_____	Ear Infections	_____	OB/GYN Disorder	_____
Anxiety	_____	Head Injury	_____	Pneumonia	_____
Arthritis	_____	Heart Disease	_____	Seizures	_____
Asthma	_____	High Blood Pressure	_____	Speech/Hearing	_____
Caffeine Use	_____	Infections/		Stomach/	
Cancer	_____	Communicable Diseases	_____	Eating Disorder	_____
Dental Problems	_____	Kidney Disease	_____	Surgeries	_____
Depression	_____	Learning disabilities	_____	Thyroid Disorder	_____
Diabetes	_____	Liver Disorder	_____	Tobacco Use	_____

Unresolved Physical Pain _____ Other_____

Have they ever, or are they currently, receiving treatment for this condition? ☐ Yes ☐ No (If yes, please explain):_____

Are you currently using prescription medication(s)? ☐ Yes ☐ No
(If yes, list medication/dosage amount/prescribing physician. For additional space, please use the backside of this form.)

Medicine:	Dosage:	Physician:	Medicine:	Dosage:	Physician:

Do you or any member of your family suffer from allergies or adverse drug reactions? Yes No
(If yes, please list): _____

Date of Client's last physical exam: _____ Date of Client's Last Dental exam:_____

Does the client currently use tobacco products? ☐ Yes ☐ No Any Recent Weight gain/loss? ☐ Yes ☐ No

Has the client been hospitalized in the past year? ☐ Yes ☐ No (If yes, please explain;)

_____

Your family Physician/Primary Care Physician: Name: _____City:_____

I hereby authorize New Heights Counseling Resources, Inc., to share information with my Physician for the purpose of coordinating my care: ☐ Yes ☐ No
Please note: If yes, a release of information will be required and a letter of attendance will be sent.

Client Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____ Date: _____

(Revised 06/2015)

INFORMED CONSENT AND ABUSE REPORTING POLICY

Thank you for choosing New Heights Counseling Resources, Inc. We realize that starting counseling is a major decision and you may have many questions. This document, along with the others you have been provided, is intended to inform you of our policies, state and federal laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

Your records cannot be released to any individual or agency without your written consent. However, certain information may be released without your authorization under the following legal circumstances:

- In the event of a legitimate subpoena for court appearance.
- In the event of medical emergency.
- The receipt of information that suggests child abuse or neglect has occurred.
  New Heights Counseling Resources is legally obligated to report any such information to DHS.
- Under circumstances in which there exists a danger to yourself or others.
- Auditors may review your records to evaluate program effectiveness.

Effective April 1, 2017 - Fees for services are as follows:

- Initial Assessment	$170.00	- Individual Therapy (45 minutes)	$140.00
- Individual Therapy (60 minutes)	$160.00	- Couple/Family Therapy (60 minutes)	$160.00
- Additional (30 minutes)	$ 60.00	- Psychological Testing (60 minutes)	$170.00
		- EMDR (Additional fee)	$ 27.00

(*All fees are due at the time of service unless other arrangements have been made in advance.)

By signing this form the Client acknowledges the following:

- Client understands that New Heights Counseling after hours and emergency policies include contacting their local emergency room or dialing 911.
- Client has reviewed **"Client Bill of Rights"** posted in the reception area.
- Client understands that a "no show" fee of $50.00 may occur if there is not a 24 hour notice of cancellation.
- **CONFIDENTIALITY NOTICE:** The information in **text messages, e-mail, and any attachments** may be legally privileged and confidential. It is intended solely for the addressee. Any disclosure, copying, distribution or any action taken or omitted to be taken in reliance on it by a non-intended party is prohibited and may be unlawful. You should not retain, copy, or use text messages, emails, or any attachment for any purpose, nor disclose all or any part of the contents to any other person.

These policies have been explained to me and I acknowledge that I have received a copy of the Notice or Privacy Practices of New Heights Counseling Resources, Inc. I further authorize New Heights Counseling Resources, Inc. to bill my insurance company and to accept payment on my behalf for services received. This includes my authorization to disclose to my insurance company any Protected Health Information (PHI) needed to coordinate payment.

Client Signature_____**Date**_____

I consent that my son/daughter may be treated as a client by New Heights Counseling Resources, Inc.

Parent Signature_____**Date**_____

Therapist Signature_____**Date**_____

(Revised 04-27-2017)