A New Dawn, A New Beginning, LLC
850.329.5776 Office
888.974.6195 Fax

Client Registration Information

Please fill out the following information as completely as possible.

Patient's Last Name: _____ First Name: _____

Preferred Name: _____

Date of Birth: _____ Social Security: _____

Gender: _____ Parent/Guardian (if applicable) _____

Marital Status:_____ Spouse/Partner Name: _____

Other family members living at home:

Name:	Relationship to you:

ADDITIONAL METHODS OF COMMUNICATION – You may provide other means of communication. Each form of communication presents unique risks for unintentional disclosure. In addition to your home address, you authorize me to optionally contact you for appointment reminders below method(s):

Address Street: _____

City/State/ Zip code:_____

Home Phone: _____ Can I leave a message? □ Yes □ No

Mobile Phone: _____ Can I leave a message? □ Yes □ No

Can I send a text message? □ Yes □ No

Work or Other Phone: _____ Can I leave a message? □ Yes □ No

Email Address: _____ Can I send emails? □ Yes □ No

Preferred Method of Contact: _____

Referral Source: _____

Primary Care Physician:_____

Physician Address/Phone: _____

Can I contact your Primary Care Physician? □ Yes □ No

Office Use only Account ID: _____

Major Illnesses

Illness	Year Diagnosed

Allergies: _____

Are you currently taking medications? □ Yes □No

Previous Mental Health Services? □ Yes □ No

If yes,

Agency/Location	Time Period

Previous psychiatric hospitalization? □ Yes □ No
If yes,

Agency/Location	Time Period

Driver's License No.: _____

Employer: _____

Employer's Address: _____

Financial Support: _____

Average income:_____

For children:

Name of school: _____ Location: _____

Highest grade completed: _____

Is child involved in any special placement classes? If yes please list: _____

****

By signing this I acknowledge that I can be contacted via the ways listed above. I further agree to contact Dawna Haswell, LCSW if any of the above information changes.

_____

Signature of Patient/Guardian Date

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Medication List

Please fill out the following information as completely as possible.

Patient's Last Name: _____ First Name/Initial: _____

Date of Birth: _____

Are you currently taking medications? □ Yes □No

If yes:

Name	Dosage	Frequency	How is it taken? (Oral, Injection, Patch, etc…)

I agree the above information is correct. I agree to contact Dawna Haswell, LCSW if any of the above information changes.

_____

Signature of Patient/Guardian Date

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INSURANCE/BILLING INFORMATION

PLEASE PRINT LEGIBLY (* required information)

*Name: _____
(Last) (First) (MI)

*Home Address: _____

*City: _____ *State _____ *Zip _____

Bills may be sent to this address: Yes _____ No _____

If "no", provide an alternate billing address: _____

City: _____ State _____ Zip _____

*SS#: _____ *Date of Birth: _____

****

Do you want insurance filed for you? Yes _____ No _____

Primary Insurance Company Name: _____
*Insurance Card I.D. Number _____
Group Number _____
*Client's Relationship: Self _____ Spouse _____ Child _____

Is the Policyholder the same as above? If no, please fill out the following:
*Policyholder's Name _____
*Policyholder's DOB _____
*Policyholder's Address _____
City _____ State _____ Zip _____

Secondary Insurance Company Name: _____
*Insurance Card I.D. Number _____
Group Number _____
*Client's Relationship: Self _____ Spouse _____ Child _____

Is the Policyholder the same as above? If no, please fill out the following:
*Policyholder's Name _____
*Policyholder's DOB _____
*Policyholder's Address _____
City _____ State _____ Zip _____

I consent to entering into a client-provider relationship. I understand the relationship is confidential and voluntary and that I may discontinue the relationship at any time. I consent to the use and disclosure of my medical information; including medical, dental, HIV/AIDS, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

PART III MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above named agency and authorize it to submit a claim to Medicare for payment.

PART IV ASSIGNMENT OF As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above named agency and authorize it to submit a claim to Medicare for payment.

BENEFITS

As Client /Representative signed below, I assign to Dawna Haswell, LCSW all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to Dawna Haswell, LCSW. I authorize the release of any confidential medical information necessary to process my medical claims and for the continuation of treatment to the insurance carriers as required by them. I understand that I am required to pay any health insurance deductible, co-insurance, or any other charges incurred which are not paid by my insurers or any third party payers.

➡ *Signature: _____ *Date: _____

PART VI WITHDRAWAL OF CONSENT- By signing below you are revoking the consent for my office to bill your health insurance. Please note you are still responsible for your payment

I, _____ WITHDRAW THIS CONSENT, effective _____

Client/Representative Signature Date

_____ _____

Witness Date

A New Dawn, A New Beginning, LLC
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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

For Payment. I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. I may use or disclose, as needed, your PHI in order to support my business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, I must disclose your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. I may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. I may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. I may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. I will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. I may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, i may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. I may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. I may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, I may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. I may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. I may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. I may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses

and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Dawna Haswell, LCSW.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. I may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with us. I may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests. I may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. I will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **I will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013.

A New Dawn, A New Beginning, LLC
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Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Patient/Client Name:_____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of A New Dawn, A New Beginning, LLC, Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Dawna Haswell, LCSW at 850)329-5776

_____

Signature of Patient/Client Date

_____

Signature or Parent, Guardian or Personal Representative * Date

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ Patient/Client Refuses to Acknowledge Receipt:

_____

Signature of Staff Member ***Date***

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Informed Consent for Psychotherapy Services

Welcome! As we enter into this therapeutic relationship, I, Dawna Haswell, LCSW would like to inform you of policies and procedures I have for my practice. I am an independent practitioner, and your professional and business relationship is with me as an individual.

Appointments: Counseling sessions last 45-60 minutes and are by appointment only. It is important that I be notified at least 24 hours in advance if an appointment is to be changed or cancelled. A 35.00 dollar fee will be charged for all missed appointments unless cancelled at **least 24** hours in advance.

Phone Calls: There are times when it might be necessary to telephone me. I have voice mail service to receive calls and messages. Please call 850.329.5776 and leave a message, including your name, phone number and when I may return your call. A pro-rated fee will be charged for any phone consultations ***exceeding ten minutes***. If I am away for extended times, such as trainings or vacation, I will discuss with you before I leave, what to do and who to call in cases requiring immediate intervention. In any Urgent Crisis, please call 911 or go immediately to your local emergency room.

Fees: Please submit full payment at each session unless other arrangements have been made with me. I will provide the appropriate information and receipts for you to obtain reimbursement from your health insurance when necessary.
Your fee (or copay) will be based on your insurance carrier guidelines. Please contact your insurance provider if you have questions.

Confidentiality: Your confidentiality is of utmost importance to me. Under most circumstances, confidentiality is absolutely assured and release of any information requires your written consent. Legal/Ethical exceptions are as follows:

-Duty to Warn and Protect: When a client discloses intentions or a plan to harm another person, I, the mental health professional, will warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, I, the health care professional, am required to notify legal authorities and make reasonable attempts to notify the family of the client.

-**Abuse of Children and Vulnerable Adults:** If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or if the child (or vulnerable adult) is suspected of being in danger of abuse, I, the mental health professional am required by law to report this information to the appropriate social service and/or legal authorities. **1-800-96ABUSE**

-**Prenatal Exposure to Controlled Substances:** Mental Health professionals are also required to report admitted prenatal exposure to controlled substances that are potentially harmful.

-**Minors/Guardianship:** Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records. **Please discuss with the therapist as to whether this would be in the best interests of the child and your relationship with your child first.**

Therapeutic Relationship: The relationship between you and your therapist is special and unique. You will be sharing information that is sensitive and intimate. With time, you may come to feel close to your therapist and

may wish to spend time with them in a more social environment. However, in order to protect your confidentiality and maintain professionalism, therapist and patients do not socialize together. You should know that therapists are required to keep your identity confidential. Lastly, therapists are not permitted to give or to receive gifts from clients.

If you see someone in the waiting room, I ask that you respect that person's right to confidentiality by not revealing to others that the person is receiving counseling. I sincerely hope that you will be satisfied with the manner in which my practice operates. Should this not be the case, I would be most grateful to discuss your concerns. If you have any questions, please do not hesitate to ask.

Your signature below indicates that you have read the above statements and accept the above conditions, as well as agree to follow outpatient treatment recommendations.

_____

Signature of Client * Date

_____

Signature of Parent/ Guardian (if applicable) Date

_____

Signature of Witness or Therapist Date

Acknowledgement of receipt of client Bill of Rights

A New Dawn, A New Beginning, LLC provides each patient with the following rights:

- To be treated with courtesy and respect
- To participate in decision making about you or your child's care
- To get prompt and reasonable responses to your questions and requests
- To be informed about you or your child's condition, treatment plan, alternatives, risks, and expected outcome
- To refuse any treatment, unless required by law
- To voice a complaint or file a grievance

Your responsibilities, in part, include:

- To give health care providers, to the best of your knowledge, truthful and complete information about you or your child's health
- To report unexpected changes in you or your child's condition to providers
- To follow agreed upon provider instructions and treatment plans for you or your child
- To keep appointments and be on time, or call the providers to arrange new appointment times if you cannot keep the appointments

- **Please Note:**
  - **After two consecutive no-shows client be discharged unsuccessfully**

This is to document that you have received the client bill of rights for you and/or your child.

_____ _____

Parent/Guardian Signature (minor) Date

_____

Client Signature (if over 18)