



New Dawn Counseling and Consulting, Inc
(805) 604-5437

COUNSELING CONTRACT

Welcome! The following document will provide you with important information about your treatment and our counseling center, please discuss any questions you have with your therapist.

OUR COUNSELING STAFF:

Counseling Services are provided by _____ Trainees _____ Associates under the supervision of a Licensed Professional or by _____, Licensed Marriage and Family Therapist (LMFT) or _____, Licensed Clinical Social Worker (LCSW).

APPOINTMENTS/ATTENDANCE

- I will be responsible for keeping my regularly scheduled appointments.

PAYMENTS & INSURANCE REIMBURSEMENT

- I have agreed to pay: \$ _____ as co-payment per session.
- I understand that sessions are about 50 minutes long, and must be paid at the time of service.

CANCELLATION:

- I understand that I must cancel my appointment with at least 24 hours' notice
- I will be responsible for the full fee of \$90 for the late cancellation or no-show

TREATMENT:

- Outpatient treatment may include diagnostic services, crisis intervention, individual, group or family therapy.
- The frequency and type of treatment will be discussed with me.
- As a condition of treatment, I must be drug/alcohol free for at least 12 hours
- I understand that I am expected to benefit from therapy, but there is no guarantee that I will. Open communications with my therapist will result in the most positive outcomes.
- As a client, I have the right to review or receive a summary of my records at any time. (Some exceptions may apply)
- I understand that I may request another therapist if I am not happy with present treatment.

CONFIDENTIALITY:

- All information and records obtained in the course of treatment shall remain confidential and will not be released without your consent except under the following conditions:
 1. *You are a non-emancipated minor, a ward of the court, or an LPS conservative*
 2. *To government law agencies to protect the lives of federal and state elective constitutional officers and their families.*
 3. *To the courts subpoenaed.*
 4. *To prevent bodily harm to another person (Tarasoff vs. Regents of the University of California 1976)*
 5. *To juvenile authorities when child abuse is observed or suspected (Penal code Section 11161.5)*
 6. *If someone is at risk of hurting themselves*
 7. *To the reporting agency when suspicion of elder or dependent adult is present.*

TERMINATION:

- I understand that I have the right to terminate therapy at any time

I have read and agree to comply with the above Counseling Contract.

Print Name of Client

Signature of Client (parent or guardian if minor)

Date

Print Name of Therapist (title and Code)

Signature of Therapist

Date



INFORMED CONSENT FOR TELEHEALTH SERVICES

In order to meet your needs during these times, New Dawn Counseling and Consulting, Inc. will be providing TeleHealth services. By signing this form, you are agreeing to receive telehealth services during this period.

I understand that I have the rights with respect to telehealth:

1. I understand that Telehealth can include communication through the internet, phone call, email, videoconferencing, voicemail, and at times text messaging your counselor.
2. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
3. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
4. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. New Dawn Counseling will utilize secure, encrypted audio/video transmission software to deliver TeleHealth.
5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my counselor in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.
6. I understand that my consent is required to forward my personally identifiable information to a third party.
7. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.
8. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an

Client Full Name:

EPSDT(only)County ID:

Site:7680

emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

9. The following information pertains specifically to videoconferencing and phone sessions:
- Due to sensitive material that is covered in each session, please be alone in the room, unless otherwise agreed upon with your mental health provider.
 - Please do not call your counselor via videoconferencing while you are driving or if you are in a public area
 - Please call your counselor immediately if you are running late
 - Please dress as if you are going to an in-person appointment.
 - Please have sessions in a room with minimal distractions (No texting, emailing, internet surfing, or engage in any other activities while you are engaged in your session).
 - Please make sure all electronics are turned off while in session (TV, radio, ipods, stereos)
 - No smoking, vaping or use of tobacco products during sessions.
 - Please do not attend while under the influence of alcohol or other substances
 - Please make sure to have your devices fully charged prior to your scheduled appointment.

Patient Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction.

I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained.

I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Choose one of the following:

☐ Yes, I would like to consent for Telehealth Services

☐ No, I do not consent for Telehealth Services

☐ I do not have a camera and consent to Phone Sessions (does not apply to insurance and private pay clients)

Email ☐ I do not have an email _____
Phone

Client's Name Parent or Guardian's name

Client's or Parent Signature Date



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THANK YOU AND WELCOME TO COUNSELING SERVICES
24 Hour Cancellation & “No Show” Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, New Dawn Counseling reserves the right to charge a fee of \$90.00 for all missed appointments (“no shows”) and appointments without a compelling reason, that are not cancelled with a 24-hour advance notice.

“No Show” fees will be charged to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple “no shows” may result in termination from our practice.

We appreciate your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand the policy

I understand that New Dawn Counseling office has reserved the time for me, and has the right to charge a \$90.00 “no show fee” for any appointment not cancelled 24 hours prior to the scheduled time.

Print Patient name: _____

Patient’s signature _____ Date _____

Parents or guardians signature _____
Date _____

We thank you in advance for your understanding and cooperation.

Sincerely,

New Dawn Counseling Staff



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No Show Recurring Credit Card Payment Authorization

I authorize regularly scheduled charges to my credit card. I understand that I will be charged the amount indicated below for each service. I agree that no prior notification will be provided unless the date or amount changes.

I _____ authorize New Dawn Counseling and Consulting, Inc. to charge my
(Printed Cardholder's Name) (Merchant's Name)

Credit Card indicated below for \$ 90.00 for each No Show or cancellation less than 24 hours in advance.

Billing Information

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Card Details

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _____

Account/CC Number _____

Expiration Date ____ / ____

CVV ____ Zip Code _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify New Dawn Counseling in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____

(Cardholder's Signature)

DATE _____

New Dawn Counseling Staff



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AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

Client Name _____
Printed Name

DOB: _____

I, _____, authorize New Dawn Counseling to
(Printed name of client/parent/authorized representative of client)

☐ Release ☐ Obtain

information to/from (as specified above):

This authorization pertains to the following information:

☐ Diagnosis	☐ Treatment Plan	☐ Admission/Assessment
☐ Progress to date	☐ Discharge Summary	☐ Psycho-social History/Testing
☐ Medication	☐ Lab results	☐ Health History ☐ Entire record

Other: _____

For the purpose of:

☐Consultation ☐Evaluation/treatment planning
☐ Other: _____

This information will be provided in the following format:

☐ Written ☐Verbal ☐ Audio and/or visual

This consent can be revoked by the undersigned at any time. If not revoked earlier, this consent shall terminate one year from the date signed.

Date

Client Signature

Witnessed By

Signature of Parent or Authorized Rep. of Client

If this consent is revoked earlier prior to one year, date revoked: _____

Office Use Only	Special Pop: C W N
ID Number_____	Billing No._____
Admit Date_____	Site No._____