# 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

NEW DAWN
COUNSELING & CONSULTING

# 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

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:
    a. 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.
    b. Please do not call your counselor via videoconferencing while you are driving or if you are in a public area
    c. Please call your counselor immediately if you are running late
    d. Please dress as if you are going to an in-person appointment.
    e. 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).
    f. Please make sure all electronics are turned off while in session (TV, radio, ipods, stereos)
    g. No smoking, vaping or use of tobacco products during sessions.
    h. Please do not attend while under the influence of alcohol or other substances
    i. 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:***
*O Yes, I would like to consent for Telehealth Services*
*O No, I do not consent for Telehealth Services*
*O I do not have a camera and consent to Phone Sessions (does not apply to insurance and private pay clients)*

_____ O I do not have an email _____
Email Phone

_____ _____
Client's Name Parent or Guardian's name

_____ _____
Client's or Parent Signature Date

Client Full Name: EPSDT (only) County ID: Site:7680

# New Dawn Counseling and Consulting, Inc
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### AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

**Client Name** _____ **DOB:** _____
**Printed Name**

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:** _____

# IDENTIFICATION AND PAYER FINANCIAL INFORMATION

Youth & Families Programs

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

1. **Minor/Client Identifying Information**

Legal Name:_____ Sex:_____ Birth Date:_____
(Last / First / Middle) (mm dd yy)

Birth name:(if different from Legal Name)_____
(Last / First / Middle)

Other name used:_____ Birth Place_____
(County / State / Country)

Social Security #_____.

2. **Primary Caregiver's Information** (do not complete if client lives independently)

Name:_____ Relationship to **Minor**:_____

Address: Street_____ City_____ State____ Zip_____

Phone_____ Other Phone_____

3. **Emergency Contact Information**

Name:_____ Relationship to **Minor/Client**:_____.

Address: Street_____ City_____ State_____ Zip_____

Phone:_____ Other Phone:_____.

4. **Client Place of Residence** *(if minor/client resides out of the home, please complete this section)*

Street_____ City_____ State____ Zip_____

Phone_____ Other Phone_____ Facility Name_____

5. **Billing/Financial Responsibility:**

Billing Address: ❑Primary Caregiver's ❑Minor/Client Place of Residence ❑Emergency Contact ❑Other (complete below)

Person Responsible_____ Relationship:_____ Phone_____

Street_____ City_____ State_____ Zip_____

6. **Health Insurance Coverage of Minor/Client:** ❑Healthy Families ❑No Insurance

Medi-Cal No._____ _____ _____ _____
(County Code / Aid Code / Issue Date)

Insurance Company_____ Group Name and Number_____

Plan Member_____ Member ID Number_____

7. **Payment Authorization**

I authorize the release of any medical information necessary to process this claim for Medi-Cal and I authorize payment of these benefits to Ventura County Behavioral Health. The information I provided is true and accurate to the best of my knowledge.

Client/Minor Signature_____ Date_____

Signature of Parent, Guardian or Conservator_____ Date_____

❑Administered over the phone to:_____ Date_____

Signature of Mental Health Representative_____ Date_____

**PLEASE TURN OVER AND COMPLETE THE REVERSE OF THIS FORM**