NEW LEAF COUNSELING

NEW CLIENT INFORMATION PACKET

Outpatient Substance Use Counseling

Office Hours: 9:00 am to 5:00 pm
Monday thru Friday
(Other appointment times available upon request)

In case of an emergency or after hours please call 785.802.9024. Utilize your support system such as AA/NA members or your sponsor. In case of a mental health emergency call 911 or the 24 hour hotline at 800-609-2002.

For a list of local AA, NA, Al-Anon or OA meetings call
785-413-0334

929 S Washington St Junction City, Kansas 66441
785.802.9024
Tessa.Gutierrez@newleafcares.com

Contents

CLIENT RIGHTS

1. To be treated with dignity and respect.

2. To be free from
   - ❖ Abuse
   - ❖ Neglect
   - ❖ Exploitation
   - ❖ Restraint or seclusion, of any form, used as a means of coercion, discipline, convenience or retaliation

3. To safe, sanitary and humane environment that:
   - ❖ Provides privacy
   - ❖ Promotes dignity

4. To receive treatment service free from discrimination based on client's race, religion, ethnic origin, age, disabling or medical condition and/or ability to pay for services.

5. To privacy in treatment, including the right to not be fingerprinted, photographed or recorded without consent except for:
   - ❖ Photographing for identification and administrative purposes as provided in R03-602.
   - ❖ Video recordings used for security purposes that are maintained only on a temporary basis.

6. To receive assistance for a family member designated representative or other individual in understand, protecting, or exercising the client's rights.

7. To confidential, uncensored, private communication that includes letters, phone calls and personal visits with:
   - ❖ An attorney
   - ❖ Personal physician
   - ❖ Clergy
   - ❖ Department of DCF Staff
   - ❖ Other individuals unless restrictions of such communication is clinically indicated and is documented in the clients record

8. To practice individual religious beliefs

9. To be free of coercion in engaging in or refraining from individual religious or spiritual activity, practice or beliefs

10. To receive an individualized treatment plan that includes the following:
   - ❖ Client participation in the development of the plan
   - ❖ Periodic review and revisions of the clients written treatment plan

11. To refuse treatment or withdraw consent to treatment unless such treatment is ordered by a court or is necessary to save the client's life or physical health.

12. To receive a referral to another program if New Leaf Counseling is unable to provide a treatment service that the client requests or that is indicated in the client's assessment or treatment plan.

13. To have the client's information and records kept confidential and released according to R03-602.

14. To be treated in the least restrictive environment consistent with the client's clinical condition and legal status.

15. To consent in writing, refuse to consent or withdraw written consent to participate in research, experimentation or a clinical trial that is not a professionally recognized treatment without affecting the services available to the client.

16. To exercise New Leaf Counseling's grievance procedures.

17. To receive a response for submitting a grievance to New Leaf Counseling, the Kansas Department for Aging and Disability Services or another entity in a timely and impartial manner.

18. To be free from retaliation for submitting a grievance to New Leaf Counseling, the Kansas Department for Aging and Disability Services, Addiction and Prevention Services or another entity.

19. To receive one's own information regarding:
- ❖ Medical and psychiatric conditions
- ❖ Prescribed medications including the risks, benefits and side effects
- ❖ Whether medication compliance is a condition of treatment
- ❖ Discharge plans for medication

20. To obtain a copy of the client's clinical record at the client's own expense.

21. To be informed at the time of admission and before receiving treatment services, except for a treatment service provided to a client experiencing a crisis situation, of the following:
- ❖ Fees the client is required to pay
- ❖ Refund policies and procedures

22. To receive treatment recommendations and referrals, if applicable, when the client is to be discharged or transferred.

Signature of Client: **Date:**

CLIENT GRIEVANCE POLICY AND PROCEDURE

As a client of New Leaf Counseling, you have the right to file a grievance if you feel you have not been treated fairly in any way. You will suffer no repercussions in service delivery as a result of filing a grievance. All grievances will be addressed in a confidential manner.

If you have a grievance or recommendation, you should first discuss it with the counselor with whom you are working. If this is not successful or you feel this is not an option, you should proceed with the following steps:

1. A written statement should be prepared (including date and time of the grievance). The statement should provide some detail of the conflict that cannot be resolved. You may ask for assistance from any staff or counselor.

2. Submit the grievance to the business office/office manager with 10 working days. An appointment will be scheduled for you to meet with someone to resolve your grievance.

3. If a resolution has not occurred within 10 working days, your grievance will be referred to the program's Executive Director who will listen to the information about the incident and will mediate the grievance.

4. Any grievance that is the result of a dispute of a written service agreement will be examined to determine if the service agreement was fair and if the service agreement was in fact violated by the client or counselor.

5. If this determination is still not satisfactory to you, you may request that you transfer to another program. Three names will be given to you in writing so that you can pursue other options. You may continue to receive services at New Leaf Counseling while pursuing these options if you so desire.

6. List below is also the name and contact information of the State agency to whom complaints about care and treatment planning may be forwarded.

Completion of this review shall be done within 30 calendar days.

All written correspondence can be faxed to, mailed to or dropped off at:

New Leaf Counseling
ATTN: Grievance Review
929 S Washington St
Junction City, KS 66441
785.802.9024

KDADS
Community Services & Programs
Behavioral Health
503 S Kansas Ave
Topeka, KS 66603
785.296.6807

NOTICE OF PRIVACY PRACTICES

Effective October 1, 2020

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

I am required by law to maintain the privacy of your protected health information (PHI) and to provide you with notice of your privacy rights and my legal duties and privacy practices with respect to your PHI. I am required to abide by the terms of this notice with respect to your PHI but reserve the right to change the terms of this notice and make the new notice provisions effective for all PHI that I maintain. I will provide you with a copy of the revised notice sent by regular mail to the last address you have provided to me for this communication purpose.

UNDERSTANDING YOUR PERSONAL HEALTH INFORMATION (PHI):

Each time you visit a hospital, physician, mental health professional or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and in the case of a mental health professional, psychotherapy notes, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation and source of data for facility planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve. Understanding what is in your record and how your health information is used helps you to:
    - Ensure its accuracy
    - Better understand who, what, when, where, and why others may access your health information
    - Make more informed decisions when authorizing disclosure to others

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of my practice (the facility that compiled it), the information belongs to you. You have the following privacy rights:

1. The right to request restrictions on the use and disclosure of your PHI to carry out treatment, payment or health care operations. You should note that I am not required to agree to be bound by any restrictions that you request but am bound to each restriction I agree to.

2. In connection with any patient directory, the right to request restrictions on the use and disclosure of your name, location at this treatment facility, description of your condition and your religious affiliation. (I do not maintain a patient directory).

3. To receive confidential communication of your PHI unless I determine that such disclosure would be harmful to you.

4. To inspect and copy your PHI unless I determine in the exercise of my professional judgment that the access requested is reasonably linked to endanger your life or physical safety (note: if state law allows, "emotional safety" may be included as well) or that of another person. You may request copies of your PHI by providing me with a written request for such copies. I will provide you with copies within ten (10) business days of your request at my office. You will be charged $.25 for each page copied and you will be expected to pay for the copies at the time you pick them up.

5. To amend your PHI upon your written request to me setting forth your reason for the requested amendment. I have the right to deny the request if the information is complete or has been created by another entity.

> *I am required to act on your request to amend your PHI within sixty (60) days but this deadline may be extended for another thirty (30) days upon written notice to you. If I deny your requested amendment I will provide you with written notice of my decision and the basis for my decision. You will then have the right to submit a written statement disagreeing with my decision which will be maintained with your PHI. If you do not wish to submit a statement of disagreement you may request that I provide your request for amendment and my denial with any future disclosures of your PHI.*

6. Upon request to receive an accounting of disclosures of your PHI made within the past six (6) years of your request for an accounting. Disclosures that are exempted from the accounting requirement include the following:

- ❖ Disclosures necessary to carry out treatment, payment, and health care operations
- ❖ Disclosures made to you upon request
- ❖ Disclosures made pursuant to your authorization
- ❖ Disclosures made for national security or intelligence purposes
- ❖ Permitted disclosures to correctional institutions or law enforcement officials
- ❖ Disclosures that are a part of a limited data set used for research, public health or health care operations

> *I am required to act on your request for an accounting within sixty (60) days but this deadline may be extended for another thirty (30) days upon written notice to you of the reason for the delay and the date by which I will provide the accounting. You are entitled to one (1) accounting in twelve (12) month period free of charge. For any subsequent request in a twelve (12) month period you will be charged $.25 for each page copied and you will be expected to pay for the copies at the time you pick them up.*

7. To receive a paper copy of this privacy notice even if you agreed to receive a copy electronically.

8. The right to complain to me and to the Secretary of the U.S. Department of Health and Human Services (HHS) if you believe your privacy rights have been violated. You may submit your

complaint to me in writing setting out the alleged violation. I am prohibited by law from retaliating against you in any way for filing a complaint with me or HHS.

USES AND DISCLOSURES

Your written authorization is required before I can use or disclose my psychotherapy notes which are defined as my notes documenting or analyzing the contents of our conversations during our counseling sessions and that are separated from the rest of your clinical file. Psychotherapy notes do not include medications prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

It is my policy to protect the confidentiality of your PHI to the best of my ability and to the extent permitted by the law. There are times, however, when use or disclosure of PHI including psychotherapy notes, is permitted or mandated by law even without your authorization.

Situations where I am not required to obtain your consent or authorization for use or disclosure of your PHI psychotherapy notes include the following circumstances:

- By myself or my office staff for treatment, payment or health care operations as they relate to you.
    - *For example*: Information obtained by me will be recorded in your record and used to determine the course of treatment that should work best for you. I will document in your record our work together and when appropriate I will provide a subsequent counselor or health care provider with copies of various reports that should assist him or her in treating you once we have terminated our therapeutic relationship.
    - *For example:* A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.
- To any treatment provider who provides treatment to you in the event of an emergency.
- To defend myself in a legal action or other proceeding brought by you against me.
- When required by the Secretary of Department of Health and Human Services in an investigation to determine my compliance with the privacy rules.
- When required by law in so far as the use or disclosure complies with and is limited to the relevant requirements of such law.
    - *For Example:* To a public health authority or other government authority authorized by law to receive reports of child abuse or neglect. If I reasonably believe an adult individual to be the victim of abuse or neglect, or certain cases of domestic violence, to a governmental authority including a social services agency authorized by law to receive such reports to the extent the disclosure is required by or authorized by law or you agree to the disclosure and I believe in the exercise of my professional judgment disclosure is necessary to prevent serious harm to you or other potential

victims. If I make such a report I am obligated to inform you unless I believe informing the adult individual will place the individual at risk of serious injury.

- ❖ In the course of any judicial or administrative proceeding in response to:
    - o An order of a court or administrative tribunal so long as only the PHI expressly authorized by such order is disclosed, or
    - o A subpoena, discovery request or other lawful process, that is not accompanied by an order of a court or administrative tribunal so long as reasonable efforts are made to give you notice that your PHI has been requested or reasonable efforts are made to secure a qualified protective order, by the person requesting the PHI.
    - o Child custody cases and other legal proceedings in which your mental health or condition is in issue are the kinds of suits in which your PHI may be requested.
- ❖ In addition, I may use your PHI in connection with a suit to collect fees for my services.
  ○ In compliance with a court order or a court ordered warrant, or a subpoena or summons issued by a judicial officer, a grand jury subpoena or summons, a civil or an authorized investigative demand or similar process authorized by law provided that the information sought is relevant and material to a legitimate law enforcement inquiry, the request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought and de-identified information could not be reasonably used.
- ❖ To a health oversight agency for oversight activities authorized by law as they may relate to me (i.e. audits, civil, criminal, or administrative investigations, inspections, licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions).
- ❖ To a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.
- ❖ To funeral directors consistent with applicable law as necessary to carry out their duties with respect to the decedent.
- ❖ To the extent authorized by and the extent necessary to comply with law related to workers compensation or other similar programs established by law.
- ❖ If use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- ❖ To a public health authority that is authorized by law to collect or receive such information for the purposes of preventing or controlling a disease, injury or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth, death, and the conduct of public surveillance, public health investigations, and public health interventions.
- ❖ To a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if the covered entity or public health authority is authorized by law to notify such persons as necessary in the conduct of a public health intervention or investigation.

- To a public health authority or appropriate governmental authority authorized by law to receive reports of child abuse or neglect.
- To a law enforcement official if I believe in good faith that the PHI constitutes evidence of criminal conduct that occurs on my premises.
- Using my best judgment, to a family member, other relative or close personal friend or any other person you identify, I may disclose PHI that is relevant to that person's involvement in your care or payment related to your care.
- To authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act and implementing authority.
- To Business Associates under a written agreement requiring Business Associates to protect the information. Business Associates are entities that assist with or conduct activities on my behalf including individuals or organizations that provide legal, accounting, administrative, and similar functions. If you have questions and would like additional information you should bring this to my attention at the first opportunity. I am the designated Privacy Officer for my practice and will be glad to respond to your questions or request for information.

CLIENT CONSENT FORM

I understand that as part of my health care, the undersigned therapist originates and maintains health records describing my health history, symptoms, evaluations and test results, diagnosis, treatment, psychotherapy notes, and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other health care providers and other routine health care operations such as assessing quality and reviewing competence of healthcare professionals. The Notice of Privacy Practices for NEW LEAF COUNSELING provides specific information and a thorough description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the Notice of Privacy Practices and I have been given the opportunity to review the notice prior to signing this consent. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment, or health care operations and that I am not required to agree to any restrictions requested. I may revoke this consent at any time in writing except to the extent that NEW LEAF COUNSELING has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing. I further understand that any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. I have been provided and have received NEW LEAF COUNSELING Notice of Privacy Practices dated October 1, 2020.

_____ _____

Signature of Client or Representative Date

_____ _____

Signature of Provider

INFECTIOUS DISEASES

Infectious Pulmonary Tuberculosis

Pulmonary Tuberculosis (TB) is a contagious bacterial infection that mainly involves the lungs, but may spread to other organs. Symptoms include: Limited to minor cough and mild fever, if apparent, fatigue, unintentional weight loss, coughing up blood, fever night sweats and phlegm-producing cough. Additional symptoms that may be associated with this disease: wheezing, excessive sweating (especially at night) chest pain and breathing difficulty.

TB is a preventable disease, even in those who have been exposed to an infected person. Skin testing (PPD) for TB is used in high risk populations or in individuals who may have been exposed to TB such as health care workers.

A positive skin test indicates prior TB exposure. Preventive therapy should be discussed with your doctor. Individuals exposed to tuberculosis should be skin tested immediately and a follow-up test should be done at a later date, if the initial test is negative. Prompt treatment is extremely important in controlling the spread of tuberculosis for those who have already progressed to active TB disease. Call your health care provider if you have been exposed to tuberculosis, or if symptoms of TB develop.

Sexually Transmitted Infection (STI)

An STI is an infection can get through participating in unprotected vaginal, oral or anal sex or skin on skin contact with someone. Medical intervention is required to treat STI's.

- **Pubic Lice (crabs)**

Symptoms: Men and/or women may have redness and itching around the genitals.

Treatment: Medicine can kill the lice but they can come back if clothes, sheets and towels aren't washed to get rid of the lice. Usually both partners need to be treated.

- **Trichomoniasis**

Symptoms: Women have a heavy greenish, frothy discharge and pain with urination or while having sex. Men may also have burning with urination or ejaculation.

Treatment: Antibiotics. Usually both partners need to be treated.

- **Chlamydia**

Symptoms: Women may have no symptoms or may have pain when urinating, itching around the vagina, yellow fluid (discharge) from the vagina, bleeding between periods or pain in lower abdomen. Men may have a burning sensation when urinating and a milky colored discharge from the penis. If not treated, Chlamydia causes infertility and other problems in women and painful swelling of the scrotum in men.

Treatment: Antibiotics. Both partners should be treated.

- **Syphilis**

Symptoms: An early symptom is a red painless sore called a chancre. The sore can be on the penis, vagina, rectum, tongue or throat. The glands near the sore may be swollen. After a few months, both men and women can get a fever, sore throat, headache or pain in their joints. Another symptom is a scaly rash on the palms of the hands or bottoms of the feet. The sores and other

symptoms go away, but this does not mean that the infection is gone. Syphilis can cause serious health problems if not treated.

Treatment: Antibiotics. If one partner is infected, the other should be tested.

- **HIV/AIDS**

Symptoms: HIV (human immunodeficiency virus) causes AIDS. AIDS is a deadly, incurable disease caused by the HIV virus. HIV makes the body's immune system weak so it can't fight disease. Symptoms may take years to develop and can include infections, feeling tired for no reason, and night sweats.

Treatment: Medicines can treat symptoms but cannot cure AIDS. If one partner is infected the other should see a doctor immediately.

- **Herpes**

Symptoms: Men and women may have tingling, pain or itching in the vagina or penis. Small blisters can form in these areas and break open. When they break open, the sores can cause a burning feeling. It may hurt to urinate. Some people have swollen glands, fever, and body aches. The sores and other symptoms go away, but this does not mean the infection is gone. The sores and blisters can come back (called an "outbreak".)

Treatment: Medicine can treat symptoms but cannot cure herpes. If one partner is infected the other should be checked by a doctor.

- **Gonorrhea**

Symptoms: Women may have no symptoms or may have a green, yellow or bloody discharge from the vagina, pain when urinating, bleeding between periods, and heavy bleeding during period or fever. Both men and women can get sore throats if they had oral sex. Men may have a thick, yellow discharge and pain when urinating. The opening of the penis may become sore. Gonorrhea can cause serious health problems if not treated.

Treatment: Antibiotics. Both partners should be treated.

- **HPV/Genital Warts**

Symptoms: HPV (human papilloma virus) can cause painless warts in or around the vagina, penis, or rectum. In women, the warts can occur inside the body, on the cervix or vagina. Warts can also occur on the outside of the body, however be too small to see.

Treatment: No medicine cures HPV. External warts can be removed. HPV is linked to causing cervical cancer. There is a vaccination available, you can further discuss with your medical provider. If one partner is infected, the other should be checked by a doctor.

How You Can Protect Yourself

- Abstinence is the best way to protect yourself from STI's.
- Having sex within a monogamous relationship, with both parties actively involved in protective measures. Get checked for STI's regularly and ask your health care provider to help you decide how often and which tests you should have.

- ❖ Open communication with your partner about their history of sex and/or risky drug use (intravenous) will promote reduced risk in contracting an STI.
- ❖ Prior to engaging in sexual activity, examine your partner for any signs of an STI – rash, sores, redness or discharge. If you see anything that you are worried about don't have sex.
- ❖ Use a condom for vaginal, anal, and oral sex. Condoms will help protect you from STI's and decrease risk for contracting HIV/AIDS.
- ❖ Know the signs and symptoms of STI's. If you notice a symptoms that worries you, get it checked out. If you have an STI, don't have sex until your treatment is complete. If you contract an STI, inform your partner and encourage medical intervention.

If you would like further information call:

National STD Hotline	National AIDS hotline	AIDS Hotline (Spanish)
800-227-8922	800-342-2437	800-344-7432

CONFIDENTIALITY OF SUBSTANCE USE PATIENT INFORMATION

The confidentiality of patient's records, maintained by this program is protected by federal laws and regulations. Generally, New Leaf Counseling will not disclose to a person or agency that a patient attends the program or disclose any information identifying a patient as a substance user unless:

- The patient consents in writing
- The disclosure is allowed by a court order
- The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation
- The patient commits or threatens to commit a crime either at the program or against any person who works for the program

Violation of the federal laws and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

(See 42 U.S.C.S. 290dd-2 for federal law and 42 C.F.R. Part 2 federal regulations governing Confidentiality of Alcohol and Drug Use Patient Records.)

SIGNATURE OF CLIENT: **DATE:**

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: Date of Birth:

- ***I AUTHORIZE NEW LEAF COUNSELING TO RELEASE THE FOLLOWING INFORMATION*:**

□ Evaluation □ Progress Notes □ Verbal communication □ Admission Summary
□ Complete Chart □ Discharge Summary □ Treatment Summary □ Other:_____

- ***THIS INFORMATION SHOULD ONLY BE RELEASED TO:***

Contact Person or Organization/Capacity:

NAME: **PHONE:**

ADDRESS: **FAX:**

- **I authorize _____or his/her administrative staff to release the following information to New Leaf Counseling of 929 S. Washington St, Junction City, KS 66441:**

□ *Evaluation* □ *Progress Notes* □ *Verbal communication* □ *Admission Summary*
□ *Complete Chart* □ *Discharge Summary* □ *Treatment Summary* □ *Other:*_____

- ***PURPOSE OF DISCLOSURE:***

□ *Evaluation/Treatment Planning* □ *Continuation of Treatment*

□ *Case coordination* □ *Legal Proceedings* □ *Other* _____

I understand the information to be released may include psychiatric, psychological, therapeutic, and/or other medical information. It may also include school and legal information. This information may be released by mail, fax, or telephone. I understand I have the right to revoke this authorization in writing, at any time by sending such written notice to my therapist's office address. I understand that my revocation of this release will not be effective in cases where the therapist has used the initial authorization of information as a condition of obtaining insurance coverage. I understand I have a legal right to contest a claim. I understand that my therapist generally may not condition therapeutic services upon my signing an authorization unless the therapeutic services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and no longer protected by HIPAA Rule. The confidentiality of this information is protected by Federal Regulations and/or Kansas Statutes. Federal Regulation 42CFR Part 2 prohibits any further disclosures of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.

- **This authorization shall remain in effect until 30 days after termination of treatment unless otherwise specified: _____**

Signature of Client or Legal Representative _____ Date:_____

Signature of Witness_____ Date:_____

TELEHEALTH COUNSELING CONSENT FORM

(For clients who wish to engage in distance counseling: phone or visual telecommunications)

Distance counseling (telehealth) appointments may be available as a convenience to the clients of this practice if determined to be appropriate by New Leaf Counseling. Teletherapy is not a substitute for in-person therapy though it can be used if circumstances indicate it is therapeutically appropriate. Clients (and/or parents/guardians) must agree to the following guidelines. Your signature at the bottom of this contract indicates you understand and agree to abide by these guidelines.

- I understand that telehealth counseling is not intended to be an after-hours or emergency resource for crisis or life-threatening situations. If an after-hours emergency, crisis or life-threatening situation exists, I will call 911 or go to the nearest emergency facility immediately. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.

- I understand that telehealth appointments occur through the phone/internet and that phone/internet communication is not 100% secure and confidential. New Leaf Counseling will provide a confidential platform for video and confidential surroundings. I understand that it is my responsibility to provide confidential surroundings at my location.

- I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of New Leaf Counseling to do the same on their end.

- I understand that I may not make an audio or video recording of any telehealth session, nor will New Leaf Counseling record any telehealth session.

- It is my responsibility to seek information about telehealth security risks and ways to increase my security while using telehealth prior to my telehealth sessions with New Leaf Counseling.

- I understand that I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

- I understand that if my therapist determines that telehealth is not appropriate for me or my therapeutic situation at any time, she will suggest alternatives for me such as in-person appointments (if possible) or referral resources. I agree to comply with the recommendations of my therapist.

Signature of Client **Date**

SLIDING FEE SCHEDULE POLICY

Effective Date: _____

POLICY: To make available discount services to those in need.

PURPOSE: This program is designed to provide discounted care to those who have no means, or limited means, to pay for their services (Uninsured or Underinsured).

New Leaf Counseling will offer a Sliding Fee Discount Program to all who are unable to pay for their services. New Leaf Counseling will base program eligibility on a person's ability to pay and will not discriminate on the basis of age, gender, race, sexual orientation, creed, religion, disability, or national origin. The Federal Poverty Guidelines (http://aspe.hhs.gov/poverty.) are used in creating and annually updating the sliding fee schedule (SFS) to determine eligibility.

PROCEDURE: These guidelines are to be followed in providing the Sliding Fee Discount Program.

1. **Notification:** New Leaf Counseling will notify patients of the Sliding Fee Discount Program by:

   - ❖ An explanation of our Sliding Fee Discount Program and our application form are available on our website.

   - ❖ New Leaf Counseling places notification of Sliding Fee Discount Program in the clinic waiting area.

2. **Provision of Services:** All patients seeking outpatient services at New Leaf Counseling are assured that they will be served regardless of ability to pay. No one is refused service because of lack of financial means to pay, so long as they complete the application process and are found eligible.

3. **Requests for Discount:** Requests for discounted services may be made by patients, family members, social services staff or others who are aware of existing financial hardship. Discounted services would apply effective the date of application approval going forward. Information and forms can be obtained from the Front Desk.

4. **Administration:** The Sliding Fee Discount Program procedure will be administered through Tessa Gutierrez or her designee. Information about the Sliding Fee Discount Program policy and procedures will be provided and assistance will be offered for completion of the application. Dignity and confidentiality will be respected for all who seek and/or are provided charitable services.

5. **Alternative Payment Sources:** All alternative payment resources must be exhausted, including all third-party payment from insurance(s), Federal and State programs.

6. **Application:** The patient/responsible party must complete the Sliding Fee Discount Program application in its entirety. By signing the Sliding Fee Discount Program application, persons authorize access to personal information for the purposes of

verifying income information. Providing false information on a Sliding Fee Discount Program application will result in all Sliding Fee Discount Program discounts being revoked and the full balance of the account(s) restored and payable immediately.

Initial Application: If an application is unable to be processed due to the need for additional information, the applicant has two weeks from the date of notification to supply the necessary information without having the date on their application adjusted. If a patient does not provide the requested information within the two-week time period, their application will be re-dated to the date on which they supply the requested information. Any accounts turned over for collection as a result of the patient's delay in providing information will not be considered for the Sliding Fee Discount Program.

Renewal Applications: A patient who receives discounted services under this policy is required to submit an updated application every 12 months or if their financial situation changes. Failure to meet the annual financial information requirement may result in the patient no longer being eligible for the Sliding Fee Discount Program. If a patient is delinquent in meeting the updated annual application requirement, New Leaf Counseling will mail the patient a notice that they are being terminated from the Sliding Fee Discount Program unless they submit the required financial information within the time frame (10 business days) noted in the letter. If a patient does not submit the renewal information, they are no longer eligible for the discounted services effective as of the date in the notice letter.

7. **Discounts:** Discounts will be based on income and family size only. New Leaf Counseling defines a Family as head of household, spouse and dependent children.

8. **Income includes:** earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as food stamps and housing subsidies) do not count.

9. **Requirements:** Applicants must provide the following: prior year W-2, two most recent bank statements and two most recent pay stubs. Self- employed individuals will be required to submit detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program. Self-declaration of Income may only be used in special circumstances. Specific examples include participants who are homeless. Patients who are unable to provide written verification must provide a signed statement of income, and why he/she is unable to provide independent verification. This statement will be reviewed and final determination as to the sliding fee percentage will be made. Self-declared patients will be responsible for 100% of their charges until management determines the appropriate category.

10. **Updates:** The sliding fee schedule will be updated during the first quarter of every calendar year with the latest federal poverty guidelines, http://aspe.hhs.gov/poverty.

11. **Notice:** The Sliding Fee Discount Program determination will be provided to the applicant(s) in writing and will include the percentage of Sliding Fee Discount Program write off, or, if applicable, the reason for denial. If the application is approved for less than a 100% discount or denied, the patient and/or responsible party must immediately establish payment arrangements with New Leaf Counseling. The applicant has the option to reapply after the 12 months have expired or anytime there has been a significant change in family income. When the applicant reapplies, the look back period will be the lesser of six months or the expiration of their last Sliding Fee Discount Program application.

12. **Refusal to Pay:** If a patient verbally expresses an unwillingness to pay or vacates the premises without paying for services, the patient will be contacted in writing regarding their payment obligations.

    If the patient is not on the sliding fee schedule, a copy of the sliding fee discount program application will be sent with the notice.

    If the patient does not make effort to pay or fails to respond within 60 days, this constitutes refusal to pay. At this point in time, New Leaf Counseling can explore options not limited to, but including offering the patient a payment plan, waiving of charges, or referring for patient collections efforts.

13. Storage of Information: Information related to Sliding Fee Discount Program decisions will be maintained and preserved in a centralized confidential file located in the (title of staff member responsible for program) office, in an effort to preserve the dignity of those receiving free or discounted care.

SIGNATURE OF CLIENT: DATE:

SIGNATURE OF WITNESS:

SLIDING FEE SCALE FORM

TREATMENT SERVICE FEES

INDIVIDUAL COUNSELING a.) 90843 – 38 to 52 minutes b.) 90837 – 53 minutes or above	 $100 $125
CONTINUING CARE GROUP	$50 per 2 hour group
OUTPATIENT GROUP	$30 per hour
INTENSIVE OUTPATIENT GROUP a.) short stay b.) long stay c.) SB123	 $4,000 $4,000 plus 40 per hour $40 per hour
SB123 Assessments	$ 175
Alcohol/Drug Evaluation – court ordered w/report **Alcohol/Drug Evaluation – non court ordered w/report**	$150 $150

SLIDING FEE SCALE

(For those who qualify. Please contact our office for further information.)

INCOME	HOURLY RATE
$ 12,760.00	$ 6.25
$ 17,240.00	$ 8.46
$ 21,720.00	$ 10.67
$ 26,200.00	$ 12.88
$ 30,680.00	$ 15.09
$ 35,160.00	$ 17.30
$ 39,640.00	$ 19.51
$ 44,120.00	$ 21.72

- For families/households with more than 8 persons, add $4,480 for each additional person.
- ***A rate of $.50 per hour per $1,000 of income based on 2020 Federal Poverty Guidelines***

For Office Use Only:

Income Amount/1000= X _____

X*.5= Y _____

Sliding Fee Hourly Rate _____

SIGNATURE OF CLIENT: **DATE:**

SIGNATURE OF WITNESS: **DATE:**

PAYMENT AGREEMENT

Client Name:_____

☐ I elect to have services billed through insurance. (Complete Shaded Area Below)

☐ I elect to pay full fee for my services at a fee of $125 per hour.

☐ A second party has agreed to pay for my services at a fee of $125 per hour.

INSURANCE & BILLING AUTHORIZATION (complete only if billing insurance):

Policy Holder's Name:_____

Policy Holder's Address (if different):_____

_____

Policy Holder's SS#_____ **Policy Holder's DOB:**_____

- I hereby authorize payment directly to New Leaf Counseling, for any insurance due to me for reimbursement of claims for services provided. I agree to pay my share of fees at the time of receiving the monthly statement.
- I understand that I will be billed $30 for any appointments cancelled without 24 hours advanced notice, and that these fees will not be submitted to insurance.
- I authorize New Leaf Counseling to disclose to my insurance company the diagnosis, dates of services, type of treatment, and any other information from my records that is required for processing my insurance claims. This can include treatment notes and the entire record, if requested. If submitted for review, I understand that the records may be scanned and kept on file at BCBS or other contracting insurance managed care companies.
- I understand that if I default on payment of debt, I am authorizing release of my name and payment record to legal services needed to collect this debt, I and understand that may become public record if legal action is initiated.
- I understand that any mental health diagnosis may require New Leaf Counseling to consult with my primary care physician or psychiatrist unless I waive that requirement.

_____ I agree to waive that requirement. (Initials)

_____

Signature of Client or Legal Representative Date

_____

Tessa Gutierrez, LSCSW, LCAC