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| --- | --- |
| Client Name: | Click or tap here to enter text. |
| DOB: | Click or tap here to enter text. |

**Client Intake Form**

|  |  |  |  |
| --- | --- | --- | --- |
| For Insurance purposes: | SSN | Phone | Alt Phone |
| Legal Name | Sex |       |       |       |
|       | [ ] M/[ ] F |
| Address | Apt # | City, State | Zip Code | County |
|       |       |       |       |       |
| Gender | Pronouns | Marital Status | Race | Religion |
|       |       |       |        |       |
| School | Legal Guardian | Employer | Employer Address/Phone |
|       |       |       |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Emergency Contact | Relationship | Address | Phone Number |
|       |       |       |       |
|       |       |       |       |

 **INSURANCE POLICY INFORMATION** If contact information is the same as client information, please check here. [ ]

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Primary Insurance** | Policy Number | Name of Subscriber | Co-pay/Co-Insurance | Deductible |
|        |        |       |        |        |
| Relationship to client | DOB of subscriber | Address | Phone Number | E-mail |
|        |        |       |        |       |
| **Secondary Insurance** | Policy Number | Name of Subscriber | Co-pay/Co-Insurance | Deductible |
|       |       |       |       |       |
| Relationship to client | DOB of subscriber | Address | Phone Number | E-mail |
|       |       |       |       |       |

**PERSON RESPONSIBLE FOR OUT OF POCKET EXPENSES** If different than client and insurance policy subscriber

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | Relationship | Address | Phone Number | E-mail |
|        |        |        |        |        |

|  |  |
| --- | --- |
| Client Name: | Click or tap here to enter text. |
| DOB: | Click or tap here to enter text. |

**SERVICE AGREEMENT/ASSIGNMENT OF BENEFITS/AGREEMENT TO PAY**

You have chosen New Beginnings Counseling Service to provide services to you and your family. I hereby give consent for myself and/or my child named herein, to receive therapy and/or skill development services by New Beginnings Counseling Service. My insurance will be notified of my consent to receive services and that information will be shared with my insurance company, for the purpose of payment and service authorization, and agree to assign my insurance benefits to New Beginnings Counseling Service for purposes of payment for services/care rendered and I hereby give consent for information to be shared by and between NEW BEGINNINGS COUNSELING SERVICE and the insurance company or other paying agent. I also understand that New Beginnings Counseling Service may use a third party billing agent and electronic records system that maintains my confidential information.

No information identifying you or your family will be released or disclosed without written consent by you or a parent or other legally designated representative. You may be asked to sign a specific release of information to any other individual or agencies which staff deems important to communicate with us in the best interest of treatment. New Beginnings Counseling Service will not knowingly utilize any treatment or procedure, which is experimental, controversial or carries intrinsic risk. I understand the assigned therapist may be under supervision such as an intern or practicum student or therapist working toward licensure. I understand that this person will be fully supervised and will share information about my case for supervision purposes only. This may include video or tape recordings of sessions or processing of file notes. This is a mandatory process and is for the benefit of the client and the therapist. None of this information will be used inappropriately. I understand that my therapist my seek consultation regarding my case in order to provide me with the best service. Consultation will be done consistent with the ethical guidelines for social workers.

We/I, the undersigned, agree to accept services from New Beginnings Counseling Service. We agree to cooperate with the requirements for the services for self, our child/family and will be participating in counseling or other services. I understand that my child may receive services in the community/school/home with/without my presence. The signature below is equivalent to the signature of agreement for evaluation and treatment unless objected to in writing. I understand that should I accept any additional services from New Beginnings Counseling Services this consent will serve as consent for these services. I understand that all services are voluntary and I can terminate them at any time.

We/I, the undersigned, understand that with the proper release when information needs to be shared it may be done via fax, phone or computer e-mail. We/I also understand that individual client records may be kept on computer. We/I understand that there is no guarantee that information we disclose in a group or family setting will be held confidential by other members of the group or the family. We/I understand that in the course of treatment, many subjects will be discussed. Some of these subjects may be, but are not limited to: age, educational achievement, family background, prior treatment efforts, family relationships, marital issues, sexuality, violence, leisure activities, drug/alcohol usage, medical involvement, housekeeping, shopping habits and hygiene.

We/I understand that it is our responsibility to keep insurance information updated with New Beginnings Counseling Service We/I further understand that we/I are financially responsible for all appointments and charges associated with those appointments. **Should I fail to provide updated insurance information or do not have active coverage, I understand I may be billed the full amount of the service. I also understand and agree to provide 24 hour notice of cancellation. I understand that I may be charged for appointments not canceled within 24 hours’ notice**. We/I further agree to pay New Beginnings Counseling Service the full balance of my account. If I am unable to pay the full balance, I will contact the billing department at (515) 401-6886 to make acceptable payment arrangements. If this bill is not paid as agreed in full, the balance of the bill for care rendered may be processed through a collection agency.

This agreement will remain in effect until a new agreement is signed or this agreement is terminated in writing.

|  |  |  |
| --- | --- | --- |
|  Click or tap here to enter text. |  | Click or tap here to enter text. |
| Signature of Client/Legal Representative  |  | Date |
|  |  |  |

|  |  |
| --- | --- |
| Client Name: | Click or tap here to enter text. |
| DOB: | Click or tap here to enter text. |

**Acknowledgement of Receipt of Notice of Privacy Practices**

I, Click or tap here to enter text., hereby acknowledge I have been given an opportunity to read a copy of New Beginnings Counseling Service Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can discuss this with my provider. I am aware that this notice educates me on the way my identifiable health information may be used and disclosed. I understand that this notice also informs me of my rights in regard to my protected information.

|  |  |  |
| --- | --- | --- |
|  Click or tap here to enter text. |  | Click or tap here to enter text. |
| Signature of Client/Legal Representative  |  | Date |
|  |  |  |
|  Click or tap here to enter text. |  |  |
| Relationship/ PRINTED NAME  |  | Witness Signature |

|  |
| --- |
| Physician information |
| Primary Physician Click or tap here to enter text. | Specialty: Click or tap here to enter text. |
| Address Click or tap here to enter text. | Phone #: Click or tap here to enter text. |
|  Select one:[ ]  Please SEND diagnostic information to my primary physician[ ]  Please DO NOT send diagnostic information to my primary physician[ ]  I DO NOT have a primary care physician, please do not send diagnostic informationI understand that New Beginnings Counseling Services, my health plan representative, and my primary care physician may exchange any and all information pertaining to my services to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance, and/ or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent. I understand that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan. . Part of this exchange includes sending treatment plans, quarterly/progress reports and summary letters upon termination of our services with your family.

|  |  |  |
| --- | --- | --- |
|  Click or tap here to enter text. |  | Click or tap here to enter text. |
| Signature of Client/Legal Representative  |  | Date |
|  |  |  |
|  Click or tap here to enter text. |  |  |
| Relationship/ PRINTED NAME  |  | Witness Signature |

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|  |  |
| --- | --- |
| Client Name: | Click or tap here to enter text. |
| DOB: | Click or tap here to enter text. |

**Patient Informed Consent/ Consent for Treatment**

I have chosen to receive treatment services through the New Beginnings Counseling Service. The type and extent of services that I will receive will be based on a discussion with me (the client/legal representative) and following an initial assessment (if appropriate to the service requested).

I understand that there is no assurance that I will feel better because services are a cooperative effort between my provider and me. I will work with my counselor in a cooperative manner to resolve my difficulties. I understand that if using a 3rd party payer New Beginnings Counseling Service may be required to provide a diagnosis to describe my condition. Once that information is provided, New Beginnings Counseling Service, LLC or its employees can accept no liability for impacts to insurability or employment.

I understand that all information shared with the providers at New Beginnings Counseling Service is confidential and no information will be released without my consent. I also understand that there are expectations to this detailed below.

I understand that the state and local laws require that my counselor report the following:

1. When there is risk of imminent danger to myself or to another person the counselor is ethically bound to take necessary steps to prevent such danger.
2. When there is a suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the counselor is legally required to take steps to protect the child, and to inform the proper authorities.
3. When a valid court order is issued for medical records or a subpoena is issued for the counselor’s testimony, the counselor and the agency are bound by law to comply with such requests.
4. New Beginnings Counseling Service may occasionally find it helpful or necessary to consult other professionals about a case. During consultation, every effort is made to avoid revealing the identity of a client. The consultation is also legally bound to keep the information confidential. If you do not object New Beginnings Counseling Service staff will not tell you about these consultations unless it is important in our work together.

If I have any questions regarding this consent form or about the services offered at New Beginnings Counseling Service, I may discuss them with my provider. I have read and understand the above. I consent to participate in the services offered to me by New Beginnings Counseling Service. I understand that I may stop services at any time. I understand that I can revoke my consent at anytime except to the extent that if I do not revoke this consent, it will expire automatically one year after all claims for services have been paid. I also understand that I have the right to inspect records pertaining to my treatment.

|  |  |  |
| --- | --- | --- |
|  Click or tap here to enter text. |  | Click or tap here to enter text. |
| Signature of Client/Legal Representative  |  | Date |
|  |  |  |
|  Click or tap here to enter text. |  |  |
| Relationship/ PRINTED NAME  |  | Witness Signature |

|  |  |
| --- | --- |
| Client Name: | Click or tap here to enter text. |
| DOB: | Click or tap here to enter text. |

**Acknowledgment of Receipt of Initial Intake Packet**

I hereby acknowledge I have been given an opportunity to read a copy of New Beginnings Counseling Service Initial Intake Information. I understand that I can request a copy of the intake packet should I want one. This intake packet includes information regarding:

* An explanation of services
* Client rights and responsibilities
* Grievance procedure
* Confidentiality policy
* Abuse reporting policy
* Records
* Termination
* Managed Care Limitations
* Emergencies

I have read and understand the Initial Intake Information and agree to comply with the policies and procedures. I have had the opportunity to ask questions regarding the policies and procedures.

|  |  |  |
| --- | --- | --- |
|  Click or tap here to enter text. |  | Click or tap here to enter text. |
| Signature of Client/Legal Representative  |  | Date |
|  |  |  |
|  Click or tap here to enter text. |  |  |
| Relationship/ PRINTED NAME  |  | Witness Signature |

|  |  |
| --- | --- |
| Client Name: | Click or tap here to enter text. |
| DOB: | Click or tap here to enter text. |

**Appointment Reminder Request & Communication**

[ ]  I wish to receive e-mail appointment reminders

|  |  |
| --- | --- |
| E-Mail Address: | Click or tap here to enter text.  |

[ ]  I wish to receive text message appointment reminders

|  |  |
| --- | --- |
|  Cell Phone Number | Click or tap here to enter text.  |

|  |  |
| --- | --- |
| Cell Phone Carrier (Verizon, AT&T, etc.) | Click or tap here to enter text.  |

I authorize New Beginnings Counseling Service to contact me by any of the following methods:

[ ] E-Mail

|  |  |
| --- | --- |
| E-Mail Address: | Click or tap here to enter text.  |

[ ] Phone

|  |  |
| --- | --- |
| Phone Number | Click or tap here to enter text.  |

[ ] Text

|  |  |
| --- | --- |
| Cell Phone Number | Click or tap here to enter text.  |

In addition, I recognize that employees of New Beginnings Counseling Service may respond directly to any communication initiated by me via that method of communication even if I have not provided prior consent here.

|  |  |  |
| --- | --- | --- |
|  Click or tap here to enter text. |  | Click or tap here to enter text. |
| Signature of Client/Legal Representative  |  | Date |
|  |  |  |
| Client Name: | Click or tap here to enter text. |
| DOB: | Click or tap here to enter text. |

Credit Card Authorization Form

**CARDHOLDER INFORMATION**

|  |  |
| --- | --- |
| Name as it appears on card: | Click or tap here to enter text. |
| Billing Street Address: | Click or tap here to enter text. |
| Street Address (Cont.): | Click or tap here to enter text. |
| City, State: | Click or tap here to enter text. |
| Postal Code | Click or tap here to enter text. |
| Telephone: | Click or tap here to enter text. |

**CREDIT CARD INFORMATION**

Credit Card Type: [ ] MasterCard [ ]  Visa [ ]  American Express [ ]  Discover Card

|  |  |
| --- | --- |
| Number: | Click or tap here to enter text. |
| Expiration Month/Year (MM/YY) | Click or tap here to enter text. |
| Security Code: | Click or tap here to enter text. |
| Zip Code: | Click or tap here to enter text. |

Please review the information provided above and by signing this form you approve New Beginnings Counseling Service to charge this card for any fees for service determined to be client responsibility.

This form will remain in effect unless revoked and can be revoked or amended at any time. This consent will extend to any updated financial information provided.

|  |  |  |
| --- | --- | --- |
|  Click or tap here to enter text. |  | Click or tap here to enter text. |
| Cardholder Signature |  | Date |
|  |  |  |
| Client Name: | Click or tap here to enter text. |
| DOB: | Click or tap here to enter text. |
| [ ] Therapy | [ ]  Substance | [ ]  BHIS | [ ]  Supervised Visit | [ ] Habilitation |

**AUTHORIZATION TO RELEASE INFORMATION**

I authorize New Beginnings Counseling Service to exchange information with the following individual or agency (please include contact info such as phone, email, &/or fax): **Click or tap here to enter text.**

This information is pertinent to the client’s mental health, behavioral or academic needs as deemed by either agency. This information may contain:

Yes [ ]  No [ ]  Attendance of Treatment Yes [ ]  No [ ]  Education Records, Testing Data/Information

Yes [ ]  No [ ]  Clinical Notes Yes [ ]  No [ ]  Medical Records

Yes [ ]  No [ ]  Crisis Plan Yes [ ]  No [ ]  Police Reports

Yes [ ]  No [ ]  Diagnosis Yes [ ]  No [ ]  Progress

Yes [ ]  No [ ]  Diagnostic Tests or Assessments Yes [ ]  No [ ]  Scheduling

Yes [ ]  No [ ]  Discharge Yes [ ]  No [ ]  Treatment Plan

Yes [ ]  No [ ]  Additional Information as indicated:**Click or tap here to enter text.**

The information shared may be written and/or verbal and it may be currently in existence and/or that which is made in the future. This authorization is good for two years from the date signed. I understand I may revoke this authorization at any time by giving written notice to New Beginnings Counseling Service. I understand that any release made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

**Specific Authorization for Release of Information Protected by State/Federal Law**

I specifically authorize the release of data and information relating to:

|  |  |
| --- | --- |
| Yes [ ]  No [ ]  Substance abuse (alcohol/drug use) | Substance Abuse information for a minor will only be released if this box is signed:Click or tap here to enter text. |
| Yes [ ]  No [ ]  Mental Health |
| Yes [ ]  No [ ]  HIV/AIDS information |
|  | Substance Abuse Client Signature (under 18 years of age) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Click or tap here to enter text. |  | Click or tap here to enter text. |  |  |
| Signature of Client/Legal Representative  |  | Date |  | Witness Signature |

**PROHIBITION ON REDISCLOSURE: This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 22) prohibits further disclosure without the specific written consent of the client or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.**

 \* Only persons 18 years of age or his/her legal representative may authorize release of mental health information. \*\* Only the subject may authorize release of substance abuse information unless the subject is incompetent as defined by statute.

**Sharing information: It is the responsibility of all agencies listed to provide requested information. The recipient of the information is responsible for maintaining confidentiality of the information.**

|  |  |
| --- | --- |
| Client Name: | Click or tap here to enter text. |
| DOB: | Click or tap here to enter text. |
| [ ] Therapy | [ ]  Substance | [ ]  BHIS | [ ]  Supervised Visit | [ ] Habilitation |

**AUTHORIZATION TO RELEASE INFORMATION**

I authorize New Beginnings Counseling Service to exchange information with the following individual or agency (please include contact info such as phone, email, &/or fax): **Click or tap here to enter text.**

This information is pertinent to the client’s mental health, behavioral or academic needs as deemed by either agency. This information may contain:

Yes [ ]  No [ ]  Attendance of Treatment Yes [ ]  No [ ]  Education Records, Testing Data/Information

Yes [ ]  No [ ]  Clinical Notes Yes [ ]  No [ ]  Medical Records

Yes [ ]  No [ ]  Crisis Plan Yes [ ]  No [ ]  Police Reports

Yes [ ]  No [ ]  Diagnosis Yes [ ]  No [ ]  Progress

Yes [ ]  No [ ]  Diagnostic Tests or Assessments Yes [ ]  No [ ]  Scheduling

Yes [ ]  No [ ]  Discharge Yes [ ]  No [ ]  Treatment Plan

Yes [ ]  No [ ]  Additional Information as indicated:**Click or tap here to enter text.**

The information shared may be written and/or verbal and it may be currently in existence and/or that which is made in the future. This authorization is good for two years from the date signed. I understand I may revoke this authorization at any time by giving written notice to New Beginnings Counseling Service. I understand that any release made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

**Specific Authorization for Release of Information Protected by State/Federal Law**

I specifically authorize the release of data and information relating to:

|  |  |
| --- | --- |
| Yes [ ]  No [ ]  Substance abuse (alcohol/drug use) | Substance Abuse information for a minor will only be released if this box is signed:Click or tap here to enter text. |
| Yes [ ]  No [ ]  Mental Health |
| Yes [ ]  No [ ]  HIV/AIDS information |
|  | Substance Abuse Client Signature (under 18 years of age) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Click or tap here to enter text. |  | Click or tap here to enter text. |  |  |
| Signature of Client/Legal Representative  |  | Date |  | Witness Signature |

**PROHIBITION ON REDISCLOSURE: This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 22) prohibits further disclosure without the specific written consent of the client or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.**

 \* Only persons 18 years of age or his/her legal representative may authorize release of mental health information. \*\* Only the subject may authorize release of substance abuse information unless the subject is incompetent as defined by statute.

**Sharing information: It is the responsibility of all agencies listed to provide requested information. The recipient of the information is responsible for maintaining confidentiality of the information.**

|  |  |
| --- | --- |
| Client Name: | Click or tap here to enter text. |
| DOB: | Click or tap here to enter text. |
| [ ] Therapy | [ ]  Substance | [ ]  BHIS | [ ]  Supervised Visit | [ ] Habilitation |

**AUTHORIZATION TO RELEASE INFORMATION**

I authorize New Beginnings Counseling Service to exchange information with the following individual or agency (please include contact info such as phone, email, &/or fax): **Click or tap here to enter text.**

This information is pertinent to the client’s mental health, behavioral or academic needs as deemed by either agency. This information may contain:

Yes [ ]  No [ ]  Attendance of Treatment Yes [ ]  No [ ]  Education Records, Testing Data/Information

Yes [ ]  No [ ]  Clinical Notes Yes [ ]  No [ ]  Medical Records

Yes [ ]  No [ ]  Crisis Plan Yes [ ]  No [ ]  Police Reports

Yes [ ]  No [ ]  Diagnosis Yes [ ]  No [ ]  Progress

Yes [ ]  No [ ]  Diagnostic Tests or Assessments Yes [ ]  No [ ]  Scheduling

Yes [ ]  No [ ]  Discharge Yes [ ]  No [ ]  Treatment Plan

Yes [ ]  No [ ]  Additional Information as indicated:**Click or tap here to enter text.**

The information shared may be written and/or verbal and it may be currently in existence and/or that which is made in the future. This authorization is good for two years from the date signed. I understand I may revoke this authorization at any time by giving written notice to New Beginnings Counseling Service. I understand that any release made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

**Specific Authorization for Release of Information Protected by State/Federal Law**

I specifically authorize the release of data and information relating to:

|  |  |
| --- | --- |
| Yes [ ]  No [ ]  Substance abuse (alcohol/drug use) | Substance Abuse information for a minor will only be released if this box is signed:Click or tap here to enter text. |
| Yes [ ]  No [ ]  Mental Health |
| Yes [ ]  No [ ]  HIV/AIDS information |
|  | Substance Abuse Client Signature (under 18 years of age) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Click or tap here to enter text. |  | Click or tap here to enter text. |  |  |
| Signature of Client/Legal Representative  |  | Date |  | Witness Signature |

**PROHIBITION ON REDISCLOSURE: This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 22) prohibits further disclosure without the specific written consent of the client or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.**

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**Sharing information: It is the responsibility of all agencies listed to provide requested information. The recipient of the information is responsible for maintaining confidentiality of the information.**