New Day
Psychotherapy Group

****For Internal Use Only****
Name _____ DX _____
Office _____ Ins _____

Today's Date: _____ How did you hear about us?: _____

▶Patient Name: _____
First Middle Last

Address: _____
Number Street (Apt#) City State Zip

Email Address: _____ Okay to Email Statement? Yes☐ No☐

Home Telephone: _____ Work/Cell Telephone: _____

Social Security No.: _____ Date of Birth: _____

Occupation: _____ Marital Status: □ Single □ Married □ Domestic Partner
□ Coupled □ Divorced □ Widowed

▶If patient is a minor, please complete the following section:

Parent/Guardian Name: _____
First Middle Last

Address: _____
Number Street (Apt#) City State Zip

Parent/Guardian Social Security Number: _____ Date of Birth: _____

▶Patient Medical Information:

Patient's Physician: _____
Name City/State

Office Telephone: _____ Fax Number: _____

Current Medications including dosage: _____

For what conditions: _____

Allergies: _____

▶Insurance and Payor Information (credit card authorization is on last page of consent):

Insured Name: _____ DOB: _____ SSN: _____

Insurance Carrier: _____ Policy or ID #: _____
Medical and/or Behavioral Healthcare Organization

Insurance Telephone #: _____ Group #: _____

Insurance Address: _____ Payor EDI#: _____

_____ Effective Date: _____

▶Person to contact in case of an emergency:

Name/Relationship to patient Address Phone no.

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New Day Psychotherapy Group: New Day is a corporation that provides administrative and management services to mental health professionals. As an independent practitioner, your provider is solely responsible for all matters concerning your clinical care and all questions about that care should be addressed to her/him.

Treatment risks: Participation in psychotherapy can result in a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek treatment. Psychotherapy does involve some risks, including possible experience of intense feelings such as sadness, anger, fear, or guilt. Please remember that these experiences are natural and normal and an important part of the psychotherapy process. Sometimes in psychotherapy, clients choose to make major life decisions including decisions about family, relationships, employment, and lifestyles. Decisions made during the psychotherapy process may result from calling into question old beliefs and values that may bring about changes not originally intended. Your therapist cannot guarantee the ultimate outcome to psychotherapy.

Patients who are dependents: As the parent or guardian, you have a right and responsibility to question and understand what occurs in therapy with your child, but please remember that it is also important that your child be able to trust the therapy process. As such, your therapist will use clinical discretion as to what is appropriate disclosure of information. In particular, you can expect that the therapist will disclose information to you that is important to your child's progress and your participation in the treatment. If you are the custodial parent in a divorced relationship with your child's other parent, please provide your therapist with a copy of your court custodial order.

Professional fees: New Day therapist fees are $185 (MFT/LCSW/PhD/PsyD) and $300 (MD-Psychiatrist) for the initial assessment sessions, $135 (MFT/LCSW)/$150 (PhD/PsyD)/) for individual psychotherapy sessions, and $150 for family/couples psychotherapy sessions for all degree levels. Psychiatric medication follow up appointments with an MD are $150 a session. These fees are for both in-person and tele-mental health sessions.

Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of your therapist will be billed at $100 per hour or $25 per 15 minutes, as determined by your therapist. If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for his/her professional time even if he/she is called to testify by another party. Because of the difficulty of legal involvement, we charge $300 per hour for preparation and attendance at any legal proceeding.

Insurance: If you are using insurance coverage to pay for your therapy, you may still have a co-payment or co-insurance charge due. This fee is due at the time of service and must be paid in order to see your clinician. As a service and courtesy to you, New Day can bill your insurance company directly, provided you authorize the insurance payment be made directly to New Day. You are responsible to know the limits and specifics, including co-payment amounts and deductibles, of your insurance coverage. Oftentimes this information can be found in your employer's benefits summary booklet. New Day can help you clarify your benefits information and coverage. ***Regardless of your insurance coverage, you are solely responsible for any charges incurred. With most insurance companies, there are procedures you can use to appeal denied charges. If your insurance company denies payment for services, you are responsible for the charges incurred.***

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health

Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy. **You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.** Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

Collections: If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, we have the legal option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. ***New Day Psychotherapy Group utilizes a collection agency on all 90 day unpaid balances.***

Tele-mental health: As part of your healthcare treatment you may be offered the opportunity to be evaluated or treated by your clinician who will work with you from another location through a secure, encrypted internet program. This service is limited to those patients who are in the state of California. In order to participate in this mode of therapy, you must have an internet connection and a computer with audio and video (web cam) capabilities. There are benefits and risks in participating in this mode of therapy. Some benefits include: working with your clinician when you are unable to attend sessions in person, due to physical or other restrictions, obtaining quality therapy if you are no longer in the geographic area where New Day therapists practice, and flexibility in scheduling (depending on your therapist's availability). Some risks include: your clinician might find that this mode of therapy is not the best way to meet your clinical needs, your equipment or your clinician's equipment may stop working at any time, or others may gain unauthorized access to your information while it is being transmitted (this is unlikely). If you choose to participate in tele-mental healthcare, you will still continue to have access to the regular in-person healthcare services with your therapist at New Day Psychotherapy Group. There is no penalty for withdrawing from tele-mental healthcare at any time. Your healthcare information and video picture will be transmitted to your health care provider through a secure electronic system designed to prevent unauthorized access. Audio and video recording will not occur.

Confidentiality of information: You have the right to a confidential relationship with your therapist. Information revealed by you during the course of psychotherapy will be kept confidential and will not be released to any agency or other person without your written permission. There are important exceptions to confidentiality that are required by law and outlined herein:

1. If you threaten to harm someone else
2. If you threaten to harm yourself

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3. Where there is any suspected incidence(s) of child abuse, neglect, or molestation
4. Where there is any suspected incidence(s) of physical abuse of an elderly or dependent adult
5. Therapists must release information subpoenaed by the court as appropriate

It is important to remember that confidentiality of session material cannot be guaranteed by your therapist in a family or couples therapy situation. Please understand that each family member participating in psychotherapy has the same responsibility to maintain confidentiality for the other participating members to ensure the best chance for success.

Appointments and cancellation policies: Services are by appointment only. The length of an appointment is 45 minutes. Please give your therapist at least 24-hours notice for any appointments you need to cancel. Because each appointment is reserved specifically for you, it is necessary to charge a late cancellation fee of $75 for appointments, which are cancelled with less than 24-hours notice. New Day cannot bill your insurance for a missed appointment or late cancellation. You are responsible for missed appointment and late cancellation fees.

Messages and emergency procedures: In the case of a life-threatening emergency, please call 9-1-1. If you have a psychiatric emergency, please go to the nearest hospital emergency room and ask for the psychiatrist on duty. If you have a primary care physician, this person may also be contacted to facilitate emergency psychiatric care. If you need to reach your therapist, you can telephone the office confidential voice mail at (562) 431-8822 or (626) 808-4600 and leave a message for your therapist at his or her voicemail extension.

Termination of services: Termination of psychotherapy may occur at any time and may be initiated by either you or your therapist. Please contact your therapist if you decide to discontinue your psychotherapy so that you can schedule and meet for a final session. Termination itself can be a very constructive process and we encourage you to discuss any plans to end your treatment as soon as is necessary. If any referrals are warranted, your therapist will make them at that time.

Your rights: At any time, you may question and/or refuse therapeutic or diagnostic procedures or methods or request additional information regarding procedures. Please do not hesitate to discuss any concerns and/or complaints with your therapist so that we can work toward a resolution. Concerns can also be brought to the attention of the California Department of Consumer Affairs, the California Board of Psychology, and the California Board of Behavioral Sciences.

►Please complete and sign below:

I consent to participation in psychotherapy services with New Day Psychotherapy Group and agree to the policies of this office as detailed in the above paragraphs. I have had the opportunity to ask questions and clarify my understanding of these policies and there are no misunderstandings or disagreements. I have read, understood, and agree to the "Notice of Privacy Practices" and have received a copy for my records.

Signature: _____ **Date:** _____

I authorize my insurance carrier to pay benefits associated with my care directly to New Day Psychotherapy Group and authorize the release of information necessary to coordinate benefits, treatment, and payment (including quality improvement efforts where applicable).

Signature: _____ **Date:** _____

►For minor patients:

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I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize New Day Psychotherapy Group to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

_____ _____
Signature of Legal Guardian/Legal Representative **Date**

_____
Relationship to Patient

▸New Day Therapist:
I have reviewed the above policies and informed consent with the patient and/or parent or guardian.

Signature: _____ **Date:** _____

Appointment and Cancellation Policies

Psychotherapy services are by appointment only. The length of the appointment is 45 minutes. Please give your therapist **24** hours notice for any appointment you will need to cancel (leaving a voice mail notification on your therapist's extension is acceptable).

Because each appointment time is reserved specifically for you, it is necessary to charge a **late cancellation fee of $75 for appointments which are cancelled with less than 24 hours notice. The same fee will apply if you fail to show for a scheduled appointment without calling to cancel**. If you are using insurance to pay for your psychotherapy services, please be aware that your insurance will not pay for a missed appointment or late cancel fee.

▸Understanding of Appointment and Cancellation Policies

I have read the above statement and understand that if I fail to notify my therapist within 24 hours that I will be canceling my scheduled appointment, or fail to show for an appointment, I will be personally responsible for the $75 late cancellation or no-show fee.

_____
Printed Name

_____ _____
Signature Date

5455 Garden Grove Blvd. Suite 200
Westminster, CA 92683

595 E. Colorado Blvd. Suite 530
Pasadena, CA 91101

Tel. 562 431-8822 or 626 808-4600• Fax 562 431-8875

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Credit Card Payment Consent Form

►**Name:**

_____

First Middle Initial Last

►**Name on card if different:**

_____

First Middle Initial Last

►**I authorize New Day Psychotherapy Group to charge my credit card for professional services as follows:**

Initial all that apply

_____ a. All visits in the next 12 months, beginning ____/____/_____.

_____ b. Recurring charges for date(s) of service ____/____/_____ to

____/____/_____ , $_____ monthly, $_____semi-monthly,

$_____weekly, or $_____per visit.

_____ c. To charge my card for the balance of fees not paid for or covered by my insurance company within 180 days of the denial of payment.

_____ d. To charge my card for the balance of fees not paid 180 days from termination of service(s).

_____ e. To charge my card for any missed appointments or appointments cancelled within 24 hours for the fee of $75.

►Type of card: □ Visa □ MasterCard □ Amex □ Discover

►Credit card number: _____ Security code: _____

Expiration date of card: ____/____/_____

►Card holder's billing address for credit card statements:

_____

Street City State Zip

►Cardholder's Signature:

_____

Signature Date

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Pasadena, CA 91101

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