NEW LEAF
PSYCHOTHERAPY SERVICES

OFFICE POLICIES

1. Appointments are 45 or 60 minutes in length and scheduled for only one person/group at a time.

IF YOU NEED TO CANCEL, YOU NEED TO NOTIFIY US AT LEAST 24 HOURS IN ADVANCE OR THERE WILL BE A $100.00CHARGE. PLEASE UNDERSTAND THAT THERE ARE NO EXCEPTIONS TO THIS POLICY.

2. Afternoon and night hours are very limited. Canceling sessions without proper notice will effect future scheduling during these prime hours.

3. Information is kept confidential. If you wish to have information released, please let your therapist know, so that the proper forms can be signed.

4. Payment/co-pay is expected at the beginning of each session. If there is a question about an insurance change, please discuss this with your therapist prior to your session. Billing by mail will include a postal and administrative surcharge of $5.00.

5. Parents/legal guardians are responsible for the fees of clients who are minors.

6. In the event a child is under the age of 14 and parents are divorced. A copy of the custody order will need to be attached to opening paperwork and/ or given to the therapist at the first session.

I have read and understand the above policies and agree to these conditions and financial arrangements for treatment.

Signature_____ Date _____

Lakeside Office Park, Suite 504, Southampton, PA 18966 or

4259 W Swamp Rd, Suite 305, Doylestown, PA 18902

(p)215-354-0777 (f)215-354-0772

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COUNSELING AGREEMENT AND INFORMED CONSENT

Entering into counseling is a major investment of your time, energy, and money. The purpose of this form is to ensure you are well informed about what you might expect from your counselor and what will be expected of you. It outlines the policies of the office and the nature of the services provided. Please read the following paragraphs carefully and feel free to discuss with your therapist.

Professional Services:
As a client receiving services in this office, you are entitled to professional, respectful treatment, prompt attention to your needs and competent services provided by a duly accredited mental health professional. Your therapist is a Licensed _____.

Treatment, Assessment, Goals, Recommendations:
New clients are seen initially for the purpose of evaluating the nature of their personal needs of difficulties, discovering the desirability of entering into the counseling relationship and recommending the most appropriate type of counseling. Your therapist may refer you for psychiatric or psychological evaluation. Following through on recommendations often helps to insure the most appropriate form of counseling for you. The assessment phase extends through the first three sessions.

You have the right at any time to discuss diagnostic impressions, goal of treatment and methods for attaining these goals with your therapist. Discussion of emotional issues may be distressing but success of treatment may rely on the client's motivation and investment in the counseling relationship.

Confidentiality:
What you reveal to your counselor will be held in the strictest confidence and cannot be shared without your written consent except in limited and exceptional circumstances:

- If your therapist determines you are a danger to yourself or others.
- If your therapist is ordered by a court to disclose information.
- If your therapist suspects a child is being abused.
- If you instruct your therapist to reveal confidential information to someone.

Duration and termination:
The duration of counseling varies. Some clients require only a few sessions to meet their goals while others may require counseling over an extended period of time. Self-awareness, self-acceptance, and other counseling goals may take substantial time to achieve. Ending the counseling relationship is often mutually planned; however, you may stop at any time.

To ensure our working together with informed mutual consent, I have read, understand, and agree with the policies, procedures, and limitations to treatment stated above.

_____ _____
Client/Parent/Guardian Date

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CONSENT TO RELEASE/RECEIVE INFORMATION

Initial each choice and provide the name of each professional/organization in the space provided.

I give my consent for _____
to release the following information regarding my case to the following parties:

☐ Primary Care Provider _____

☐ Patient Refuses Permission to Communicate with Primary Care Provider

☐ Insurance Company _____

☐ Health Care Professional _____

☐ Other _____

This release of information consent will include the following:

☐ Treatment Summary
☐ Psychological Evaluation
☐ Discharge Summary
☐ School Transcript
☐ Teacher Reports
☐ Other _____

_____ I give my consent for the above parties to engage in professional conversations regarding my case.

I understand that the above permission is bound by regulations governing confidentiality of medical and psychological records and disclosure to anyone other than the person named above is forbidden without further written authorization.

I also understand that I may revoke my consent to release information at any time.

This consent will expire one year from the date of signature.

_____ Printed Name

_____ Signature

_____ Date of Birth

_____ Parent or Guardian

_____ Witness

_____ Date

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ELECTRONIC COMMUNICATION AND CONSENT FOR USE

Be advised that the use of email, cell phone texting, and the other forms of technology in psychotherapy may have security concerns and have not been defined as a best-practice strategy.

Any information exchange electronically or with the use of technology increases the risk of a breach in confidentiality. Communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed. The therapist cannot guarantee protection from unauthorized attempts to access, use, or disclose personal information exchanged electronically. Do not include personal identifying information such as the birth date, or personal medical information in any email you send.

Email/texting communication with New Leaf Psychotherapy Services will be used for the purpose of simplifying and expediting scheduling/administrative matters only. You should also know that any electronic communication I receive from you and any responses that I send to you may become a part of your legal medical record.

Email/texting communication is NOT to be used to provide/receive treatment services or take the place of therapy sessions. Therefore, email/texting should NOT be used to communicate suicidal or homicidal thoughts or plans, urgent or emergency issues, serious or severe side effects or concerns, or rapidly worsening symptoms. In a life-threatening emergency clients should: Call 911. Proceed to the nearest hospital emergency room, and/or call a suicide crisis hotline 800-273-8255 or the following crisis intervention hotline.

Bucks County: 800-499-7455 Montgomery County: 610-279-8100 Philadelphia County: 215-686-4420

I have thoroughly considered all of the above information. By signing this Client Communication form, I consent to the use of email/cellphone texting as needed for scheduling and administrative purposes only, within the guidelines above. If more urgent help is needed, I will utilize the crises services listed above. Furthermore, if at any time my therapist or I believe email/texting is interfering in my therapeutic process or being used ineffectively, either of us can revoke this consent verbally, refuse to respond to emails/texts, and insist upon a verbal conversation before proceeding.

_____ _____

Client Signature Date

_____ _____

Legal Guardian / Parent Signature Date

_____ _____

Therapist Signature Date

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FEE SCHEDULE

Client: _____

Therapist: _____

The following services are the sole responsibility of the client:

1.The office does not bill your secondary insurance. You will be responsible for the co-pay as determined by your primary insurance carrier. New Leaf Psychotherapy Services will provide you with a receipt indicating that payment has been made for the session. You are responsible for obtaining the explanation of benefit (EOB) from the primary insurance and submitting the receipt and explanation of benefit (EOB) directly to the secondary carrier. This is available to you on your insurance carrier's website. The secondary insurance will reimburse you directly.

2. Phone calls: up to 10 minutes: $65. An appointment needs to be scheduled if longer time is required.

3. Basic letter: $65

4. Forms to be completed: $120

5. Client report requested: $220

6. Out of pocket, full sessions of $125

7. Court fees (preparation time, travel and all associated fees, all communications - fax, phone, email), time in court: $250/hour

By signing below, I acknowledge that I have read and understand the fee schedule above.

Client: _____ Date: _____

Guardian signature: _____ Date: _____

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CLIENT AUTHORIZATION FOR CARD PAYMENT AND FINANCIAL RESPONSIBILITY

NOW ACCEPTING CREDIT, DEBIT, HEALTH SAVINGS ACCOUNT (HSA) and FLEXIBLE SPENDING ACCOUNT (FSA) CARDS

SESSIONS AND COPAY FEES

We accept several payment options as a convenience for those who would like to pay with a credit, debit or Health Savings Account (HSA) and (FSA) card. Agreed upon full sessions or copayments of $125 or contracted rate will be charged after each appointment through our secure online card processing systems.

NO SHOW AND LATE CANCELLATION FEES

Effective April 1st, 2024, a credit or debit card will be placed on file. The card will automatically be charged a fee of $100 in the event of a No Show or Late CANCELLATION not made at least 24 hours in advanced of scheduled appointments. HSA/FSA cards may not be used for this purpose.

INSURANCE COVERAGE

Our intake staff will attempt to verify your insurance coverage. Please note that it is your responsibility to be familiar with your policy. There are times when our staff is unable to verify the coverage using the insurance companies' website and are faced with excessively long wait times to speak with an agent, or the website is unclear. We will make every effort possible. However, if it is not possible to verify the coverage, we will ask you to arrange for written documentation of the coverage and financial responsibility. You will be responsible for the contracted rate until we receive such documentation or have received an explanation of benefit.

I acknowledge that I am responsible for any balance that may be due to the clinician because of:

- co-insurance or co-pay amount
- yearly deductible amount
- noncovered services
- out of network charges
- terminated coverage
- denied workman compensation claims
- no insurance coverage
- no referral from EAP
- failure to respond to insurance carrier correspondence
- failure to respond to coordination of benefits inquiry

I understand that I will receive a statement for any balance due, after the claim has been processed by my carrier. I understand and am agreeable that the balance of my statement will be paid in full to the clinician within 30 days.

I HAVE READ AND AGREE WITH THE ABOVE. MY SIGNATURE AUTHORIZES MY CARD TO BE CHARGED.

Client Name _____ Card # _____

Cardholder _____ Expiration Date _____ Zip Code_____

Signature _____ 3-digit code _____

PAYMENTS METHODS STILL INCLUDE: CASH, CHECKS

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