Welcome to New Creation Counseling Center!

Included in this PDF file is all the paperwork that you will need to complete before your first counseling appointment. Please see below for a description of the different intake forms. On the day of your appoinmtnet please bring completed paperwork, as well as your photo ID and insurance card (if you are using insurance for treatment). If you have any questions, please call us at 937-667-4678. We look forward to seeing you!

Informed Consent for Counseling:

- Please print your name and date at the top. If you agree with the elements of the informed consent sign your name at the bottom. Please sign your name, even if the client is a minor and you are the guardian.

Electronic signature:

- If you are the client, sign your name on the "client" line. If you are going to provide us with your photo ID please check the box that indicates so. If you are the guardian of a client who is a minor, print their name on the "client" line and then sign your name on the "parent or guardian of minor" line.

Health History (Three Pages):

- Please complete to the best of your ability. Acknowledge if someone has been diagnosed with a specific medical condition by checking "yes". Then check mark if the diagnosis was given to you (or your child if they are the client), a family member or both. Please print and sign your name on the last page once you have completed the packet.

Client Rights and Responsibilities:

- The forms marked "Client Rights and Responsibilities", "Counseling Appointment Information", and "HIPAA" are for you to review and keep.

Covenant Agreement for Treatment:

- Please initial by each statement if you agree and sign your name on the "Client Signature" line.

Client Email Informed Consent Form

- Please print your name and email at the bottom of the page. If the client is a minor, please print the client's name, the guardian's email, and print and sign the guardian's name on the appropriate lines.

Financial Covenant Agreement

- **If you are using insurance or a form of Medicaid for counseling**: please complete the "Insurance" section at the top of the page. If there is a secondary form of insurance you would like us to bill please fill out that information. If there is no secondary form of insurance please leave the section blank**.**
- **If you do not have insurance**: please complete the "Sliding Fee Scale" section on the lower half of the page. Write the per-session fee that you discussed with our intake department in the "Agreed Amount" section. If you cannot remember the agreed-upon per-session fee, leave this blank.
- **If you are using Title XX funds or are a pastoral client**: check the appropriate line on the lower half of the page.
- Please sign your name and date

Outcome Questionnaire (OQ 45.2) (Two Pages)

- Please read the instructions carefully and complete both pages. If the client is a minor age 13 or younger, please disregard this form.

Client Problem and Goal List with Consent for Treatment (Two Pages)

- If the client is a minor age 13 or younger, the guardian should complete this form. Otherwise, disregard this form.

Authorization for Release of Information (Two copies included)

- If you are coming for individual counseling, please disregard this form.
- If you are coming for couples counseling:
    - The **client** will fill out one copy of this form. At the top of the form, on the line that says "Name of Person to Receive Information", please write your partner's name.
    - The client's **partner** will fill out the other copy of this form. At the top of the form, on the line that says "Name of Person to Receive Information", please write the client's name.
    - Please check each type of information that you want released (e.g. "Copy of My Clinical Record", "Progress of My Treatment")
    - DO NOT SIGN YOUR NAME TO THIS FORM UNTIL YOU ARE IN THE PRESENCE OF YOUR THERAPIST.

Please call New Creation Counseling Center at (937) 667-4678 if you have any questions

Informed Consent for Counseling Services

Name_____ Date _____

Services and Staff: I understand that New Creation Counseling Center is a professional, Christian counseling agency offering a wide range of counseling services, and that these services are provided by licensed mental health professionals including a psychologist, counselors, and social workers. In addition to providing direct counseling services, this agency provides training, consultation, and support groups.

Confidentiality: I understand that all information disclosed within sessions is confidential and may not be revealed to anyone outside the Counseling Center without my written permission. I also understand that client care is discussed within clinical supervision among the professional staff on a routine basis. The only exceptions where client information can be disclosed outside the agency without the client's written permission is in situations where disclosure is required by law:

1. if I present an imminent threat of harm to myself or others,
2. when there is an indication of abuse of a child or dependent adult;
3. if I become gravely disabled, and
4. by court subpoena, but only if accompanied by a proper release of information

Communication: New Creation Counseling Center will use my telephone number(s) and email address(es) that I provide to communicate with me in person or electronically, including staff-dialed and automated telephone calls, text messages and email communications. I can opt out of any or all of these communication methods at any time by contacting the Counseling Center or by choosing opt-out options that are included in the messages I receive from the Counseling Center. New Creation Counseling Center may make multiple attempts to deliver a message and may use more than one delivery method if they are not confident that I have received the message. Their communication with me will include messages such as appointment reminders and confirmations, emergency closing announcements, communication about missed appointments, directions, communication about my financial account, satisfaction surveys, preventive care messaging, and other messages closely related to New Creation Counseling Center's mission to provide the best possible healthcare to me.

Risk and Benefits: I understand that there is a possibility of risks and benefits which may occur in counseling. Counseling may involve the risk of remembering unpleasant events and may arouse strong emotional feelings. Counseling can impact relationships with significant others. The benefits from counseling may be an improved ability to relate with others; a clearer understanding of self, values, goals; spiritual growth; increased academic productivity; and an ability to deal with everyday stress. Taking personal responsibility for working with these issues may lead to greater growth.

Eligibility, Appropriateness, and Referrals: I understand that the delivery of services from this agency to me shall be contingent upon whether the Counseling Center staff and I can agree that the services are appropriate given the needs and conditions I present. If it is decided that this is not the appropriate agency to meet my needs, I understand I will be given referral to resources more appropriate to my needs and goals.

Child Custody and Visitation Issues: New Creation Counseling Center **does not** make recommendations for custody or visitation of children in disputed cases. Such recommendations are beyond the scope of our services.

I HAVE HAD THE OPPORTUNITY TO DISCUSS ANY QUESTIONS I HAVE ABOUT THIS INFORMATION.

Client's Signature_____ Date_____

I HAVE DISCUSSED THIS INFORMATION WITH THE CLIENT.

Staff Signature_____ Date_____

***Community Crisis Centers: Miami & Shelby Counties – 937-335-7166 daytime; 1-800-351-7347evenings/weekends**
Darke County – 937-548-1635 daytime; 1-800-351-7347 evenings/weekends
Montgomery County – 937-224-4646 daytime and evening/weekends

Consent for Using Your Electronic Signature **CHART # _____**

New Creation Counseling Center uses Electronic Health Records for documentation of your initial assessment, treatment plan and progress notes. As stated in HIPAA regulations and in the Client Rights and Responsibilities that you have read, you will be participative in all treatment. We ask for your signature each session as agreement that you were present and participative. This will be done by you clicking in a box indicating that you have signed the form electronically.

We assure authenticity of your signature by identifying you by your picture ID at the time of obtaining your initial signature in person.

This signature below attests you will be e-signing your documents indicating that you are the one who was present in the session and participated.

Minor Clients:

The designated guardian of a minor child will be required to show a picture ID as well. The guardian will sign the diagnostic assessment and treatment plan(s) of the minor child. Either the guardian or the minor will sign the progress notes, depending on the age of the minor and what is deemed most appropriate by the counselor and guardian.

- ☐ I have produced a picture ID for the assurance that my signature is authentic.
- ☐ I do not have a picture ID, but I attest that this is my signature.

_____ _____

Client **Date**

_____ _____

Guardian of Client (if applicable) **Date**

- ☐ I have verified the authenticity of this client's signature with his/her photo identification and witnessed this signature.
- ☐ I have verified the authenticity of this client's signature with his/her acknowledgement that s/he does not have a photo ID.

_____ _____

Witness of this signature **Date**

HEALTH HISTORY QUESTIONNAIRE

Client Name (First, MI, Last)	**Client No.**	**Age**

Has the client or family member had any of the following health problems? What was the family relationship?

	Yes	self	Family	What Treatment Received and Date(s)
Anemia	☐	☐	☐	
Arthritis	☐	☐	☐	
Asthma	☐	☐	☐	
Bleeding Disorder	☐	☐	☐	
Blood Pressure (high or low)	☐	☐	☐	
Bone/Joint Problems	☐	☐	☐	
Cancer	☐	☐	☐	
Cirrhosis/Liver Disease	☐	☐	☐	
Diabetes	☐	☐	☐	
Epilepsy/Seizures	☐	☐	☐	
Eye Disease/Blindness	☐	☐	☐	
Fibromyalgia/Muscle Pain	☐	☐	☐	
Glaucoma	☐	☐	☐	
Headaches	☐	☐	☐	
Head Injury/Brain Tumor	☐	☐	☐	
Hearing Problems/Deafness	☐	☐	☐	
Heart Disease	☐	☐	☐	
Hepatitis/Jaundice	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lung Disease	☐	☐	☐	
Menstrual Pain	☐	☐	☐	
Oral Health/Dental	☐	☐	☐	
Stomach/Bowel Problems	☐	☐	☐	
Stroke	☐	☐	☐	
Thyroid	☐	☐	☐	
Tuberculosis	☐	☐	☐	
AIDS/HIV	☐	☐	☐	
Sexual Transmitted Disease	☐	☐	☐	
Learning Problems	☐	☐	☐	
Speech Problems	☐	☐	☐	
Anxiety	☐	☐	☐	
Bipolar Disorder	☐	☐	☐	
Depression	☐	☐	☐	
Eating Disorder	☐	☐	☐	
Hyperactivity/ADD	☐	☐	☐	
Schizophrenia	☐	☐	☐	
Sexual Problems	☐	☐	☐	
Sleep Disorder	☐	☐	☐	
Suicide Attempts/Thoughts	☐	☐	☐	
Chronic Bronchitis	☐	☐	☐	
Sickle Cell Anemia	☐	☐	☐	
Substance Use Disorder	☐	☐	☐	
Other:	☐	☐	☐	

Client Name (First, MI, Last)	**Client No.**	**Age**

Has client had medical hospitalizations/surgical procedures in the last 3 years?

☐ No ☐ Yes If yes, complete information below.

Hospital	City	Date	Reason

☐ None **Allergies/Drug Sensitivities**

☐ Food (specify):

☐ Medicine (specify):

☐ Other (specify):

☐ Not Pertinent **Pregnancy History**

Currently pregnant? If yes, expected delivery date.
☐ No ☐ Yes

Receiving pre-natal healthcare? If yes, indicate provider.
☐ No ☐ Yes

Are you currently breast feeding? ☐ **No** ☐ **Yes**

Last Menstrual Period Date

Any significant pregnancy history? If yes, explain.
☐ No ☐ Yes

Last Physical Examination

By Whom	**Date**	**Phone No.** (if known)

Has client had any of the following symptoms in the past 30 days? Please check.

☐ Ankle Swelling	☐ Coughing	☐ Lightheadedness	☐ Penile Discharge	☐ Urination Difficulty
☐ Bed-wetting	☐ Cramps	☐ Memory Problems	☐ Pulse Irregularity	☐ Vaginal Discharge
☐ Blood in Stool	☐ Diarrhea	☐ Mole/Wart Changes	☐ Seizures	☐ Vision Changes
☐ Breathing Difficulty	☐ Dizziness	☐ Muscle Weakness	☐ Shakiness	☐ Vomiting
☐ Chest Pain	☐ Falling	☐ Nervousness	☐ Sleep Problems	☐ Other:
☐ Confusion	☐ Gait Unsteadiness	☐ Nosebleeds	☐ Sweats (night)	
☐ Consciousness Loss	☐ Hair Change	☐ Numbness	☐ Tingling in Arms & Legs	☐ Other:
☐ Constipation	☐ Hearing Loss	☐ Panic Attacks	☐ Tremor	

☐ Not Applicable **Immunizations/Test**

Immunizations - Has client had or been immunized or tested for the following diseases? Please check.
☐ Hepatitis B ☐ TB ☐ Flu ☐ Hepatitis A
☐ Tetanus ☐ Other:

Immunizations Within the Past Year

Height/Weight

Height	**If reporting for a child, has height changed in the past year?** ☐ No ☐ Yes If yes, by how much (+ or -)?
Weight	**Has client's weight changed in the past year?**

Client Name (First, MI, Last)	**Client No.**	**Age**

	☐ No ☐ Yes If yes, by how much (+ or -)?

Nutritional Screening (please check if within the last 30 days)

☐ No Problem	**Eating** ☐ More ☐ Less ☐ Not Eating	**Fluids** ☐ More ☐ Less ☐ Takes Liquids Only	**Appetite** ☐ Increased ☐ Decreased

☐ Nausea ☐ Vomiting ☐ Trouble Chewing or Swallowing

How many meals do you eat per day?

Where do you eat your meals? ☐ Home ☐ Friend/Family ☐ Shelter/Drop-in Center ☐ Church ☐ Other:

Special Diet	**Other**

Comments:

Pain Screening

Does pain currently interfere with your activities? ☐ No ☐ Yes

If yes, how much does it interfere with these activities (please check) ☐ Not at All ☐ Mildly ☐ Moderately ☐ Severely ☐ Extremely

Please indicate the source of the pain.

Substance Use History/Current Use (please check appropriate columns)

Substance	No Use	Past Use	Current Use	**Substance**	No Use	Past Use	Current Use	**Substance**	No Use	Past Use	Current Use
Alcohol/Beer/Wine	☐	☐	☐	Sleep Medication	☐	☐	☐	Cocaine/Crack	☐	☐	☐
Marijuana	☐	☐	☐	Tranquilizers	☐	☐	☐	Heroin	☐	☐	☐
Hashish	☐	☐	☐	Hallucinogens	☐	☐	☐	Pain Medication	☐	☐	☐
Stimulants	☐	☐	☐	Inhalants	☐	☐	☐	Other:	☐	☐	☐

Caffeine use? If yes, form (coffee, tea, pop, etc.) ☐ No ☐ Yes	**How much per day** (cups, bottles)**?**
Tobacco use? If yes, form (cigarettes, cigars, smokeless, etc.) ☐ No ☐ Yes	**How many per day** (packs, etc.)**?**

Print Name of Person Completing this Questionnaire	**Signature of Person Completing this Questionnaire**	**Date**

Signature/Credentials of Person Reviewing this Questionnaire	**Date**
Comments or Referrals Made:	

Client Rights and Responsibilities

As a Client at New Creation Counseling Center you have the following Rights:

- The right to be treated with consideration and respect for personal dignity, autonomy and privacy;
- The right to reasonable protection from physical, sexual or emotional abuse and inhumane treatment;
- The right to receive services in the least restrictive, feasible environment;
- The right to participate in any appropriate and available service that is consistent with an individual service plan (ISP), regardless of the refusal of any other service, unless that service is a necessity for clear treatment reasons and requires the person's participation;
- The right to give informed consent to or to refuse any service, treatment or therapy, including medication absent an emergency;
- The right to participate in the development, review and revision of one's own individualized treatment plan and receive a copy of it;
- The right to freedom from unnecessary or excessive medication, and to be free from restraint or seclusion unless there is immediate risk of physical harm to self or others (NOTE: New Creation Counseling Center does not use restraint or seclusion as part of the treatment process.);
- The right to be informed and the right to refuse any unusual or hazardous treatment procedures;
- The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies, photographs or other audio and visual technology.
- The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information under state and federal laws and regulations;
- The right to have access to one's own client record unless access to certain information is restricted for clear treatment reasons. If access is restricted, the treatment plan shall include the reason for the restriction, a goal to remove the restriction, and the treatment being offered to remove the restriction;
- The right to be informed a reasonable amount of time in advance of the reason for terminating participation in a service, and to be provided a referral, unless the service is unavailable or not necessary;
- The right to be informed of the reason for denial of a service;
- The right not to be discriminated against for receiving services on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws;
- The right to know the cost of services;
- The right to be verbally informed of all client rights, and to receive a written copy upon request;
- The right to exercise one's own rights without reprisal, except that no right extends so far as to supersede health and safety considerations;
- The right to file a grievance;
- The right to have oral and written instructions concerning the procedure for filing a grievance, and to assistance in filing a grievance if requested;
- The right to be informed of one's own condition; and,
- The right to consult with an independent treatment specialist or legal counsel at one's own expense.

Clients have the responsibility to:

- Give accurate information about your mental health, substance use, and domestic violence issues as well as other circumstances which might impact the care of your children or dependent adult;
- Assist by making and keeping a safe environment including no smoking within the building and refraining from carrying any kind of weapon in the building;
- Notify the agency if scheduled appointments need to be changed;
- Notify the agency if there is a change in your income, insurance and/or living arrangements;
- Work with staff in planning, reviewing and changing your individual service plans;
- Inform staff immediately if you have any concerns or problems with the service you are receiving (see Input Procedures or Grievance Procedure below).
- Note that the following items are banned items from New Creation Counseling Center and should not be carried into the facility: illegal drugs, legal drugs including alcohol, tobacco products, prescription medications and all weapons.

Counseling Services at New Creation Counseling Center may be terminated if:

- You habitually fail to keep scheduled appointments without notifying the Center;
- You display behavior while in the Center that is disruptive to other clients in the Center;
- You fail to meet your Covenant Agreement in terms of payment plan and do not respond to Business Office attempts to assist you with timely payments;
- You fail to be truthful in providing pertinent information to the Counselor or Business Office;
- You do not show effort in working your Individualized Service Plan to improve.

You may restore your relationship with New Creation Counseling Center if terminated by:

- Meeting with the Clinical or Associate Director for an action plan to improve any of the conditions above.

How to Give Input:

There are several ways to give input for improvement to services:

1. Talk to your counselor about your ideas. Your counselor will inform the most appropriate personnel.
2. Several times a year, client satisfaction surveys are done. You can do this at any time, however. They are located on the information table in the waiting room with a sealed envelope that you can give to the Business Office or mail in.
3. Contact the Director, John Jung, or Associate Director, Kitty Kincaid, to discuss your ideas (937-667-4678).

How to Handle a Grievance:

1. Contact the Client Rights Officer by telephone or written letter. The Client Rights Officer is Kitty Kincaid, Associate Director. Her availability is Monday – Friday during regular business hours. She will respond within five working days. Her number is 937-667-4678 and address is 7695 South County Rd. 25A, Tipp City, OH 45371.
2. If your grievance is an emergency or crisis, any member of the New Creation Counseling Center staff or contract counselors will consult with the client on his/her rights.
3. If your grievance is not handled to your satisfaction from the Client Rights Officer, you may contact New Creation Counseling Center Board of Trustees Chairman, Attorney David Mikel at 937-339-0511.
    - All grievances are reviewed on a regular basis by the Board of Trustees of New Creation Counseling Center as well as the accreditation bodies including the Tri-County Board of Recovery and Wellness Services and the Ohio Department of Mental Health and Addiction Services.
    - You also have the right to file a grievance directly to: Ohio Department of Mental Health and Addiction Services; Disability Rights Ohio; or, U.S. department of health and human services, civil rights regional office in Chicago.

Counseling Appointment Information

Our Mission…to provide distinctively Christian profession counseling to those in need, regardless of their ability to pay.

It is our desire that your experience with us be helpful and encouraging. Listed below are some of the things you can expect from us:

CHRISTIAN CARE:

- You will receive sensitive and non-preferential care offered in the name of Christ.
- You will be treated with respect and dignity, using person-first language, representative of your worth in God's eyes.
- We will do our best to offer biblically sound perspective and compassionate attitudes in dealing with your needs.
- Your presence at the Counseling Center and all conversations with your counselor will be kept confidential. Confidentiality limits/exceptions:
    1. If you report or we observe indicators of child or senior abuse, we are legally mandated to report this abuse to Children's Services.
    2. If you exhibit suicidal or homicidal behavior, we will contact appropriate persons so that the safety of all involved, including yourself, can be protected.

TREATMENT PROCESS:

- Please be honest in conversations with your counselor. Growth in wholeness occurs only in an environment of truth.
- Be willing to work hard on the issues you are dealing with in your session. No healing can come without your active, prayerful participation, even though the process may be painful at times.
- Please complete any homework assignments your counselor may give you.

As we mutually respect and practice these expectations, we believe Christ will work in your life to bring healing and wholeness. If for any reason we conclude that referral or termination is needed, we will do our best to explain our reasons and to help you plan for your immediate future.

APPOINTMENTS:

- Sessions typically last 45-50 minutes. This is the standard "clinical" hour. Sessions that may require additional time will be billed accordingly.
- We ask that you be faithful in attending your scheduled sessions with your counselor.
- We will attempt to remind you of your appointments two days prior to your appointment. Therefore, we ask that you give us 24 hours advance notice if you are not able to keep your appointment. New Creation Counseling Center, Inc. has a policy that when a client does not attend or cancel his/her appointment with less than 24 hours notice, twice in a three-month period, the assigned Counselor may choose to only meet with the client on a same-day call-in basis.

HIPAA

The Health Insurance Portability and Accountability Act of 1996

New Creation is compliant with the HIPAA Act. This Act is intended to help the insured in several ways. For additional information about this act beyond what is stated here, please see the receptionist.

STANDARDS WERE INTENDED TO:

- Simplify administration of health insurance claims and their associated costs by encouraging promulgation of national standards.
- Give patients more control over and access to their medical information.
- Protect individually identifiable health information (IIHI) from real or potential threats of disclosure through setting and enforcing standards.
- Improve efficiency in health care delivery by standardizing electronic data interchange (EDI).

WHAT DOES THIS MEAN?

The Privacy Rule limits the ability of covered entities and their business associated to use or transmit "protected health information" (PHI) without the advance authorization of the individual/insured and the advance notification to the individual of the covered entity's privacy practices.

- grants covered entities a variety of exceptions from the advance authorization requirement.
- requires that, even when permitted to disclose protected health information, covered entities make reasonable efforts to limited disclosure to the minimum necessary to accomplish the intended purpose of the use or disclosure.

There are a variety of exceptions to the "minimum necessary" standard.

- allows individuals to inspect their protected health information.
- allows individuals to request restrictions on the uses or disclosures of protected health information for which the covered entity may otherwise possess the right to use or disclose. The covered entity does not have to agree to the restriction. If the covered entity agrees, then it must document compliance with the restriction.

What

Protected health information (PHI) means individually identifiable health information that is:

- Transmitted by electronic media
- Transmitted or maintained in any other form or medium
- Permitted uses and disclosures:
  To the individual
  For treatment, payment and health care operations
- Use and disclosure after obtaining authorization:
  (similar to current usage)
- Disclosures required by law:
  Victims of domestic violence
  Court orders
  Subpoenas, discovery request, etc. that are not accompanied by court order
  To law enforcement officials for a law enforcement purpose
  Child abuse or neglect
  Reports for preventing or controlling disease, injury or disability
  Communicable disease reports
  To employers under certain restrictions

Client Name _____

Client Case Number _____

COVENANT AGREEMENT FOR TREATMENT

Please initial next to each statement, indicating your consent and understanding.

Topic: Client Rights & Responsibilities and Grievance Procedures.

_____ I have received the New Creation Counseling Center Client Rights and Responsibilities, which includes the policy and procedure of filing a grievance.
(Mailed or presented in person at New Creation Counseling Center).

_____ I have read and understand the New Creation Counseling Center Client Rights and Responsibilities.

_____ I have read and understand how to handle a grievance at New Creation Counseling Center.

Topic: HIPAA

_____ I have been given the HIPAA guidelines.
(Mailed or presented in person at New Creation Counseling Center)

_____ I have read and understand the HIPAA guidelines.

Topic: My Counseling Agreement:

_____ I have received a description of my counseling services.
(Mailed or presented in person at New Creation Counseling Center.

_____ I will be asked to sign Consent to treat form that outlines confidentiality and the counseling arrangement. I understand that my counselor will assess and appraise my mental and emotional condition, explore possible solutions with me, and develop an individualized treatment plan for my mental and emotional adjustment or development.

_____ I understand that session times are 45-50 minutes.

_____ I understand that New Creation Counseling Center asks for 24 hours notice for cancellations. I understand that the New Creation Counseling Center, Inc. has a policy that when I do not attend or cancel my appointment with less than 24 hours notice, twice in a three-month period, my Counselor may choose to only meet with me on a same-day call-in basis.

_____ _____
Client Signature (Parent/guardian if client is a minor) Date

_____ _____
Business Office Signature Date

New Creation Counseling Center
Client Email Informed Consent Form

I am cautioned that email is not a confidential means of communication. Risks can include, but are not limited to, the following:

- Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Email senders can easily misaddress an email or text and send the information to an undesired recipient.
- Backup copies of emails may exist even after the sender and/or the recipient has deleted his or her copy.
- Employers and on-line services have a right to inspect emails sent through their company systems.
- Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
- Email may be used as evidence in court.
- Emails may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

New Creation Counseling Center is not liable for improper disclosure of confidential information, and is not liable for breaches of confidentiality caused by the client or any third party.

It is unlikely that I will be able to communicate with my counselor through email. New Creation Counseling Center cannot ensure that email messages will be received or responded to if my counselor is not available. Email should not be used for emergency situations, and use of email to discuss clinical matters is discouraged. For these situations I am encouraged to come to or call the Counseling Center during regular business hours, to call the Community Crisis Center, or the after-hours emergency phone for New Creation Counseling Center.

I hereby authorize New Creation Counseling Center to do the following:

1. Reply to my messages via email, including information that the Counseling Center deems appropriate, that would otherwise be considered confidential; and
2. Communicate with me via email about the following: information about resources that I can use as part of my treatment; upcoming and missed appointments; notification of billing statements; re-engagement efforts; other information deemed appropriate by my therapist; and
3. Communicate with me about regular updates (including, but not limited to, newsletters, teaching articles, workshop information, and notices about new website content) through use of a "Constant Contact" email mailing list. No clinical information will be communicated using this email list. *NOTE: To opt out of the Constant Contact email mailing list, please indicate by checking the box at the bottom of this consent form*

Client Acknowledgement and Agreement: I acknowledge that I have read and fully understand this consent form. I agree that New Creation Counseling Center shall not be liable for any breach of confidentiality that may result from this use of email via the Internet. I understand the risks associated with the communication of email between myself and New Creation Counseling Center, and I consent to the conditions and instructions outlined, as well as any other instructions that my therapist may impose to communicate with me by email.

Client name: _____ Chart#:_____

Client Email: _____

Client signature: _____ Date: _____

Parent/Legal Guardian name: _____

Parent/Legal Guardian signature: _____ Date: _____

☐ I do not wish to be added to New Creation Counseling Center's mailing list for Regular Updates, as described in item #3 above.

Client Name: _____

Client's Chart No.: _____

For: Counseling Psychiatry (Circle One)

FINANCIAL COVENANT AGREEMENT

___ Insurance/Medicaid *(Fill out this section if you are using insurance to pay for treatment)*

Primary Mental Health Insurance Carrier:		
Name of Insurance:	Policy #:	Group #:
Policy Holder:	Relationship to insured:	SS#:
ABOUT THE INSURED (if client is not the policy holder):	**Name:**	
Home Address:		
Insured's SS#:	Insured's DOB:	Phone #:

Secondary Mental Health Insurance Carrier:		
Name of Insurance:	Policy #:	Group #:
Policy Holder:	Relationship to insured:	SS#:
ABOUT THE INSURED (if client is not the policy holder):	**Name:**	
Home Address:		
Insured's SS#:	Insured's DOB:	Phone #:

Payment Methods Other Than Insurance *(Fill out this section if insurance is not applicable. Covenant Agreements are determined based on household income and number of people in household)*

___ Sliding Fee Scale	___ Pastoral	___ Title XX	___ Other (specify)
Agreed Amount: _____ Staff Initials: _____	☐ fee ☐ no fee	Proof of Income ☐ yes ☐ Provided? no	
Contact (if applicable):			

AUTHORIZATION AND RELEASE

I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE. Regardless of any insurance payments to New Creation Counseling Center, INC, I understand I am personally responsible for paying any insurance co-pays, deductibles, or negotiated fees, and that there is an expectation that I pay on my balance at every session. I understand that I am responsible for providing any documents verifying income as needed by New Creation Counseling Center. I also understand that if I do not turn in required documents, I will be billed for the entire cost of services. I understand that if I have an outstanding balance greater than 90 days from the date of the first statement for that balance I will not be able to schedule another appointment until I make a minimum payment (as determined by New Creation Counseling Center) on the outstanding balance. I authorize New Creation Counseling Center, INC, to release any information necessary to process any Insurance Claims. **I authorize payment of Insurance Benefits to New Creation Counseling Center. I also understand that any statements that need to be sent for fees owed will be mailed to the person who signs below:**

Signed: _____ Date: _____

Outcome Questionnaire (OQ 45.2)

Name: _____ Age: _____ Date: _____

Directions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category that best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work and so forth.

	Never	Rarely	Sometimes	Frequently	Almost Always	OFFICE USE SD	IR	SR
1. I get along well with others.	4	3	2	1	0		☐	
2. I tire quickly.	0	1	2	3	4	☐		
3. I feel no interest in things.	0	1	2	3	4	☐		
4. I feel stressed at work/school.	0	1	2	3	4			☐
5. I blame myself for things.	0	1	2	3	4	☐		
6. I feel irritated.	0	1	2	3	4	☐		
7. I feel unhappy in my marriage/significant relationship.	0	1	2	3	4		☐	
8. I have thoughts of ending my life.	0	1	2	3	4	☐		
9. I feel weak.	0	1	2	3	4	☐		
10. I feel fearful.	0	1	2	3	4	☐		
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never").	0	1	2	3	4	☐		
12. I find my work/school satisfying.	4	3	2	1	0			☐
13. I am a happy person.	4	3	2	1	0	☐		
14. I work/study too much.	0	1	2	3	4			☐
15. I feel worthless.	0	1	2	3	4	☐		
16. I am concerned about family troubles.	0	1	2	3	4		☐	
17. I have an unfulfilling sex life.	0	1	2	3	4		☐	
18. I feel lonely.	0	1	2	3	4		☐	
19. I have frequent arguments.	0	1	2	3	4		☐	
20. I feel loved and wanted.	4	3	2	1	0		☐	
21. I enjoy my spare time.	4	3	2	1	0			☐
22. I have difficulty concentrating.	0	1	2	3	4	☐		
23. I feel hopeless about the future.	0	1	2	3	4	☐		

Please turn page over to complete questionnaire.

Outcome Questionnaire (OQ45.2) - Page 2

	Never	Rarely	Sometimes	Frequently	Almost Always	OFFICE USE SD	IR	SR
24. I like myself.	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐	☐		
25. Disturbing thoughts come into my mind that I can't get rid of.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐		
26. I feel annoyed by people who criticize my drinking (or drug use). (If not applicable, mark "never)."	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐		☐	
27. I have an upset stomach.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐		
28. I am working/studying less well than I used to.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐			☐
29. My heart pounds too much.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐		
30. I have trouble getting along with friends and close acquaintances.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐		☐	
31. I am satisfied with my life.	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐	☐		
32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never").	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐			☐
33. I feel that something bad is going to happen.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐		
34. I have sore muscles.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐		
35. I feel afraid of open spaces, or of driving, or being on buses, subways, etc.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐		
36. I feel nervous.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐		
37. I feel my love relationships are full and complete.	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐		☐	
38. I feel that I am not doing well at work/school.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐			☐
39. I have too many disagreements at work/school.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐			☐
40. I feel something is wrong with my mind.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐		
41. I have trouble falling asleep or staying asleep.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐		
42. I feel blue.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐		
43. I am satisfied with my relationships with others.	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐		☐	
44. I feel angry enough at work/school to do something I might regret.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐			☐
45. I have headaches.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐		
						+	+	
						Total =		

Client Problem and Goal List
With Consent for Treatment

PROBLEMS: Check all that apply to your child; circle the particular symptoms or problems that apply.

_____ depression: sadness, feeling "blue," suicidal thoughts or comments, irritability, appetite changes, sleep changes, low energy

_____ anxiety: feeling nervous or jittery, excessive fears

_____ eating problems: binge eating, purging, excessive dieting or exercise

_____ alcohol or drug abuse, blackouts

_____ hearing voices, thinking that people are against me

_____ confusion, racing thoughts, memory or concentration problems, recurring troublesome thoughts

_____ abuse: physical, emotional, sexual; indicate whether abuse is current or past

_____ marital problems; family problems (circle any that apply)

_____ codependency (e.g. living with a drug/alcohol abuser either now or in the past)

_____ behavior problem: aggression, self-destructiveness, oppositional/defiant; recurrent troublesome behavior; other, describe:_____

_____ parenting problem (e.g., overwhelmed by emotional or behavioral problems of child)

_____ referred for evaluation by _____

_____ school or employment problems (circle one or both)

_____ other _____

GOALS: Check all that apply.

Relief from: ___depression ___anxiety ___suicidal thoughts ___thinking problem

Improved self-control of: ___ drugs/alcohol ___eating ___spending ___aggressiveness ___impulsiveness ___feelings

Improved: ___family/other relationships ___parenting skills ___self-esteem ___social skills

I am concerned about: ___medical problems ___housing ___ employment or training ___money problems

Other concerns or comments:_____

Please see reverse side

CONSENT FOR TREATMENT OF MINORS

Name of Client _____

Date of Birth _____

Counselor(s) _____

By my signature, I am stating that I am the custodial parent or guardian of this child, and that I have the legal right to request treatment for this minor child. Any records generated on this minor child may be shared with non-custodial parent, upon the parent's request, in compliance with the law and with policies of New Creation Counseling Center. This should be discussed with the child's counselor prior to request for records.

New Creation Counseling Center desires to be an agent of help to the child, and in that light, desires that both custodial and non-custodial parents, or parents who share parenting, work together for the good of the minor client being seen at New Creation Counseling Center.

This treatment may include individual or group psychotherapy, counseling, and testing. This treatment may include consultations with other associates of this institution.

Counseling sessions will be considered to be confidential except in cases of abuse, neglect or potential harm to client or others.

_____

Signature of Parent/Guardian Date

_____

Printed Name of Parent/Guardian

_____

Street Address

_____

City/State/Zip

_____ _____

Area Code/Phone # Witness/Title

*Expiration Date*_____
Not to exceed 6 months after original date of signature.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby grant my permission for release of information between the following:

_____ and New Creation Counseling Center
Name of Person to Receive Information

_____ 7695 South County Rd. 25A
Organization or Relationship to Client

_____ Tipp City, OH 45371
Address

(937) 667-4678 FAX: (937) 667-4963

Method of Sending Information if applicable
☐ Mail ☐ FAX ☐ E-Mail

The purpose of this release of information is:
☐ To provide continuity of my care
☐ To correspond to an insurance/disability entity
☐ To process a request for a legal representative
☐ Other: Specify _____

This MAY include information related to treatment or rehabilitation or drug and/or alcohol abuse or psychiatric treatment. (**Consent for release of HIV information requires a separate authorization.) I specify that this Release is to include:

☐ Copy of my Clinical Record
☐ Attendance during my Counseling Sessions
☐ Ability to make or change my counseling appointments
☐ Identifying Information for a referral including purpose
☐ Progress of my treatment
☐ Diagnostic Impression
☐ Financial information related to my treatment
☐ Other, Specify: _____

I direct that all information obtained in association with the Release be held in strict confidence by the recipient and is not to be further disclosed without my specific written authorization.

PLEASE NOTE: All matters relating to alcohol or drug abuse patient records are considered privileged and the following Federal Law applies directly to you. This information has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulations Section 2.31 of P.1.93-282, 42 CFR, part 2, prohibits further disclosure of it without the specific written consent of the person to whom it pertains, or as to otherwise permitted by such regulation. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

Please print name used when treatment occurred:

_____
First Middle Last

Social Security Number _____ Date of Birth _____

Client or Guardian's* Signature _____ Date _____

(Relationship to client)_____

Witness Signature _____ Date _____

☐ I have verified the authenticity of the signature by a picture ID

Signed:_____ Date_____

If the above signature is not that of the patient, explanation will be provided and documentary evidence of guardianship may be required to accompany this authorization.

☐ I withdraw this Release of Information as of this date: _____

Client or Guardian Signature:_____ Witness:_____

*Must be same signature as original document.

*Expiration Date*_____
Not to exceed 6 months after original date of signature.

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☐ Other, Specify: _____

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