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Introduction and Privacy Notice of New Leaf Resources

We want you to be an informed participant in the care you receive at New Leaf Resources. Below you will find a copy of our Mission Statement, our Philosophy Statement. You will also find a description of the therapeutic process, and a detailed privacy notice as we are required to provide. We trust that this information will help you understand how we function and what you can expect from your participation in therapy at New Leaf Resources.

NEW LEAF RESOURCES MISSION STATEMENT

We are a specialized Christian ministry which promotes healthy living and intervenes in the cycle of addiction, compulsion and dysfunctional relationships. We provide education, prevention, intervention, referral, counseling and consultation services to individuals, families, organizations and communities.

NEW LEAF RESOURCES STATEMENT OF PHILOSOPHY

We believe that all people are created in God's image and have immeasurable value, regardless of their life circumstances. As an organization and as individuals, we openly acknowledge our own brokenness and dependence on God's healing grace and love in our lives. We believe that God works compassionately in the lives of people, calling and equipping us to participate in this ministry. There is a grace at work, the movement of God's redemptive activity which calls upon the gifts, skills, training and experience of the staff to encourage, promote and facilitate this process of healing in our broken world. We seek to bring Christ-like care, restoration and hope in a manner which is sensitive to the complexity of the human condition, which includes the mental, emotional, physiological, social and spiritual dimensions.

We believe that ministry grows out of community. The quality of our staff life and the health of our organizational functioning are directly correlated with the quality of care we have to offer. In this ministry we seek to proclaim and embody God's forgiving and reconciling love. It is our goal that God's ministry of grace and love be reflected in our self-care, our communal life, and in the lives of those we serve.

THE THERAPEUTIC PROCESS:

People enter therapy for a variety a reasons, hoping to grow and heal. We congratulate you for having the courage to take this step. If you ever have questions about your therapy work at New Leaf, please feel free to discuss this with your therapist or Executive Director. We will be happy to respond to your concerns.

When you enter therapy at New Leaf, your therapist will initially spend time with you exploring the issues you brought to therapy. Together you will set goals that you wish to achieve in your work. Periodically you will review your progress in therapy. The length of therapy will vary depending on the concerns you bring to therapy and the issues that may come up for you while in therapy.

The changes that you seek can be difficult and painful at times. Therapy can stir up intense feelings like fear, anger, guilt, loneliness, abandonment, depression etc. In the process of therapy you may make changes in yourself and your relationships that you never anticipated. Personal growth is seldom easy. Please talk to your therapist about these matters or concerns.

If you ever have questions regarding your therapy, fees, billing, insurance, scheduling, etc., feel free to talk to your therapist or the appropriate administrative staff.

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PRIVACY NOTICE of NEW LEAF RESOURCES

This notice is in effect as of May 1st, 2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY

1. Our Responsibilities

- We are required by law to maintain the privacy and security of your Protected Health Information (PHI).
- We are required to follow the duties and privacy practices described in this notice, and to give you a copy of it.
- We are required to train our staff so that they understand privacy and confidentiality.
- We are required to have a plan for disciplinary action in place if someone breaks the rules or fails to follow the privacy and confidentiality policies we have in place.
- We are required to let you know promptly if a break occurs that may have compromised the privacy or security of your information.
- We are required to do what we can to decrease any harm to you if a breach occurs.

We will not use or share your information unless you tell us we can in writing, unless we are required to do so by law. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information visit: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

We have the right to change the terms of this notice based on New Leaf's needs, and changes in the state and federal law. If we change this notice, we will provide you with a revised notice in writing.

2. Your Rights

You have the right to know how we use or share your PHI. These rights include:

- You can ask us for a paper or electronic copy of this notice at any time, for any reason. We also have copies of the notice on our website, and in our waiting rooms.
- You can ask to see or get a copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee for this.
    - We might say "no" to your request if we believe it would cause you harm.
    - We will not share your provider's personal notes, or information that was given to us by someone else (unless it is another healthcare provider) with the understanding that it would be kept confidential, if sharing it with you would be likely to reveal the source of the information.
    - In some cases, if we say "no" to your request, you can ask to have our decision reviewed by another licensed professional within 60 days. This might be the case if we believe that sharing your record with you may harm you or someone else. Ask us if your situation qualifies for a review, and how to go about doing it.
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

  - We may say "no" to your request, but we will tell you why in writing within 60 days. Even if we say "no," you can still ask us to attach a letter (written by you) to your records to explain your disagreement. If you do, we might attach our own letter explaining why we did not make the correction in our records.
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all disclosures except for those about treatment, payment, and health care operations, and those that you asked us to make. The first list each year is free, but we will charge a reasonable cost-based fee if you ask for this more than once in a 12-month period.
- You can ask us to contact you in a specific way (for example, a specific phone number) or to send mail to a different address. We will say "yes" to all reasonable requests. For simplicity, we encourage you to not share phone numbers or addresses with us if you do not want us to use them.
- You can ask us (in writing) not to use or share certain health information for treatment, payment, or our operations. We have a form available where you can make that request, if you want to use it. We are not required to agree to your request, and we may say "no" if it would affect your care. If we say "yes" we are required to comply with your request until we inform you in writing that we are going to stop complying, unless there is an emergency.
- You can ask us not to share information about your treatment with your health insurer if you pay for your services out-of-pocket, in full. We will follow your request unless a law requires us to share that information.
- You can ask us (in writing) to share your information or records with someone else, for any purpose you choose. We have a form available for you to make this request if you would like to use it. You can cancel that request if you want us to stop sharing information or records with that person, but we won't be able to take back any information that we have already shared.
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- You can complain if you feel we have violated your rights by contacting us using the information on page 4. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Right (their contact information is also on page 4). <u>We will not retaliate against you for filing a complaint.</u>

3. Use and Disclosure of Protected Health Information (PHI)

New Leaf adheres to Illinois and Federal Law that requires written authorization in order to disclose any PHI outside of New Leaf. However, by signing the Consent and Agreement for Treatment form, you are giving us permission to use or disclose your PHI in the following situations:

- *Treatment*. We can use your health information and share it with other professionals who are treating you. *Illinois law requires that we never share substance abuse treatment records without your written permission.
- *Payment.* We can use and share your information to bill and get payment from you, from health plans or other entities. This might include verifying your insurance eligibility, benefits and coverage, arranging for a third-party payor at your request, and/or collecting unpaid balances.

- *Healthcare Operations*. We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- *Emergencies*. We can use and share your health information when doing so is necessary to address an immediate emergency, or if we believe it is necessary to prevent or decrease a serious threat to the health and safety of you or someone else.
- *Judicial Proceedings*. We can share health information about you in response to a court or administrative order, or in response to a subpoena, depending on state law.
- *Abuse and Neglect*. We are required by law to share your information with authorities in cases where we suspect child, elder or institutional abuse or neglect.
- *Government Requirements.* We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- *Criminal Activity or Danger to Others.* If a crime is committed on our premises or against our personnel, we may share information with law enforcement to apprehend the criminal.
- *Others involved in your healthcare.* Unless you object, we can share your information with your family, close friends, or others involved in your care.
- *Marketing/continuity of care.* We may contact you to provide information about appointments, or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- *Fundraising.* We may contact you as a part of a fundraising effort, or to solicit testimonials for our fundraising activities. You can ask us not to do this.

4. Contact Person for Complaints or Further Information

To request more information about this notice, you may contact the person listed below. You may complain either directly to us or to the Secretary of Health and Human Services if you believe that we have not properly protected your health information. You will not be retaliated against in any way for filing a complaint. To file a complaint with us, you may submit one in writing that includes as many details as possible to:

S. Terry Top, Executive Director
New Leaf Resources
2325 - 177th Street
Lansing, IL 60438
terry@newleafresources.org
(708) 895-7310 x1012
Fax: (708) 895-7602

Region V, Office of Civil Rights
U.S. Department of Health & Human Services
233 North Michigan Ave., Suite 240
Chicago, IL 60601
(312) 886-2359
Fax: (312) 886-1807

Megan Fisher, Privacy Officer
New Leaf Resources
11035 Broadway, Suite D
Crown Point, IN 46368
megan@newleafresources.org
(219) 226-1810 x2016

U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Avenue, S.W.,
Washinton, D.C. 20201
1-877-696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints

Consent and Agreement for Treatment

Consent to Collect, Create, Use, Maintain and Disclose Your Health Information

(A separate form must be completed for **each adult participating** in treatment.)

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. This information may include your health records, health history, symptoms, examination and test results, diagnosis, treatment, treatment plans, and billing and health insurance information. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment, or for other business (such as supervision) or required government functions (such as reporting abuse).
The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read the Privacy Notice before you sign this Consent form.

Informed Consent

Informed Consent is an interactive process between client and therapist involving your right to have the following information explained to you:

- your condition or diagnosis
- the nature and purpose of treatment
- the likelihood of success
- the risks and potential consequences of treatment, including refusing treatment, and the consequences of doing so
- the alternatives to treatment, including refusing treatment, and the potential consequences of doing so
- the right to include or exclude your family or significant other/s in treatment, to the extent permitted by the law

By signing this form, I am indicating:

- I have read, understand, and agree to the terms of the **Consent and Agreement for Treatment** as outlined above, except as otherwise noted in writing.
- I have been given the opportunity to review and have received a copy of the **Notice of Privacy Practices** of New Leaf Resources. New Leaf Resources reserves the right to change its notice and practices at any time, if it sends a copy of the revised notice to the address that I have provided.
- As a consenting adult, I agree to permit the staff at New Leaf Resources to provide me with treatment services.
- I understand that I have the right to request restrictions on the use or disclosure of my information. I understand that New Leaf Resources is not required to agree to those restrictions, but if it does, it must honor the restriction unless I revoke the request or it notifies me that it is no longer going to honor the request. New Leaf Resources has a form available for me to complete if I wish to request a restriction.
- I understand that I have the right to discontinue treatment at any time.

Note: If you do not sign this consent form, we will not be able to treat you, unless we are required to do so by law. After you have signed this consent, you have the right to revoke it, in writing, and we will comply with your wishes from that time forward. Revoking consent does not affect actions already taken by New Leaf Resources.

_____ _____

Printed Name of Client (or parent of minor client) Date of Birth

_____ _____

Signature of Client (or parent of minor client) Date

_____ _____

Witness Signature Date

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Consent for Treatment of a Minor

Client (Child) Name: _____ **Date of Birth**: _____
(A separate form must be completed for **each child** participating in treatment.)

I have received and reviewed a Consent and Agreement for Treatment form for adults. I, (parent) _____ do hereby authorize New Leaf Resources to provide counseling/treatment to (child) _____, as described on the adult consent form. I give this consent as the client's custodial parent or legal representative. I understand that I will also be required to consent to treatment if I participate in sessions with my child's therapist.

I understand that, even if I do not participate in treatment, the therapist is able to share with me the following information without authorization from the client:

- Current mental condition/status
- Diagnosis
- Treatment needs/recommendations
- Times and Dates of Service
- Billing/Insurance/Payment information

Clients under age 12: The parent or legal representative has the right to all treatment information.

Clients aged 12-18: The parent or legal guardian has the right to access only the information listed above, unless the client signs an authorization specifically releasing more information.

I also understand I may revoke this consent at any time by giving written notice to the therapist.

ILLINOIS CLIENTS: Minors receiving services in Illinois, who are age 12 or over, are permitted to consent on their own behalf for up to 5 sessions, up to 45-minutes in length, and may request that their parents not be notified of the services. Under these circumstances, the parent cannot be held liable for the cost of services.

_____
Printed Name of Custodial Parent or Legal Representative

_____ _____
Signature of Custodial Parent or Legal Representative Date

_____ _____
Signature of Witness Date

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Client Data Sheet – Youth

Date: _____

Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Address: _____

Primary Phone: _____ Social Security # _____

School: _____ Grade: _____

Teacher: _____

Father's Name: _____ Date of Birth:_____

Address (if different): _____

Primary # (if different): _____ Alternate # _____

Secondary #: _____ Highest Level of Education: _____

Employer: _____

Mother's Name: _____ Date of Birth: _____

Address (if different): _____

Primary # (if different): _____ Alternate # _____

Secondary #: _____ Highest Level of Education: _____

Employer: _____

Religion: _____

Please list any medical problems:

_____

Medications currently taking: _____

Primary Care Physician: _____

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How did you hear about New Leaf Resources? _____

Previous Counseling or Therapy (with whom and when):

_____

Reason:

_____

What are the issues or concerns you would like addressed:

_____

Is there any other information that would be important for your therapist to know?

_____

List the members in your immediate family, and all others living in your home:

Name	Age	Relationship	Living with you
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has anyone else in the family received counseling services?

_____

Does anyone in the family have a problem with drugs or alcohol currently or in the past?

_____

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Client Commitment

(Effective May 1, 2014)

- The fee for the initial assessment session is $160 per hour.
- The fee for subsequent sessions is $130 per hour.
- The fee for group therapy sessions is $50 per person, per hour.

Please place an "X" by the pre-approved commitment option below.

1. _____ I agree to pay the full fee listed above out of pocket.

2. _____ I will be filing insurance. By law, New Leaf Resources will bill my insurance at the full fee listed above. I will pay $75 for each session at the time of service, *UNLESS* I provided my insurance information to New Leaf in advance of the first visit. If my quoted coverage has already been determined, I agree to pay my co-payment at each session.

3. _____ I will be filing insurance. By law, New Leaf Resources will bill my insurance at the full fee listed above. However, I cannot afford to pay the fee established by my insurance coverage. I have spoken with the office staff and they agreed to provide me with financial assistance toward the cost of my therapy sessions. **Agreed Amount: _____**

4. _____ I do not have insurance coverage and I cannot afford to pay the full fee listed above. I have spoken with the office staff and they agreed to provide me with financial assistance toward the cost of my therapy sessions. **Agreed Amount: _____**

New Leaf Resources is able to offer limited financial assistance from the "Marty Doot Client Assistance Fund."
Contributions to the fund are received from individuals, churches and businesses that support the ministry.

As a client of New Leaf Resources, I am aware that my responsibilities include:

- An honest assessment of my ability to pay.
- Promptly notifying New Leaf Resources of any life changes that would result in an adjustment of the amount of help I am receiving from the "Marty Doot Client Assistance Fund."
- Paying my fee and any balances accrued promptly.
- **Being charged and being responsible to pay a $75 fee when…**
    - **I fail to give a 24 hour notice when canceling an appointment.**
    - **I do not show up for a scheduled appointment.**
    - **I understand that my insurance, if any, will not cover the cost of this fee.**

If New Leaf Resources will file insurance claims on my behalf, I am aware that my additional responsibilities include:

- Complying with any/all requests for documentation from my insurance carrier in a timely manner.
- Taking financial responsibility for the full fee for any/all sessions not paid by my insurance due to my failure to provide such documentation.
- **Understanding that any quote of insurance coverage provided by my insurance carrier, and obtained on my behalf by New Leaf Resources, is an estimate of coverage**, and that New Leaf Resources is not responsible for any errors in the information provided.
- **Understanding that I am responsible for all fees not covered by my insurance.**

I understand New Leaf Resources reserves the right to pursue collection of delinquent accounts.
I understand that in the event my account is sent to collections,
I will be responsible for <u>all collection costs and legal fees.</u>

Print Name _____

Signature _____ Date _____

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Client Billing Information

The primary client's information entered on this form will be used to submit any insurance claims.

*Separate **Consent for Treatment** forms will be required for each individual participating in counseling.*

*Separate **Client Billing Information** forms may be required if clients listed here have separate therapists or participate in multiple counseling processes.*

Primary Client Information:

Name_____ Age _____

Address _____

City _____ State _____ Zip_____

Primary # _____ Alternate # _____

Secondary # _____ E-Mail _____

Date of Birth _____ ☐ M ☐ F

Marital Status _____ Social Security # _____

Employer or School _____

Employment Status _____

New Leaf Office Location ☐ **Lansing** ☐ **Crown Point** ☐ **Wheatfield**

Would you like to receive New Leaf Resources quarterly Newsletter & Updates? ☐ ***Mail*** ☐ ***E-mail***

Please list any family members that may participate in counseling sessions with the primary client:

Other Client's Name _____ Date of Birth _____

Other Client's Name _____ Date of Birth _____

Other Client's Name _____ Date of Birth _____

Other Client's Name _____ Date of Birth _____

Other Client's Name _____ Date of Birth _____

Billing Information (If financially responsible party is other than the client):

Name_____ Age _____

Address _____

City _____ State _____ Zip_____

Primary # _____ Alternate # _____

Secondary # _____ E-Mail _____

Date of Birth _____ ☐ M ☐ F

Marital Status _____ Social Security # _____

Employer or School _____

Employment Status _____

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Client Insurance Information

*This form ONLY needs to be completed **IF** the client has insurance coverage and would like New Leaf Resources to submit claims on his/her behalf, **AND** the primary insured on the insurance policy is different from the primary client information provided on the Client Billing Information form, **OR** one or more insurance cards are not available for us to copy for our records.*

Primary Insured Information:

Client Relationship to Insured: ☐ Self ☐ Spouse ☐ Child/Other _____

If client relationship to insured is "Self," you may not need to complete this form!

Insured's Name_____ Age _____

Address _____

City _____ State _____ Zip_____

Primary # _____ Alternate # _____

Secondary # _____ E-Mail _____

Date of Birth _____ ☐ M ☐ F

Marital Status _____ Social Security # _____

Employer or School _____

Insurance Company Information:

Insurance Company _____

Address _____

City _____ State _____ Zip_____

Phone Number/s _____

Plan Name: _____

Policy Number: _____ Group Number: _____

Secondary Insured Information:

Client Relationship to Insured: ☐ Self ☐ Spouse ☐ Child/Other _____

If client relationship to insured is "Self," you may not need to complete this form!

Insured's Name _____

Address _____

City _____ State _____ Zip_____

Primary # _____ Alternate # _____

Secondary # _____ E-Mail _____

Date of Birth _____ ☐ M ☐ F

Marital Status _____ Social Security # _____

Secondary Insurance Company Information:

Employer or School _____

Insurance Company _____

Address _____

City _____ State _____ Zip_____

Phone Number/s _____

Plan Name: _____

Policy Number: _____ Group Number: _____