New Hope Christian Centers, Inc. &
New Hope Christian Counseling Foundation, Inc.
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The therapists and staff wish to welcome you to our office and thank you for selecting us for your care. We at **New Hope** are honored by the trust that you place in us and we will do everything to help you through this difficult time.

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Our vision is to help those who are seeking emotional and/or spiritual growth. We know the responsibility to hurting people is great; therefore, each member of our staff is professionally trained and has extensive experience in a variety of specialty areas.

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There is an answer to the problems we face daily and no need to continue with the pain and suffering which constantly drain our energy and direction in life. With a rapidly changing society and all the external and internal pressures, both families and individuals can at times feel alone, alienated, frustrated and even tom apart.

We believe there is hope for change. Our goal at **New Hope** is to provide comfort, hope and healing in times of struggle, confusion and despair. We help bring individuals and families to a place of peace, hope and understanding.

We at **New Hope** have joined together and committed ourselves to help individuals and families change in their time of need.

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Before beginning treatment, we are providing you with these written explanations so that the therapists are able to refer to them during your initial appointment. We understand that paper work is the last thing you are probably concerned with at this time, but we have found that clients have found it very helpful to have a full understanding of procedures and policies. In fact, many clients see that many of the policies were implemented for their protection. As well, many clients have found that this information gives them more choices during their counseling process.

Further more, we want you to be fully aware of procedures, and policies which will help you in consideration of treatment options. We take pride in giving each client the individualized attention they require and full disclosure about treatment options and financial matters before treatment. So, read each page carefully and sign where indicated.

Your therapist will be with you shortly. May God richly bless you.

New Hope Christian Centers, Inc. &
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Serving Southern California since 1985

PERSONAL INFORMATION

____ ________
FIRST NAME MIDDLE NAME LAST NAME DATE OF BIRTH

______ ____________________ ____________________
AGE F M SOCIAL SECURITY NO. DRIVERS LICENSE NO.

______________________________ ____________ _____ ____________
HOME ADDRESS CITY STATE ZIP

WORK PHONE: ___________ CELL PHONE: __________ HOME PHONE:__________
MAY WE CALL YOU AND LEAVE A MESSAGE HOME: WORK: CELL:
EMPLOYER: ______________________ OCCUPATION:__________________________
WORK ADDRESS:____
STREET NO. CITY ST ZIP CODE

MARITAL STATUS: MARRIED SINGLE SEPARATED DIVORCED WIDOWED

FAMILY INFORMATION

SPOUSE'S NAME:________________ SPOUSE'S EMPLOYER:__________________
SPOUSE'S WK. ADD.:____
STREET NO. CITY ST ZIP
SPOUSE'S WK PHONE: _____________________

NAMES OF CHILDREN & AGE

1)____________________( ) 5)____________________( )
2)____________________( ) 6)____________________( )
3)____________________( ) 7)____________________( )
4)____________________( ) 8)____________________( )

Client Name:________________________________.
Client Signature:_____________________________ Date:_______________

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INSURANCE INFORMATION

INSURED NAME:_____________________________ DATE OF BIRTH:_______________
INS. CO.NAME:______________ INS. CO. PHONE#: ____________ GROUP ID #: ________
POLICY #: ____________ EFFECTIVE DATE OF POLICY: ____________
INS. CO.ADDRESS:____
STREET NO. CITY ST ZIP CODE

INS. CO. #2: ______________ INS. CO. PHONE#:___________ GROUP ID #:___________
POLICY 2 #: ____________ EFFECTIVE DATE OF POLICY#2:_______________
INS. CO. #2 ADDRESS:____
STREET NO. CITY ST ZIP CODE
INSURED INDER: _______________________
PRIME (MEMBER#)______________________
SECONDARY (MEMBER #)_______________

IN CASE OF AN EMERGENCY NOTIFY
Name__________________________________ Phone:__________________________

Emergency Address:____

Street no. City St Zip Code

*GENERAL CONSENT TO THERAPY & *24 HOUR NOTICE POLICY*

I apply for and consent to counseling, psychotherapy and diagnostic test as prescribed by the therapist. I agree to be responsible for payment of $ ______per hour which is payable at time of session unless prior arrangements have been made with the office. This does include phone consultations. I UNDERSTAND THAT APPOINTMENTS NOT KEPT OR CANCELED 24 HOURS IN ADVANCE WILL BE CHARGED FOR AND IT WILL BY MY RESPONSIBILITY TO PAY FOR MISSED SESSIONS.

I do do not Authorize New Hope to contact my insurance company to (1) verify insurance benefits and (2) to bill my insurance for payment of services rendered.

REFERRED TO NEW HOPE BY : DOCTOR____________OTHER_____________________

MAY WE THANK THE PERSON WHO REFERRED YOU TO NEW HOPE: YES NO

Client Name :__________________________________
.
Client Signature:________________________________ Date:________________

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AGREEMENTS, AUTHORIZATIONS & CONSENT TO TREATMENT

PRIVACY POLICY: I acknowledge having been offered New Hope Christian Counseling Center's "Notice of Privacy Policy." My rights including the right to see and have a copy of my record, to limit disclosure of my health information, and to request an amendment to my record is explained in the Policy. My right to make a complaint and fi le a grievance has also been explained. I understand that I may revoke in writing my consent for release of my health care information except to the extent that New Hope has already made disclosure with my prior consent.

TREATMENT: The undersigned client, or the parent/legal guardian if the client is a minor, requests, consents to, and authorizes New Hope and its mental health practitioners, to perform all counseling and psychological services which may be deemed advisable or necessary. This agreement may be revoked at any time. Service provided through this program is optional.

INFORMATION RELEASE: I understand that any records kept regarding me and my treatment are the property of New Hope. Such records can be made available, upon my written release, to other qualified mental health professionals. Or public welfare agencies.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION*:* I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the health care operations of New Hope. I authorize New Hope to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that New Hope may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

Client Name:________________________________ .

Client Signature:______________________________ Date:_______________

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AGREEMENTS, AUTHORIZATIONS & CONSENT TO TREATMENT (CONT)

4. AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION: I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the health care operations of New Hope. I authorize New Hope to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that New Hope may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

5. EXCEPTION TO CONFIDENTIALITY: Although New Hope adheres to confidentiality standards and thus will not release any information to others without signed consent, there are exceptions which arise from certain California legal mandates. These exceptions are:

A) The necessity of reporting to authorities, with or without the client’s consent, any information which may indicate the presence of child or elder abuse or neglect.

B) The necessity of reporting to authorities and the potential victim, with or without the client's consent, should it appear that the client or a person known to the client intends to seriously hurt another person, destroy another's property.

C) The necessity to take appropriate steps to prevent a suicide attempt, with or without the client's consent, should a suicide attempt appear imminent. In all cases an effort will be made to inform the client and/or the legal guardian that a report will be made to the appropriate authorities, before such a report is actually made.

6. MAILINGS: I agree to have my names placed on a mailing list to receive follow-up contact from New Hope including but not limited to a New Hope Newsletter, Seminar information, and/or education information, etc. (_______) initial Each of the undersigned acknowledges that he/she has read and understand the foregoing provisions and that the person signing as parent, or legally responsible party certifies that he/she is lawfully entitled to act on behalf of the client.

Client Name:________________________________.

Client Signature:_____________________________ Date:_______________

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POLICY INFORMATION

Dear Client,

As we begin this therapy process we want to be sure that you understand our polices and something about the way we view therapy.

THERAPY: Because we will be dealing with issues which are personal and of great importance to you, your therapist is committed to providing you with the best professional service possible. In order for this to be truly effective, it will be necessary for you to make our sessions one of your highest priorities during this time.

SESSIONS: Generally, sessions will last for 45-55 minutes, unless you and your therapist agree on a different arrangement. Your therapist will do his/her best to start and stop on time, although there may be times when this will be difficult for various reasons.

TERMINATING THERAPY: Bringing therapy to a close is often one of the most important parts of this process and should be done in a planned and deliberate way rather than as a sudden decision. This allows you are your therapist time to work through key issues.

TRANSFER OF CASE UPON DEATH/INCAPACITATION: In the event of my death or incapacitation I appoint the directors at New Hope Christian Center Inc. New Hope Christian Counseling Foundation, Inc. whose main office is located at 1175 E. Garvey Street, Ste 102, Covina, CA 91724, phone 626-967-6421, to properly care for your case in regard to proper care and transfer of your clinical file and transfer case to another therapist.

We have found that the standards described here enhance the work we will do together and will help to ensure that you get the most out of this experience. Your therapist welcomes any questions you may have about this so please feel free to discuss it with them.

Sincerely, **Clinical Directors of New Hope**

I have read, understand and agree to the policies stated above.

Client Name:________________________________.

Client Signature:______________________________ Date:_______________

New Hope Christian Centers, Inc. &
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Appointment Policy

We understand that life can be busy and full of unexpected changes. However, our mission is to help those that are suffering and in need of counseling so regular counseling is necessary to get the results you are looking for.

Our Staff set aside time specifically for you so it is important to make the regular appointments as scheduled.

As mentioned previously we have a 24-hour notice policy if you are going to cancel appointments otherwise you will be charged for the time missed. The advance notice. allows our therapists to open up the time for someone else that may need to come in.

For County referred clients, after 2 missed sessions (this includes cancellations and no-show appointments) the County will be contacted regarding the missed sessions. ACT/CAST clients are required to have regular weekly counseling in most cases and CARES at least every other week. Cases will be terminated after a pattern of missed sessions as per our contract with the County.

I understand New Hope's appointment policy and agree to abide by the policy.

Client Name:________________________________.

Client Signature:_____________________________ Date:_______________

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Telemedicine Informed Consent Form

I ________________________hereby consent to engaging in telemedicine with New Hope Christian Counseling as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California or outside of California. I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive expectations to confidentiality including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an as certain victim; and where I make my mental or emotional state an issue to a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Client Name:________________________________.

Client Signature:_____________________________ Date:_______________

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POLICY INFORMATION (CONT)

(3) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmissions of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that telemedicine based services and care may not be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improved, and in some cases, may even get worse.

(4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed
or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with California law.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Client Name:________________________________.

Client Signature:_____________________________ Date:_______________

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Terms and conditions

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from clients for the cost incurred in their care, and financial responsibility on the part of each client must be determined before treatment or during the initial session. *This office cannot render services on the assumption that our chargers will be paid by an insurance company. You are responsible for the full amount of the fee if for some reason your insurance fails to pay.

Clients who carry health insurance understand that all services furnished are charged directly to the client, and that he or she is personally responsible for payment of all counseling services unless arrangements to bill your insurance is made. In some cases our office will prepare the clients insurance forms or assist in making collections from insurance companies and will credit any such collections to the client accounts. Alternately, your therapist can give you a superbill to send to your insurance company for reimbursement. However, .this office cannot render services on the assumption that our charges will be paid by an insurance company. You are responsible for the full amount of the fee if for some reason your insurance elects not to pay.

In consideration for the professional services rendered to me or at my request, by the therapist, I agree to pay therefore the reasonable value of said services to the therapist at the time of said services are rendered, or within five (5) days of billing if credit shall be extended. There will be a
$35.00 service charge for all NSF checks returned to our office. I further agree that a ·waiver of any breach of any time or condition here under shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney's fee’s if suit be instituted hereunder. I grant my permission to New Hope and assigned staff, to telephone me at home and/or work to discuss matters related to this form.
*I have read the above conditions of treatment and understand the policies stated above. I further agree to their content and agree to the fee amount of $ per hour which includes therapy sessions and phone consultations.

Preference of payment

*IF COUNTY IS PAYING Check Here
Cash on day of treatment: Master card: Visa: Discover Card:
Credit Card Number:_______________________ Expiration date: MO____ YR_____
CCV 3 digit code______
Name on Credit Card:______________________________
Insurance Co-payment of:$_______ * Insurance will pay:$___________
Other:__________________________

Client Name:___________________________________.

Client Signature:________________________________ Date:________________

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CLIENT INFORMATION QUESTIONNAIRE

When were you last examined by a physician?

Physicians name:

List any major health problems from which you currently receive treatment:

List any medications (prescription and nonprescription) you are now taking:

Have you ever been hospitalized? If yes, please give approximate dates and reasons:

Have you ever received counseling before? if yes, with who and for what?

Please give approximate dates To: From:

Are you presently receiving counseling? Yes No
If yes, with who and for what?

In your own words, please describe the problems that brought you to counseling:

What are the clients strengths?

PLEASE CHECK ANY OF THE FOLLOWING PROBLEMS WHICH PERTAIN TO YOU

Nervousness	Sleep	Relaxation	Loneliness
Bowel Troubles	Alcohol Use	Headaches	Inferiority
Appetite	Sexual problems	Tiredness	Concentration
Children	Stomach Issues	Shyness	Separation
Legal Matters	Education	Finances	Self Control
Memory	Career Choices	Being a parent	Unhappiness
Ambition	Health Issues	My thoughts	Depression
Drug Use	Anger	Energy	Temper
Divorce	Stress	Insomnia	Nightmares
Fears	Work	Marriage	Relationships
Friends			Making Decisions

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AUDIO/VIDEO RELEASE

I authorize New Hope Christian Counseling Center to make an audio/video recording of my counseling session(s) for the purpose of supervision, with the therapist's supervisor. It is my understanding that the tape will be erased at my request or when supervision is completed. I understand that all audio/video recordings are available for my listening/viewing.

*This release must be signed by all family members 18 years of age or older, or those who are emancipated minors.

Client Name:________________________________.
Client Signature:_____________________________ Date:_______________

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NOTICE TO PROSPECTIVE CLIENTS:

This notice will inform you that the counselor with whom you are conferring does not yet have a license as either a Marriage, Family or Child Counselor, or a Clinical Psychologist, from the State of California.

However, this does not mean that your counselor is not competent. Indeed, she/he has been professionally trained to become a counselor, and will be happy to discuss with you her/his training and educational degrees received. What this notice means is that either your counselor has not amassed the number of counseling hours (3,000) required to apply to take the qualifying examinations, he/she is awaiting the results of such examinations, or in the case of a trainee, is finishing his/her masters degree in counseling.

Please be assured that not only is your counselor professionally educated and trained, she/he is also supervised by either a licensed Marriage, Family and Child Counselor or a Clinical Psychologist.

Our intent with this notice is not only to comply with state regulations, but to avoid any implications of licensure when there is only registration.

Please feel free to ask any questions you might have concerning this notice, or about our counseling facilities.

INTERN: ______________________________

REGISTRATION#: AMFT #__________

SUPERVISOR: **Max J Kayes, LMFT**

LICENSE #: **MFC 22998**

Yes, I have read and understand the above information.

Client Name:________________________________.

Client Signature:_____________________________ Date:_______________

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CLIENT E-MAIL/TEXTING INFORMED CONSENT FORM

Although electronic media is very useful in communicating with your therapist, we wanted you to be informed and aware of the potential risks in communicating with your therapist using Email or Texting.

1. Risk of using email/texting the transmission of client information by email' and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

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

2. Conditions for the use of email and texts Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Clients/Parent's/ Legal Guardians must acknowledge and consent to the following conditions:

   a. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
   b. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.

Client Name:___________________________________.

Client Signature:________________________________ Date:________________

c. All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.
d. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
e. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
f. Provider is not liable for breaches of confidentiality caused by the client or any third party.
g. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

3. Client Acknowledgement and Agreement I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Therapist may impose to communicate with me by email or text.

Yes, I have read the above and consent to unencrypted, but confidential email/text correspondence.

No, I am not interested in email/text correspondence.

E Mail Address: ___________________________________
Client name: ____________________________________
Client signature: _________________________________Date:_________
Provider name: ___________________________________
Provider signature: ______________________________Date:_________