**PROFESSIONAL DISCLOSURE STATEMENT**

**OUR PHILOSOPHY**

At Newlife Counseling Services, LLC, we believe in facilitating a solution-focused recovery and maximizing potentials through identifying strengths and building new foundations. We help empower children, adults and families with intellectual, emotional, developmental and behavioral challenges toward making meaningful life choices and/or exploring possibilities for change.

PROFESSIONAL BACKGROUND

Our staff have extensive counseling experience with specialties in diverse psychopathologies and clinical focus. We serve children, adolescents, and adults. We engage in individualized strength-based treatment services tailored to the speciﬁc needs of individual clients. We provide conﬁdential, collaborative, quality, and professional-level mental health and substance use counseling and psychotherapy services using integrative and evidence-based clinical treatment models (Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, EMDR, Family Systems, Psychosocial etc.). Emphasis is on skills building, relationship development, individual strengths and proactive intervention.

Counseling is a collaborative process which is designed to assist you in ﬁnding resolution to your concerns, coming to a greater understanding of yourself, and using effective means of coping which utilizes personal and interpersonal resources. The counseling process involves sharing personal information with your counselor which may at times be sensitive, very private, or even distressing. Therefore, it is not uncommon during the course of counseling to feel somewhat anxious or upset for a time. During your ﬁrst counseling session, the counselor will review your concerns and will consider these concern in light of your personal history and life experiences. This information gathering is crucial to the counseling process and may take more than one session to accomplish.

Counseling may have both benefits and risks. Often counseling can lead to a significant reduction in feelings of distress, improvement in relationships, and/or resolution of specific issues. However, there are no guarantees for a “cure” or improvement of any condition. There are many variables that affect the counseling process. Those variables are both internal and external. Risk and may involve experiencing uncomfortable feelings (i.e. sadness, guilt, anxiety, anger….) or discussing unpleasant aspects of your life.

PROFESSIONAL SERVICES FEES

The amount of $220.00 for the Intake, $140.00 per individual, family or couple session; $140.00 per group session. (Fees may be adjusted on a sliding scale to meet a client’s financial ability). Session are approximately 30, 45, or 60 minutes. (See Financial Policy for other fees.)

Newlife Counseling Services, LLC accepts some health insurance plans, credit card, cash and check payments. You will be responsible and co-payments according to your insurance plan at the time services are rendered. Claims will be filled by Newlife Counseling Services, LLC for Out-of-Network health insurance plans, documentation will be provided to you to file a claim with your insurance company for reimbursement. It is important to note that some health insurance companies will reimburse clients for counseling services and some will not.

In addition, most will require documentation of a diagnosis of a mental-health condition before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. Any diagnosis made will become part of your permanent insurance record.

**NOTE:** Clients referred by contracted governmental agencies are not responsible for payment of services provided. Payment will be made by referring governmental agencies.

CANCELLATION POLICY: 24-hour notice is required for appointment cancellation, otherwise, a full-service fee will be charged including applicable co-payment.

CONFIDENTIALITY: In accordance with ethical guidelines, what you discuss with your counselor becomes part of the clinical record, and is kept conﬁdential and may not be released to other parties with the following exceptions: 1. You direct Newlife Counseling Services, LLC in writing to disclose information to others; 2. It is determined you are a danger to yourself or others (including child or elder abuse), or

3. Newlife Counseling Services, LLC is ordered by a court to disclose information.

COMPLIANT PROCEDURES: **Step I:** If a client has a complaint or grievance, the company encourages the client to bring the complaint or grievance to the attention of the staff person involved. The staff member will address the concerns and attempt to solve the problem with the client. **Step II:** if the client is unable to complete step I or if complaint or grievance has not been resolved by meeting with the staff member involved, the client may request a telephone conference with the clinical supervisor. Upon receipt of request, the clinical supervisor will

contact the client within 48 hours. **Step III:** if complaint or grievance is still unresolved, the client may orally request a face to face meeting with the staff member and the clinical supervisor. The meeting will be held within 5 business days of request receipt. A response will be made within 5 business days: **Step IV**: If complaint or grievance is still unresolved to the c1ient’s satisfaction, the client may request in writing a meeting with the Director of Counseling and Consulting Services. A meeting. **Step V:** If a resolution is not accomplished the Newlife Counseling Services, LLC complaint and grievance process, the client may pursue resolution as follow. If necessary, the agency will assist the client in submitting the written grievance or complaint.

1. If enrolled in the local RBHA, you may contact the Grievance and Appeals Dept. at: Mercy Maricopa Integrated Care at

4350 E. Cotton Center Blvd, Bldg. D., Phoenix, AZ 85040 Phone: 1-800-564-5465

1. If grievance remain unresolved, the client may write to Arizona Department of Health Services at: State of Arizona Department of Health 150 N. 18th Avenue, Suite 420, Phoenix, AZ 85007 Phone: 602-364-4575

**CLIENT NOTICE OF CONFIDENTIALITY**

The conﬁdentiality of alcohol and drug abuse client records maintained by this facility is protected by Federal law and regulations. Generally, the practice may not say to a person outside the practice that a client receives services from this practice, or disclose any information identifying a client as an alcohol or drug abuser,

Unless:

1. The client consents in writing.

2. The disclosure is allowed by court order, or

3. The disclosure is made to medical personnel in a medical emergency or to qualiﬁed personnel to research, audit, or program evaluation. (a medical emergency is deﬁned as suicidal, homicidal ideation’s or any physical health issue).

Violation of Federal law and regulations is a crime, Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a client either at the program or against any person who works for the program or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

By signing below, I acknowledge that I have received the “CLIENT NOTICE OF CONFIDENTIALITY”

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**Client//Guardian Signature Date**

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Name (print)

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**Clinician Signature Date**

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Name (print)

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**INFORMED CONSENT FOR TREATMENT**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, DOB: \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_request to be accepted for psychiatric, mental health, or alcohol and drug abuse treatment as described to me.

1. I give my authorization and consent to receive outpatient diagnostic and treatment services from Newlife Counseling Services, LLC.

2. I have been given information regarding my rights and responsibilities as a participant.

3. l have been given information regarding the limits of confidentiality of my records.

4. I have been given information regarding the cost of services from Newlife Counseling Services, LLC. I understand that l am responsible to pay a copay and that it is payable each time I come for treatment.

5. I understand that I may address any concerns or grievances with my therapist or any other representative of Newlife Counseling Services, LLC or the professional board which regulates my therapist's professional practice.

6. l am freely choosing to enter into treatment, and I understand that l may discontinue treatment at any time.

7. I have been given information about the advantages and disadvantages of the treatment recommended as well as other alternatives.

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Client Signature/Parent/ Guardian Date

Date

**MINOR (Emancipated Minors Only)**

Due to the following reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have the legal capacity under applicable Arizona State law to apply for consent to such treatment and services mentioned in this form, without parental consent.

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**Signature Date**

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**Witness Date**

**CLIENT RIGHTS**

* The right to be treated with dignity, respect, and consideration.
* The right to be free:

(a) Abuse;( b) Neglect; (c) Exploitation; d) Coercion; (e) Manipulation (f) Sexual abuse; (g) Sexual assault (h) Restraint or seclusion;

(i) Retaliation for submitting a complaint to the Department or another entity; or (j) Misappropriation of personal and private property by a

counseling facility's staff member, employee, volunteer, or student; and (k) Discrimination against based on race, national origin, religion,

gender, sexual orientation, age, disability, marital status, or diagnosis;

* To receive services that supports and respects your individuality, choices, strengths, and abilities; ~ be provided within 5 business days of the meeting
* To receive privacy while receiving services;
* To review, upon written request, your medical record according to A.R.S. §§ l2-2293, 12-Z294, and 12-2294.01;
* To receive a referral to another health care institution if this facility is not authorized or not able to provide the services you need;
* To participate or have the patient’s representative participate in the development of, or decisions concerning, the counseling provided to the patient;
* To participate or refuse to participate in research or experimental treatment;
* To receive assistance from a family member, the patient’s representative, or other individual in understanding protecting, or exercising the patient’s rights.
* For you or your representative:

1. Except in an emergency situation, can consent to or refuse services;
2. May refuse or withdraw consent for receiving counseling before services are imitated:
3. Except in an emergency situation, is informed or alternatives to proposed psychotropic medications or surgical procedure and associated risks and possible complications of proposed psychotropic medication or surgical procedure
4. Is informed of the following:
5. Newlife Counseling Services’ policy on health care directives, and
6. Newlife Counseling Services’ complaint process;
7. May consents to photographs before being photographed, except when a photograph is taken for identification and administrative purposes at the time of admission;
8. Except as otherwise permitted by law, provide written consent to the release of your:

1. Medical record, or
2. Financial records

* The right to be informed of all fees that the client is required to pay and of the agency’s refund policies and procedures before receiving a behavioral health service, except for a behavioral health services provided to a client experiencing a crisis situation.
* The right to submit grievances to agency staff members and complaints to outside entities and other individuals without constraint or retaliation. The right to have grievances considered in a fair, timely and impartial manner.
* Should a client become dissatisfied with the services rendered by Newlife Counseling Services, LLC the should:

Contact the staff member involved. If still unsatisfied, the client may orally request a telephone conference with the clinical supervisor. The supervisor will contact the client within 48 hours. If no resolution is reached, a face to face meeting may be scheduled within 5 business days or request. A response is provided within 5 business days of meeting. If still unsatisfied, a written request may be submitted to meet with the Director of Counseling Services. A meeting is scheduled within 14 days of receipt of request. A response will be provided within 5 business days of the meeting.

* Upon receiving any written client complaint, the Program Administrator or designee will respond in writing to the complaint within five working days.
* If a resolution is not accomplished by the Newlife Counseling Services complaint and grievance process, the client may pursue a resolution as follow. If necessary, the agency will assist the client in submitting the written grievance or complaint.

Mercy Maricopa Integrated Care at

4350 E. Cotton Center Blvd, Bldg. D.,

Phoenix, AZ 85040

Phone: 1-8000564-5465

If grievance remain unresolved the client may write to Arizona Department of Health Services at:

State of Arizona Department of Health

150 N. 18th Avenue, Suite 420

Phoenix, AZ 85007

Phone: 602-36404575

DES – Adult Protective Services, 602-255-0996 DES – Child Protective Services, 1-888-767-2445 Division of Behavioral Health Services, 602-364-4558 Human Rights Advocate, 602-364-4558 Mercy Maricopa integrated Care, 1-800-564-5465

**I acknowledge receipt of Client Rights:**

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**Client/ Guardian Signature Date**

Name (print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF HEALTH -INFORMATION (Outpatient Clinic)**

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeﬁciency Syndrome (AIDS), Human Immunodeﬁciency Virus (HIV), and other communicable diseases, Behavioral Health Care/Psychiatric Care, treatment of alcohol and/or drug abuse and genetic testing: my signature authorizes release of any such information. I may refuse to sign this authorization form.

I understand that Newlife Counseling Services will not condition or deny treatment on my signing this authorization. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Newlife Counseling Services’ Notice of Privacy Practices explains the process for revocation, which includes a request in writing. I understand that I have a right to receive a copy of this authorization.

This Authorization pertains to the dates speciﬁed on this Authorization. Unless I revoke this authorization earlier, it will expire 12 months from the date signed. I understand that if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.

I release Newlife Counseling Services, LLC, its employees and agents, medical staff members and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

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**Client/Guardian Signature Date**

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**PCP & Other Medical Provider Contact Information**

PCP Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last PCP Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Medical Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**NEWLIFE COUNSELING SERVICES, LLC**

**FINANCIAL POLICY**

Newlife Counseling Services, LLC accepts clients with insurance coverage as well as private pay clients. It is important that you understand that your insurance coverage is a contract between you and the insurance carrier. Newlife Counseling Services, LLC will gladly file your insurance claims. Newlife Counseling Services, LLC will wait a reasonable amount of time for your insurance company to pay the claim. If a claim remains unpaid by your insurance company for more than 90 days, Newlife Counseling Services, LLC will look to you for payment of the claim. Newlife Counseling Services, LLC highly recommends that you become very familiar with your insurance policy and what your benefits are under your policy. The policies can be somewhat confusing, so it may be necessary for you to call your insurance carrier directly to gain clarification regarding your benefits. In most cases, you will have a co-pay or a deductible which will be paid to our office prior to your appointments with your Therapist. When an insurance company pays Newlife Counseling Services, LLC, we will then bill you or collect from you at your next appointment any remaining co-pay, deductible, or coinsurance that is not paid at the time of service. Billed balances are due and payable within 30 days. Newlife Counseling Services, LLC does exercise the right to share your billing information to a collection agency if you have a balance that has been left unpaid for more than 90 days. Payment plans for unpaid balances may be an option and would need to be discussed with our Business Manager.

Newlife Counseling Services, LLC does have a cancellation policy which requires you to cancel your session within 24 hours prior to the session to avoid being charged. The charge for late cancellations and appointments in which there is no cancellation and no attendance is $50.00 payable to Newlife Counseling Services, LLC. Newlife Counseling Services, LLC does understand at times there may be extenuating circumstances which prevent you from canceling or coming to your appointment. Newlife Counseling Services, LLC will consider these situations on a case by case basis. A successful outcome in therapy will be fostered by your commitment to the process.

**Rates are below:**

**Intake/Assessment** (1hour) $220.00 **Individual/Family/Couples** Therapy Session (50 minutes) $140.00 **Group** Fees are based on the type of group. (Please ask for rate prior to attending the group.) Services performed outside of the office have additional fees.

**COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.**

Payment Options:\_\_\_\_\_\_ Cash: \_\_\_\_\_\_ Check: \_\_\_\_\_\_Credit Card: Name on Credit Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CC#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EXP. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ CC Code#\_\_\_\_\_\_\_ CC Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Address if different from home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I have read and understand this policy and will honor the guidelines of this policy:**

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**