Client Name: _____

Date of Birth: _____

Today's Date: _____

Informed Consent and Receipt of Privacy Policies

Your child has been referred for mental health services at A New Dawn Psychotherapy Associates, LLC. If you are in agreement with your child receiving services, please complete this form and return it to us.

If this **Informed Consent to Counseling** relates to a request by you for A New Dawn Psychotherapy Associates, LLC to provide services to a minor child, in cases of separation and/or divorce, the **Informed Consent to Mental Health Services** must be approved by both parents prior to any services being provided. Your signature below indicates consent by you for your child to see a Licensed Counselor/Licensed Social Worker at A New Dawn Psychotherapy Associates, LLC.

I have received a copy of A New Dawn Psychotherapy Associates, LLC, **HIPAA** and the A New Dawn Psychotherapy Associates, LLC, **Informed Consent to Counseling** and have had the opportunity to ask anything that is not clearly understood. I agree to comply with the policies and information presented.

I further certify that:

- ☐ There is no custody order for legal custody for this child and there are no petitions for custody that have been filed by any person in any court that I am aware of
- ☐ There is a custody order and I have shared legal custody of this child (Please provide a copy of the order)
- ☐ There is a custody order and I have sole legal custody of this child (Please provide a copy of the order)
- ☐ This child resides with both biological parents.
- ☐ The other parent of this child has not been involved in this child's life for over two years and I have no ability to contact them to get consent (Must complete Parental Certification Form)
- ☐ This child is in the custody of a county agency. Consent is given by the caseworker or appropriate legal representative (Please provide a copy of the authorizing court order)

_____	_____	_____
Relationship (Parent/Guardian 1)	Print Name (1)	Date
_____	Attorney Involvement: _____ _____	_____
Client/Responsible Party Signature (1)	Yes No	Contact Phone

OFFICIAL USE ONLY:

Administrative Staff that made the call: _____ Date: _____

Administrative Staff spoke with: _____ Approved for Treatment: ____ Yes ____ No

A New Dawn Psychotherapy Associates, LLC
308 East Broad Street
Bethlehem, PA 18018
Phone/ 610-861-8779
Fax/ 610-861-4677
www.anewdawnpa.com

Client Name: _____

Date of Birth: _____

Date of Plan: _____

Consent for Treatment

1. CONFIDENTIALITY: You have the right to a confidential relationship with our group practice by receiving services provided by a Licensed Counselor or Licensed Social Worker. Within certain legal limits information revealed to our agency will not be revealed to any other person or agency without your consent. The major exceptions to confidentiality are threats to harm yourself or others, or those mandated by law (such as child abuse/neglect). Please understand that you are acknowledging that information relating to your treatment, i.e.: therapy notes, may be communicated to your primary care doctor, your Insurance and Behavioral health company, EAP, and your referral source. If you received behavioral health care in the past you will contact that provider and have the records sent to A New Dawn Psychotherapy Associates (ANDPA). You have the right to have your records released to other agencies as you specify in writing. Your signature acknowledges that you are in agreement that you may be contacted at the end of services by calls or letters for satisfaction and follow-up.

2. CONSENT FOR TREATMENT: I agree to participate in behavioral health care services offered by ANDPA. I understand that I am consenting & agreeing only to those services that the provider is qualified to practice. If the patient is under the age of (18) or unable to consent to treatment, I attest that I have legal custody of this individual & that I am authorized to initiate & consent for treatment and /or legally authorized to initiate consent to treatment on behalf of this individual.

3. AFTER HOURS COVERAGE: If you have a personal emergency after hours or a crisis arises, please call 610-861-8779 and we will direct you to the appropriate level of care for assistance. If a true life threatening emergency occurs, please call 911 or report to the closest emergency room. Follow the crisis plan developed with your therapist to manage your symptoms as you are able to.

4. HIPAA: I am aware that Health Insurance Portability and Accountability Act (HIPAA) information regarding the privacy of my health information has been made available to me.

ONLY VALID FOR ONE YEAR FROM THE DATE IT IS SIGNED

Client Signature	Print Name	Date
Client Signature (If couples)	Print Name	Date
Parent Signature (If client under 14)	Print Name	Date

A New Dawn Psychotherapy Associates, LLC
308 East Broad Street
Bethlehem, PA 18018
Phone/ 610-861-8779
Fax/ 610-861-4677
www.anewdawnpa.com

Client Name: _____

Date of Birth: _____

Date of Plan: _____

Client Bill of Rights

You have the right to:

- Be treated with respect and dignity.
- Have your privacy protected in a confidential manner.
- Develop a plan of care and services which meets your unique needs.
- Participate in decisions regarding your mental health care.
- Receive services in an easily accessible location.
- Request information about names, locations, phone numbers, and languages for local agencies.
- Receive the amount and duration of services you need.
- Receive age and culturally appropriate services.
- Understand available treatment options and alternatives.
- Receive care which does not discriminate against you.
- Be free of any sexual exploitation or harassment.
- Have the opportunity to make an advance directive which states your choices and preferences for mental health care.
- Receive quality services that are medically necessary.
- Choose a mental health care provider or choose one for your child who is under fourteen years of age.
- Should you have a concern our Clinical Director, Rana Dimmig, MSS, MLSP, LCSW, can be reached at: 610-861-8779 if you believe your rights have been violated.

You have the responsibility to:

- Provide the information needed for your care.
- Understand your mental health.
- Follow the plans for care that you have agreed to with your doctor or therapist.

ONLY VALID FOR ONE YEAR FROM THE DATE IT IS SIGNED

Client Signature	Print Name	Date
Client Signature (If couples)	Print Name	Date
Parent Signature (If client under 14)	Print Name	Date

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Fax/ 610-861-4677
www.anewdawnpa.com

Revised 4/15/18

Client Name: _____

Date of Birth: _____

Date of Plan: _____

Communication Preferences

I hereby authorize **A New Dawn Psychotherapy Associates LLC** to communicate with me in the selected ways. Any methods of communication below I have checked may be used by A New Dawn Psychotherapy Associates LLC to communicate with me regarding information pertaining to my appointments and treatment. I understand that A New Dawn Psychotherapy Associates LLC is committed to maintaining my privacy and will only leave messages containing protected health information if I have indicated my approval below. I am aware that Health Insurance Portability and Accountability Act (HIPAA) information regarding the privacy of my health information has been made available to me.

Please indicate all that apply

☐ Home Phone _____ May leave voicemail? ____ Yes ____ No

☐ Cell Phone _____ May leave voicemail? ____ Yes ____ No

☐ Work Phone _____ May leave voicemail? ____ Yes ____ No

☐ Email Address _____

Please indicate which is your preferred method for appointment reminders:
☐ Text Message ☐ Email ☐ Phone Call ☐ Prefer not to receive appointment reminders ☐ Remind both parents

Please list any other communication preferences: _____

Social Media Policy: As part of our commitment to maintaining your privacy, A New Dawn Psychotherapy Associates, LLC, maintains a policy whereby our therapists will not use Social Media to contact you. We request that you not request to connect with our therapists via Social Media. While reviews on websites are welcome. We do not require or recommend that you provide such reviews on any platform. Please remember that submitting reviews of a therapist or our practice may expose your involvement in services at our agency without us disclosing it. A New Dawn Psychotherapy Associates, LLC, will never disclose, nor allow the publication, of any client data online. If you have concerns regarding this policy, please contact Rana Dimmig, MSS, MLSP, LCSW at 610-861-8779 or rana@anewdawnpa.com.

ONLY VALID FOR ONE YEAR FROM THE DATE IT IS SIGNED

Client Signature	Print Name	Date
Client Signature (If couples)	Print Name	Date
Parent Signature (If client under 14)	Print Name	Date

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Client Name: _____

Date of Birth: _____

Date of Plan: _____

Insurance Release Of Information Authorization Form

Health Insurance/Behavioral Health Company: _____

Employee Assistance Program: _____

I hereby authorize A New Dawn Psychotherapy Associates LLC to disclose, release, or obtain records from the listed parties above for the purpose of coordination of my care, billing, and payment. A New Dawn Psychotherapy Associates LLC may communicate regarding information pertaining to my assessment, treatment, notes, medication, admission, discharge, social history, school data, treatment progress for the purpose of evaluation treatment and continuity of care. I understand that confidentiality will be waived if mandated by law or to prevent a clear and present danger to myself and/or another. I am aware that Health Insurance Portability and Accountability Act (HIPAA) information regarding the privacy of my health information has been made available to me.

1. APPOINTMENTS AND CANCELLATIONS: Therapy sessions are generally 45-60 minutes long based on your insurance, you acknowledge and agree to the office policy that **therapy appointments missed or cancelled with less than 24-hours notice will be billed directly to you at $50.00 per appointment.** This fee is due immediately & future sessions will not be scheduled until the fee is paid in full. INSURANCE COMPANIES DO NOT PAY FOR MISSED APPOINTMENTS
2. PAYMENT AND INSURANCE: **Co-pays, deductibles & payment of services must be made at each session.** We will submit a bill to insurances that we participate with, but you are ultimately responsible for payment if the claim is denied or your insurance is terminated. **Your signature below authorizes the insurance company to directly pay ANDPA. You understand that you are financially responsible for all charges, regardless of insurance coverage.** There is a $40.00 Return Check Fee for insufficient funds paid to A New Dawn Psychotherapy Associates. I acknowledge that non-payment of a balance may result in the use of a collection agency/legal action; I acknowledge any fees associated with collection costs, legal fees, attorney fees, magistrate fees & court costs will be my responsibility as the client. I acknowledge that in the event ANDPA must take action with a collection agency and/or magistrate that I waive confidentiality in order for ANDPA to collect all costs owed to them for services that are provided to me. The only information released is the client's name, type of services provided and the total amount due including collection costs.
3. REPORTS AND MEDICAL RECORDS: Report preparation is not covered by an insurance company. Report preparation is paid by the client prior to the report being completed. Reports include the following: reports for court, disability forms, FMLA, custody evaluations, social security, education, immigration evaluations, progress reports, etc.
4. MEDICAID CLIENTS: **Medicaid clients will never be billed for missed appointment fees or copayments.** Please make sure to maintain consistent coverage. Issues with coverage will be communicated when noted by A New Dawn Psychotherapy Associates.

ONLY VALID FOR ONE YEAR FROM THE DATE IT IS SIGNED

Client Signature	Print Name	Date
Client Signature (If couples)	Print Name	Date
Parent Signature (If client under 14)	Print Name	Date

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308 East Broad Street
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Client Name: _____

Date of Birth: _____

Today's Date: _____

Physician Release/Request Of Information Authorization Form

By completing and signing this form, I/We authorize A New Dawn Psychotherapy Associates, LLC to release/ request protected information pertaining to my clinical record for the purpose of treatment planning or continued treatment from the contact listed below. I/We understand that a letter will be sent to my primary care provider to inform them of my enrollment in services at A New Dawn Psychotherapy Associates, LLC.

Name of Primary Care Doctor: _____

Name of Primary Practice: _____

Addresss: _____

City, State, Zip: _____

Phone: _____ Fax: _____

PLEASE CHECK OFF THE INFORMATION TO BE RELEASED/REQUESTED:

- ☐ Treatment Plan
- ☐ Discharge Summary
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Complete Medical Record of Any Part Thereof
- ☐ School Records
- ☐ Progress Reports
- ☐ Recommendations
- ☐ Verbal Communication
- ☐ Other_____

I/We understand that in order to protect the confidentiality of my records under HIPAA, I only agree to the release of information form to the party listed above, and will be effective only 1 year from the date signed. I/We also understand that this authorization can be revoked (except to the extent that action has been taken) at any time by dated, written communication to A New Dawn Psychotherapy Associates, LLC. Refusal to sign this form will not impact my treatment.

ONLY VALID FOR ONE YEAR FROM THE DATE IT IS SIGNED

Client Signature Print Name Date

Client Signature (If couples) Print Name Date

Parent Signature (If client under 14) Print Name Date

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.