Patient Name: _____

Date Of Birth: _____ Today's Date: _____

CONSENT FOR COURT ORDERED THERAPY AND FINANCIAL CONTRACT

1. CONFIDENTIALITY: Court ordered therapy differs with regards to confidentiality. While generally, all content explored in sessions remains confidential, a court order generally includes some type of reporting expectation, either to the court, to the attorneys, or to a third party named. ANDPA must comply with the reporting expectation in the court order and all parties must acknowledge that there is no right to confidentiality when services have been court ordered. Additionally, any reports of intent to harm self or others and reports of abuse must be reported in accordance with state and federal laws.
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. APPOINTMENTS AND CANCELLATIONS: Therapy sessions are generally 45-60 minutes. 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.
4. PAYMENT AND INSURANCE: **Payment of services must be made at each session.** We do not bill insurance for court ordered services. All fees are payable by the individual(s) engaged in therapy. Payment is due in full before the start of each session, regardless of your personal attendance (i.e. a child's individual appointment). All agreements about splitting the costs of sessions must be made between the parties. We do not negotiate payment arrangements. **You understand that you are financially responsible for all charges.** 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.
5. 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. Report fees are $125 per hour, based on the amount of time it is estimated that the report will take to complete.
6. COURT TESTIMONY: Court testimony requires a subpoena no less that seven (7) days prior to the requested date, and payment of a non-refundable court testimony fee of $1250 due no less than (7) days prior to the requested date. Your therapist must reserve the entire day for court testimony and ANDPA is unable to refund monies for continuances and cancelled court dates. Testimony by phone requires prepayment of $125 per hour reserved and a subpoena no less than seven (7) days prior to the requested date. Any additional time required not pre-arranged will be billed at $250 per hour. Either party may issue a subpoena for testimony.
7. AFTER HOURS COVERAGE: If you have a personal emergency after hours or a crisis arises, the voicemail at 610-861-8779 will direct you to an emergency number to call for assistance.

_____

Patient Signature (14 and older) Date

_____

Patient Signature (14 and older) Date

_____

Parent/Guardian Signature (Under 18) Date

_____

Parent/Guardian Signature (Under 18) 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

Patient Name: _____

Date Of Birth: _____ Today's Date: _____

Informed Consent and Receipt of Privacy Policies

Dear Parent/Guardian:

Your child _____ has been referred for the following mental health services at our practice. 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.

_____	_____	_____
Relationship (Parent/Guardian 1)	Print Name (1)	Date
_____	Attorney Involvement: _____ _____	_____
Client/Responsible Party Signature (1)	Yes No	Contact Phone
_____	_____	_____
Relationship (Parent/Guardian 2)	Print Name (2)	Date
_____	Attorney Involvement: _____ _____	_____
Client/Responsible Party Signature (2)	Yes No	Contact Phone

OFFICIAL USE ONLY:
Administrative Staff that made the call: _____ Date: _____

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

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

Patient Name: _____

Date Of Birth: _____ Today's Date: _____

CONSENT FOR COMMUNICATION/ RELEASE OF INFORMATION

I hereby authorize A New Dawn Psychotherapy Associates LLC to disclose, release, or obtain records from the following parties below for the purpose of coordination of my care. Any parties below I have checked and 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.

Place an (X) next to all that apply (please include address/phone if available)
THIS CONSENT WILL REMAIN IN EFFECT FOR ONE YEAR FROM THE DATE SIGNED.

( ) Health Insurance/Behavioral Health Company _____

( ) Employee Assistance Program _____

( ) Primary Care Physician_____ Address/City_____

PCP Phone number_____ Fax Number_____

( ) Psychiatrist _____ Address/City_____

Psychiatrist Phone number_____ Fax Number_____

( ) School District_____

( ) Spouse/Significant Other_____

( ) Family Member (child, husband, wife, parent)_____

( ) Lawyer_____

( ) Other_____

_____

Patient Signature (14 and older) Date

_____

Patient Signature (14 and older) Date

_____

Parent/Guardian Signature (Under 18) Date

_____

Parent/Guardian Signature (Under 18) Date

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308 East Broad Street
Bethlehem, PA 18018
Phone/ 610-861-8779
Fax/ 610-861-4677
www.anewdawnpa.com

Patient Name: _____

Date Of Birth: _____ Today's Date: _____

Patient 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.

_____

Patient Signature (14 and older) Date

_____

Patient Signature (14 and older) Date

_____

Parent/Guardian Signature (Under 18) Date

_____

Parent/Guardian Signature (Under 18) Date

Patient/Parent/Guardian Refused to Sign: _____

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Patient Name: _____

Date Of Birth: _____ Today's Date: _____

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.

Place an (X) next to 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 ( ) I 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.

_____

Patient Signature (14 and older) Date

_____

Patient Signature (14 and older) Date

_____

Parent/Guardian Signature (Under 18) Date

_____

Parent/Guardian Signature (Under 18) Date

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Patient Name: _____

Date Of Birth: _____ Today's Date: _____

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 as per a court order.

Court Information:

County _____ Docket Number _____

Assigned Master _____ Assigned Judge _____

Address _____ Phone _____

City _____ State _____ ZIP _____ FAX _____

Plaintiff's Attorney:

Name of Contact _____

Address _____ Phone _____

City _____ State _____ ZIP _____ FAX _____

Defendant's Attorney:

Name of Contact _____

Address _____ Phone _____

City _____ State _____ ZIP _____ FAX _____

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. This release 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.

_____

Patient Signature (14 and older) **Date**

_____

Patient Signature (14 and older) **Date**

_____

Parent/Guardian Signature (Under 18) **Date**

_____

Parent/Guardian Signature (Under 18) **Date**

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