Welcome to New Day Counseling and Psychiatric Services, Inc.

What you can expect from New Day Counseling and Psychiatric Services, Inc. (New Day):

- **Informed Consent**: You have the right to make informed decisions about your care and will be provided information about the services that you receive, as well as, those services that may be recommended. You have the right to refuse any recommended service and to discontinue a service at any time. You have the right to ask for a different service provider if you are not comfortable with the assigned provider.

- **Confidentiality**: Your personal information will be protected by New Day according to federal and state law. No information will be released without your written consent, except in the following situations:
  - A danger of harm to yourself and /or others is present; including possible child/elder abuse/neglect
  - The client is a minor –A non-residential parent of a child is entitled to access, under the same terms and conditions as the residential parent, to any record that is related to the child and to which the residential parent of the child legally is provided access, unless the court determines that it would not be in the best interest of the child for the non-residential parent to have this access. **If such a court order exists, <u>it is the responsibility of the residential parent to provide a copy of the order to the agency</u>. If a court order is not provided, the non-residential parent will <u>not</u> be denied access.**
  - Audits and Compliance Reasons - Your record may be accessible to any of the following: mental health and recovery services board auditors, funding source auditors, and authorized agency personnel, for the purpose of ensuring that quality care is provided to you and that the services provided are in compliance with accrediting entities, funding sources (including insurance companies) and professional standards.
  - Confidentiality of substance abuse information in client records is maintained in accordance with 42 CFR Part 2. A written copy of the statute is available upon request.

What New Day Counseling and Psychiatric Services, Inc. (New Day) expects from you:

- Regular attendance at scheduled appointments.
- Cancellation of appointments 24 hours in advance.
  *** A $25.00 fee will be charged for appointments that are cancelled less than 24 hours in advance.
- Payment at the time of service, unless other payment arrangements are made.
- Participation of your parents/guardians/family when determined necessary by you and your treatment provider.
- Reports of increase in symptoms and thoughts of harm to self and/or others.
- Notification of changes in your income, insurance, living situations, etc.

Clinical Services Consent for Treatment

Benefits and Risks of Treatment:
The recovery process has many benefits, which may include an improved quality of life, improved decision-making skills, enhanced ability to function on a daily basis, and an increased sense of well-being. However, you may also experience a temporary increase in uncomfortable feelings, and in some cases, changes in your personal relationships can occur.

Discontinuation of Services:
The agency reserves the right to discontinue services for reasons such as:

- Treatment goals have been met to your satisfaction.
- Not making an attempt to pay the agreed on fee.
- Canceling or failing to show for 2 appointments without a valid reason.
- Physical aggression or verbal threat to other clients/persons on the premises of New Day or to New Day staff members.
- Refusing to be an active participant in the treatment process.

By signing below, I verify that I have read the above Consent for Treatment guidelines and agree to them as stated, and that I have been given copies of the *Clinical Services Consent for Treatment* and the *Client Rights and Grievance Procedures booklet.* These documents contain the *Notice of Privacy Practices for Healthcare Providers,* a summary of *42 CFR part 2,* and program rules and expectations. I am also authorizing New Day Counseling and Psychiatric Services of Stark County, Inc. to evaluate and treat myself and/or _____, for whom I claim legal responsibility as parent/guardian, for both mental health services and alcohol or other drug related services.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Staff Signature Date

Refusal to Consent:
I refuse to consent to treatment. I understand that my refusal to consent means that treatment, including the diagnostic assessment, will not be provided to me.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Staff Signature Date

New Day Counseling
& Psychiatric Services, Inc

Client / Guardian Financial Responsibility

All appointments must be kept (on time) or canceled at least 24 hours in advance. Failure to do so will result in a $25 cancellation fee. Clients should arrive at least 5 to 10 minutes prior to scheduled appointment. Insurance information must be provided at the initial visit. All status changes must be given to the billing office immediately (changes in address, phone number, employment, insurance and dependents).

FEES
The initial counseling session and a diagnostic assessment are $150 per hour. The initial med-som session and a diagnostic assessment are $200 per hour. Our counseling basis fee thereafter is $110 per counseling session (based on a 50-minute time frame per session). Our med-som basis fee thereafter is $50 per session (based on a 15-minute time frame per session). Should your session exceed the established time frame per session you will be billed accordingly.

FEE PAYMENT
Payment of determined fee is to be made at each visit. We are aware that circumstances exist that may prohibit a full payment and we will be glad to work with you if you bring this to our attention. If you do not attempt to make payment after two sessions, our services may be suspended.

INSURANCE
All insurance is processed through our office. The initial counseling appointment is a diagnostic assessment and the charge is $150 per hour for up to two hours. A fee of $110 per counseling session is charged thereafter. The initial med-som appointment is a diagnostic assessment and the charge is $200 per hour for up to two hours. A fee of $50 per med-som session is charged thereafter. Depending on the insurance provider involved, payment may be none, partial or 100%. The client is responsible for any amount not covered by their insurance provider. Clients will be reimbursed for any overpayment.

If the client has insurance coverage and neglects to submit proper paperwork to New Day, then the client becomes responsible for the full amount due.

Should you have questions regarding any of the above, please feel free to talk with a representative in our Billing Department. All information remains confidential. We are glad to be of service to you and look forward to your visits.

By signing below I indicate that I understand my financial responsibility regarding services provide by New Day Counseling and Psychiatric Services, Inc.

_____

Client / Guardian Signature *Date*

CLINICAL RECORD **NEW DAY COUNSELING AND PSYCHIATRIC SERVICES, INC.**
Client Questionnaire

Client Name:_____ Date Completed:_____

Please help New Day get to know you (or your child) by completing this questionnaire.

Provide a Brief Description of Why You (or your child) are Seeking Services (symptoms and problems, when they started, who referred you, etc.) _____

_____

_____

_____

Describe What Goals and Expectations You (or your child) Have for Treatment (what you want to gain from services, how long you expect it to take, etc.) _____

_____

_____

_____

Psychosocial Checklist (Check all the problem areas that apply)

_____ nutritional/eating pattern changes/disorders
_____ impulsivity
_____ relationship/family difficulties
_____ inattention
_____ depressed mood/sad
_____ substance use/addictions
_____ bereavement/grief issues
_____ other addictive behavior
_____ anxiety
_____ sleep problems
_____ traumatic stress
_____ legal problems
_____ anger/aggression
_____ employment problems
_____ oppositional behavior
_____ school problems
_____ mood swings/hyperactivity
_____ housing problems

Explain problems checked above and provide any additional information that may assist us in helping you (or your child).

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you!

HEALTH HISTORY QUESTIONNAIRE

This form should be completed as fully as possible by client but reviewed by medical or clinical staff.

Client Name (First, MI, Last)	**Client No.**	**Age**

Has the client had any of the following health problems?

	Now	**Past**	**Never**	**What Treatment Received and Date(s)**
Anemia				
Arthritis				
Asthma				
Bleeding Disorder				
Blood Pressure (high or low)				
Bone/Joint Problems				
Cancer				
Cirrhosis/Liver Disease				
Diabetes				
Epilepsy/Seizures				
Eye Disease/Blindness				
Fibromyalgia/Muscle Pain				
Glaucoma				
Headaches				
Head Injury/Brain Tumor				
Hearing Problems/Deafness				
Heart Disease				
Hepatitis/Jaundice				
Kidney Disease				
Lung Disease				
Menstrual Pain				
Oral Health/Dental				
Stomach/Bowel Problems				
Stroke				
Thyroid				
Tuberculosis				
AIDS/HIV				
Sexual Transmitted Disease				
Learning Problems				
Speech Problems				
Anxiety				
Bipolar Disorder				
Depression				
Eating Disorder				
Hyperactivity/ADD				
Schizophrenia				
Sexual Problems				
Sleep Disorder				
Suicide Attempts/Thoughts				
Other:				
Other:				

Please note family history of any of the above conditions and client's relationship to that family member.

Client Name (First, MI, Last)	**Client No.**

Has client had medical hospitalizations/surgical procedures in the last 3 years?

☐ No ☐ Yes If yes, complete information below.

Hospital	City	Date	Reason

☐ None **Allergies/Drug Sensitivities**

☐ Food (specify):

☐ Medicine (specify):

☐ Other (specify):

☐ Not Pertinent **Pregnancy History**

Currently pregnant? If yes, expected delivery date. ☐ No ☐ Yes	**Receiving pre-natal healthcare?** If yes, indicate provider. ☐ No ☐ Yes
Last Menstrual Period Date	**Any significant pregnancy history?** If yes, explain. ☐ No ☐ Yes

Last Physical Examination

By Whom	**Date**	**Phone No.** (if known)

Has client had any of the following symptoms in the past 60 days? Please check.

☐ Ankle Swelling	☐ Coughing	☐ Lightheadedness	☐ Penile Discharge	☐ Urination Difficulty
☐ Bed-wetting	☐ Cramps	☐ Memory Problems	☐ Pulse Irregularity	☐ Vaginal Discharge
☐ Blood in Stool	☐ Diarrhea	☐ Mole/Wart Changes	☐ Seizures	☐ Vision Changes
☐ Breathing Difficulty	☐ Dizziness	☐ Muscle Weakness	☐ Shakiness	☐ Vomiting
☐ Chest Pain	☐ Falling	☐ Nervousness	☐ Sleep Problems	☐ Other:
☐ Confusion	☐ Gait Unsteadiness	☐ Nosebleeds	☐ Sweats (night)	
☐ Consciousness Loss	☐ Hair Change	☐ Numbness	☐ Tingling in Arms & Legs	☐ Other:
☐ Constipation	☐ Hearing Loss	☐ Panic Attacks	☐ Tremor	

☐ Not Applicable **Immunizations** (required for child or MR/DD only)

Immunizations - Has client had or been immunized for the following diseases? Please check.

☐ Chicken Pox	☐ Diphtheria	☐ German Measles	☐ Hepatitis B	☐ Measles
☐ Mumps	☐ Polio	☐ Small Pox	☐ Tetanus	☐ Other:

Immunizations Within the Past Year

Height/Weight

Height	**If reporting for a child, has height changed in the past year?** ☐ No ☐ Yes If yes, by how much (+ or -)?
Weight	**Has client's weight changed in the past year?** ☐ No ☐ Yes If yes, by how much (+ or -)?

Client Name (First, MI, Last)	**Client No.**

Nutritional Screening (please check)

☐ No Problem	**Eating** ☐ More ☐ Less ☐ Not Eating	**Drinking** ☐ More ☐ Less ☐ Takes Liquids Only	**Appetite** ☐ Increased ☐ Decreased

☐ Nausea ☐ Vomiting ☐ Trouble Chewing or Swallowing

Special Diet	**Other**

Pain Screening

Does pain currently interfere with your activities? If yes, how much does it interfere with these activities (please check)
☐ No ☐ Yes ☐ Not at All ☐ Mildly ☐ Moderately ☐ Severely ☐ Extremely

Please indicate the source of the pain.

Substance Use History/Current Use (please check appropriate columns)

Substance	No Use	Past Use	Current Use	**Substance**	No Use	Past Use	Current Use	**Substance**	No Use	Past Use	Current Use
Alcohol/Beer/Wine				Sleep Medication				Cocaine/Crack			
Marijuana				Tranquilizers				Heroin			
Hashish				Hallucinogens				Pain Medication			
Stimulants				Inhalants				Other:			

Caffeine use? If yes, form (coffee, tea, pop, etc.) ☐ No ☐ Yes	**How much a week** (cups, bottles)**?**
Tobacco use? If yes, form (cigarettes, cigars, smokeless, etc.) ☐ No ☐ Yes	**How much a week** (packs, etc.)**?**

Print Name of Person Completing this Questionnaire	**Signature of Person Completing this Questionnaire**	**Date**

Clinician Reviewer Comment if any

☐ Medical Review Needed

Provider Signature/Credentials	**Date**

Comments, Recommendations, or Referrals by Medical Reviewer ☐ No Referral Needed

Check Referral(s) Needed and Specify Action(s)

☐ Primary Care Physician: _____

☐ Healthcare Agency: _____

☐ Specialty Care: _____

☐ Other (specify): _____

Recommendations shared with client?
☐ No ☐ Yes If yes, client's response.

If no, how will recommendations be shared with client?

Medical Reviewer Signature/Credentials (Nurse, PA, NP, MD, DO)	**Date**

4450 Belden Village Street N.W. • Canton, Ohio 44718 • 330-305-9696

I, _____ _____
CLIENT NAME (PLEASE PRINT) DATE OF BIRTH

OR

I, _____legal guardian for_____
LEGAL GUARDIAN (PLEASE PRINT) CLIENT NAME (PLEASE PRINT)

Hereby give New Day Counseling and Psychiatric Services, Inc. permission to discuss personal medical information for the above named client with the following individual(s):

NAME	DATE of BIRTH	RELATIONSHIP TO CLIENT
NAME	DATE of BIRTH	RELATIONSHIP TO CLIENT
NAME	DATE of BIRTH	RELATIONSHIP TO CLIENT
NAME	DATE of BIRTH	RELATIONSHIP TO CLIENT

I understand that the information that my be discussed includes, but is not limited to: My health history, Diagnostic results, Plan of care, and Medical financial information unless otherwise restricted here:

_____

_____

I understand that this authorization will remain in effect until terminated by myself in writing.

_____ _____
CLIENT / LEGAL GUARDIAN SIGNATURE SIGNATURE DATE