A New Day Counseling & Education Services, LLC
New Client Information

Welcome to A New Day Counseling & Education Services, LLC

It is our goal that you see A New Day as a place where you can accomplish goals through therapy, education, or both. A New Day is a safe place, a place where you can feel free to openly share, learn, grow, and heal. If at any time you have any questions, comments or concerns, you are encouraged to discuss them with your therapist, instructor, or any other member of our staff.

Please take the time to review the information below, as you may find it beneficial as a client of A New Day Counseling & Education Services, LLC.

APPOINTMENTS

Appointments at A New Day are generally set by our scheduler. You can contact our office at 317-884-5750 to schedule an appointment. We generally have someone available to answer the office telephone. In the event that we cannot immediately take your call, please leave a detailed message and we will return your call at our earliest opportunity. There are times when it may be more convenient for you, or your therapist, if the therapist schedules your appointment instead of our scheduler. This is perfectly acceptable. A New Day makes every possible effort to schedule your therapy appointments to meet your specific needs. If the situation arises where a suitable appointment time cannot be arrived at through conventional measures, your therapist and our scheduler will work with you to obtain a suitable time for your therapy appointment.

Education clients (PRIME for Life, etc.) generally work with the instructor to arrive at a class time that will suit their needs. It is important for these clients to remember that if a referral source is involved, the class time and length may be determined by that referral source.

CANCELLATIONS

We at A New Day understand that there are times when life happens and you cannot make a scheduled appointment. If you must cancel an appointment, we ask that you provide us with a minimum of twenty-four hours notice. A fee of forty-dollars will be assessed for any appointment canceled without twenty-four hours notice. A cancelation with the minimum of twenty-four hours notice will not be assessed a fee. Please note that it is our goal for you to make every appointment. Missed appointments can disrupt the therapy process.
Cancelations due to inclement weather will be dealt with on a case by case basis.
Late cancellations, missed appointments or failure to contact your therapist can result in services being terminated. Unfortunately, services will be terminated following the third incident. Please make every effort to stay in contact with your therapist, she or he is here to assist you.

PAYMENT

Full payment is expected before each therapy session. If we file an insurance claim for you, the full co-pay is expected before each session. If we do not know how much your insurance will pay, we expect you to pay 50% of the session charge until a determination has been received from your insurance provider. If we have not been reimbursed by your insurance provider within ninety days, the full amount due is expected from you. Any overpayment will be applied toward future sessions or refunded at your request. If circumstances prevent you from paying as requested; please contact our office to make arrangements. Please note: PRIME for Life clients are expected to pay the full class fee before the beginning of the first class.

Welcome!

A New Day Counseling & Education Services, LLC

Client Information

Patient ID
DX

Client Identifying Information

Date: ____/____/____ Last Name:_____ First Name:_____ M.I. _____

Address: _____ City: _____ State: ____ Zip: _____

Social Security Number: _____ Date of Birth: ___/___/___ Age: _____ Sex: _____

Home Telephone: _____ Cell: _____ Work Telephone: _____

Do we have permission to leave messages at your ❑Home ❑Cell ❑Work ❑No messages please

Email (optional): _____ What is your preferred method of contact? _____

Primary Care Physician: _____ Primary Care Physician Telephone: _____

Occupation: _____ Employer: _____ Education Level: _____

Marital Status: _____ Do you attend Church? _____ If so, where? _____

Name(s) and Age(s) of Children: _____

Spouse/Guardian Information

Last Name: _____ First Name: _____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____ Contact Telephone: _____

Social Security Number: _____ Date of Birth: ___/___/___ Age: _____ Sex: _____

Marital Status: _____ Education Level: _____ Relationship to client: _____

I hereby give permission for evaluation and treatment by A New Day Counseling & Education Services, LLC. I agree to pay for all services provided by this office and will pay for such services at the time they are rendered. If this is impossible, I will speak with my therapist to make arrangements for payment. If payment is not made as agreed, this office may take all legal action necessary to collect this debt. I agree to pay for any action necessary to collect this money, including collection fees, filing and service fees, attorney's fees and post judgment fees. I hereby request all third party payments be sent directly to the provider and agree to pay any portion of the fee not covered by insurance. ***I understand that I will be charged a fee of forty dollars for any appointment canceled with less than twenty-four hours notice. I further acknowledge that A New Day Counseling & Education Services, LLC may terminate my treatment if I cancel without twenty-four hours notice three times within a calendar year period.*** I also understand that as a service to me, for use in crisis or emergency situations, I have access to emergency numbers. If my call is handled by an A New Day Counseling & Education Services, LLC therapist I will be billed in fifteen-minute increments of my full fee.

Client/Parent/Guardian/Responsible Party signature: _____

Date: ____/____/____

A New Day Counseling and Education Services, LLC
Child-Adolescent Personal History

IDENTIFYING INFORMATION

Name: _____ Age: _____ Sex: M❑ F❑ Date of Birth: ___/___/___

Address: _____ City: _____State: _____ Zip Code: _____

Parent/Gaurdian Name: _____ Telephone: _____ Cell: _____

Religious Affiliation: (optional)

_____

What brings the child-adolescent to A New Day Counseling and Education Services, LLC? _____

_____

_____

_____

How long has this issue been a part of the child-adolescent's life?

_____

Do you (parent/guardian) perceive these problems to be: ❑Very Serious ❑Serious ❑Not Serious ❑Not Sure

What are your current expectations of your child-adolescent?

_____

What changes would you like to see in your child-adolescent?

_____

What changes would you like to see in yourself?

_____

What changes would you like to see in your family?

_____

FAMILY

The child-adolescent currently lives with: (check all that apply) ❑Mother ❑Father ❑Step Mother ❑Step Father

❑Brother(s) (Names, ages) _____

❑Step Brother(s) (Names, ages) _____

❑Sister(s) (Names, ages) _____

❑Step Sister(s) (Names, ages) _____

❑Cousin(s) (Names, ages, sex) _____

❑Grandmother ❑Grandfather ❑Step Grandmother ❑Step Grandfather ❑Aunt ❑Uncle ❑Other

If there is further information concerning your child-adolescent's home situation that you would like to share, or if you checked other, please explain: _____

_____

_____

Is the child-adolescent adopted? ❑Yes ❑No Age when the child-adolescent was first in the home: _____

What has the child-adolescent been told?

_____

_____

_____

How many times has the child-adolescent moved? ____ Has the child-adolescent ever lived away from home?

❑Yes ❑No

If yes (lived away from home), please explain:

_____

What are the major family stressors at the present time, if any? _____

_____

Does the child-adolescent have a family history containing drug and/or alcohol abuse? ❑Yes ❑No ❑Not sure

If yes, please explain:

_____

Does the child-adolescent have a family history of depression, anxiety, or other mental health issues? ❑Yes ❑No

If so, explain:_____

Has the child-adolescent had any major illnesses or injuries? ❑Yes ❑No ❑Not sure If so, explain: _____

_____

Is the child-adolescent currently taking any medication? ❑Yes ❑No If so, what: _____

_____

SOCIAL DEVELOPMENT

Does the child-adolescent attend school regularly? ❑Yes ❑No

Does the child-adolescent appear motivated for school? ❑Yes ❑No

Has the child-adolescent ever been suspended or expelled from school? ❑Yes ❑No

Does the child-adolescent have any specific learning difficulties? ❑Yes ❑No

Does the child-adolescent participate in extracurricular activities? ❑Yes ❑No (explain) _____

In school, how many friends does the child-adolescent have? ❑A lot ❑ A few ❑A Couple ❑None

What are the child-adolescents educational aspirations? ❑Quit school ❑Graduate High School ❑College ❑Not sure

What are the child-adolescents special interests, or hobbies?

_____

What is the child-adolescents current grade level in school? _____

Is there anything that you would like your child-adolescent's therapist to know, or be aware of? _____

_____

_____

_____

_____

_____

A New Day Counseling & Education Services, LLC
Insurance Disclosure & Consent for Release

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: ____/____/___ Sex: _____

Primary Insurance Carrier: _____ Member ID Number: _____

Group/Plan Number: _____ Insurance Provider Telephone: _____

Secondary Insurance Carrier: _____ Member ID Number: _____

Group/Plan Number: _____ Insurance Provider Telephone: _____

Primary Care Physician: _____Primary Care Physician Telephone: _____

Responsible Party Name: _____ Date of Birth: _____/_____/_____

Responsible Party Address: _____

I verify the above information to be correct to the best of my knowledge and by signing this document I agree that if I do not disclose all insurance coverage information I can be held responsible for all charges incurred.

Insured Signature: _____ Date: ____/____/____

Consent for Release of Confidential Information
Insurance Provider(s) & Primary Care Physician

I understand that the information shared is to be related only to and used for my counseling at A New Day Counseling & Education Services, LLC. I understand that the information shared includes my treatment goals, participation in services, progress/barriers to successful completion of goals, and other matters related to my mental/physical health.
I understand that I may revoke this consent at any time by notifying the administrator in writing.
I understand that this consent is valid for one year (365 Days) after the date of consent. However, I willingly and voluntarily authorize this consent to remain in force until I am discharged from services at A New Day Counseling & Education Services, LLC.

_____ ___/___/____
Client Signature (Parent/Guardian if under 18) Date

_____ ___/___/____
Witness Signature Date

NOTICE TO RECIPIENT OF INFORMATION: Information has been disclosed to you from records whose confidentiality is protected by federal and/or Indiana laws and regulations. Such laws prohibit you from making further disclosure of the information without specific written consent of the person to whom the information pertains or as otherwise permitted by such laws and regulations. The information is intended only for the use of the individual(s) or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, or distribution of this information is strictly prohibited.