Anew Perspective, Inc.
6201 W. Main Street, Suite 120
Maryville, IL. 62062
Phone: (618) 977-6252|(618) 208-1690
Fax: (618) 772-7200
www.anewperspectiveinc.com

Welcome to Anew Perspective!

Please fill out this intake packet as it pertains to the client being seen for services. Pardon the length of this form. However, the nature of our services necessitates detailed coverage of our policies and procedures. Be sure to let the therapist working with your family know if you would like clarification or have questions about the terms outlined in this document.

Thank you!

CLIENT INFORMATION:

Today's Date: _____
Client's First Name: _____ Client's Last Name: _____
Birthday: _____ Age: _____ Gender: _____
Marital Status: _____
Address: _____
State: _____ Zip code: _____
Phone: _____
E-mail: _____

I authorize Anew Perspective, Inc. to provide the following (please circle one):

Send mail to the address listed above	YES	NO
Leave voice messages on the phone listed above	YES	NO
Leave text messages on the cell phone listed above	YES	NO
Send e-mail to the e-mail address listed above	YES	NO

Guardian Information (if client is under 18 years old):

Guardian's First Name: _____ Last Name: _____
Address: _____
State: _____ Zip code: _____
Phone: _____
E-mail: _____
Relationship to Client: _____

EMPLOYMENT INFORMATION:

Occupation/Title: _____
Place of Employment: _____

For Students (if enrolled in school):
School: _____
City: _____ State: _____
Grade/Year in School: _____

EMERGENCY CONTACT:
Name: _____ Relationship: _____
Address: _____
Phone: _____

REFERRAL SOURCE:
How did you hear about us (please circle one)?

Facebook Psychology Today Physician/Psychiatrist Website Friend/Family Member

Name of Referral Source: _____

INSURED/RESPONSIBLE PARTY INFORMATION:
All items in this section must be completed in order to bill your insurance for services. If you are Private Pay, please write N/A and skip to the next section.

Policy Holder Information:
Policy Holder's Full Name: _____
Policy Holder's Address: _____
Policy Holder's Phone: _____
Policy Holder's Date of Birth: _____
Relationship to Client: _____

Insurance Provider Information:
Insurance Company: _____
Insurance I.D. Number: _____
Insurance Group Number: _____
Mental/Behavioral Health Phone (1-800 number on back of card): _____

COORDINATION OF TREATMENT:
It is important that all healthcare providers work together to provide the best care possible to you. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. *If you prefer to decline consent, no information will be shared with your provider.*

Check One: _____ You may inform my **PHYSICIAN and PSYCHIATRIST**
_____ I decline to inform my **PHYSICIAN and PSYCHIATRIST**

Primary Care Physician's Name: _____
Address: _____
Phone: _____

Psychiatrist's Name: _____
Address: _____
Phone: _____

_____ _____
Client Signature (12 years and older) Date

_____ _____
Guardian Signature Date

PRESENTING PROBLEM AND TREATMENT HISTORY:
Presenting Problem and Current Symptoms:
_____
_____
_____

Please list any previous counseling, outpatient treatment, substance abuse treatment, or psychiatric hospitalizations (include approximate dates, facilities, and therapists):
_____
_____
_____

Significant Medical History:
_____
_____
_____

Please list all prescription and non-prescription medications taken (include dosages, time of day taken, and prescribing physician):
_____
_____
_____

Do you take your medication as prescribed (please circle one)? YES NO N/A

LIFE EVENTS/STRESSORS:

Please check all significant life events/stressors that you have experienced within the past year:

___ End of Relationship	___ Divorce/Separation	___ Recent Move
___ Marriage/Commitment	___ Substance Abuse	___ Job Change
___ Employment/School Pressure	___ Major Illness	___ Legal Issue
___ Trauma	___Financial	___ Other

If other, please explain: _____

PSYCHIATRIC QUESTTIONNAIRE (please circle one):

Have you ever attempted to end your life?	YES	NO	N/A
Do you currently have a plan to harm yourself or end your life?	YES	NO	N/A
Do you have a history of self-harm (i.e. cutting, burning, etc.)?	YES	NO	N/A
Do you have a family history of suicide?	YES	NO	N/A
Do you ever think about hurting or killing others?	YES	NO	N/A
Do you have a plan to harm someone else?	YES	NO	N/A
Have you ever been diagnosed with a psychiatric disorder?	YES	NO	N/A
Do you have a family history of mental health concerns?	YES	NO	N/A

If you answered yes to any of the questions above, please elaborate further:

_____

_____

_____

TREATMENT AND INSURANCE AUTHORIZATION:

I hereby authorize treatment deemed necessary by Anew Perspective, Inc. I authorize Anew Perspective, Inc. to release my health plan and any information necessary regarding my treatment to insure prompt payment of all charges for services rendered. I hereby assign the payment for all insurance benefits to Anew Perspective, Inc. for all charges incurred in connection with services provided to me. Additionally, I consent to a copy of this authorization be used in place of the original copy.

I understand that I remain responsible to pay Anew Perspective, Inc. for all charges not reimbursed by either my insurance provider and/or Employee Assistance Program. Payment shall be due at the time of service/appointment. Furthermore, I understand Anew Perspective does not offer refunds for any reason, including but not limited to, my dissatisfaction with any therapy sessions, written reports, outcome of legal proceeding or recommendations provided by my therapist.

_____ _____

Client Signature (12 years and older) Date

_____ _____

Guardian Signature Date

CREDIT CARD AUTHORIZATION AGREEMENT:

I authorize Anew Perspective, Inc. to keep my signature, credit card information, and physical copy of credit card on file for the following:

- Charges for services rendered; including, but not limited to outstanding copays, coinsurance, or deductible amounts not covered in full by the insurance source.
- Charges for missed appointments and those not cancelled within 24 hours.
- I understand that if I do not remit payment in full on the date services are rendered or come back processed through insurance, 20% of the original charge will be added each week I am late. If Anew Perspective exercises its right to use a collection agency and/or file suit to collect fees past due, we will collect 100% for all fees incurred from the collection agency, attorneys and the Court. This may involve hiring a collection agency or going through a small claims court, which will require us to disclose information to the third-party collection agency such as personal information including your name, address, phone number, services rendered and/or amount due.

Cardholder's Name: _____

Cardholder's Address: _____

City: _____ State: _____ Zip code: _____

Payment Method (please circle one): Visa Master Card Discover American Express

Account Number: _____

Expiration Date: _____ CVV Code: _____

_____ _____

Client Signature (12 years and older) Date

_____ _____

Guardian Signature Date

FEES NOT COVERED BY INSURANCE:

The following fees are not covered by major insurance plans. Should you have a need for the following service(s), the charges incurred will be considered "out of pocket" expenses:

Clinical Phone Consultation:

60 Minutes	$125.00
45 Minutes	$95.00
30 Minutes	$65.00
15 Minutes	$35.00

Private Pay Therapy Sessions:

60 Minutes (EMDR Therapy)	$150.00
60 Minutes (Psychotherapy)	$125.00
60 Minutes (Co-Parenting Therapy)	$200.00
60 Minutes (Reunification Therapy)	$200.00

Records Preparation and Court Appearance:

Medical Records Preparation	$30.00/15 min. increment of time
Report Preparation	$30.00/15 min. increment of time
Court Appearance Retainer/Hourly Fee	$700.00 retainer
	$350.00 per hour (not incl. travel)

IMPORTANT INFORMATION REGARDING COURT-RELATED SERVICES:

The therapists at Anew Perspective cannot provide legal advice. Therefore, the professional services provided should in no way be construed as legal services or giving legal advice.

1. None of the services or educational materials provided, including parenting plans/custody services, and/or any written materials created should be construed as legal advice or legal information.
2. No service provided by the therapists at Anew Perspective, whether written or verbal, constitutes legal advice/information. Therefore, the court-related services provided should not, in any way, be construed as legal services, legal advice or the practice of law.
3. Health insurance does not cover the cost of therapy services that are court-ordered or done for a legal purpose, as insurers may distinguish these from services that are "medically necessary."
4. All other services not covered above including letters, email (reading and responding), telephone consultation, etc. are billed at the hourly rate of Anew Perspective.
5. Collateral Time-reviewing documents, reading emails, phone calls to parents, guardians or collaterals is all considered "billable time."
6. Any retainers/holding fees paid in advance for Court appearances, depositions, etc. are non-refundable deposits.

_____ _____

Client Signature (12 years and older) Date

_____ _____

Guardian Signature Date

GENERAL INFORMATION

This document is intended to be informational: what you can expect, Anew Perspective Inc. policies, State and Federal Laws regarding treatment, and your rights and responsibilities as a client.

APPOINTMENTS:
Each scheduled appointment time will last 45-60 minutes. The professional hour deemed by most major insurance companies allows for 45-minute sessions.

OFFICE HOURS:
Office hours are by appointment only. You may reach the office by phone at (618) 208-1690 or (618) 977-6252 to schedule an appointment. If we are unavailable, you may leave a message on our voicemail and a staff member will return your call as soon as possible. **If you are having a psychiatric emergency, please call 911 or go to your nearest Emergency Room.**

INSURANCE/FINANCIAL OBLIGATION:
Anew Perspective, Inc. will bill your respective insurance company for services provided. Ultimately, you are responsible to be knowledgeable about your coverage and benefits. You will be responsible for any remaining balances or sessions not covered by insurance. All co-pays are due at the time services are rendered. If you have not met your deductible, the full fee is due per session until the deductible is met.

NO SHOW AND LATE CANCELLATION POLICY:
It is our policy that you contact our office within 24 hours of your appointment time if you are unable to attend your scheduled appointment. If you do not show for you appointment or cancel in less than 24 hours' notice, a no show/late cancellation fee of **$125.00** may be charged for the missed appointment. This cost is not covered by insurance and will be your responsibility to pay prior to the next scheduled appointment. If you accrue two "no-shows" or late cancellations in a row, we reserve the right to remove any future appointments you have from the schedule.

We understand that 'life happens' and not all appointments can be cancelled within 24 hours. We ask that you respect our time and give us as much notice as possible to reschedule.

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:
Anew Perspective, Inc. collects specific information about you to provide you with the necessary services you need. The information we collect about your mental and physical health is considered "private," and is protected by state and federal law. This information is referred to as "Protected Health Information" or "PHI." This notice educates you on the ways that we may use this information, to whom/how we share it, and your rights regarding your PHI:

- **Treatment-**A doctor or nurse you are seeing may need to consult with your therapist to provide the best care.
- **Payment-**Our billing company may need to provide information to your health insurance company so that we are able to access payment for our services.
- **Healthcare Operations-**We may use information in your record to review the quality of our care.

You have the following rights regarding PHI:

- The right to request restrictions on certain uses and disclosures of PHI.
- The right to receive confidential communication.
- The right to inspect, copy and amend PHI.

COVID-19 DISCLAIMER:

By requesting services from Anew Perspective, Inc., you acknowledge the following:

1. Anew Perspective cannot guarantee that you will not become infected with COVID-19.
2. You understand the risk of becoming exposed to and/or infected with COVID-19. You voluntarily seek services provided by Anew Perspective and acknowledge that you are increasing your risk of exposure to COVID-19.
3. You hereby release and agree to hold Anew Perspective, Inc. harmless from, and waive on behalf of yourself any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to yourself. You understand that this release discharges Anew Perspective, Inc. from any liability or claim that you may have against the office with respect to injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from Anew Perspective, Inc.

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

If an emergency arises in which you feel immediate attention is necessary, you are instructed to contact 911 or proceed to the nearest Emergency Room for assistance. **Your therapist is not on-call.** Nevertheless, your therapist will follow-up with emergency services utilized with standard support and/or counseling thereafter.

Verbal communication and clinical records are confidential, except for scenarios covered in the Notice of Privacy Practices. Please note that confidentiality cannot be guaranteed if you use electronic communication with therapists, including e-mail, instant messaging, social media, and text messaging.

As mental health providers, our therapists are required by law to report allegations of abuse or neglect, and this reporting must not be interpreted as a display of support for the individual who made the allegations or against the person being accused, or as an indication that the therapist finds the allegations credible.

Recording devices are prohibited, under all circumstances. If you fail to comply with this stipulation, services will be terminated immediately.

I have reviewed, received a copy of and agree to Anew Perspective, Inc.'s General Information document outlining the following: appointments, office hours, insurance/financial obligations, no show and late cancellation policy, informed consent, and the Notice of Privacy Practices and client rights.

_____ _____

Client Signature (12 years and older) Date

_____ _____

Guardian Signature Date