



1850 Lee Road, Suite 116, Winter Park, FL 32789 • Phone 407-644-8588 • Fax 407-644-8184

CLIENT INFORMATION

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Can we contact you at this email address? Yes No

Can we email New Leaf Center newsletters and special events at this email address? Yes No

Date of Birth _____ Age _____ Soc. Sec. Number _____

Relationship Status Single Married Divorced Life Partner Significant Other
 Other _____ Spouse/Partner Name _____

Who referred you to this office? _____

Reason for referral _____

Employer _____ Occupation _____

Business phone _____ May we contact you at work? Yes No

Person responsible for account _____ Relationship _____

Address (if different from above) _____

City _____ State _____ Zip _____ Home Phone _____

List the names and ages of those currently residing in your household in addition to yourself:

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Emergency Contact _____ Relationship _____

Address _____

Home Phone _____ Work Phone _____

PAYMENT POLICY

1. Fees are due and payable at the time services are rendered.
2. A \$25.00 service fee will be charged for all returned checks.
3. Failed appointments or cancellations with less than 48 hours notice will be billed at full rate.
4. Additional fees may be charged for long distance telephone calls, telephone consultations, or compilation of reports or records.
5. Information relating to appointment dates and fees may be released to a third party for the purpose of collecting delinquent accounts.
6. The New Leaf Center does not accept insurance assignments.

I understand the above policy and request the services of The New Leaf Center.

Client Signature _____ Date _____



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CLIENT MEDICAL HISTORY

Name _____ Date of Birth _____ Sex M F

Have you ever been diagnosed or treated for any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Nephritis |
| <input type="checkbox"/> Asthma, Hay Fever | <input type="checkbox"/> Nervous or Mental Disorder |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Peptic Ulcer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Chorea (St. Vitis Dance) | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Poliomyelitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Drug Allergies | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Fractured Bones or Serious Injuries | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Other (Please specify) _____ |
| <input type="checkbox"/> Hypertension | _____ |
| <input type="checkbox"/> Malaria | _____ |

Please describe any yes responses, including dates of diagnosis or treatment: _____

Any other serious conditions which have required treatment: _____

MEDICATIONS

Do you take prescription or over-the-counter medications regularly?
(include vitamins, tonics, sleeping aids, etc.) Yes No

If yes, please describe: _____



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CLIENT MEDICAL HISTORY – PAGE 2

Name _____

Have you ever received outpatient or inpatient counseling or therapy services? Yes No

If yes, please describe including dates _____

Describe your past and current use of alcohol and/or drugs _____

SLEEP -- Do you usually sleep well? Yes No

Do you often have difficulty getting to sleep? Yes No

How would you describe your usual sleep? Deep Moderate Light

Do you often wake up during the night or have difficulty getting back to sleep? Yes No

How often do you take sleeping medication?

Never Rarely Once per week or more Several times a month

STRESS -- Check the box which best describes the stress in the following areas of your life:

Job None Low Medium High

Home None Low Medium High

Finances None Low Medium High

Relationships None Low Medium High

Have you ever taken tranquilizers or other sedatives for as long as a week? Yes No

Have you ever been treated by a psychiatrist for anxiety or depression? Yes No

Please note any additional comments or health matters of concern to you _____

Client Signature _____ Date _____



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CLIENT INFORMED CONSENT

- I have chosen to receive outpatient psychotherapy services through The New Leaf Center, Inc. My choice is voluntary and I understand that I may terminate therapy at any time.
- I understand that successful psychotherapy is a cooperative effort between myself and my therapist. I will work with my therapist in a cooperative manner to resolve my difficulties.
- I understand that during the course of my psychotherapy, material may be discussed which will be upsetting in nature and that this may be necessary to help resolve my problems.
- I understand that confidentiality of records and information collected about me will be held or released in accordance with state or federal laws regarding confidentiality of such records and information.
- I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others.
- I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or the elderly and *suspected* abuse or neglect of minors or the elderly.
- I understand the basic rights of individuals who undergo treatment through The New Leaf Center, Inc. These rights include:
 1. The right to be informed of the various steps and activities involved in receiving services.
 2. The right to confidentiality under federal and state laws relating to the receipt of services.
 3. The right to humane care and protection from harm, abuse or neglect.
 4. The right to make an informed decision whether to accept or refuse treatment.
- I understand it is my responsibility to keep my appointments and be on time. I understand that I will be billed for a full session if I am late, and that I will be billed for a full session if I cancel an appointment with less than 48 hours notice, and if I fail to show for a scheduled appointment.
- I understand that The New Leaf Center, Inc. does not accept insurance assignments, and that psychotherapy fees are due when services are rendered, unless other arrangements are made. Payment may be made by cash, check, MasterCard, or Visa.

I have read and understand the above, and have received a copy of Client Orientation and Information.

Client Printed Name

Client Signature

Date



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CLIENT ORIENTATION & INFORMATION

Statement of Confidentiality: The confidentiality of patient records maintained by The New Leaf Center is protected by Federal law and regulations. The program may not say to a person outside the program that a client attends the program, or disclose any information identifying the client UNLESS:

1. The client consents in writing;
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a client either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about actual or suspected child or elderly abuse or neglect from being reported under State law to appropriate State or local authorities. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations.)

If a client fails to comply with payment policies and it becomes necessary to refer a client's account to a collection agency, the only information provided to the collection agency is dates of service and fees. No clinical, diagnostic, or protected health information is disclosed.

Services provided: The NewLeafCenter is an outpatient counseling center offering services for substance abuse and mental health treatment to adults. Services include individual and group counseling, as well as assessment and referral resources to offer clients the best options for their needs. If it is determined appropriate for a client to be admitted into the program at The New Leaf Center, the client will participate in individual counseling (50 minutes one-on-one) or group counseling (one and one-half hour sessions). The treatment program includes counseling, educational sessions, and reading and/or written assignments. The treatment planning process will guide clients in following the best therapeutic plan for their needs and to meet certain guidelines, such as legal system requirements. Treatment services will be provided to substance abuse clients under the supervision of a qualified supervisor.

Admission Criteria: A client will be recommended for admission to The New Leaf Center when it has been determined through the assessment process that the services offered through The New Leaf Center program will provide assistance to the client in meeting their needs. The client will be informed of the recommendations and overall treatment plan, and the time and cost commitment that these recommendations will require. The client has the right to decline any recommendations provided by the counselor or staff of The New Leaf Center.

CLIENT ORIENTATION & INFORMATION – PAGE 2

Discharge Criteria: When it is determined that a client has attained maximum benefit from the program at The New Leaf Center, discharge planning will be initiated. Plans will include involvement in support systems appropriate for the client's ongoing needs and will include The New Leaf Center as a resource as needed for additional support or referral to other appropriate resources. Discharge planning will also be initiated if it appears that client is no longer willing to participate in the program at The New Leaf Center, or if client fails to meet treatment plan objectives or legal requirements. Appropriate referral sources will be offered whenever possible. If a client is court ordered to the program at The New Leaf Center, the court will be notified prior to discharge.

Client's Rights

1. You have the right to considerate and respectful treatment.
2. You have the right to refuse treatment and to know what the consequences will be if you do so.
3. You have the right to a safe and private environment. Participation in the program at The New Leaf Center is confidential.
4. You have the right to participate in the development of your treatment plan.
5. You have the right to expect a reasonable response to appropriate requests.
6. You have the right to know the cost details of your treatment.
7. You have the right to obtain complete and current information concerning your diagnosis and treatment process.
8. You have the right to expect continuity of care.
9. You have the right to anonymity during and after your time in treatment.
10. You have the right to file a grievance about any possible violation of your rights.

Program Rules

1. Use, possession, or dealing of alcohol or illicit drugs is not tolerated in or around the center.
2. No physical violence, or threats of physical violence, verbal or otherwise, is tolerated toward the members of the staff or other clients.
3. No abusive language, disruptive behavior, or overt sexual conduct is allowed in or around the center.
4. No weapons are permitted on the premises.
5. No acts of vandalism to the property, staff, or clients is tolerated.
6. Clients and staff are expected to dress and behave in a manner that expresses respect and consideration for the rights and property of others.

Client Grievance Procedure

1. Report grievance to Executive Director of the program.
2. Executive Director will gather information pertinent to the grievance and will offer resolutions to correct the problem and prevent its recurrence. Client's input will be included in this process and client will be informed of all options available. The NewLeafCenter will not discourage or prevent a client from contacting the Department of Children and Family Services.

Procedure for reporting abuse, neglect, and exploitation: All actual or suspected cases of abuse, including incest, neglect, and exploitation of minors or the elderly will be reported to the county social services. If a counselor suspects that abuse, incest, neglect, or exploitation may be involved with a client at The New Leaf Center, the client will be informed of these suspicions and all attempts will be made to offer help and support to the family. An oral report will be made immediately to the local welfare agency and a written report will be made within three days. Clients may also report suspected abuse, neglect, or exploitation through the DCF Hot Line at 1-800-96-ABUSE.

DCF Substance Abuse and Mental Health Program Office: 407-245-0420
Local Florida Advocacy Council: 800-342-0825

CLIENT ORIENTATION & INFORMATION – PAGE 3

Exposure Control: If any staff, volunteers, or clients are exposed to infectious diseases, they will be notified of such exposure and advised to seek medical care as soon as possible.

Procedures for reporting communicable diseases: Communicable diseases must be reported to the Health Department within 48 hours and, in some cases, must be phoned in immediately. The Health Department prefers that all cases are phoned in, rather than sending a written report. On the following list, some phone numbers are given for a specific disease; if not, the number to use is 407-244-2680. Name, address, date of onset, date of birth, race, and sex are to be provided. (T) - Report immediately by telephone. (H) - Cases in animals to be reported only if associated with a human case.

List of Communicable Diseases that must be reported

AIDS	Meningitis
Amebiasis	Aseptic
Animal Bite (of humans only by a potentially rabid animal) 244-2634	Meningococcal
Anthrax (T) (H)	Haemophilus Influenza
Botulism (T)	Strep, Group B
Brucellosis (H)	Other Bacterial
Campylobacteriosis (H)	Meningococcal Disease
Chancroid 244-2670	Mumps 244-2614
Dengue Fever	Paralytic Shellfish Poisoning (T)
Diphtheria (T) 244-2614	Pertussis 244-2614
Encephalitis	Pesticide Poisoning
Eastern Equine	Plague (T)
St. Louis	Poliomyelitis (T) 244-2614
Post-infectious	Psittacosis
Other	Rabies 244-2634
Giardiasis (acute) (H)	Relapsing Fever (T)
Gonorrhea 244-2670	Rocky Mountain Spotted Fever (R. Rickettsia)
Granuloma Inguinale 244-2670	Rubella (including congenital) 244-2614
Hansen's Disease (Leprosy)	Salmonellosis (H)
Hemorrhagic Fevers (T)	Schistosomiasis
Hepatitis:	Shigellosis
Hepatitis A	Smallpox (T)
Hepatitis B	Syphilis 244-2670
Hepatitis Non-A, Non-B (assoc. w/blood, blood products)	Tetanus 244-2614
Hepatitis Non-A, Non-B (not assoc. w/blood, blood products)	Toxoplasmosis (acute)
Hepatitis, unspecified	Trichinosis (H)
Histoplasmosis	Tuberculosis 244-2648
Legionnaire's Disease	Tularemia (H)
Leptospirosis (H)	Typhoid Fever
Lymphogranuloma Venereum 244-2670	Typhus (T)
Malaria	Vibrio Cholera (T)
Measles (T) 244-2614	Vibrio Infections
	Yellow Fever (T)
	Any disease outbreak (community, hospital, or other institution, or foodborne/waterborne)