NEW DIRECTIONS
COUNSELING SERVICES, LLC
WEXFORD • ROBINSON

Psychiatric Intake Information – Child

Child's Name: _____ Date of Birth: _____ SS#: _____
Child's Address: _____
_____
With whom does the child reside? _____
Name of person completing this form: _____ Relationship to child:_____

Guardian's Name:_____ DOB: _____ Relationship to child:_____
❑ Address same as child's or _____
Email Address: _____ Okay to contact via email? ❑ yes ❑ no
Cell: _____Okay to leave voicemail? ❑ yes ❑ no Okay to text? ❑ yes ❑ no
Home: _____Okay to leave voicemail? ❑ yes ❑ no
Work: _____Okay to leave voicemail? ❑ yes ❑ no

Guardian's Name:_____ DOB: _____ Relationship to child:_____
❑ Address same as child's or _____
Email Address: _____ Okay to contact via email? ❑ yes ❑ no
Cell: _____Okay to leave voicemail? ❑ yes ❑ no Okay to text? ❑ yes ❑ no
Home: _____Okay to leave voicemail? ❑ yes ❑ no
Work: _____Okay to leave voicemail? ❑ yes ❑ no

Other Legal Guardian's (e.g., step-parent's) Name, Address, and Phone: _____
_____
Names of other adults residing with child: _____

Emergency Contact:
Name: _____ Phone: _____ Relationship: _____

Preferred Pharmacy:
Name: _____ Address: _____ Phone: _____

Insurance Company: _____ Phone: _____
Name & DOB of PRIMARY Subscriber: _____DOB: _____
Employer: _____ Group #: _____ ID #: _____
Medicare Secondary Insurance ID#:_____ Group#:_____

Referral Information (How were you referred to our practice?)**:**
❑ Professional referral from a clinician or facility (Name: _____)
❑ Personal referral from a family member or friend (Name: _____)

Referral Information (cont.):

❑ Internet search (specify): ❑ Google ❑ Yahoo ❑ Facebook ❑ Bing ❑ Other _____
❑ Previous client returning for services (Previous provider: _____)
❑ Other (specify): _____

We may recommend that the child participate in **counseling services** in addition to receiving treatment and/or medications from our psychiatric providers. Please indicate the level of interest in counseling services:
❑ Currently receiving counseling services ❑ Very interested ❑ Somewhat interested ❑ Not interested

Are you aware that we offer **nutrition services** at our practice? A dietitian can help with many health and wellness challenges including, but not limited to, weight management, disordered eating, disease management, and hormonal imbalances. Our staff dietitians are available to help make desired lifestyle changes.
Are you interested in learning more about our **nutrition services** for the child? ❑ Yes ❑ No

Treatment Information:

What are the primary concerns and symptoms?

1.
2.
3.

When did the symptoms start?: _____
What (if anything) triggered the symptoms: _____

Chief Complaints (check all that apply):

❑ Depression ❑ Anxiety ❑ Panic Attacks ❑ Mood Swings ❑ Memory Issues
❑ Pain ❑ Anger ❑ Attention/Concentration ❑ Drugs/Alcohol
❑ Headaches ❑ Other: _____

Please check if the child is experiencing /feeling any of the following:

❑ Mood Swings ❑ Feeling Depressed ❑ Anxious
❑ Angry/Irritable ❑ Crying ❑ Nightmares
❑ Fatigue ❑ Decreased Appetite ❑ Low Self-Esteem
❑ Social Isolation ❑ Negative Thoughts ❑ Suicidal Thoughts
❑ Feeling Worthless ❑ Loss of Interests/Motivation ❑ Feeling Hopeless/Helpless
❑ Difficulty Falling/Staying Asleep ❑ Behavior Problems ❑ **Appetite** is: ❑ normal ❑ low ❑ high

Please check and describe if the child is experiencing any of the following:

❑ Obsessions: _____
❑ Delusions: _____
❑ Paranoia: _____
❑ Hallucinations: _____
❑ Flashbacks: _____

Mood Swings (if applicable):

Has there ever been a period of time when ***the child was not their usual self and*** (check all that apply):

❑ Was much more talkative than usual ❑ Had much more energy than usual

❑ Was more social/outgoing than usual ❑ Spent excess money or got the family in trouble

❑ Did things that were unusual or that others might have thought excessive, foolish, or risky

Cognitive Symptoms:

Long-term Memory Issues: ❑ None/Intact ❑ Some impairment ❑ Serious impairment

Short-term Memory Issues: ❑ None/Intact ❑ Some impairment ❑ Serious impairment

Please check if the child is experiencing any of the following:

❑ Forgetful ❑ Problems concentrating ❑ Problems with attention

❑ Problems with organization ❑ Problems with word substitution ❑ Easily confused

❑ Problems with information processing ❑ Easily distracted ❑ Driving skills

Provide details if any of the above are checked: _____

_____

Current Stressors (check all that apply):

❑ School ❑ Relationship Issues ❑ Pain/Disability ❑ Social Issues ❑ Family Issues

❑ Work/Job ❑ Financial Issues ❑ Other: _____

History of Past Trauma/Traumatic Experiences?: ❑ no ❑ yes If yes, explain: _____

_____

List all health care practitioners from whom the child receives care (PCP, specialists, etc.):

Practitioner:	**Type of Service:**

List all medications, vitamins, and herbal preparations (prescription & over the counter):

Product name:	**Dosage:**	**Reason for taking:**	**For how long:**	**Prescribed by:**

List all medications, vitamins, and herbal preparations (cont.):

Product name:	Dosage:	Reason for taking:	For how long:	Prescribed by:

Does the child take any medications that were prescribed for someone else? ❑ no ❑ yes (If yes, what?: _____)

Drug Allergies: ❑ no ❑ yes (If yes, what drug(s): _____)
Describe the reaction(s): _____

Past Psychiatric Medications Attempted (check all that the child has taken):

❑ Prozac ❑ Zoloft ❑ Paxil ❑ Celexa ❑ Lexapro ❑ Effexor XR ❑ Viibryd
❑ Trintellix ❑ Cymbalta ❑ Pristiq ❑ Wellbutrin ❑ Remeron ❑ Pamelor ❑ Elavil
❑ Trazodone ❑ Depakote ❑ Tegretol ❑ Topomax ❑ Lamictal ❑ Lithium ❑ Risperdal
❑ Invega ❑ Latuda ❑ Zyprexa ❑ Geodon ❑ Abilify ❑ Seroquel ❑ Haldol
❑ Xanax ❑ Klonopin ❑ Ativan ❑ Valium ❑ Buspar ❑ Ambien ❑ Lunesta
❑ Restoril ❑ Ritalin ❑ Adderall ❑ Concerta ❑ Vyvanse ❑ Neurontin ❑ Strattera
❑ Fetzima ❑ Rexulti ❑ Other: _____

Side effects?: _____

How long did the child take each medication?: _____
_____

List all prior psychiatric/mental health/substance abuse treatment (in/outpatient, IOP, etc):

Practitioner/Facility:	Dates of Service:	Reason for services:	Medications prescribed:

History of suicide attempt(s)?: ❑ no ❑ yes If yes, when?: _____

Medical History (check all that apply to the child):

❑ Diabetes ❑ Asthma ❑ Hypertension ❑ Heart Disease ❑ Neurological
❑ Other: _____

Rate the child's general level of health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Extremely Poor

Please check and describe if the child has a history of any of the following (please include dates):

❑ Surgeries: _____

❑ Hospitalizations: _____

❑ History of concussion or other accident: _____

❑ Current active medical problems: _____

Is the child **pregnant**?: ❑ Yes ❑ No ❑ Maybe/Possible ❑ Not applicable

Family History of Psychiatric Illness and/or Alcohol or Drug Abuse:

Father	❑ None or describe:
Mother	❑ None or describe:
Brother(s)	❑ None or describe:
Sister(s)	❑ None or describe:
Grandparent(s)	❑ None or describe:
Aunts/Uncles/Cousins/Other	❑ None or describe:

Has anyone in the family ever been diagnosed with Bipolar Disorder?: ❑ no ❑ yes _____

Has anyone in the family ever completed suicide?: ❑ no ❑ yes _____

Developmental History:

Mother's Pregnancy:

❑ Smoked during pregnancy ❑ Drug use during pregnancy ❑ Alcohol use during pregnancy

Duration of pregnancy (weeks): _____ ❑ Complications: _____

Delivery:

Type of labor: ❑ Spontaneous ❑ Induced

Type of delivery: ❑ Normal ❑ Breech ❑ Cesarean

Complications: ❑ Cord around neck ❑ Hemorrhage ❑ Infant injury ❑ Other: _____

Duration of labor/delivery (hours): _____ Birth weight: _____

Post Delivery:

❑ Jaundice ❑ Infection ❑ Incubator care ❑ Cyanosis (blue baby)

❑ Other: _____

Infancy:

❑ Difficult to calm or comfort ❑ Colicky ❑ Excessively irritable ❑ Head banging

❑ Difficulty nursing ❑ Disturbed sleep patterns ❑ Other: _____

Were any developmental milestones delayed?: ❑ no ❑ yes If yes, explain: _____

_____

Social History:

Substance use:

Cigarette use: ❑ no ❑ yes If yes, how many per day? _____

Alcohol use: ❑ no ❑ yes If yes, what kind?_____ How much?_____ How often?_____

Illicit drug use: ❑ no ❑ yes If yes, what kind?_____ How much?_____ How often?_____

Prescription drug abuse: ❑ no ❑ yes If yes, what kind?_____ How much?_____ How often?_____

Is the child currently on Methadone or Buprenorphine? ❑ no ❑ yes

If yes, where does the child receive these services?: _____

Has the child ever had a DUI?: ❑ no ❑ yes If yes, details: _____

Do family/friends complain about the child's alcohol/drug use? ❑ no ❑ yes

If yes, please describe: _____

Level of social support from family and friends:

❑ High ❑ Moderate ❑ Low ❑ None

Please list the child's extracurricular activities and/or hobbies:

	Last enjoyed:
	Last enjoyed:
	Last enjoyed:
	Last enjoyed:
	Last enjoyed:
	Last enjoyed:

Education:

Current grade in school: _____ Name of school: _____

Average grades: ❑ A ❑ B ❑ C ❑ D ❑ F Repeated any grade? ❑ no ❑ yes If yes, which? _____

Has there been any recent change in the child's academic performance?: ❑ no ❑ yes If yes, please explain:

_____

Academic strengths: _____

Academic weaknesses: _____

Learning disability: ❑ no ❑ yes If yes, please describe: _____

Discipline problems: ❑ no ❑ yes If yes, please describe: _____

Has there ever been an IEP or 504 plan in place?: ❑ no ❑ yes If yes, which grade(s)? _____

If yes to above, the IEP is for: ❑ learning support ❑ emotional support ❑ gifted education

Employment:

❑ Employed full-time ❑ Employed part-time ❑ Not employed

Place of employment (if applicable): _____

Type of work performed (if applicable): _____

Military Service:

❑ None ❑ Current

If child has served, age of enlistment: _____

Any service related medical conditions? ❑ no ❑ yes If yes, describe: _____

Legal history:

Has the child ever had legal trouble? ❑ no ❑ yes If yes, explain: _____

Has the child ever been arrested? ❑ no ❑ yes If yes, explain: _____

❑ Past charges _____ ❑ Current charges _____

❑ Prison time If yes, provide details: _____

Is there anything else you would like the psychiatric provider to know in order to better help the child?:

_____

_____

If you cannot make your appointment, please provide at least 24 hours notice of your cancelation by calling our office at 724-934-3905. There is a $175 fee for missing a Psychiatric Evaluation.

Receipt of NPP Acknowledgement and Consent to Treatment and Fee Agreement

Child - Clinical Services

I, the undersigned, acknowledge that I have read or heard the **Notice of Privacy Practices** (NPP). This notice reminds you that during evaluation and treatment at New Directions Counseling Services, LLC, we will be collecting "protected health information" (PHI) about you. We may use or disclose your PHI for treatment, payment, and health care operations purposes with your consent. With your signature below, you are consenting to the use of your PHI for these purposes. If we make changes to our NPP, it will be updated in our waiting room and on our website, or you can get a copy from any staff member. You may revoke this authorization to use or disclose your PHI at any time, but you must do so in writing. If we have already relied on this authorization, we cannot change that, and third party insurers have a right to contest this claim.

I, the undersigned, further acknowledge that I have read or heard the **Treatment and Fee Agreement - Clinical Services** (Agreement), I fully understand the Agreement, and I intend to abide by the Agreement. If I pay for services with third party benefits, I authorize New Directions Counseling Services, LLC to release any and all information necessary to obtain authorization and/or payment for services. I understand that if I am responsible for any part of the payment for services, it is due on the date of service. I acknowledge that I have been given the opportunity to ask questions about the Agreement with a representative of New Directions Counseling Services, LLC. I acknowledge that New Directions Counseling Services, LLC reserves the right to make changes to this Agreement with 30 days' notice.

I seek and consent to actively participate in treatment at New Directions Counseling Services, LLC:

_____	_____	_____
Printed Name of Minor Child	**Signature of Minor Child (*optional*)**	**Date of Receipt**

I consent to my child's participation in treatment at New Directions Counseling Services, LLC, and I certify that I have legal custody and authority to make decisions regarding the care and treatment of this Minor Child:

_____	_____	_____
Printed Name of Parent/Legal Guardian	**Signature of Parent/Legal Guardian**	**Date of Receipt**
_____	_____	_____
Printed Name of Parent/Legal Guardian	**Signature of Parent/Legal Guardian**	**Date of Receipt**

Email Consent:

I consent to receive correspondence from New Directions Counseling Services, LLC by email:

- ❑ NO
- ❑ YES Email Address: _____
  Client name associated with email: _____

Text Consent:

I consent to receive correspondence from New Directions Counseling Services, LLC by text:

- ❑ NO
- ❑ YES Mobile Phone Number: _____
  Mobile Phone Service Provider (e.g., Verizon): _____
  (Text reminders are not available for Cricket or Mobile PCS Phones)

Consent to Communication with Primary Care Provider

Most health insurance companies and managed care organizations request that our office have communication with your Primary Care Physician's (PCP) office for the purposes of coordination of care and of meeting quality assurance standards. This communication typically includes date of first contact, diagnostic information, medications, and treatment recommendations. You have the option of declining to provide your consent for communication between our office and your PCP's office.

If you would like to ***grant consent*** for our office to release information to your PCP's office, please print your name, sign and date below, and please provide your PCP's name and address where indicated:

Consent granted for:

_____	_____	_____
Printed Name of Client	**Signature of Client/Legal Guardian**	**Date**

Name and address of PCP:

_____

_____

_____

_____

Phone and Fax of PCP: _____

If you prefer to ***deny consent*** for our office to release information to your PCP's office, please print your name, sign and date below:

Consent denied for:

_____	_____	_____
Printed Name of Client	**Signature of Client/Legal Guardian**	**Date**

Credit Card Authorization

PLEASE PRINT INFORMATION CLEARLY:

Credit Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration Date: **Month** ___ ___ **Year** ___ ___ ___ ___

CVV Code (back of card): ___ ___ ___

Type of Card: ❑ **Credit** ❑ **Debit** ❑ **Health Savings/Flexible Spending Account**

Name and Address associated with Card:

_____

_____

_____

_____

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY:

I authorize New Directions Counseling Services, LLC to apply charges to the card listed above under any of the following circumstances:

- At the time of participation in services for the expected amount of an appointment fee to be applied to a health insurance deductible.
- At the time of participation in services for the portion of each appointment fee for which I am responsible including self-pay fees, health insurance copayment amounts and health insurance coinsurance amounts.
- After violation of the practice's cancellation policy requiring payment of a fee for a ***late cancelation or missed appointment*** per the practice's Consent to Treatment and Fee Agreement.

I am aware that New Directions Counseling Services, LLC will be unable to notify me before processing this card on file and that my card may be charged at any time at the discretion of New Directions Counseling Services, LLC for the reasons listed above.

_____ _____ _____

Printed Name of Client **Signature of Client/Legal Guardian** **Date**

Treatment and Fee Agreement - Clinical Services

PLEASE REVIEW THIS INFORMATION CAREFULLY AND TAKE IT WITH YOU FOR FUTURE REFERENCE.

At New Directions Counseling Services, LLC (NDCS) our aim is to nurture transformation and foster sustainable well-being for individuals and families. We are a heart-centered practice dedicated to helping our clients create positive, life-altering changes through traditional and alternative health care solutions. Our team is focused on building connections and providing personalized care for each client.

Financial Information for Clinical Services:

Fees for Services

Initial Evaluation Psychotherapy	$200
Individual Therapy Session	$175
Couples or Family Therapy Session	$160
Group Therapy Session	$60
Psychiatric Diagnostic Evaluation	$300
Psychiatric Follow-Up Visit	$100-$200

Additional fees may be incurred for phone consultations and/or for time spent producing requested reports or completing requested documents (e.g., letters for school or work, worker's compensation or disability claims).

Payment for Services

If you have a health insurance policy or some other type of third-party benefits that you would like to utilize to pay for services, you must notify us prior to or at your initial appointment. Please be aware that if you use a third-party to pay for services, we must provide some of your protected health information to the payor to process claims for services rendered. Our office will verify your benefits and submit claims directly to your benefits carrier. ***Please be aware that you assume ultimate responsibility for knowing the specific coverage provided by your benefits, including coverage limitations, and service authorization requirements.***

Payment is due at the time services are delivered (e.g., self-payments, copayments). For psychotherapy services, please be prepared to provide payment to your therapist for the amount of each session's fee that is your responsibility including copayments. Your therapist will notify you of the amount for which you are responsible. Patients maintain financial responsibility for any claims denied by their third-party benefits carrier and for any checks sent directly to a patient by their third party benefits carrier.

If for any reason a check is returned to us by a financial institution due to insufficient funds, it will be necessary for you to pay us the amount of the original check plus a **$25 returned check fee**. Additional fees may be incurred from your financial institution for which NDCS does not maintain responsibility.

If you accumulate a balance of more than $100, you will be required to make payment to reduce your account balance before you can schedule additional appointments at our practice.

Any account with an outstanding balance more than 90 days past due, without a payment arrangement approved by our office, will be sent to a Collections Agency. In these situations, you (the client) agree to reimburse New Directions Counseling Services, LLC for the amount of the fees of any Collections Agency (initially 33% of the total debt and over time up to 50% of the debt), and all costs and expenses (including reasonable attorneys' fees) that New Directions Counseling Services, LLC incurs in such collection efforts.

Credit Card Policy

We require a valid credit card on file at all times if your insurance plan has a deductible, if you are paying for our services without the use of third-party benefits (i.e., self-pay), or if you are receiving services with a psychiatric provider. There is a Credit Card Authorization form included with this packet for you to complete if we require a credit card on file at this time. We will charge your credit card at the following times:

- When you are using third party benefits to pay for our services and you have a deductible, we will charge your credit card *after each visit at our practice* for your benefits carrier's contracted rate that we anticipate will be applied to your deductible.
    - Please note that a refund will be issued to your credit card if the charges we have applied exceed the amount of your health insurance deductible.
- At each appointment if you are self-pay.
- At each appointment with a psychiatric services provider for any copayment or coinsurance payment amounts due.
- Any time you have outstanding copayment or co-insurance payment amounts due for psychotherapy services.

After violation of the practice's cancellation policy for the fee associated with a ***late cancelation or missed appointment*** (as defined below).

Late Cancelation and Missed Appointment Policy

If you need to cancel a scheduled appointment, you are required to provide us with 24 hours advance notice. The only exceptions are for emergency situations when advance notice is not possible. Cancellations made with less than 24 hours' notice or no notice (missed appointments), will be assessed the following fees:

Psychotherapy Appointment	$75
Psychotherapy Diagnostic Evaluation	$175
Psychiatric Follow-Up Appointment	$100

Such late cancellation or missed session fees cannot be reimbursed to any extent through third party benefits, and you will be responsible for this fee. Please note that text and email reminders are provided as a courtesy, and we cannot guarantee delivery of these reminders. It is your responsibility to manage your appointments and provide notice at least 24 hours in advance.

General Information about Clinical Services:

Initial evaluations for therapy and psychiatry are 60 minutes in length. Follow-up therapy sessions are typically 45-60 minutes in length and follow-up psychiatric appointments are 20 minutes in length. Please arrive on time for your appointments, as we are not able to extend appointments due to late arrivals. We will also make every effort to begin your appointments at their designated times, but if a clinician begins an appointment late you will get the benefit of the full treatment time. You must check in at the administration window for all psychiatric appointments.

Out of consideration for other patients, ***if you arrive late by ten minutes or more for a psychiatric follow-up visit then your appointment will be rescheduled and a missed appointment fee (see Financial Information below) will be assessed***.

Treatment at NDCS may include evaluation, assessment, setting treatment goals, psychotherapy, and prescription of psychotropic medications. The methods, techniques, and therapeutic approaches used for treatment will vary by provider, and you have the right to ask for information about the approach to treatment being used with you at any time.

You have the right to get a second opinion or to terminate treatment at any time. If you are considering terminating treatment, we suggest that you discuss your decision with your treatment provider before making a final decision so that your provider can provide referrals or make other suggestions to ensure you get the care you need. Please note that if you terminate treatment, you must pay for the services you have already received.

Your treatment provider at NDCS also reserves the right to terminate treatment due to lack of progress with treatment goals, consistent failure to comply with treatment recommendations, or failure to attend or pay for appointments. Every effort will be made to discuss such treatment concerns with you before services are discontinued.

All providers at NDCS follow the ethics code for the professional association with which they are a member. All providers also adhere to all applicable federal and state laws governing the provision of psychiatric, psychological, and psychotherapeutic services including our Privacy Practices.

Although we can make no promises as to the results of treatment, we strive to provide the highest quality services at NDCS, and we hope that you are satisfied with the care that you receive here. During or after treatment, you may be asked for your perceptions of the treatment you are receiving or have received here. If you have any suggestions or concerns regarding the services that we provide, please contact our Clinical Director, Dr. Michael Schneider, by phone at 724-934-3905x30 or by email at mschneider@newdirectionspgh.com.

Information specific to Psychiatric Services

If you receive treatment with one of our psychiatric providers, a main aspect of your care will involve prescription of psychotropic medications. Such medications can cause side effects which will be explained to you during your appointment. You have the right to accept or refuse treatment with the use of psychotropic medications. You are responsible for taking prescribed medications according to the dose and schedule prescribed by your provider.

Medications will only be prescribed at scheduled appointments. If a prescription is lost, misplaced, stolen, or finished sooner than prescribed, your prescription will not be replaced until the appropriate time as determined by the psychiatric services provider.

Medication refills are not provided between appointments. There may be rare exceptions to this policy at the discretion of the psychiatric services provider, and a **$25 fee** may be required before a refill will be forwarded to your pharmacy.

Confidentiality of Clinical Services

In order to protect your confidentiality, we adhere to the following procedures:

1. Inquiries about you made in person, in writing, or by telephone will not be acknowledged by any of our staff members without your authorization. You must sign our Authorization to Release Information form before any information about you will be given to any party outside New Directions Counseling Services, LLC, unless it meets the exception criteria outlined below in sections two and three.
2. Pennsylvania state law requires exceptions to confidentiality including but not limited to:
    a. If you express a serious threat or intent to kill or seriously injure yourself or an identifiable person or persons.
    b. If we have reasonable cause to suspect abuse or neglect of a child or vulnerable adult.
    c. When we are required to do so by legal order of a court.
3. New Directions Counseling Services, LLC is a group practice and providers at the practice share administrative resources. This means that other providers at the practice may have indirect access to your information (e.g., your name). On occasion, your provider may also engage in collaboration or consultation with other providers at the practice with the aim of providing the highest quality treatment to you. Further, your clinical record may be utilized by more than one treatment provider in the event that you are receiving treatment with our therapeutic and/or psychiatric practitioners. Our administrative staff members also have access to your information strictly for administrative purposes. All clinical and administrative staff members adhere to our Privacy Practices.

Regarding sections two and three above, providers will, whenever possible, inform you of their intent to share information with a third party. If you express thoughts about harming yourself or someone else, every effort will be made to resolve the issue through treatment before information is released to an outside party.

Limitations of Clinical Services:

NDCS is an outpatient practice and thus we are not able to provide 24-hour care. Therefore, appropriate referrals are given to individuals in need of more intensive treatment, such as but not limited to in-patient detoxification, in-patient treatment, intensive outpatient treatment, or a partial treatment program. We conduct an initial evaluation to determine if you need help with immediate safety concerns and to determine if we have the skills and resources to provide you with the therapeutic support that you need. If services are requested or needed that are beyond the scope of our competencies or resources, we will refer you to other treatment providers or resources.

For urgent issues that occur after administrative office hours, please follow the instructions provided at the voice mail extension for urgent calls on our telephone voicemail system. If you are having an emergency and you are not able to contact the office or reach your therapist, you should immediately proceed to the emergency room of the medical facility that is nearest to you at the time of the emergency.

Notice of Privacy Practices - Abbreviated*

THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures for Treatment, Payment, and Health Care Operations
We may **use** or **disclose** your **protected health information (PHI)**, for **treatment**, **payment**, and **health care operations** with your consent. **PHI** refers to identifying information in your health record. **Treatment** is when we provide or manage your health care. **Payment** is when we obtain reimbursement for your healthcare. **Health care operations** relate to the performance and daily routines of the practice. **Use** applies to activities within the practice. **Disclosure** applies to activities outside of the practice.

Uses and Disclosures Requiring Additional Authorization
We may also use or disclose your PHI for purposes outside of treatment, payment, and health care operations, however, you must sign a separate Authorization to Release Information form to allow this. You may revoke any authorizations of PHI at any time, but you must do so in writing. You may not revoke an authorization to the extent that we have already relied on the authorization and third party insurers have a right to contest this claim.

Uses and Disclosures with Neither Consent nor Authorization
We may use or disclose your PHI without your consent or authorization in the following circumstances. There may be additional disclosures of PHI that we are required or permitted by law to make without your consent, but the ones listed below are the most common.

- If you express a serious threat to kill or injure yourself or an identifiable person or persons, we must notify the potential victim or victims and others (such as law enforcement personnel) to keep you or others safe.
- If we have reasonable cause to suspect abuse of a child or vulnerable adult.
- When we are required to do so by legal order of a court.
- For worker's compensation, disability, and other similar programs.

Client's Rights

- You have the **right to request restrictions** on certain uses and disclosures of your PHI.
- You have the **right to receive confidential communications by alternative means and at alternative locations**. For example, you could ask us to send your bill to a different address or call you only at home and not at work.
- You have the **right to review** your PHI. There may be a charge if copies are requested.
- You have the **right to amend** your PHI by written request if you believe your record is incorrect.
- You have the **right to notification** if there is a privacy breach of your PHI.
- You have the **right to an accounting** of disclosures of your PHI.
- You have the **right to a paper copy** of this notice.
- You have the **right to file a complaint** if you feel your privacy rights have been violated. Complaints must be in writing and sent to our compliance officer (listed below). You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for exercising this right.

Health Care Provider's Duties

- We are required by law to maintain the privacy of your PHI and to notify you of our legal duties and privacy practices regarding your PHI.
- We are required to abide by the terms of this notice, although we have the right to change the privacy policies and practices described here as long as we provide proper notification.
- We are required to provide proper notification if we revise the policies and procedures listed here.

If you have any questions or concerns related to this notice or additional rights which may be granted to you by the laws of Pennsylvania, please contact our compliance officer, Dr. Michael Schneider, by phone at 724-934-3905x31 or by email at mschneider@newdirectionspgh.com.

***This abbreviated version provides the basic information about your privacy rights and what we do to protect your privacy rights. A longer, more detailed version is available in our waiting room, on our website, or from any staff member.**

724.934.3905 NEWDIRECTIONSPGH.COM

IMPORTANT INFORMATION FOR PSYCHIATRIC VISITS

FOLLOW-UP MEDICATION CHECKS
are typically 20 minutes long.

IF YOU ARE 10 MIN. LATE OR MORE
you will be asked to reschedule &
a **missed appointment fee** will be charged.

YOU CANNOT HAVE TWO(2) APPOINTMENTS
on the same day. Health insurance restrictions often do not allow a psychiatric and counseling appointment on the same day.

MEDICATION REFILLS ONLY PROVIDED IN-PERSON
Medication refills are not provided between scheduled appointments. You must be in-person at a scheduled appointment to receive a refill.

WE CANNOT GUARANTEE APPOINTMENTS
at certain times of the day. Patients are expected to return for follow-up visits as specified by your psychiatric provider.

$25 FEE FOR URGENT MEDICATION REFILLS
If approved by your psychiatric provider, refills between appointments will incur a $25 Fee. Providers can only send refills during their regular office hours.

MEDICATION CHANGES ONLY DURING
in-person appointments.

ADMINISTRATIVE OFFICE HANDLES ALL
communication for psychiatric providers. Please leave your name and number by voice mail or send email to **info@newdirectionspgh.com**

GO TO THE EMERGENCY ROOM
If you are having a severe reaction to your medication.

NEW DIRECTIONS
COUNSELING SERVICES, LLC