NewDay

Affordable Therapy Fee Contract (updated 5/1/2023)

Service	Fees
Counseling with Supervisor Licensed Therapist	**$150.00**
Counseling with Licensed Therapist	**$120.00**
Counseling with Associate	**$90.00**
Counseling with Intern/Practicum Student	**$65.00**
Counseling with Pastoral Counselor	**$100.00**
Missed Appointments & Late Cancellation	**$35.00**
Hourly Rate for Other Professional Services (Reading and responding to email/texts, phone calls, consultations with third parties, psychological testing, report writing, letter writing, travel time, home visits, legal proceedings, record preparation, etc.)	**$120.00**

General Fee Information

- All fees are due prior to the start of each appointment unless other arrangements are made.
- We require that you have a credit, debit, or HSA card on file. NewDay accepts Mastercard, Visa, American Express or Discover. A credit card will not required for patients who have a state Medicaid plan.
- A fee will be charged the same day as a missed appointment or an appointment that is not canceled with at least 24 hours' notice. In these cases, you will be charged $35 of your session fee. This fee is not reimbursable by insurance companies. You will not be charged if you have a state Medicaid plan, however, NewDay may refer you to another agency in the event missed appointment become excessive.
- We can provide you with a receipt if you would like to seek out-of-network reimbursement from your insurance company. Your clinical diagnosis may be listed on the receipt we provide you. You should verify whether your counseling is considered an eligible expense if using your health savings account card to pay for services.
- Fees are updated annually and any time your therapist changes his or her rates.
- If your fee is reduced through our Affordable Therapy Program, your fee contract will also be reviewed when your reduction expires or if your annual household income changes.

Managing Financial Barriers to Seeking Counseling

- If the cost of therapy makes it difficult to continue sessions, talk with your therapist about your options. Shorter sessions or less frequent sessions could be appropriate.
- Fee reductions may be available for a limited number of sessions if your therapist has space on his or her caseload for reduced fee work, or through our Affordable Therapy Program.
- Clients with Medicaid may seek counseling elsewhere with an in-network provider and have your counseling covered at no cost to you. We can assist you in finding an in-network provider if you prefer.

Professional Services Related to Court or Legal Proceedings

- Before requesting a therapist participate in a court proceeding, please remember:
    - Counselors serving in a therapeutic role are prohibited from assessing and making recommendations about custody or forensic matters.
    - Counselors serving in a therapeutic role can only offer information as it pertains to the client's therapy and what is being done in session to enhance the client's mental and emotional health.
    - Getting a written summary of treatment is often a better and more cost-effective option.
- The following professional services are billed per hour and due no later than the day of service:
    - Phone calls, emails, and note preparation to respond to subpoenas.
    - Collecting signatures for releases of information related to subpoenas.
    - Traveling to and from court or related meetings, waiting for court or related meetings, and appearing in court or related meetings
    - Preparations of notes, letters, and treatment summaries related to court matters.
- Requirements for therapist to appear in court or a related meeting:
    - The minimum charge will be for 6 hours and must be paid as a deposit in cash or by cashier check one-week prior to the meeting.
    - If court is canceled or reset within 72 hours, 30% of the deposit is non-refundable.
    - If less than one week's notice is given to appear in court or a related meeting, an "express" fee of $500 will be charged.

Consent for Debit/Credit Card Payment

- I authorize NewDay to charge my credit/debit/health account card for appointments, professional services, and for fees related to missed appointments.
- I verify that I will provide accurate and up to date credit card information. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Client Name	Cardholder Name
_____	_____
Client Signature	Cardholder Signature
_____	_____
Date	Date

Fee Agreement: _____

Informed Consent and Confidentiality Statement

COUNSELING SERVICE OVERVIEW—NATURE OF COUNSELING

- NewDay Center is a place to promote, for those who are willing, the continuous journey to be transformed into the image of Christ. I have made a voluntary choice to seek counseling at NewDay Center with a licensed mental health professional (each a "Counselor"). I understand counseling is a cooperative effort between myself and my Counselor. I understand that I may withdraw this Consent for Treatment and Confidentiality Statement ("Consent") in writing and terminate counseling at any time.
- NewDay Center is a Christian organization that approaches the subject of addiction and mental health from the point of view of Christian theology. NewDay Center offers individual and group counseling that is provided by Counselors, Counselors in training and ordained clergy. I understand that counseling often involves talking about and expressing intense and possibly painful emotions, facing and dealing with difficult situations in the present, or recalling frightening or challenging parts of my personal history. Therefore, it may get harder before it gets easier. I understand that while attempting to resolve unpleasant current and past situations, I may have moments of discomfort and temporary increases in emotional pain. I understand that I may discuss any questions or concerns I have about the possible risks and benefits of counseling with my Counselor, Pastor, Counseling Training Student and I agree to work with my Counselor, Pastor, Counseling Training Student training in order to process and/or resolve my symptoms or concerns.
- If a situation comes up during the therapeutic process where I am uncomfortable, in any way, I should immediately notify NewDay Center or my Counselor, Pastor, Counseling Training Student so that the situation can be discussed at that time. It is essential to have trust in this relationship. I understand that I have a right to decline counseling against professional advice at any time.
- I understand that I must sign this Consent before counseling begins. **If I am under the age of 18 years**, I must have a parent or legal guardian sign this Consent before counseling begins.

COUNSELING FORUM

- I understand my sessions may occur face-to-face with my Counselor, Pastor, Counseling Training Student or through online technology called "teletherapy." Teletherapy differs from in-person services in that it uses interactive technology (audio, video or other electronic communications) between my Counselor, Pastor, Counseling Training Student and myself when we are not in the same physical location. I understand that any exchange of information or paperwork during a teletherapy session will likely be through electronic means.
- I understand that during teletherapy, the electronic systems used by my Counselor, Pastor, Counseling Training Student will incorporate network and software security protocols to help protect the privacy and security of health information and any imaging data and will include reasonable measures to safeguard the data to ensure its integrity against intentional or unintentional corruption. I further understand that I will need access to, and have familiarity with, the appropriate technology in order to participate in teletherapy, and will advise my Counselor, Pastor, Counseling Training Student if such technology becomes unavailable to me.
- I understand that teletherapy is to be utilized for regularly scheduled sessions only. **I understand and agree that if I am in crisis or having an emergency, I will utilize 911 or other emergency services in my area.**
- I understand that the laws and professional standards of care that apply to in-person counseling apply equally to teletherapy.
- I further understand that if my Counselor, Pastor, Counseling Training Student and I use teletherapy, we will reassess its appropriateness regularly. If at any time I choose to decline further teletherapy sessions, I can do so without jeopardizing my access to future care or services at NewDay Center.

CONFIDENTIALITY

1. I understand my treatment will be kept in confidence and is protected by state and federal laws and regulations. A release of information to others can only occur with my informed and signed consent. Exceptions to that are disclosures allowed by law, including but not limited to: suspected child abuse/neglect (which will be reported to appropriate state or local authorities), danger to self or others, a court order, and release of treatment information regarding minors to parents and/or legal guardians (except minors being treated for substance abuse). I also understand my appointments may be discussed by my Counselor internally and privately within NewDay Center with a licensed supervisor or during regular staffing check-ins. Counselors in training consult with supervisors and

with fellow students in a structured classroom setting and in individual supervision about clients' progress. All supervisors hold a master's degree in a field of counseling and are licensed by the state of Indiana as Mental Health Counselors, Marriage and Family Therapists, or Clinical Addiction Counselors.

- I further understand that information regarding a positive COVID-19 diagnosis may be shared by my Counselor, Pastor, Counseling Training Student or NewDay Center staff as reasonably necessary, including to for purposes of facilitating contact tracing.
- We are also ethically and legally obligated to maintain records of each time we meet, whether in-person or through teletherapy. This also includes times you and your Counselor, Pastor, Counseling Training Student may talk on the phone or correspond via other technology such as email. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting. A judge can subpoena your records for a variety of reasons, and if this happens, we must comply.
- Counseling records and individual documents are maintained electronically in accordance to HIPAA standards. Client records will be kept for *at least* seven (7) years after the date of the last contact with our office.
- I understand that teletherapy relies on technology, which can allow for greater convenience and flexibility in service delivery. However, there are risks in transmitting information with technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.
- I also understand that, while using teletherapy, it is my responsibility to maintain privacy on my end of the communication. I understand that there is not a guarantee of confidentiality if I choose a public setting to conduct a teletherapy appointment.
- I understand that NewDay Center cannot absolutely ensure the confidentiality of any form of communication through electronic media, including text messages and emails. At my written request, however, NewDay Center will communicate via email regarding scheduling or cancellations.
- I understand that NewDay Center policy does not allow counselors to "*friend*" or "*follow*" current or recent clients on Facebook, Twitter, or other social media platforms. The NewDay Center feels that it is not in the best interest of our clients to engage with them on social media and puts the ability to maintain confidentiality at risk.

CLIENT'S RIGHTS AND RESPONSIBILITIES

- The length of therapy is greatly determined by each situation. The goal is to resolve the issues that brought you in as thoroughly and quickly as possible. Initially, most appointments are scheduled every week or every other week. It is your right to discontinue treatment any time you feel it is in your best interest to do so. It is the Counselor, Pastor, Counseling Training Students ethical responsibility to end counseling when it is reasonably clear that you are no longer benefiting from treatment.
- I understand that while I am physically at NewDay Center I will help maintain other people's privacy by refraining from taking pictures or making recordings of any kind. I will also silence my phone while in session. This will help me make the most of my session.
- I understand that after 60 consecutive days of not attending sessions of any type, my file will be closed. I understand that I am free at any point to contact NewDay Center to restart counseling and have the file reopened.
- I understand that, due to a number of factors, my Counselor, Pastor, Counseling Training Student may occasionally need to start my session a few minutes later than scheduled. If I have been waiting for 10 minutes, I am encouraged to check in with (if attending in-person) or call (if teletherapy) the Counseling Center receptionist
- I understand that if I am more than 15 minutes late to my session, my Counselor, Pastor, Counseling Training Student may not be able to see me that day, and I will need to reschedule.
- I understand that if I transfer to a new counselor, Pastoral Counselor or Counselor in Training, they will receive my old file.

PAYMENT

Payment in credit card is expected in full at the time of service. You may choose to keep a credit card on file that authorizes NewDay Center to charge this card for therapy session.

Name on Card:_____

Type of Card __Visa __Mastercard ___Discover ___AmEx

By signing below you are stating you are the holder of this card and have authorized NewDay Center to charge this card.

_____

CANCELLATION POLICY
Appointments are to be kept at their scheduled time. If an appointment must be cancelled, 24 hours' notice is required. If the cancellation is given with less than 24 hours' notice, half of the fee will be charged. If no cancellation takes place and you miss your appointment, the full fee will be charged. Late cancellations and missed appointments are not covered under any insurance. In the case of a serious emergency, inclement weather, or illness, notify NewDay Center immediately and we will reschedule your appointment without additional charge. If your credit card is on file, you will be charged automatically.

CONSENT AND AFFIRMATION OF UNDERSTANDING
I have read this Consent or have had it read to me if I am unable to do so. I fully understand its terms and sign it freely and voluntarily without inducement. I have been given the opportunity to ask any questions about the use of both face-to-face counseling and teletherapy sessions and understand the differences and risks associated with each. My questions have been answered to my full satisfaction, and, unless otherwise noted on this form, I am freely consenting to counseling using either means.

With my signature below, I voluntarily consent to counseling as described in this Consent. I will receive a copy of this Consent if I request one.

Client's Name (printed): _____ Date: _____

Client's Signature: _____ Date**:** _____

Counselor's Signature: _____ Date: _____

Client's Parent/Legal Guardian Name and Signature (if Client is a minor):

_____ _____
Name Signature

_____ _____ __
Relationship to Client Date

Informed Consent for Video Recording

I am requesting your permission to record our counseling session(s) on video file(s). The purpose of this recording is to help me serve you better and to review and evaluate my counseling techniques as a student in training. No recording will be done without your prior knowledge and consent. Viewers of the video file(s) may include my supervisors and peers in my group supervision class. All viewers of the video file(s), including myself, are bound by the ethical standards of the American Counseling Association. The video file(s) will be treated with confidentiality by being stored on a password protected computer and will be destroyed at the termination of the semester.

By signing below, I am stating that I have read and understood the Informed Consent for Video Recording and that I am permitting _____ to video record our session(s) and review the video file(s) with the aforementioned individuals for supervision purposes.

_____ _____

Client Signature Date

_____ _____

Counselor Signature Date

Consent for Residential Treatment Statement

RESIDENTIAL TREATMENT

NewDay Center provides 24-hour care and counseling services to each residential client in its residential treatment facilities, where Counselors and ordained clergy assist in stabilizing and preparing clients for outpatient treatment. Care includes supervised living, laundry, activities, and food services. Counseling services include individual and group counseling provided by Counselors and ordained clergy who promote abstinence from substance and drug use and support change in client lifestyles, attitudes, and values through a faith-based program.

By signing this Consent for Residential Treatment Statement ("Residential Consent"), I request and authorize NewDay Center, its agents and employees and my physicians, their associates and assistants who may attend to me during residential or outpatient visits to provide and perform such medical care, tests, procedures, drugs and other services and supplies as are considered advisable by my physician for my health and well-being. I understand this may include, but is not necessarily limited to, group therapy, individual counseling, drug screens, laboratory tests, medication-assisted treatment and clinically managed detoxification ordered by my physician. I understand my treatment will consist of the following components, all of which will be approached from evidence-based counseling theories and will be from the point of a Biblical worldview:

a. Daily clinical services and participation in planned programming and activities;
b. Involvement in counseling, group work, and educational groups that assist with my developmental stage and level of understanding;
c. Monitoring to ensure I adhere to my prescription medication regimen and weekly meetings with my medical team to care for my medical needs;
d. Drug screening as required under my treatment plan;
e. Physical examinations as determined by my medical condition, performed under program policy; and
f. Withdrawal management that is designed to safely assist me through withdrawal.

INDEPENDENT PHYSICIANS AND OTHER PROVIDERS

I recognize that physicians who provide services to me at NewDay Center are independent contractors and are not agents or employees of NewDay Center. This includes but is not limited to physicians and physicians' assistants, laboratories, and psychiatrists. I understand and agree that each of the above referenced is not subject to the control and supervision of NewDay Center. Should I have any questions regarding the relationship between the physician providing services to me and NewDay Center, I understand I have the right to ask those questions.

CONSENT FOR BODY FLUID-BORNE INFECTIOUS DISEASE TESTING

I authorize NewDay Center to test for body fluid-borne infectious diseases including, but not limited to, hepatitis, Acquired Immune Deficiency Syndrome ("AIDS"), and Human Immunodeficiency Virus ("HIV") if a physician orders such test(s) or if ordered by protocol. The results of these tests will become part of my confidential medical record and reported to my provider, and other providers as permitted or required by law. I understand I have the right to refuse testing and failure to consent to these tests will not result in denial of admission to NewDay Center.

SEARCH OF ITEMS BROUGHT ONTO FACILITY PREMISES AND PERSONAL VALUABLES

To maintain the safety of its premises, NewDay Center reserves the right to search all items brought onto its premises including purses, wallets, and other personal effects. Please refrain from bringing items posing a potential safety threat into NewDay Center locations or send such items home with a friend or relative. If NewDay Center determines, within its sole discretion, that an item poses a potential safety threat, NewDay Center will: (1) dispose of the item; (2) place the item in NewDay Center's safe until the conclusion of your appointment or time of your discharge; or (3) turn over the item to law enforcement. NewDay Center will not be liable for any personal articles that are lost, stolen or damaged. NewDay Center encourages patients to send personal items and valuables home with a relative or friend. If this is impossible, NewDay Center will place valuables in NewDay Center's safe upon request.

FINANCIAL CONSENT / ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby assign payment to (1) NewDay Center; (2) contracted health care providers such as physicians and mental health providers; and (3) other health care providers, affiliates, or entities such as paramedics and laboratories, who provide services in connection with my treatment. I authorize them to release a copy of my medical records and to release any other information necessary for them to obtain my assigned payment from my insurance, Medicare, Medicaid, workers' compensation carriers, and social security administrators with whom I have coverage or from whom benefits are, or may become, payable to me, including settlements or judgments from the incident for which I am receiving treatment. I acknowledge that the providers in categories two (2) and three (3) above are not employees or agents of NewDay Center, and I understand the NewDay Center is not liable for the acts of the providers in categories two (2) and three (3). I agree to pay, when billed or requested by NewDay Center, any amount charged for NewDay Center services not covered by the above payers. I authorize NewDay Center and NewDay Center's agents to call my cell phone by auto-dialer in order to collect any amounts I owe.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

- By signing this Residential Consent, you agree to abide by all the terms contained herein. You also agree to pay NewDay Center and the health care providers listed above all charges promptly when due. If your NewDay Center account or account with the health care providers listed above is forwarded to a collection agency or attorney, you will be responsible for any court costs, reasonable attorneys' fees, and interest as allowed by Indiana law, related to the collection of any outstanding account balance.
- I acknowledge that the services and/or procedures to be provided by NewDay Center and physicians are necessary to treat or diagnose my medical condition. I further acknowledge that I am responsible for knowing the limitations of my insurance benefits and agree to be personally responsible for services and/or procedures that are denied by my insurance carrier including, but not limited to, items denied as "not medically necessary, investigational or experimental." NewDay Center will make every reasonable effort to seek insurance coverage for services and to notify me in advance of items that it knows are not covered; however, should services ultimately be denied by my health insurance coverage for services provided by NewDay Center, I will be charged at NewDay Center's charge description master (price list) rates less a discount comparable to discounts provided to third-party insurance payers.
- I acknowledge it is my responsibility to present any questions I may have regarding charges for services provided to me by NewDay Center within 60 days of receiving my first bill from NewDay Center or any of its agents.

CONSENT AND AFFIRMATION OF UNDERSTANDING

I have read this Residential Consent or have had it read to me if I am unable to do so. I fully understand its terms and sign it freely and voluntarily without inducement. I have been given the opportunity to ask any questions about residential treatment. My questions have been answered to my full satisfaction, and, unless otherwise noted on this form, I am freely consenting to residential treatment.

With my signature below, I voluntarily consent to residential treatment as described in this Residential Consent. I will receive a copy of this Residential Consent if I request one.

Client's Name (printed): _____ Date: _____

Client's Signature: _____ Date**:** _____

Counselor's Signature: _____ Date: _____

Counselors/Intake Name (printed): _____ Date: _____