|  |  |
| --- | --- |
| Insert date | Choose name |

**New Hope Community Services, LLC**

**Service Intake Form**

Please complete the information requested based on the individual receiving services.

|  |  |  |
| --- | --- | --- |
| Intake Date | Insert date |  Has the child been treated here before? [ ]  Yes [ ]  No |
| Name of Individual filling out this form: |       |
|  |  |
| Patient’s Name: |                         |
|  | First | Middle | Last | Social Security Number |
|  |  |  |  |  |
| Address: |              |
|  | Street |  |  | Apt # |
|                   |
| City |  |  | State | Zip |
|  |  |  |  |  |
| Home Telephone # | (     )             | Daytime # | (     )             |  |
|  |  |  |  |  |
| Parent Cell Phone # | (     )             |  | Child Cell Phone # | (     )             |
|  |  |  |  |  |
| Can we leave a message concerning the appointments? | [ ]  Yes [ ]  No Phone # (     )      -       |
|  |  |  |  |  |
| Would you prefer email or text message notifications? | [ ]  Text [ ]  Email:       |
|  |  |  |  |  |
| Date of Birth: |       | Age: |       | GENDER: [ ]  M [ ]  F ETHNICITY:       |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of LEGAL Guardian: |       | SS#:  |       |
|  |  |  |  |  |  |
| Person to Contact in Case of Emergency: |       |
|  |  |  |  |  |  |  |
| Relationship |       | Phone # |       |
|  |  |  |  |
| Annual House Hold Income: |  | If Sliding Scale: | ***For Office Use Only:*** |
|  |  |  |  | **[ ]  SFS** **[ ]  $50** **[ ]  $75 [ ]  $100**  |
| If filing Insurance: |  |  |  |  |
| **PRIMARY INSURANCE** |  |  |  |  |
| Name of Insured: |       | SS# |       | Date of Birth: |       |
|  |  |  |  |  |  |
| Type of Insurance: |       |
|  |  |  |  |  |  |
| Subscriber ID# |       | Group ID# |       |
|  |  |  |  |  |  |
| Current Primary Care Physician: |       | Phone: |       |
|  |  |  |  |  |
| **SECONDARY INSURANCE** |  |  |  |  |
| Name of Insured: |       | SS# |       | Date of Birth: |       |
|  |  |  |  |  |  |
| Type of Insurance: |       |
|  |  |  |  |  |  |
| Subscriber ID# |       | Group ID# |       |

**PLEASE NOTE: If authorization is required and has not been obtained, YOU may be responsible for entire balance of services performed.**

|  |  |  |
| --- | --- | --- |
| **RELATIONSHIP STATUS of BIOLOGICAL PARENTS:** |  | **EDUCATIONAL STATUS** |
| [ ]  | Single |  |  |  | [ ]  | In School,       grade |
| [ ]  | Married/Partnered |  |  |  | [ ]  Private [ ]  Public |
| [ ]  | Separated\*\* |  |  |  | [ ]  | Home Schooled |
| [ ]  | Divorced\*\* |  |  |  | [ ]  | Not Registered |
| [ ]  | Living With |  |  |  |  |  |  |
| [ ]  | Remarried |  |  |  |  |  |  |
| [ ]  | Incarcerated | [ ]  Mother | [ ]  Father |  |  |  |  |
| \*\*If separated or divorced, what is current custodial agreement? |  |  |  |
| [ ]  | Joint | [ ]  | Sole | [ ]  Supervised |  |  |  |
|  |  |  |  |
| **Other Parents Name:**  |       | Phone # |       |
|  |
| **\*\*Note: If Separated, Divorced, or soon-to-be Divorced, you are required to fill out the Parent Policy Form.** |
| **\*\*NOTE: If DVO/EVO active, must have copy on file** |  |  |  |
| Please list below all individuals that you authorize to obtain information about the child’s treatment/evaluation: |
|  |  |  |  |
| Name: |       | Phone: |       |
|  |  |  |  |
| Address: |       |
|  |  |  |  |
| Name: |       | Phone: |       |
|  |  |  |  |
| Address: |       |
|  |  |  |  |
| Name: |       | Phone: |       |
|  |  |  |  |
| Address: |       |
|  |  |  |  |
| You have the right to revoke the transfer of any and all information by submitting in WRITING to revoke this authorization to share information. However, your revocation will not be effective to the extent that New Hope has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a right to consent a claim. |
|  |  |  |  |
| **REFERRAL REASON** |  |  |  |
| [ ]  | Abuse |  | [ ]  | Neglect |  |  |  |
| [ ]  | Anger |  | [ ]  | Parenting (Protection & Permanency Involvement) |
| [ ]  | Anxiety |  | [ ]  | Pressure/Stress |  |  |
| [ ]  | Depression | [ ]  | Pre-Marital Counseling |  |  |
| [ ]  | Drug/Alcohol Problems | [ ]  | PTSD |  |  |
| [ ]  | Social Problems | [ ]  | School Problems |  |  |
| [ ]  | Eating Disorder | [ ]  | Self Esteem Problems |  |  |
| [ ]  | Home/Family Problems | [ ]  | Sexual Abuse |  |  |  |
| [ ]  | Legal Problems | [ ]  | Self |  |  |
| [ ]  | Life Changes (Loss/Divorce) | [ ]  | Sexual Dysfunction |  |  |
| [ ]  | School/Academic Problems | [ ]  | Suicide Issue |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Briefly described the circumstances that triggered you to bring your child / adolescent for services |
|       |
| What do you hope to gain from counseling for your child / adolescent and you? |
|       |

|  |  |  |  |
| --- | --- | --- | --- |
| **What specific questions would you liked answered:** |  |  |  |
| Does s/he have: | [ ]  ADHD | [ ]  a learning disability |  |  |  |
| Is s/he | [ ]  Psychotic | [ ]  depressed | [ ]  anxious |
| Does s/he need | [ ]  Medication | [ ]  therapy |  |  |  |
| Has s/he been | [ ]  Sexually abused | [ ]  traumatized |  |  |
| Why doesn’t s/he | [ ]  listen | [ ]  behave | [ ]  do his/her homework |  |
| [ ]  | Other? |  |  |  |  |
|       |
|  |  |  |  |  |  |  |  |
| **HISTORY of CURRENT PROBLEM** |  |  |  |  |  |
| How old was child/adolescent when these problems began? |       |
|  |  |  |  |  |  |  |  |
| Has the child/adolescent ever had treatment for these problems in the past? | [ ]  Yes [ ]  No |
|  |  |  |  |
| MD/Center: |       | Phone: |       |
|  |  |  |  |
| Address: |       |
|  |  |  |  |
| MD/Center: |       | Phone: |       |
|  |  |  |  |
| Address: |       |
|  |  |  |  |
| MD/Center: |       | Phone: |       |
|  |  |  |  |
| Address: |       |
|  |  |  |
| List all current medications and dosages |  |  |
|  |  |  |  |  |  |  |  |
| Medication:       | Dosage:       | Times per day:       |
| Medication:       | Dosage:       | Times per day:       |
| Medication:       | Dosage:       | Times per day:       |
| Medication:       | Dosage:       | Times per day:       |
| Medication:       | Dosage:       | Times per day:       |
|  |  |  |  |  |  |  |  |
| List other medications taken in past: |  |  |
|  |  |  |  |  |  |  |  |
| Medication:       | Dosage:       | Times per day:       |
| Medication:       | Dosage:       | Times per day:       |
| Medication:       | Dosage:       | Times per day:       |
| Medication:       | Dosage:       | Times per day:       |
| Medication:       | Dosage:       | Times per day:       |
|  |  |  |
| Has the child/adolescent ever been in a hospital or residential facility for behavior or mental problems? | [ ]  Yes [ ]  No |
|  |  |  |  |
| Center: |       | Phone: |       |
|  |  |  |  |
| Address: |       |
|  |  |  |  |
| Center: |       | Phone: |       |
|  |  |  |  |
| Address: |       |
|  |  |  |  |
| Center: |       | Phone: |       |
|  |  |  |  |
| Address: |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CURRENT FAMILY** |  |  |  |  |  |
| List all persons currently living in household: |  |  |  |  |
| Name:       Age:       |  | Name:       Age:       |
| Name:       Age:       |  | Name:       Age:       |
| Name:       Age:       |  | Name:       Age:       |
| Name:       Age:       |  | Name:       Age:       |
| Name:       Age:       |  | Name:       Age:       |
|  |  |  |  |  |  |
| **Parental History** |  |  |  |  |  |
| Please describe parents’ relationship with each other: |  |  |
|       |
|  |  |  |  |  |  |  |  |
| **PARENT #1 INFORMATION:** |  |  |
|  |  |  |  |  |  |  |  |
| Name:  |       | Age: |       |
| **PARENT EDUCATIONAL HISTORY** |  |  |  |  |  |
| Graduate of High School? | [ ]  Yes [ ]  No | If no, please indicate departure year (age) |
|       |
|  |  |  |  |  |  |  |  |
| College Graduate? | [ ]  Yes [ ]  No | If no please indicate # of years attended |
|       |
|  |  |  |  |  |  |  |  |
| Other training – skills sets |  |  |
|       |
| **EMPLOYMENT HISTORY** |  |  |  |  |  |
| Currently Employed? | [ ]  Yes [ ]  No | If yes, please give location / years |
|       |
|  |  |  |  |  |  |  |  |
| **PARENT HEALTH HISTORY** |  |  |  |  |
|  |  |  |  |  |  |
| Are there any histories of family alcoholism or drug addiction? [ ]  Yes [ ]  No |
| If YES | [ ]  Father | [ ]  Mother |  |  |  |
| Please list drug(s): |  |  |  |  |  |
|       |
|  |  |  |  |  |  |
| Are there any histories of family mental illness? [ ]  Yes [ ]  No |
| If YES | [ ]  Father | [ ]  Mother |  |  |  |
| Please list diagnoses if known |  |  |  |  |
|       |

|  |
| --- |
| Are there histories of parent involved with legal / court problems? [ ]  Yes [ ]  No |
| If YES | [ ]  Father | [ ]  Mother |  |  |  |
| Please list charges if known: |  |  |  |  |
| Charges:       Date:       |  | Charges:       Date:       |
| Charges:       Date:       |  | Charges:       Date:       |
| Charges:       Date:       |  | Charges:       Date:       |
| Charges:       Date:       |  | Charges:       Date:       |
|  |  |  |  |  |  |
| Are Grandparents involved in child / adolescent’s life? [ ]  Yes [ ]  No |
|  |  |  |
| **PARENT #2 INFORMATION:** |  |  |
|  |  |  |  |  |  |  |  |
| Name:  |       | Age: |       |
|  |  |  |  |  |  |
| **PARENT EDUCATIONAL HISTORY** |  |  |  |  |  |
| Graduate of High School? | [ ]  Yes [ ]  No | If no, please indicate departure year (age) |
|       |
|  |  |  |  |  |  |  |  |
| College Graduate? | [ ]  Yes [ ]  No | If no please indicate # of years attended |
|       |
|  |  |  |  |  |  |  |  |
| Other training – skills sets |  |  |
|       |
|  |  |  |  |  |  |
| **EMPLOYMENT HISTORY** |  |  |  |  |  |
| Currently Employed? | [ ]  Yes [ ]  No | If yes, please give location / years |
|       |
|  |  |  |  |  |  |  |  |
| **PARENT HEALTH HISTORY** |  |  |  |  |
|  |  |  |  |  |  |
| Are there any histories of family alcoholism or drug addiction? [ ]  Yes [ ]  No |
| If YES | [ ]  Father | [ ]  Mother |  |  |  |
| Please list drug(s): |  |  |  |  |  |
|       |
|  |  |  |  |  |  |
| Are there any histories of family mental illness? [ ]  Yes [ ]  No |
| If YES | [ ]  Father | [ ]  Mother |  |  |  |
| Please list diagnoses if known |  |  |  |  |
|       |

|  |
| --- |
| Are there histories of parent involved with legal / court problems? [ ]  Yes [ ]  No |
| If YES | [ ]  Father | [ ]  Mother |  |  |  |
| Please list charges if known: |  |  |  |  |
| Charges:       Date:       |  | Charges:       Date:       |
| Charges:       Date:       |  | Charges:       Date:       |
| Charges:       Date:       |  | Charges:       Date:       |
| Charges:       Date:       |  | Charges:       Date:       |
|  |  |  |  |  |  |
| Are Grandparents involved in child / adolescent’s life? [ ]  Yes [ ]  No |
|  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **DEVELOPMENTAL / MEDICAL HISTORY OF CHILD / ADOLESCENT** |  |  |
| Was the child / adolescent born full-term? [ ]  Yes [ ]  No If premature: wks/mos?       |
|  |  |  |  |  |  |
| Any complications during pregnancy? [ ]  Yes [ ]  No If yes, briefly explain: |
|       |
|  |  |  |  |  |  |
| Did birth mother participate in any of the following activities while pregnant? |
|  |  |  |  |  |  |
| [ ]  Smoke cigarettes | [ ]  Drink alcohol | [ ]  Do illicit drugs | [ ]  Take prescription drugs |  |
| [ ]  none of the above |
|  |  |  |  |  |  |
| Please describe child’s / adolescent’s temperament as a baby:  |
| [ ]  Easy | [ ]  Difficult | [ ]  Slow to warm up | [ ]  Withdrawn |  |  |
|  |  |  |  |  |  |  |
| Describe his / her activity level as an infant: |
| [ ]  Extremely Active | [ ]  Very Active | [ ]  Active | [ ]  Inactive | [ ]  Extremely Inactive |
|  |  |  |  |  |  |  |
| Who was the primary care giver of the child as an infant? |  |  |
| [ ]  Mother | [ ]  Father | [ ]  Grandparent | [ ]  Other: |       |
|  |  |  |  |  |  |  |
| Were there any disruptions of care during infant years?  |  |  |
| [ ]  Change in Caregiver | [ ]  Divorce | [ ]  Separation | [ ]  Short-term Separation | [ ]  Removed from Family | [ ]  Adopted |
|  |  |  |  |  |  |
| How old was child/adolescent when: |  |  |  |  |
| Talked: |       | Walked: |       | Potty Trained: |       |
|  |  |  |  |  |  |
| Does child still wet bed? | [ ]  Yes | [ ]  No | [ ]  Occasionally |  |  |
|  |  |  |  |  |  |
| Does the child / adolescent sleep in their own bed? | [ ]  Yes | [ ]  No |  |  |
| Does s/he sleep alone on a consistent basis? | [ ]  Yes | [ ]  No | [ ]  Sometimes | [ ]  Never |
|  |  |  |  |  |  |
| Has or does the child / adolescent ever had seizures | [ ]  Yes | [ ]  No | If yes, please explain: |
|       |
|  |  |  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Has the child ever been knocked out or had a head injury? | [ ]  Yes | [ ]  No |  |
|  |  |  |  |  |  |
| Has the child / adolescent ever had any major: |  |  |  |
| [ ]  accidents | [ ]  injuries | [ ]  illnesses | [ ]  diseases | [ ]  hospitalizations? | If so, please explain: |
|       |
|  |  |  |  |  |  |  |
| Has the child had any problems with the following? |  |  |  |
|  |  |  |  |  |  |  |
| [ ]  language | [ ]  stuttering | [ ]  self-control | [ ]  impulsivity | [ ]  aggression | [ ]  physical-motor delays |
| [ ]  separation anxiety | [ ]  school phobia | [ ]  soiling | [ ]  wetting | [ ]  bed wetting |  |
| [ ]  none of the above |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **TRAUMA HISTORY** |  |  |  |  |  |
| Has the child / adolescent ever been physically beaten or abused? [ ]  Yes [ ]  No [ ]  Unknown [ ]  Suspected |
| If yes, please describe: |  |  |  |  |  |
|       |
|  |  |  |  |  |  |  |
| Has the child ever had sexual experiences and / or abuse? [ ]  Yes [ ]  No [ ]  Unknown [ ]  Suspected |
| If yes, please describe: |  |  |  |  |  |
|       |
|  |  |  |  |  |  |  |
| Has the child witnessed or experienced any of the following? |  |  |
|  |  |  |  |  |  |  |
| [ ]  Domestic Violence | [ ]  Neglect | [ ]  Divorce | [ ]  Death(s) | [ ]  Loss of Loved Ones |
| [ ]  Catastrophe or Natural Disaster |  |  |  |  |
| [ ]  other: please describe: |  |  |  |  |  |
|       |
|  |  |  |  |  |  |  |
| Has the child / adolescent ever had a parent abandon them? [ ]  Yes [ ]  No [ ]  Unknown [ ]  Suspected |
| If yes, how long? |       |  |  |  |  |
|  |  |  |  |  |  |  |
| How many times has the child moved in his/her life? |       |  |  |
|  |  |  |  |  |  |  |
| **SOCIAL HISTORY/ACTIVITIES AND DAILY LIVING** |  |  |  |
| What does the child / adolescent like to do after school and on weekends? |
| [ ]  Play sport(s) | [ ]  Go to movies | [ ]  Play alone | [ ]  Read books | [ ]  Watch TV |       | Hrs/day |
| [ ]  Play video games  |       | Hrs/day | [ ]  Listen to music |  |  |
| [ ]  Play w/friends | [ ]  Ride Bikes | [ ]  Play w/sibling(s) |  |  |  |
| [ ]  other – please list: |  |  |  |  |  |
|       |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
| What is his/her favorite activity: |  |  |  |  |  |
|       |
|  |  |  |  |  |  |  |
| Does the child / adolescent have chores / responsibilities at home? |  |  |
| Chore: |       | How well is it completed? | [ ]  Great [ ]  Good [ ]  So-So [ ]  Poor |
| Chore: |       | How well is it completed? | [ ]  Great [ ]  Good [ ]  So-So [ ]  Poor |
| Chore: |       | How well is it completed? | [ ]  Great [ ]  Good [ ]  So-So [ ]  Poor |
| Chore: |       | How well is it completed? | [ ]  Great [ ]  Good [ ]  So-So [ ]  Poor |
| Chore: |       | How well is it completed? | [ ]  Great [ ]  Good [ ]  So-So [ ]  Poor |
|  |  |  |  |  |  |  |
| Does the child / adolescent have friends? | [ ]  Yes [ ]  No [ ]  Unknown [ ]  Suspected |
| [ ]  Same age | [ ]  Younger | [ ]  Older | [ ]  Don’t know |  |  |
|  |  |  |  |  |  |  |
| How many ‘close’ friends does the child have? |       | [ ]  Don’t know |  |  |
|  |  |  |  |  |  |  |
| Do you have any concerns about the child’s / adolescent’s social interactions? | [ ]  Yes [ ]  No  |  |
| If yes, why? |  |  |  |  |  |
|       |
|  |  |  |  |  |  |  |
| Does the child have a history of aggression toward | [ ]  peers | [ ]  adults | [ ]  animals | [ ]  none |
|  |  |  |  |  |  |  |
| Does the child / adolescent get teased or tease others? | [ ]  Yes [ ]  No [ ]  Unknown [ ]  Suspected |
|  |  |  |  |  |  |  |
| Has s/he ever had trouble with: | [ ]  shyness [ ]  making friends [ ]  keeping friends [ ]  bullying [ ]  being bullyied |
|  |  |  |  |  |  |  |
| **LEGAL HISTORY** |  |  |  |  |  |
| Has the child / adolescent been or is now involved in any active cases (civil, criminal)? | [ ]  Yes [ ]  No | If yes, please list circumstances |
|       |
|  |  |  |  |  |  |  |  |
| Is the child /adolescent currently on diversion or in DJJ Court Designated Worker? | [ ]  Yes [ ]  No | If yes, please provide CDW’s or DJJ officer’s contact: |
|       |
|  |  |  |  |  |  |  |  |
| Please list your charges, approximate dates (or age), and current status: |  |  |
| Charges:       Date:       |  | Charges:       Date:       |
| Charges:       Date:       |  | Charges:       Date:       |
| Charges:       Date:       |  | Charges:       Date:       |
| Charges:       Date:       |  | Charges:       Date:       |
|  |  |  |  |  |  |  |
| Is this evaluation related to any current legal problems? | [ ]  Yes [ ]  No |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
| **DRUG/ALCOHOL HISTORY** |  |  |  |  |  |
| Has or does the child / adolescent ever use any of the following: |  |  |
|  |  |  |  |  |  |  |  |
| [ ]  Smoke cigarettes | [ ]  Drink alcohol | [ ]  Smoke Marijuana | [ ]  Benzodiazepines (Xanax, Valium) |  |
| [ ]  Cocaine [ ]  Heroin [ ]  LSD/ACID/Mushrooms [ ]  Stimulants (Speed/Ritalin) [ ]  I/V Drugs [ ]  Energy Drinks |
| [ ]  Bath Salts [ ]  Vapor smokes |  |  |
|  |  |  |  |  |  |  |  |
| First use: |       | Most recent: |       |  |
|  |  |  |  |  |  |  |  |
| Do you currently suspect use? | [ ]  Yes [ ]  No |  |  |  |
|  |  |  |  |  |  |  |  |
| Has the child / adolescent ever received treatment for substance abuse? | [ ]  Yes [ ]  No |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Please list your charges, approximate dates (or age), and current status: |  |  |
| Charges:       Date:       |  | Charges:       Date:       |
| Charges:       Date:       |  | Charges:       Date:       |
| Charges:       Date:       |  | Charges:       Date:       |
| Charges:       Date:       |  | Charges:       Date:       |
|  |  |  |  |  |  |  |
| **EDUCATION HISTORY** |  |  |  |  |  |
| Where does the child / adolescent go to school at? |       |
|  |  |  |  |  |  |  |
| What is the current grade of attendance? |       |  |  |
|  |  |  |  |  |  |  |
| What are the current grades? | [ ]  Above Avg [ ]  Avg [ ]  Below Avg - [ ]  As [ ]  Bs [ ]  Cs [ ]  Ds [ ]  Fs |
|  |  |  |  |  |  |  |
| Has s/he ever repeated a grade? | [ ]  Yes [ ]  No | If yes, which grade? |       |  |
|  |  |  |  |  |  |  |
| Does the child / adolescent currently receive any educational services? | [ ]  Yes [ ]  No | If yes, please choose which ones |
|  |  |  |  |  |  |  |
| [ ]  Speech Therapy |  | [ ]  Resource Room Help |  | [ ]  504 Plan |  |  |
| [ ]  Tutoring |  | [ ]  Behavioral Disorder Class |  | [ ]  Active IEP |  |  |
|  |  | [ ]  Learning Disability Class |  |  |  |  |
|  |  |  |  |  |  |  |
| In what grade did the child / adolescent begin to receive special education services? |       |  |
|  |  |  |  |  |  |  |
| Has the child / adolescent ever been: | [ ]  Suspended | [ ]  Expelled | How many times? |       |
|  |  |  |  |  |  |  |
| Does the child respect authority and get along with others? | [ ]  Yes [ ]  No |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Please list any other comments you wish to share at this time: |  |  |  |
|       |
|  |  |  |  |

**New Hope Community Services, LLC**

**Outpatient Services Contract**

**Statement of Professional Disclosure**

Welcome to New Hope Community Service Center (NHCS). This document contains important information about our professional services and business policies. Please read it carefully and write down any questions you may have so that we may promptly discuss them with you. When you sign this document, it will represent an agreement between you and NHCS.

GENERAL INFORMATION

At NHCS, we have a variety of mental health and substance abuse professionals to serve you. Among them are Licensed Professional Clinical Counselors (LPCCs), Licensed Professional Counselor Associates (LPCAs), Professional Counselor Interns (Master Level Graduate Students), Certified Alcohol and Drug Counselors (CADCs), and CADC Interns. Under the care of our medical licensed staff (Medical Doctors – M.D.), we deliver you the best care and service we can. Each licensed clinician holds a Master’s degree or PhD and has gone through rigorous education, training, and supervision to become licensed by the state. “Interns” are unlicensed and uncertified individuals who are under the guidance of a licensed professional supervisor. Interns have Master’s degrees and are practicing under supervision for licensure or are graduate students who have completed the bulk of their education and are now gaining the necessary clinical experience to graduate. Your therapist will inform you of the level of their training and answer any questions you may have about their qualifications.

COUNSELING SERVICES

Psychotherapy varies depending on personalities of the therapist and the consumer (you) as well as what problems have brought you here. There are different methods we may use to deal with specific concerns. In order for the therapy to be most successful, you will work on things we talk about during sessions and at home.

Psychotherapy has benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. But there are no guarantees to what you will experience.

CONFIDENTIALITY

The laws and standards of the mental health profession require that clinicians keep treatment records. In general, the law protects the privacy of all communications between a consumer and a therapist, and your information may only be released with your written permission. But there are a few exceptions:

In most legal proceedings, you have the right to prevent disclosure of information about your treatment. In some cases, specifically involving children, a judge may order a therapist’s records or testimony to question your emotional condition. There are some situations where the mental health professional is legally and ethically bound to take action to protect you or others from harm, even if that means revealing some information about treatment. For example, if the clinician believes that a child, elderly person, or disabled person is being abused, they may be required to file a report with appropriate state agency(ies).

If a therapist believes that the consumer constitutes a danger to him/herself or to others, they are required to take protective action. These actions may include helping the consumer make a safety plan, notifying potential victims, contacting police, or seeking hospitalization for the consumer.

These situations rarely occur in our practice. If such a situation does arise, we will make every effort to fully discuss it with you before taking action.

**We may also disclose to insurance company information they need to insure reimbursement – like your diagnosis.**

MINORS: if you are under the age of sixteen (16), please be aware that the laws may provide your parents with the right to examine your records.

TRAINING FACILITY

As a training facility, we routinely consult with our interns and other licensed professionals about cases. During consultation, we make every effort to maintain confidentiality of the consumer. The consultants, interns, and supervisors are also legally bound to keep information confidential. The process of training and supervision is fundamental to the work we do here at NHCS, so we will routinely use live observation, “co-therapy” with a senior therapist and video recording during therapy sessions. All the rules concerning confidentiality apply to live and taped observations, and any recordings made will be treated with the utmost respect and care as your written records. You may choose to “opt-out” of the observation process. However, this may preclude you from participating in our reduced-fee services, which are offered by our interns.

It is important that you discuss any questions or concerns that you have regarding confidentiality with your therapist. We will be happy to discuss these issues with you if you have specific questions. While we provide you with general legal and ethical guidelines which govern our practice and those that operate under our service, we cannot provide you with legal advice.

The fee schedule has been given to you for review. All clients have the option of being billed according to the sliding fee scale which is determined by your family income and family size. We also accept health insurance reimbursement. However, it is the consumer’s responsibility to ensure that your service is covered by your insurance. We will attempt to provide you with the most accurate data on what insurance programs are accepted and rate of reimbursement. If you would like us to bill your insurance company on your behalf, you will be billed according to the schedule of reasonable and customary fees. If there is a deductible that must be met, you will be responsible for paying the full amount of the reasonable and customary fee until your deductible is met. After meeting the deductible, you will be responsible for meeting the co-pay each visit. If your insurance company denies services of coverage for any reason, it will be your responsibility to pay the reimbursable fee based on current service rates. Submitting for insurance reimbursement requires your authorization to release the protected health information necessary to process the claim, including your mental health diagnosis. Your authorization is also necessary so that we may receive payment directly from your carrier. If we are assisting you in filing your insurance, please initial the following statements:

|  |  |
| --- | --- |
|  | I authorize the release of any medical or other protected health information necessary to process the claim. I also request payment of government benefits either to myself or to the party who accepts assignment as indicated on the claim. |
|  | I authorize payment of medical benefits to the physician or supplier for services described on the claim. |
|  | I agree to inform NHCS of any change in my financial status or special arrangements that have been made to cover the cost of my services (e.g. assistance provided by your church or other resources). |
|  | I understand, should my insurance company, for any reason, decide NOT to cover my benefits, I am responsible for any and all charges incurred to date. |

PROFESSIONAL AND OTHER FEES

Your hourly fee is $100.00. In addition to appointments, we charge this amount for other professional services you may require. “Other services” include report writing, telephone consultations, telephone conversations with you lasting longer than 15 minutes with therapist, attendance at meetings with other professionals you have authorized, preparation of records and/or treatment summaries, and the time spent performing any other professional service that you may request. If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time even if we are called to testify by another party on your behalf. Because of the difficulty of legal involvement, we charge a fee of $250.00 per hour for preparation and attendance at any legal proceeding.

BILLING AND PAYMENT

You will be expected to pay for each session at the time of your appointment, unless we agree otherwise. Payment schedules for other professional services will be agreed upon prior to performance of said services. In circumstances of unusual financial hardship, we may be willing to negotiate a fee adjustment or installment plan.

CANCELLATIONS AND NO-SHOWS

Our schedules are very busy. Therefore, in order to remain accessible to people as possible, the following guidelines have been established:

* NHCS will charge for mental health and counseling appointments that have not been canceled within **24 HOURS PRIOR** to scheduled appointment. Exceptions to this policy will be made only if proved an emergency.
* The client will be billed standard professional rates in event of no-show or missed appointment (no portion of the fee will be billed to your insurance carrier or other third-party payer). Payment will be expected prior to next scheduled appointment. After three (3) cancellations, patients will be added to daily call-in sheet and will not be rescheduled for 90-days – you must call-in same day to be seen.
* Front desk personnel will be happy to answer your questions but **DO NOT** have the AUTHORITY to change this policy.

APPOINTMENT REMINDER

NHCS will call, email, or text the consumer the day before to confirm your appointment. NHCS will contact the phone number or email that is provided on the first page of the intake form specified by the consumer. If the consumer does not wish to be reminded of the appointment, please confirm with your therapist.

PHONE CALLS

Telephone appointments may be set at the discretion of the counselors and will be billed in the same manner as in-person appointments with the exception that insurance cannot be billed.

In general, the therapists have very limited availability outside of scheduled appointments and after-hour appointments are scheduled on an “as-needed” event. Therefore, if services are needed after hours, consumers are encouraged to visit their local emergency rooms or phone local crisis line or emergency services (911) if a need arises. If the counselor is available, the consumer will be billed for any phone call lasting longer than 10-minutes. The phone calls will be billed in the same manner of in-person appointments with the exception that insurance cannot be billed.

NON-DISCRIMINATION POLICY STATEMENT

It is the policy of NHCS to provide services to all people without regard to race, color, national origin, religion, sexual orientation, age, or disability. No person shall be excluded from participation in, or denied the benefits of any service, or be subjected to discrimination because of race, color, national origin, religion, sexual orientation, age, or disability.

COMPLAINT PROCEDURE

Any grievances must be made in writing to NHCS’s Compliancy Officer –

 Ms. Donna Burke, Director of Operations

 Compliancy Officer, NHCS

 901 US HWY 68, Ste 900

 Maysville, Kentucky 41056

The complaint must include your name, address, telephone number, and a brief description of what occurred which lead you to believe you were discriminated against. In this way the appropriate person may respond to your complaint.

You may also file a complaint against the establishment by contacting:

Office of the Ombudsman

Cabinet of Family Health Services

275 East Main Street, 1E-B

Frankfort, Kentucky 40621

You will not be intimidated, harassed, threatened or suffer penalty because you filed a complaint. Any penalty or reprisal against you or other involved person(s) is prohibited by law.

CONSENT

I voluntarily consent to receive therapeutic services through NHCS.

I understand that I have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued. Furthermore, if I decide not to receive therapeutic assistance from NHCS, referrals to other qualified professionals can be provided.

If I have any questions and/or concerns now or in the future about the limitations of confidentiality, qualifications of my therapist, the potential risks of therapy, or anything else related to therapy, I understand that I should consult my therapist.

By signing this form, I am granting consent to NHCS to use and disclose my protected health information, such as my name, address, phone number, for the purpose of treatment, payment and agency operations. NHCS’ Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have legal right to review our Notice of Privacy Practices before signing this consent and we encourage you to read it in full. You have a right to request us to restrict how we use your and disclose your protected health information for the purposes of treatment, payment or agency operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

I certify that this form has been fully explained to me, that I have read it, or had it read to me, and that I understand its contents.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Client Signature |  | Date |
|  |  |  |
|  |  |  |
| Guardians Signature |  | Date |
|  |  |  |
|  |  |  |
| Witness Signature |  | Date |
|  |  |  |
|  |  |  |
| Therapist Signature |  | Date |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| ***For Office Use Only:*** |  |  | Diagnosis Code: |       |
|  Auth Needed [ ]  Yes [ ]  No | Date Auth Received: |  |  |
| **Billing Code(s):** |  Auth #  |       |  |
| [ ]  99203/5 | [ ]  90832-30 | [ ]  90849-F3 |  Auth Expires:  |  |  |
| [ ]  99212/15 | [ ]  90834-45 | [ ]  90853-G |  Insurance Card Copied [ ]  |  |  |
| [ ]  99241/45 | [ ]  90837-60 | [ ]  90885-RRvw |  DL/ID Copied [ ]  |  |  |
| [ ]  90791-Dx | [ ]  90839-CR | [ ]   | **\*\*codes not listed see billing manual codex** |
| [ ]  90792-WD | [ ]  90840-CR2 | [ ]   | MM-Medication Mgmt |  |  |
| [ ]  96102-MMPI | [ ]  90846-F | [ ]  90887-Intx | ND-no doc WD-w/doc |  |  |
| [ ]  90785-PT | [ ]  90847-F2 | [ ]  90899-Unlst | CR-Crisis / H-Home Visit | Counselor: |  |

**CONFIDENTIAL EXCHANGE of**

**INFORMATION FORM**

**[NOTICE OF TREATMENT]**

|  |
| --- |
| Dr.  |

We require contracted behavioral health practitioners and provider(s) to coordinate treatment with other behavioral health practitioners and providers, primary care practitioners (PCPs), and other appropriate medical practitioners involved in a member’s care. This form acts as a notification that the patient listed below is currently under our care for behavioral health support services.

|  |  |
| --- | --- |
| **PATIENT** |  |
| Name: |                         DOB:       LAST 4 SS#:       |
|  | First | Middle | Last | Maiden |
|  |  |  |  |  |
| Address: |              |
|  | Street |  |  | Apt # |
|                   |
| City |  |  | State | Zip |
|  |  |  |  |  |
| 1. **BEHAVIORAL HEALTH FACILITY/PRACTITIONER**
 |  |
| Name: |                         |
|  | First | Middle | Last | Credentials |
|  |  |  |  |  |
| Clinic Name: | New Hope Community Services, LLC |
|  |  |  |  |  |
| Telephone # | (606) 584 7055 | Fax # | (866) 533 4929 |  |
|  |  |  |  |  |
| Address: | 901 US HWY 68 900  |
|  | Street |  |  | Ste # |
| Maysville KY 41056 |
| City |  |  | State | Zip |
|  |  |  |  |  |
|  |  |  |  |  |
| **PATIENT CLINICAL INFORMATION** |  |  |
| Patient is being treated for the following behavioral health situation: |
|  |  |  |  |
| [ ]  | Addiction |  | [ ]  | Neglect |  | [ ]  | Other: |
| [ ]  | Anger |  | [ ]  | Parenting Skills |  |  |
| [ ]  | Anxiety |  | [ ]  | Pressure/Stress |  |
| [ ]  | Depression | [ ]  | Pre-Marital Counseling |  |
| [ ]  | Drug/Alcohol Problems | [ ]  | PTSD |  |
| [ ]  | Employment Problems | [ ]  | School Problems |  |
| [ ]  | Eating Disorder | [ ]  | Self Esteem Problems |  |
| [ ]  | Home/Family Problems | [ ]  | Sexual Abuse |  |  |
| [ ]  | Legal Problems | [ ]  | Self |  |
| [ ]  | Life Changes | [ ]  | Sexual Dysfunction |  |
| [ ]  | Marital Problems | [ ]  | Suicide Issue |  |  |
|  |  |  |  |  |

**EoI Form – Page 2**

|  |
| --- |
| Patient is taking the following prescribed psychotropic medication(s): |
|  |  |  |  |
| [ ]  | AntiDepressant - SSRI | [ ]  | Antidepressant-Tricyclic | [ ]  | Antidepressant-MAOI |
| [ ]  | AntiDepressant-Wellbutrin | [ ]  | Lithium | [ ]  | Antipsychotic-Atypical |
| [ ]  | Clozaril | [ ]  | Stimulant | [ ]  | Anxiolytic |
| [ ]  | Anticonvulsant/Mood Stabilizer |  |  |  |
| [ ]  | Other: |  |  |  |  |
|  |       |
|  |
| Date Mailed or Faxed to PCP / Facility: |  |
| (copy of this form must go into patient’s file) |  |
|  |  |  |  |  |

I herby freely, voluntarily and without coercion, authorize the behavioral health practitioner listed above in Section A to release the information contained on this form to the practitioner/provider listed in section A above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last ONE YEAR from the date of signature. I understand that I may revoke my consent at any time.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Client Signature |  | Date |
|  |  |  |
|  |  |  |
| Behavioral Health Clinician orFacility Representative Signature |  | Date |
|  |  |  |

|  |
| --- |
| My Primary Care Provider is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |
| [ ]  | I am not currently receiving services from a PCP or other medical practitioner |
| [ ]  | I am not currently receiving services from any other behavioral health practitioner/provider |

**For Patient Records Applicable under Federal Law (42) CFR Part 2**

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) CFR Part 2 prohibit you from taking any further disclosure of it without the specific written consent of ht person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

**This is NOT A REQUEST FOR MEDICAL RECORDS**



**DIVORCED/SEPARATED/SOON-TO-BE DIVORCED**

**PARENTAL POLICY**

New Hope Community Services seek to provide a high quality of care to our patients and their families. Divorce can intrude on, or complicate, this service. The following is NHCS Policy as of such:

1. New Hope **REQUIRES** a copy of the custodial agreement or court order at the child’s FIRST appointment. If one cannot be obtained, reasonable time will be allotted but if it cannot be produced, treatment will be postponed until this document can be presented.
2. Court-related evaluations require a court order.
3. New Hope **REQUIRES** that the parent requesting treatment and/or evaluation through this office notify the other parent (birth or adoptive) that treatment is being sought. It is the responsibility of the treatment-seeking party to request consent from the other parent. If New Hope is informed that a parent with decision-making rights does not consent to this treatment or evaluation, New Hope will not continue to provide said services.
4. New Hope asks that both parents schedule an appointment to provide important information regarding the child and to receive periodic treatment updates. Exceptions may be made on an individual basis with legally-bound reasons being provided.
5. This office does **NOT** accept responsibility for seeking payment from the non-treatment seeking parent, regardless of your arrangement. The treatment seeking parent is responsible for paying for the reimbursement from the other party, if relevant.
6. New Hope does **NOT** agree to keep information provided by one parent from the other parent, if you share joint LEGAL custody. Information important to the well-=being of the child will be openly shared and discussed. Step-parents may be asked to participate in evaluation and treatment, where appropriate.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (parent or legal guardian), have read the divorce polity provided. I understand the policy and agree to its terms and provisions. I provide my consent for the provider(s) to speak to my child(dren)’s other parent and related parties regarding the treatment and/or evaluation provided.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Signature Date



**OUTPATIENT SERVICES AGREEMENT**

Welcome to New Hope Community Services. This document contains important information about services and policies. Please review it CAREFULLY and discuss any questions you may have with reception.

**Appointments and Professional Fees:** Sessions are typically 45 minutes in length and can be scheduled by phone or in person. Standard fees are set by your insurance carrier and contracted according to the base rates allowed by Kentucky Medicaid. If you use insurance to pay for services, please be aware that you may be responsible for ALL charges that your insurance company REFUSES to pay or your insurance coverage LAPSES and you are no longer covered. To avoid a surprise bill from New Hope, you are advised to call your insurance company to CONFIRM what mental health benefits are covered under your plan, and to obtain any required pre-authorizations for your services PRIOR TO YOUR APPOINTMENTS or otherwise clarify you need assistance with this when you initialize your support services. Bills are distributed monthly, but it may be to your advantage to keep track of your balance by asking staff.

|  |  |  |
| --- | --- | --- |
| Initial Appointment-Intake |  | $150 – per event |
| Individual, Family, Couples Therapy |  |  |
|  Master Clinicians |  | $100 – per session |
|  Doctoral Clinicians |  | $150 – per session |
|  Psychiatrist |  | $185 – per session |
| Adolescent Intervention Program |  |  |
|  Individual Therapies |  | $100 / per session |
|  Family Therapy |  | $100 / per session |
|  Couple Therapy (Parents) |  | $100 / per session |
|  Mentoring |  | $25 / Hour |
|  Case Management |  | $350 / Month |
| Psychological Testing – 6-Hour Testing |  | $450 / Full Battery |
| Adt’l Testing - Report Writing - Interpretations |  | $140 / Partial |
| Psychoeducation (Parenting, Anger Management, DVO, LifeSkills) |  | $375 - Course |
| Additional Professional Services (report & letter writing, completion of forms, telephone calls, attendance at meetings) |  | $125 – per hour |
| Forensic / Court Services (preparation & attendance at legal proceedings, even if called to testify by/for another party) ***NOTE: non-refundable for rescheduled court appearances.*** |  | ***PRE-PAID*** $250/hour – court attendance$125/hour – court preparation |
| Copies of Medical Records (after initial free copy) |  | $25 – 100 pgs / adt’l pgs .30/copy |
| Drug Testing |  | $35 – per event |
| Missed Appointments (for **ANY** reason other than weather) |  | $100 – Master’s Level$150 – Doctorate Level$185 – Psychiatrist/NPR |
| Late Cancellations (For **ANY** reason-less than 24-hour notice) |  | $100 – Master’s Level$150 – Doctorate Level$185 – Psychiatrist/NPR |
| (cannot be billed to insurance company if you miss – Patient will be responsible for FULL AMOUNT) |

|  |
| --- |
|  |

Initial

Note: Your appointment times are **SPECIFICALLY** **RESERVED** for **YOU**. Therefore, you **MUST** notify the office **24 hours in advance** if you need to cancel or reschedule. It typically requires that amount of time to attempt to fill your missed appointment slot with another patient.

**PAYMENT AND/OR ALL CO-PAYS ARE REQUIRED AT TIME OF SERVICE IN**

**ALL CIRCUMSTANCES REGARDLESS OF WHO ATTENDS THE SESSION(S).**

Most insurance companies require you to authorize New Hope to provide them with a clinical diagnosis from the Diagnostic and Statistical Manual of Mental Disorders. We may have to pride additional clinical information such as treatment plans or summaries, or even copies of the entire record. New Hope has NO CONTROL over what they do with this information once it is in their hands. In some cases, they may share the information with a national medical information database.

 **PLEASE NOTE:**  In the event of account default, all costs of collection including attorney fees, collection fees, and contingent fees to collection agencies up to 40% is patient/guardian responsibility. Such contingency fees will be added and collected by the collection agency immediately upon referral of patient’s account to the collection agency. In the case of a court action, the patient/guardian is the responsible party and will be responsible for any court costs, serving fees, and/or attorney fees.

.

CONTACTING OFFICE PERSONNEL: New Hope offices are typically open for BUSINESS OPERATIONS from 8:30 AM to 5:00 PM Monday through Friday. The majority of your phone calls will be returned on the same day that you make it, with the exception of weekends and holidays. However, we cannot be responsible for electronic glitches or answering service mistakes that do not record nor deliver your message to us. If you have not heard back from us within 24 hours, PLEASE return your call. After hours, you will receive a message instructing you with directives of what to do in case we are not available. If you have a true clinical emergency, please go to your nearest emergency room support center and let them know you are under the care of New Hope. All phone calls that are greater than 5 minutes will be charged at the hourly rate prorated in 15-minute increments.

RECORDS: You are entitled to ONE (1) free copy of your records (in whole or part) unless we feel that seeing them would be emotionally damaging. In this case, we will send them to a mental health professional of your choosing for you to review them together. We may also decide to review them with you before we distribute them outside of our agency.

*Your signature below indicates that you have read the documents, understand them, and agree to abide by their terms during this professional relationship.*

|  |
| --- |
|  |

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Signature Date

|  |
| --- |
|  |

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Witness Date



**CREDIT/DEBIT CARD GUARANTEE OF PAYMENT**

|  |
| --- |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree that New Hope Community Services, may bill my credit/debit card for the following: |

* Any services that have not been paid by myself or my insurance carrier within sixty (60) days of billing for said service;
* Missed appointments and appointments I have cancelled with less than 24-hours advanced notice (standard profession charge per Outpatient Service Agreement Fee Schedule).
* The original amount plus $50 bank fee for bounced checks, charge backs, or insufficient funds.
* Any work NHCS completes for me outside the normal therapy time (prorated @ $150/hour).

*I will NOT dispute charges (“charge backs”) made in accordance with the terms of this authorization.*

*I understand this authorization is valid for three years or until cancelled in writing.*

Type of Card: (check one) [ ]  Visa [ ]  MasterCard [ ]  Discover [ ]  AmExpress

Name as it appears on card: (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_ / \_\_\_\_\_\_\_ CVV2/CID Code (back of card – 3 digits): \_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_

 Street City State Zip

Card Holder’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_

*Note: NHCS will charge a status fee of $0.05 in order to verify validity of card and will be credited to your account.*