Renewal Life Counseling, LLC

NEW CLIENT INTAKE PACKET

Date:	Referred by (Name/Phone#):	
Client's Name:		
Marital Status: Single Married Separated Divorced Other		Sex:
Street Address:		
City, State, Zip Code:		County:
Home Phone:	Cell Phone:	
Social Security No:	Birthdate:	Age:
Employer:		
Email Address:		

Primary Insurance:		
Address:		
Phone#:	Policy#:	Group#:
Insured's Name:	Insured's SSN:	Insured's DOB:
Insured's Employer:	Insured's Phone#:	

Secondary Insurance:		
Address:		
Phone#:	Policy#:	Group#:
Insured's Name:	Insured's SSN:	Insured's DOB:
Insured's Employer:	Insured's Phone#:	

Emergency Contact:		
Name:	Phone#:	Relationship:
Name:	Phone#:	Relationship:

Primary Physician (Name/Phone#)**:**
Current Medical Problems:
Allergies:
Current Medications:
Reason for Today's visit:
Additional information you may want us to know:

AUTHORIZATION TO DISCLOSE INFORMATION

Please remember that insurance is considered a method of reimbursing the provider for services rendered. Some companies will pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is the client's/guarantor's responsibility to pay the deductible amount, coinsurance, copays, or any other balance not paid by your insurance company prior to services being rendered.** If we are filing a claim, we will allow 60 days from the filling for the insurance carrier to process your claim and make payment accordingly. If payment from your insurance company is not received within the time period specified above, we will notify you to clear your account of all balances.

I certify that I have read and fully understand the provider's billing policy and agree to make payment in full and/or satisfactory arrangements to be determined by Renewal Life Counseling, LLC or an affiliate provider.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of my medical records. I hereby assign all medical benefits, to include major medical benefits to which I am entitled via Medicare, Medicaid, private insurance and/or other health plans to Renewal Life Counseling, LLC.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. **I understand that I am financially responsible for all charges whether or not paid by the insurance carrier.**

I hereby authorize said assignee to release all information necessary to secure payment. Should the account be referred to an attorney/company for collection, the undersigned shall pay reasonable fees and collection expenses.

Client's Name: ____

Client's Signature: ____

Date: ____

INTIAL EVALUATION POLICY

If you are a new client, you may be seen for an Initial Evaluation by Tamara Houston, LISW-CP or an affiliate provider. You will be asked questions regarding your symptoms, diagnosis, and treatment. At the end of the evaluation, your provider will discuss with you whether:

Therapeutic services can be provided to you as a client OR services cannot be provided to you. In this case, a recommendation for the appropriate services may be made when possible.

Being scheduled for an Initial Evaluation does not mean that you have become a client of the provider, but that you are scheduled for assessment only. If accepted for treatment, you will be asked to sign a **Consent to Treat**, either at the end of your initial session, or at the beginning of your follow-up session.

Each provider is a licensed professional providing therapeutic services or medication management based on their training and in accordance with their licensure and scope of practice guidelines.

Clients seeking treatment or evaluation for completion of documentation, disability evaluation, anger management or legal proceedings must inform the practice of this information at the time of intake and during the Initial Evaluation so that the appropriate treatment recommendations can be made. Failure to do so may result in dismissal from the practice. Please note that additional charges may incur for completing forms, writing letters, and record preparation at request of client or other requesting entity.

Please check ONE option and sign.

- ○ I agree to the above policy and will be seen by Tamara Houston, LISW-CP or other licensed professional for an Initial Evaluation. Please complete the remaining forms and return to practice personnel.
- ○ I decline to see Tamara Houston, LISW-CP or other licensed professional for an Initial Evaluation at this time. Please return all forms to the practice personnel.

Signature: ____ Date: _______________

Renewal Life Counseling, LLC

Acknowledgement of Receipt of Notice of Privacy Practices

This signed form acknowledges that you have received a copy of our practice's Notice of Privacy Practices as required by Federal Law. Your signature does not mean that you have read this notice yet, only that you received a copy to read. If you have any questions regarding the information set forth in this Notice of Privacy Practices, please do not hesitate to ask our staff or call us later.

Printed Client's Name: ____

Client's Signature: ____

Date of Birth: ____

Signature of Authorized Person (if not client): ____

Today's Date: ____

For client's receiving this notice via mail, please sign and return this signed form to:

Privacy Officer:
Tamara Houston, LISW-CP
Renewal Life Counseling, LLC
127 Commons Way Greenville, SC 29611

TRAINING PRACTICE POLICY

This signed form acknowledges that you are aware that Renewal Life Counseling, LLC is an intern and supervisee-friendly practice. Providers may accept interns/supervisees to their practice to participate in observation of services being rendered. With your permission, an intern/supervisee may be assigned as a co-lead clinician to engage clients in the therapeutic or medication management process, under the supervision of a licensed professional. As a client, you have the right to refuse this engagement or observation.

I have read and understand this policy.

Print Client's Name: ____

Client/Guarantor Signature: ____

Date: ____

Renewal Life Counseling, LLC

PRACTICE TREATMENT & FINANCIAL POLICY

IMPORTANT: Renewal Life Counseling clinicians and affiliate providers may not be available 24 hours a day. In the event of a problem or question, please call Renewal Life Counseling, LLC during the hours Monday-Thursday 9am-5pm and Friday 9am-1pm. In the event of an emergency or urgent situation after-hours and on weekends, please go to your nearest emergency room for treatment. Your provider may have additional requests in regards to handling emergencies.

PRIVATE PAY (NO INSURANCE): I do not have insurance coverage. I will not file to any insurance company for reimbursement. I understand that I am responsible for my bill at the time of service.

Client/Guarantor Signature: ______________________________________ Date: ________________

Medicare, Managed Care Companies (MEDICAID), and Private Insurance (COMMERCIAL): As a professional courtesy, we will file your insurance. We cannot assume responsibility of your payment by your insurance carrier. Some providers may accept assignment from these plans, as in-network or out-of-network providers, and will bill for services provided. The client is responsible for their portion of the allowable charges at the time of service, to include, copay, deductible, coinsurance, and any services not covered within the benefits. Failure to do so may result in rescheduling your appointment or dismissal from receiving services.

Employee Assistance Programs: Some providers may contract with EAP, and will accept the negotiated rate for specified services per the EAP contract. There may be instances where no call, no show fees will be allowed per the EAP contract, and will be the responsibility of the party identified in the EAP intake forms or contract with provider.

Other information:

- A client may be dismissed from services after missing 2 appointments ("no shows"), and charges may incur due to missed visits (does not apply to MCOs and most EAPs).
- Clients that are 15 minutes late will have to reschedule at provider's convenience.
- A cancellation or reschedule call must be received 24 hours prior to scheduled appointment. Otherwise, a $50 fee may be assessed to account balance (does not apply to MCOs and most EAPs).
- Arrangements to satisfy balance must be made prior to appointment being rescheduled.
- Each provider reserves the right to dismiss any client who is non-compliant with treatment or this contract.

I have read and understand this policy.
Print Client's Name: ____
Client/Guarantor Signature: ____
Date:____

Fee Schedule

Renewal Life Counseling, LLC

Please note the following fees will be applied to your account for services rendered at Renewal Life Counseling, LLC by clinicians or affiliate providers. Providers agree to accept assignment from your insurance plan or Employee Assistance Plan for these services.

Service	Fee
Initial Psychotherapy Eval	$165
Follow-Up Psychotherapy (60 or 45 min)	$165/$145
Family Therapy	$185
No-Call (24 hours), No-Show Fee*	$50 (must be paid prior to rescheduling)
Medical Records Request	$25 (up to 15 pages) .10/p for thereafter
Disability Services**	$75+ (must be paid prior to completion)

*NCNS-does not apply to Medicaid plans and most Employee Assistance Plans (EAPs)

Disability Services-paperwork will not be completed under Employee Assistance authorizations, unless the EAP contracts for that service. Pt must be seen for at least four **(4) sessions prior to completion of any disability paperwork for other insurance plans and private pay clients.

I have read and understand this policy.

Print Client's Name: ____

Client/Guarantor Signature: ____

Date: ____

*************************Remainder of Page Intentionally Left Blank*************************

Consent for Email, Text Messages, and Phone Messages Communications

Clients being seen at Renewal Life Counseling, LLC by Tamara Houston, LISW-CP or an affiliate provider may be contacted via email, text messaging, or phone message to remind you of an appointment.

If at any time I provide an email, text address, or phone number at which I may be contacted, I consent to receiving appointment from the Practice.

____ (Client Initials) I consent to receive text messages or phone messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails, text messages, or phone messages will apply to all future appointment reminders unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages or phone messages for appointment reminders, feedback, and general health reminders/information is_______________________________.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/statements/information is____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation

____I hereby revoke my request for future communications via email/text/phone messages.

____I hereby revoke my request to receive any future appointment reminders, feedback, statements, and general health via email.

Note: This revocation only applies to communications from this Practice.

Client's Name: ____

Client/Client Representative Signature: ____

Note: Client acknowledges that communications made via email or text may not be HIPAA compliant. It is strongly suggested that client does not provide any Personal Health Information (PHI), outside of need to cancel or reschedule an appointment. Should you need to discuss specifics about your treatment, please call the main office number or the number provided to you by your provider to communicate those needs or contact through client portal email.

____ (Client Initials) I hereby acknowledge that communications via text or outside client portal email are not HIPAA compliant.