Renewed Relationships Counseling and Psychological Services
Adult Social/Medical History

Patient Name:_____DOB: _____ Sex: _____ Race: _____
Emergency Contact Name and Number:_____Marital Status:_____

1. Please list the concerns that bring you here today._____

_____

2. Have you had previous counseling or treatment? ☐ YES ☐ NO
If yes, please list dates, types of treatment (including medications), and outcome of treatment._____

_____

3. Medical
Physician name and contact information:_____
Current medications and dosage:_____

_____

Please list all medical conditions, illnesses, surgeries._____

_____

4. Have you ever had suicidal thoughts or attempts? YES ☐ NO ☐
If yes, please provide date and details. _____
Have you ever tried to hurt another person? YES ☐ NO ☐
If yes, please provide date and details. _____

5. Please describe your past and current substance use, including drugs, alcohol, caffeine, or other. Include past substance use if it relates to your treatment. _____

_____

6. Family history: Please describe any family history of mental health or substance abuse. Include condition and family member.

_____

_____

Have you ever experienced any form of abuse? YES ☐ NO ☐
If yes, please provide dates, perpetrator, and whether it was reported. _____

_____

Please indicate who you lived with while growing up and describe past and current relationships with family members. _____

_____

_____

7. Educational and occupational:
Occupation:_____ Highest grade completed: _____
Spouse's occupation: _____ Highest grade completed: _____

Please describe any difficulties you have had in school or at work with behavior, learning, authority, or social interactions._____

_____

8. Social: Please describe the nature and quality of your social relationships, including your support network and ability to make friends.

_____

Please describe your current romantic relationship status. If married, please list how long and if this is your first marriage. _____

_____

Patient Name:_____ DOB: _____

Do you have children? ☐ YES ☐ NO

If yes, please list their names, ages, and where they live. _____

_____

9. Do you have a faith or religious belief system? ☐ YES ☐ NO

If yes, please describe. _____

10. Please list your hobbies and interests. _____

11. Legal history: Please describe any history with the courts or legal system._____

_____

12. Please select any symptom below that has been present in the last ***two months.***

Physical		**Social**	
Change in appetite	**Disturbed sleep**	**Difficulty Getting Along with others**	**Irritability**
Muscle tension	**Diminished energy**	**Withdrawing from others**	**Losing temper easily**
Weight loss/gain		**Difficulty sustaining relationships**	
Performance		**Thoughts/Feelings**	
Poor motivation	**Difficulty completing tasks**	**Intrusive thoughts**	**Crying easily**
Impaired concentration	**Difficulty making decisions**	**Episodes of terror or panic**	**Low self-esteem**
Poor academic or work performance		**Racing thoughts**	**Becoming angry easily**
Other		**Mind goes blank**	**Feeling sad or blue**
Urges to harm others	**Cutting/self harm**	**Feeling anxious or stressed**	**Difficulty feeling pleasure**
Suicidal thoughts	**Repetitive behaviors**	**Excessive guilt**	**Feeling worthless**
Feeling like you are being watched or talked about	**Thoughts of death/dying**	**Feeling easily overwhelmed**	**Feeling hopeless**

Please provide details about circled symptoms and list any other symptoms. _____

_____

_____

_____

_____

13. Is there any other information you would like to share that you believe to be relevant to your treatment?_____

_____

_____

Patient's signature _____ Date _____

Renewed Relationships Counseling and Psychological Services

CONTACT AND BILLING INFORMATION

Date_____

Patient Name_____ Date of Birth_____

Employer_____ D.L. #_____

Email address_____ Cell Phone_____

Home Phone_____ Work Phone_____

Address_____

How may we contact you with appointment reminders? (please check one if desired)
_☐_email, _☐_cell phone call, _☐_text to cell phone

How did you hear about us? (select one and write name of individual)

Psychology Today ☐ internet search ☐ pastor ☐ physician ☐ insurance company ☐
employer ☐ friend ☐ other ☐ name: _____

Responsible Party, Parent or Legal Guardian Information (if applicable-leave blank if same)

Name_____ Date of Birth _____

Employer_____ D.L. #_____

Email address_____ Cell Phone_____

Home Phone_____ Work Phone_____

Address_____

Primary Insurance Information (if applicable)

Policy Holder_____ Policy Holder D.O.B._____

Relationship to Patient_____ Insurance Company_____

Patient ID_____ Group #_____

Policy Holder's Employer_____

Home Phone_____ Work Phone_____

Address_____

Secondary Insurance Information (if applicable)

Policy Holder_____ Policy Holder D.O.B._____

Relationship to Patient_____ Insurance Company_____

Patient ID_____ Group #_____

Renewed Relationships Counseling and Psychological Services
Treatment and Diagnostic Services Consent

Patient: _____ **Date of Birth:_____**

Welcome to our practice. This document contains important information about our professional services and business policies. You will also be given access to a HIPAA Notice of Privacy Practices. We will be happy to discuss with you their contents and to answer any of your questions.

Services: The services provided to you or your dependent will be based on currently accepted practice in the field of mental health. We cannot guarantee the outcome of treatment and any services continue only with your voluntary consent. Your therapist will normally conduct an initial evaluation to determine if he/she is the best person to meet your clinical needs, as well as discuss resources and potential referrals.

Confidentiality: All services you will receive are confidential, and you can expect privacy in our meetings. Exceptions to confidentiality include a patient's threat to him/herself or to others, as well as suspicions of abuse. In those cases, we are obligated to seek help for the concerned party.

The law allows parents to have access to their dependents' records. We ask that parents respect their child's privacy and not ask questions about treatment, though we are willing to meet with parents periodically to discuss treatment progress and any concerns. If the child is in danger or poses a threat to another, we will notify the parents of our concerns.

Clinical hours and contact: Clinic hours are Monday through Thursday from 8 am until 9 pm, and office hours are Monday through Thursday from 8 am until 3 pm. If we are not immediately available by phone, please feel free to leave a detailed message or send an e-mail, and we will contact you as soon as we become available. If it is an emergency, please call 911 or go to the nearest emergency room. By signing this form, you give us permission to contact you by mail, telephone, or email to discuss scheduling, billing and payment, completion of forms, and any others questions related to your services.

Insurance and billing: By signing this document, you authorize us to bill your insurance company and give them full information necessary to obtain payments for services. You are responsible for the payment of fees and knowledge of your individual policy. While we will attempt to work with you to address any insurance concerns, we **cannot be responsible for quoting any benefit information**. Co-pays and fees for session are due at the time of each session. Missed appointments are not covered by insurance, and we reserve the right to bill you at the usual fee for any appointment that is missed without 24 hours notice. A failure to pay your balance in a timely manner may result in the clinic contracting with a collections agency, and you will be responsible for any fees associated with this process.

Documentation and Limits of Services: I understand that I am consenting to treatment, and this treatment is focused on assisting me emotionally, not a psychological evaluation for the court system. I will not ask my therapist or Renewed Relationships to provide fact or expert testimony, attend court hearings, or speak to legal counsel regarding my substance use, my abilities as a parent, parental custody, or any services provided by our clinic. If a therapist is required to attend court hearings for any reason (i.e.-court ordered), I understand that I will be liable for a Legal Consultation cost of $200/hour. This will apply to all time spent outside the therapist's office, including but not limited to: all time spent in court, travel to and from court, time preparing written documentation, gathering medical records, and speaking to counsel, in anticipation of canceled patients. Charges will not include only the time required to testify.

I also understand that Renewed Relationships charges a $30 fee for records review or paperwork outside of clinical documentation. This can include but is not limited to disability paperwork, providing copies of a patient's chart, letters for academic accommodations, or any documentation of session attendance/progress for a third party. Regular communication with a physician or other provider will not result in this charge.

Your signature below acknowledges that you are voluntarily authorizing diagnostic and treatment services at Renewed Relationships Counseling and Psychological Services for yourself or your dependent. You recognize that you may refuse any aspect of treatment. You also recognize that such a refusal may, in some instances, result in termination of services. Your signature below indicates you have read this document and agree to its terms.

_____

Signature of Patient or Parent/Guardian Date

Consent for Telehealth/Telemedicine

I, _____,hereby consent to engaging in telemedicine at Renewed Relationships Counseling and Psychological Services (Renewed Relationships), as part of my medical treatment and psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psycheducation using interactive audio, video, or data communications. I understand that, with my signed consent, telemedicine may also involve the communication of my mental health information, both orally and visually.

Technology: I understand that I will need to have secure internet connection or a smart phone device with a strong connection at a location deemed appropriate for services. A variety of HIPAA compliant platforms may be used, and my provider will discuss this with me.

Risks: I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/session if it is felt that the videoconferencing connections are not adequate for the situation. My provider will reach out to me via phone if our connection is interrupted.

Financial Obligation: Fees associated with telemedicine appointments are billable to most major insurance companies and Renewed Relationships will bill my insurance on my behalf. Any fees associated will my telemedicine services not covered by my insurance remain my responsibility. I agree to have my credit/debit card information on file at Renewed Relationships. My card will be billed the same day (or the next morning) as my scheduled telemedicine appointment. If my card is declined, Renewed Relationships will cancel my appointment and I will be charged in accordance with the cancellation policy.

Clients with insurance: I am responsible for contacting my insurance company, if applicable, to determine what my out-of- pocket costs may be. I authorize insurance benefits to be paid directly to Renewed Relationships and for the release of any information to my insurance provider required for processing my claims.

Self-pay clients: I am aware of the fees associated with telemedicine appointments and agree to pay at the time of my appointment. I understand that I am responsible for cancelled telemedicine appointments in accordance with the Renewed Relationships cancellation policy as documented by my signature on the informed consent. I understand that using the Telemedicine platform allows access to mental health services that might not otherwise be available to me due to my mental health, and/or my physical, resource, or geographic limitations.

Scheduling: I understand that scheduling is conducted through Renewed Relationships and is based on my provider's normal clinic hours. Telemedicine appointments are considered outpatient services and not intended as a substitute for emergency or crisis services.

_____ _____

Patient Full Name Signature

_____

Date

Email I wish to use for communication about my care: _____

Best phone number to reach me should our connection be interrupted: _____