

Renewed Relationships Counseling and Psychological Services
CONTACT AND BILLING INFORMATION FOR CHILDREN/ADOLESCENTS

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
employer friend other name: company _____

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 _____

Additional Parent or Legal Guardian Information (if applicable-leave blank if same)

Name _____ Date of Birth _____

Employer _____ D.L. # _____

Email address _____ Primary Phone _____

Address _____

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 _____

Renewed Relationships Counseling and Psychological Services
Child/Adolescent Social/Medical History

Patient/Child's Name: _____ DOB: _____ Sex: _____ Race: _____
Emergency Contact Name and Number: _____ Person Completing Form: _____

1. Please list the concerns that bring the child here today and include what you have done to try to address these concerns. _____

2. Has the patient 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. Has child ever had suicidal thoughts or attempts? YES NO
If yes, please provide date and details. _____
Has child ever tried to hurt another person? YES NO
If yes, please provide date and details. _____

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

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

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

Please indicate who lives with child and describe past and current relationships with family members. _____

7. Developmental: Please describe child's milestones, such as walking, talking, etc. Include any developmental delays and complications in early childhood (attachment issues, tantrums, biting, rocking, etc.). _____

8. Educational and occupational:
Grade: _____ School attending: _____ Current GPA: _____

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

Patient/Child's Name: _____

DOB: _____

9. Social: Please describe the nature and quality of child's social relationships, including support network and ability to make friends.

10. Does child and/or family have a faith or religious belief system? YES NO

If yes, please describe. _____

11. Please list child's hobbies and interests. _____

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

13. Please indicate any symptom below that has been present in the last **two months**.

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

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 child's treatment? _____

Parent/guardian signature _____ Date _____

Renewed Relationships Counseling and Psychological Services

Child/Adolescent Treatment and Diagnostic Services Consent

(must be signed by both parents in cases of shared custody)

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 can. 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 the treatment of my child, and this treatment is focused on assisting my child 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 child's welfare, my abilities as a parent, my child's preference for 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 by 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

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 psychoeducation 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 with 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: _____