Renewal, LLC
Preliminary Client Information for Minors

Please fill out and bring to first session.

Client (Minor) Information:

Last Name	First Name	Home Phone	Cell Phone

Address	City/State	Zip Code

Email	Date of Birth	Age	M / F	School/Grade

Communication Clearance: *(Check if I can contact you in this way.)* ☐ Home Phone ☐ Cell Phone ☐ Email	Name of Siblings and Ages

Guardian Information

_____
Name of Person Filling Out This Form

_____ _____
Mother's Name Date of Birth

_____
Employer

_____ _____
Father's Name Date of Birth

_____
Employer

Who is the legal guardian? _____ Do both parents agree to therapy services? _____

Briefly describe why you are seeking services for your child at this time:

_____

_____

_____

_____

_____

_____

Please indicate which of the following problems the child experiences. Check all that apply:

- ☐ Crying spells
- ☐ Excessive fears or anxieties
- ☐ Difficulty being away from specific family members
- ☐ Hearing voices
- ☐ Getting into trouble at school/play
- ☐ Temper tantrums
- ☐ Difficulty falling asleep/inability to sleep at night
- ☐ Decreased/increased appetite
- ☐ Loss of interest in usual activities
- ☐ Hyperactivity
- ☐ Bullying/picking fights
- ☐ Refusal to respond to authority
- ☐ Nightmares
- ☐ Obsessions/compulsion with specific activities
- ☐ Lack of motivation
- ☐ Lack of self-confidence
- ☐ Difficulty making or keeping friends
- ☐ Other: _____

Referral Source (Check all that apply)

- ☐ Google Search
- ☐ Renewal Counseling Website
- ☐ Online Index or Yellow Pages
- ☐ Insurance Company
- ☐ Doctor: _____
- ☐ Church: _____
- ☐ Client of Renewal Counseling: _____
- ☐ Other: _____

Agreement

By signing below, I acknowledge the following:

1. *I have received a copy of the Notice of Privacy Policies.*
2. *I have received a copy of the Client Information & Policy Statement.*
3. *I have read and agreed to the payment/cancellation policy.*

_____ _____

Signature of Legal Guardian Date

RENEWAL, LLC
Consent for Counseling Minors

Name of Parent or Guardian

Name of Minor Recipient of Counseling Services ("Minor" or "Child")

Minor's Date of Birth

Are you the parent of this Child? ☐ YES ☐ NO

Are you currently married to the Child's other parent? ☐ YES ☐ NO

Are you divorced? ☐ Yes ☐ No If yes, are you the custodial parent of the Child? ☐ YES ☐ NO
If yes, please provide Renewal, LLC, with a copy of the divorce decree.

Are you the legal guardian of the Child? ☐ YES ☐ NO
If yes, please provide Renewal LLC, with a copy of the guardianship form.

* * * * * * * * * * *

By signature below, I certify that I authorize and give permission to Renewal, LLC, to provide counseling services to my child. I understand that counseling services may include individual, family, and group psychotherapy. I understand such counseling services may include consultation with other members of Renewal, LLC and also may include referrals to other appropriate professional, county, or state agencies, where necessary.

Signature of Parent/Guardian/Custodial Parent — Date

Signature of Parent/Guardian/Custodial Parent — Date

Street Address

City — State — Zip

Home Phone — Work Phone

Emergency Contact (other than yourself):

Name — Phone

Signature of Witness

Signature	Title	Date

Renewal, LLC
Client Consent and Policy Statement

This document contains important information about the nature of your sessions and the therapeutic process. It is important that you read this very carefully and ask your therapist any questions you may have so we can discuss them.

Nature of Counseling
Your participation in therapy is completely voluntary and you can, if you choose, discontinue sessions at any time. The counseling relationship is a collaborative journey, and you are encouraged to take an active role in the planning of your journey.

Beginning counseling is a big step and it is important that you understand that there could be risks involved. Sometimes people try to avoid their problems and by talking about them, initially things may seem worse as you are dealing with them. Also, the growth that you make throughout this process may affect relationships with those in your life that are not growing along with you.

Treatment will be tailored to your needs. You may reserve the right to decline treatment against professional advice. You have the continuing right to an explanation of the benefits of how therapy is being conducted. Understand that there is no assurance that you will feel better.
The length of therapy is greatly determined by each situation. The goal in regards to the length of therapy is to resolve the issues that brought you in as thoroughly but quickly as possible.

Most sessions are scheduled for 50-55 minutes unless otherwise specified. 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 therapist's ethical responsibility to end therapy when it is reasonably clear that you are no longer benefiting from treatment.

Appointments are to be kept at their scheduled time. If an appointment must be cancelled, a 24-hour notice is required. If the cancellation is given with less than a 24-hour 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 us immediately and we will reschedule your appointment without additional charge. If your credit card is on file, you will be charged automatically.

INITIAL HERE: _____ *I have read and accept the cancellation policy.*

Availability
Our general philosophy regarding emergencies is that clients are assumed to be self-responsible (functioning, and not in need of day-to-day supervision). As a private practice, we cannot assume responsibility for a client's day-to-day functioning as can institutions, nor can we be available for 24-hour per day crisis care. If you are anticipating a crisis situation, you must discuss any expectations you have with us and agree to develop and follow a written step-by-step crisis plan. If the need for crisis care arises unexpectedly, proceed to the nearest hospital or call 911. In the event that your therapist is out of town or unavailable, they will make every effort to let you know in advance and provide you with an alternative counselor to see in their absence.

Confidentiality
Confidentiality is vital to the therapeutic relationship. Your right to confidentiality will be protected, however, there are a few circumstances that limit this right. These include:

1. you, as a client, give Renewal, LLC, permission to release your records to a third party specified by you. In this situation, you will sign a release of information form before anything will be shared. If you are seeing more than one therapist at Renewal, LLC – this informed consent covers you for all practitioners involved in your care and your care can be discussed between those practitioners,
2. law mandates reporting if you present a danger to yourself or imminent danger to others,
3. law also mandates reporting if there is evidence to believe that abuse or neglect of a child or vulnerable adult is occurring,
4. instances where the court or government subpoena records,
5. information will be shared if you choose to involve insurance providers.
6.

Due to the confidential nature of the therapeutic relationship, we do not engage in online social networking with current or previous clients (including but not limited to Facebook, LinkedIn, Instagram or Twitter).

Record Keeping

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. If you do not have an appointment scheduled and have not been seen for 60 days, we will make your chart inactive and you will need to contact us to reactivate your chart.

Disagreements

If a situation comes up during therapeutic process where you are uncomfortable in any way, please notify us immediately so that it can be discussed at that time. It is essential to have trust in this relationship. Do not worry about offending us in any way. We are here to help you and any negative thoughts or feelings would be counter-productive to your sessions.

Payment

Payment in cash, check, or credit card is expected in full at the time of service. There will be a $25 charge for each "non- sufficient funds" check returned and if this occurs more than two (2) times, payment will only be accepted in the form of cash or credit.

Agreement

I have read this information completely, understand what is said, and have discussed any questions that I might have with the counselor. I realize that this is a binding agreement and will be held to all standards mentioned above and by signing this, I agree with this document in its entirety.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

HIPAA Email Consent

Email is a very popular and convenient way to communicate for a lot of people, so HIPAA (Health Insurance Portability and Accountability Act) allows clients the option of communication with counselors as long as clients understand the risks.

When we send you an email, or you send us an email, the information that is sent is not encrypted. Renewal has taken the steps to attain HIPAA compliant email; however, at this time, we do not use encryption. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.

Email is not appropriate for urgent or emergency situations. Email should be utilized to communicate basic information and should be concise. It is best to avoid communicating sensitive information; such as credit card numbers.

It is Renewal's policy to read all emails and if necessary, print it and add to you file. After that the email is deleted. Renewal will not forward your emails outside of our own network of counselors. We are not liable for breaches of confidentiality caused by unencrypted email.

Choose one of the following options:

☐ I authorize email communication

☐ **DO NOT** communicate with via email

Appointment Reminders:

Renewal, LLC provides clients with the option to receive appointment reminders via email or text. Please indicate which type of reminders you would like to receive. Please note that Renewal, LLC does not communicate any information outside of appointment reminders via text messages. Replies will not be received. I understand that if I opt in to text message reminders that standard text messaging rates may apply.

Please check all that apply:

☐ I authorize email reminders

☐ I authorize text (SMS) message reminders

☐ I opt out of appointment reminders

I understand that Renewal, LLC may transmit my protected health information electronically as described above unless and until I revoke or amend this authorization by submitting notice to Renewal, LLC in writing. This authorization does not allow for electronic transmission of my protected health information to third parties, and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

By signing below, I acknowledge my authorization of electronic communication email address on file with your office.

_____

Printed Name

_____ _____

Signature **Date**

Renewal, LLC
Credit Card Authorization Form

Client Name:

_____

Name on Card (if different than client):

_____

Type of Card: Visa ☐ MC ☐ AmEx ☐ Discover ☐

By signing this document, you are stating that you are the holder of this card and you authorize Renewal, LLC to charge this card for this and future sessions or no show/late cancel fees.

_____ _____

Signature Date