the Renaissance Center
Christian Counseling

6665 Security Boulevard
Woodlawn, Maryland 21207

Last Name: _____ **First Name**: _____ **MI**: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Birthday: _____**Social Security Number**: _____

Sex: _____**Male** _____**Female** **Marital Status**: ☐ S ☐ M ☐ D ☐ W

Email Address: _____

Home Phone: (___) _____-_____**Work Phone**: (___) _____-_____ **Cell Phone**: (___) _____-_____

Emergency Contact Name: _____**Relationship**: _____**Phone:** (___) _____-____

Primary Insurance:

Insurance Company: _____**Insured Name**: _____

Relationship: _____ **DOB**: _____

Co-Pay: _____ **Effective Date**: _____

Policy Number: _____ **Group Number**: _____

Employer: _____

****If you are using your EAP *(Employee Assistant Program*) Benefits please complete the following information: ****

EAP Company Name: _____

Authorization Number: _____ **Number of Authorized Sessions**: _____

Guarantor Information: (Parent, Guardian, or Responsible Party)

Name: _____ **DOB**: _____ **Relationship**: _____

Address: _____ **Phone Number**: (___) _____-_____

City: _____ **State**: _____ **Zip**: _____

AUTHORIZATION:

I authorize The Renaissance Center to apply for benefits on my behalf for services rendered by the facility. I request payment from my insurance company to be made directly to The Renaissance Center and its Associates. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand nothing herein relieved me of the responsibility and obligation to pay for medical services provided, when a statement is rendered. I agree that all bills are due when rendered and I agree I will be charged a fee for missed appointment without 24 hour notice. I agree that all such amounts are reasonable. I further agree in the event that my account shall be referred to an attorney for collection, that I agree to pay and be responsible for the amount of such bill together with any and all collection costs, private process servers fees, attorney fees of one-third of the amount of such bill at the time of referral at time of collection, which sum I further agree is reasonable plus court costs.

Signature of Client of Guardian: _____ **Date**: ____/____/___

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6665 Security Blvd. Woodlawn, MD 21207
Office: 410-265-7291 Fax: 410-265-7294

POLICIES AND PROCEDURES

Welcome to The Renaissance Christian Counseling Center. Please read all documents thoroughly and complete them where necessary, so that you are prepared to discuss any questions with your therapist during your first session.

1. RELEASE OF INFORMATION FORM

All information obtained/derived by the course of treatment is fully confidential; disclosures you share with your therapist are confidential unless you have SIGNED a consent form to release part or all of the information.

Therefore, to wither release or obtain information from a specific individual or agency, a Release of Information must be obtained. Exceptions to this guideline include instances when 1) the patient is a clear danger to (a) themselves or (b) others, and 2) instances when the patient is a minor (under the age of 18) and reports that he or she is or has been a victim or physical or sexual abuse, and/or 3) there is any suspected abuse to a child or adult. Please sign and date all Release of Information documents.

In addition, cases are occasionally discussed by the center's professional staff to obtain feedback and provide alternative treatment plans and continuity of care (e.g. your therapist, if unlicensed, will discuss your case with his or her Clinical Supervisor). Your signature on this form will allow this process to proceed smoothly.

2. TELEPHONE CALLS

Occasionally the need to talk to your therapist may arise between normally scheduled sessions. It is difficult to conduct psychotherapy over the phone but your therapist will respond to your call during his or her normal business hours. If there is an emergency and a therapist or anyone at The Renaissance Center is unable to be reached, call 911 or go immediately to your local Emergency room.

3. LENGTH OF SESSION

The psychotherapy session is about 45-50 minutes in length beginning at our appointed time. Therefore, it is to your benefit to arrive 10 minutes in advance of the scheduled. Since your therapist has sessions scheduled after yours, **the sessions must end 45-50 minutes after the appointment time regardless of your arrival time** (full fee for the session will be charged).

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4. FEES AND PAYMENTS
All co-pays are due at the time of service. We accept VISA, MC and Cash. Personal checks are accepted, they should be made payable to MSBC FIVE STAR PROGRAM INC. There is also a $15.00 charge for letters to lawyers, schools, employer, etc. A $25.00 service will be levied on all checks returned by a bank for insufficient funds. Our current fee per session is between $125 and $150 per session.

5. INSURANCE
We will gladly file insurance forms for you; however, you are responsible for any amount not covered by your insurance for whatever reason. We cannot accept responsibility for negotiating a settlement on a disputed claim.

If your insurance changes or is terminated, please notify The Renaissance Center at 410-265-7291 and let the Administrative Staff know your new information so that they can verify your new coverage. Please note that you are responsible for the entire fee if the insurance changes and you fail to notify us prior to your scheduled appointment.

6. CANCELLATIONS AND MISSED APPOINTMENTS
When an appointment is scheduled, that time is reserved for you. If the appointment is missed or cancelled without sufficient notice, the therapist is unable to make use of that time. Please note that the reason for missing an appointment is not relevant to the cancellation fee being assessed. **This fee is assessed regardless of whether or not it is the client's "fault" that they missed the scheduled appointment**. The reason for this is that our counselors have reserved this time for the client. **Therefore, sessions must be cancelled 24 hours in advance or a cancellation fee of $60 will be charged. This fee is due at your next scheduled session.**

We trust that your involvement within our Clinical System will be helpful and profitable to you. If you have any questions regarding these arrangements or other aspects of your relationship with us, please discuss them with your therapist of the Executive Director.

This is to certify that I have read, understand, and have been given a copy of this document.

Patient's Name (printed) _____ **Date:** _____

Patient's Signature: _____

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FINANCIAL AND SCHEDULING POLICY AGREEMENT

PROFESSIONAL/PASTORAL COUNSELING

Professional and Pastoral counseling is intended to encourage mental, emotional and spiritual growth in a person's life. The counselor is trained to listen, support, clarify and assist the client in goal setting and alleviation of distress brought on by the presenting problem. A termination appointment is requested to bring closure to counseling.

COUNSELING STAFF

Counselors are licensed in the State of Maryland, certified, in the process of being licensed/certified, or are counseling interns/students enrolled in an accredited master's program in counseling.

CONFIDENTIALITY

We endeavor to protect the confidentiality of all people receiving pastoral counseling. What you and your counselor discuss is not shared with anyone else, except possibly with a professional counselor for purposes of collaboration and supervision. In these instances, your circumstances will be discussed without using your name. These circumstances will be kept confidential with respect to all other persons outside of the supervision or collaboration. Confidentiality cannot be guaranteed in group, family and marital counseling.

If a client intends to take harmful, dangerous or criminal activity against another human being or himself/herself then it is our responsibility to warn appropriate persons of those intentions.

LEGAL RESPONSIBILTY

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a client either at The Renaissance Center or against any person who works for the center or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

COUNSELING PRECAUTIONS

Most clients report great benefit from counseling but there are a few risks. Counseling may make clients experience negative feelings and they may recall unpleasant memories. Both in individual and

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group counseling the client may feel worse before he/she feels better. Marriage counseling has helped many couples experience increased marital satisfaction but counseling cannot eliminate the possibility of divorce.

FINANCIAL

Payment is expected at the time service is rendered. If you choose to pay by check for counseling service, please be prepared to supply a form of ID, such as a driver's license.

FOR INSURANCE PAYMENTS:

: I/We understand that even though The Renaissance Center is billing my/our insurances that I/We are responsible for any balance that insurance does not cover.

: All balances on accounts will be collected from clients 90 days after insurance has been billed.

This means that The Renaissance Center is giving your insurance company 90 days to pay the claim. The law states that it must be processed within 30 days of receipt.

: After 90 day, you are responsible to pay The Renaissance Center directly. We will give you a receipt, which you can use to try to get your insurance company to reimburse you.

: I\/We understand that by signing this form, I/We agree to pay The Renaissance Center any unpaid balance on my/our account in a prompt manner.

SCHEDULING

Normally our counselors schedule clients into a particular time slot, which is either a weekly or every other week time slot.

It is our policy to allow once cancellation for every two months that you occupy a particular spot. After that you lose your normal appointment time and will have to fit into another available slot.

: Note: Everything on this forms pertains to keeping your normal spot. If you cancel with less than 24 hours' notice, the cancellation fee of $60 applies.

I, _____ have received and understand the above reference to my confidentiality/counseling rights and the financial/scheduling policy at The Renaissance Center. I further understand that this form and my signature are to become a permanent part of my record at The Renaissance Center.

_____

Patient's Signature **Date**

_____

Patient's Signature **Date**

_____

Parent/Guardian Signature **Date**

_____

Counselor's Signature **Date**

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HEALTH QUESTIONNAIRE

Name: _____ **DOB**: _____

Last Complete Physical Exam: _____ _____

Date **Physician/Facility**

Primary Care Doctor or Pediatrician Name: _____

Address: _____**Phone Number**: (___) _____-_____

ALLERGIES:

	MEDICATION/SUBSTANCE	**TYPE OF REACTION**
1.	_____	_____
2.	_____	_____
3.	_____	_____

Past or Present Illnesses: (Circle any that apply)

1. Asthma
2. Bed Wetting
3. Cancer
4. Diabetes
5. Head Injury
6. Heart Problems/Murmur
7. Hepatitis
8. High Blood Pressure
9. Kidney Disease
11. Prematurity
12. Seizure/Epilepsy
14. Sexually Transmitted
14. Tuberculosis
15. HIV/AIDS
16. Sickle Cell or Blood Disorders
17. Other: _____

Do you have any present pain? Yes_____**No**_____ if yes, describe and rate (1=slight pain to 10=serve pain)

_____

_____

Surgeries:

_____

Over the counter medicines taken regularly (for example: vitamins, aspirin, laxatives, etc.):

_____

Prescription Medicines:

_____

_____

Circle answers to the following:

Tobacco Use: ☐ **YES** ☐ **NO**
Alcohol Use: ☐ **YES** ☐ **NO**
Other Drug Use: (e.g. street drugs) ☐ **YES** ☐ **NO**
Caffeine Use: (e.g. coffee, tea, chocolate, cola) ☐ **YES** ☐ **NO**

Sexually Active: ☐ **YES** ☐ **NO**
Birth Control Method (male & female) _____

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Family History:

1. **Mental Health**: _____
2. **Mental Retardation**: _____
3. **Substance Abuse**: _____
4. **Kidney Disease**: _____
5. **Heart Problems**: _____
6. **Cancer**: _____
7. **Diabetes**: _____
8. **Lung Disease**: _____
9. **Other**: _____

_____ _____

Client Signature **Date**

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Counselor Signature **Date**

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(410) 265-7291 Office (410) 265-7294 Fax

AUTHORIZATION TO RELEASE INFORMATION

I _____, hereby consent and authorize The Renaissance Center to disclose and/or receive the following information.

- □ Diagnosis/ Assessment
- □ Treatment/Rehabilitation
- □ Medications/Prescriptions
- □ Latest Physical Examination
- □ Record of Treatment from your facility
- □ All of the above
- □ Results of Drug Screen/Testing
- □ Attendance & Fee Payment History
- □ Education/Vocational Assessment
- □ Psychological Assessment
- □ Discharge Summary

Information is to be released to the following:

Name: _____

Phone #: _____ Fax #: _____

_____ _____
Client's Signature Date

_____ _____
Last four digits of SSN Date of Birth

Guardian (if applicable): _____ _____
Print Name Date

Signature: _____ Relationship to Client: _____

I understand that my records are protected under the Federal Confidentiality Regulations (42 CFR) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent, in writing, at any time except to the extent that action has taken has been taken in reliance on it. This consent expires one year from the above date or upon my termination of service from The Renaissance Center.

Client or Guardians Initials: _____

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Woodlawn, Maryland 21207

HIPPA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Practices describe how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health services.

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your counselor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay for your health care bills, to support the business activities of your counselor's practice and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI as necessary to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your counselor's practice. These activities include, but not limited to, quality assessment activities, employee review activities, training of intern students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your PHI to intern students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your counselor. We may also call you by name in the waiting area when your counselor is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Research; Criminal Activities; Military Activity and National Security; Workers Compensation; Inmates; Required Uses and Disclosures; under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 165:500.

Payment: Your PHI will be used, as needed, to obtain payment for your mental health care services. For example, obtaining approval for office visits may require that your relevant PHI be disclosed to the plan to obtain approval for the office visits.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your counselor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
Following is a statement of your rights with respect to your Protected Health Information.

You have the right to inspect and copy your PHI, Under federal law, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who maybe involves in your case or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your counselor is not required to agree to a restriction that you may request if the counselor believes it is in your best interest to permit use and disclosure of your PHI. Your PHI will not be restricted. You then have the right to use another health professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your counselor amend your PHI. If we deny your request for amendment, you will have the right to file a statement of disagreement with us and we may prepare a rebuttal of your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserves the right to change the terms of this notice and will inform you by mail of any changes. You have the right to object or withdraw as provided in this notice.

Complaints:

You may complain to us or to the Secretary of Health and Human Service if you believe your privacy rights have been violated by this center. You may file a complaint with us by notifying our privacy contact, Charisse Mercer, Group Administrator, of your compliant. We will not retaliate against you for filing complaints.

Patient's Signature: _____ Date: _____