Welcome to Renew Wellness!

Our mission is to guide individuals in discovering their "best self" through emotional, physical, and spiritual healing. We look forward to working with you to improve your emotional and physical health through a variety of holistic approaches.

The Intake packet includes the following:

- **Personal Information**
- **Current Issues**
- **Health Self-Assessment**
- **Informed Consent for Treatment**
- **Client Policies**
- **Client Fee Agreement & Authorizations**

We ask that you sign where it indicates "**Client**" (if over 18 yrs) or "Parent/Guardian" (if under 18 yrs) and do your best to provide as much requested information as possible. For minors, fill out the assessment on behalf of your child with information relating to the child.

Please present your **payment upon arrival** including but not limited to your insurance card, co-payment or fee. Be sure to provide updates of any address or phone number changes during further visits. If applicable, for your designated service, insurance cards must be presented each visit.

Parents/Guardians of children under 18 must check their child in and wait with them until the therapist has come to greet you.

Please do not hesitate to ask questions of your Wellness Professional. Thank you for coming to Renew Wellness! We look forward to helping you find your best self!

INTAKE – Today's Date:_____

Client Information: (if under 18 years parent should fill out on behalf of the child)

Last Name: _____ First Name: _____

Preferred Pronouns: _____ Social Security Number: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Do you give permission for us to contact you via phone? ☐ Yes ☐ No

Do you give us permission to leave you a message? ☐ Yes ☐ No

Email: _____

Do you give permission for us to contact you via email? ☐ Yes ☐ No

In case of emergency, Name of whom should we contact?_____

Relationship to Client: _____

Home Phone Number: _____ Cell Phone Number: _____

How did you find out about our services at Renew Wellness?

CURRENT CONCERNS

Please state briefly in your own words the nature of your concerns(s):

Have you had help previously with this type of concern? If yes, please explain:

How do you hope that your requested service (list) will help?

HEALTH HISTORY/SELF-ASSESSMENT

Have there been any concerns with your health within the past five (5) years (i.e., serious illness, hospitalization, emotional problems, physical injuries, etc.)? If yes, what was the concern?

Please check the current medical services you are receiving, names of practitioners, and date of last visit:

Service	Name	Date of Last Visit
☐ Physician	_____	_____
☐ Counselor	_____	_____
☐ Psychiatrist	_____	_____
☐ Nutritionist	_____	_____
☐ Massage therapist	_____	_____
☐ Physical therapist	_____	_____
☐ Chiropractor	_____	_____
☐ Other	_____	_____

Please list any medications you are taking at present (including any over-the-counter medications taken regularly.)

Name of drug	Dosage	Frequency taken	Reason

Renew Wellness

Do you have, or have you had any of the following diseases, conditions, or problems? Please check all that apply to you.

- ☐ Heart Problems/stroke
- ☐ High Blood Pressure
- ☐ Fainting
- ☐ Poor Memory
- ☐ Seizures
- ☐ History of Brain Injury
- ☐ Depression
- ☐ Sexual Dysfunction
- ☐ Eating Problems
- ☐ Vision/Hearing Problems
- ☐ Poor Concentration
- ☐ Pain/Aches/Headaches
- ☐ Often Tired
- ☐ Diabetes
- ☐ Nausea/Digestive Problems
- ☐ Breathing Difficulty
- ☐ Frequent Alcohol Use
- ☐ Frequent Substance Use
- ☐ Addiction Issues
- ☐ Seeing/Hearing Unusual Things
- ☐ Temper Outbursts
- ☐ Compulsions
- ☐ Fears/Phobias
- ☐ Confusion
- ☐ Problems with Relationships
- ☐ Developmental Disabilities
- ☐ Emotional/Mental Abuse
- ☐ Sexual Abuse
- ☐ Feelings of Hopelessness
- ☐ Physical Abuse
- ☐ Thoughts of Suicide
- ☐ Suicide Attempts
- ☐ Family History of Substance Abuse
- ☐ Family History of Mental Health
- ☐ Sleep Problems
- ☐ Other please describe: _____

Renew Wellness

Adverse Childhood Experience (ACE) Questionnaire

While you were growing up, during your first eighteen (18) years of life:

1. Did a parent or other adult in the household often swear at you, insult you, put you down, or humiliate you, or act in a way that made you afraid that you might be physically hurt? **Yes or No** If **Yes**, enter **1** _____

2. Did a parent or other adult in the household often push, grab, slap, or throw something at you, or ever hit you so hard that you had marks or were injured? **Yes or No** If **Yes**, enter **1** _____

3. Did an adult or a person at least five (5) years older than you ever touch or fondle you or have you touch their body in a sexual way, or try to or actually have oral, anal, or vaginal sex with you? **Yes or No** If **Yes**, enter **1** _____

4. Did you often feel that no one in your family loved you or thought you were important or special, or that your family didn't look out for each other, feel close to each other, or support each other? **Yes or No** If **Yes**, enter **1** _____

5. Did you often feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you, or that your parents were too drunk or high to take care of you or to take you to the doctor if you need it? **Yes or No** If **Yes**, enter **1** _____

6. Were your parents ever separated or divorced? **Yes or No** If **Yes**, enter **1** _____

7. Was your mother or stepmother often pushed, grabbed, slapped, or had something thrown at her; or was she sometimes or often kicked, bitten, hit with a fist, or hit with something hard; or was she ever repeatedly hit over, at least, a few minutes or threatened with a gun or a knife? **Yes or No** If **Yes**, enter **1** _____

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs? **Yes or No** If **Yes**, enter **1** _____

9. Was a household member depressed or mentally ill, or did a household member ever attempt suicide? **Yes or No** If **Yes**, enter **1** _____

10. Did a household member go to prison? **Yes or No** If **Yes**, enter **1** _____

Now add up your "Yes" answers: _____ This is your ACE Score.

CLIENT POLICIES

As a client at Renew Wellness, you can expect that the following rights will be met:

- The right to be treated with consideration and respect for personal dignity, autonomy, and privacy;
- The right to service in a humane setting which is the least restrictive feasible as defined in the treatment plan;
- The right to be informed of one's own condition, of proposed or current services, treatment, or therapies, and of the alternatives;
- The right to consent to or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any service, treatment, or therapy on behalf of a minor client;
- The right to confidentiality of communications and of all personally identifying information within the limitations and requirements for disclosure of various funding and/or certifying sources, state of federal statutes, unless release of information is specifically authorized by the client or parent or legal guardian of a minor client or court-appointed guardian of the person of an adult client in accordance with Rule 5122":2-3-11 of the State of Ohio Administrative Code;
- The right to have access to one's own treatment records, unless access to particular identified items of information is specifically restricted for that individual client for clear treatment reasons in the client's treatment plan. "Clear treatment reasons" shall be understood to mean only severe emotional damage to the client such that dangerous or self-injurious behavior is an imminent risk. The person restricting the information shall explain to the client and other persons authorized by the client the factual information about the individual client that necessitates the restriction. Any person authorized by the client has unrestricted access to all information. Clients shall be informed in writing of agency policies and procedures for viewing or obtaining copies of personal records;
- The right to be informed in advance of the reason(s) for discontinuance for service provision, and to be involved in planning for the consequences of that event;
- The right to receive and explanation of the reasons for denial of service;
- The right to know the cost of services;
- The right to be fully informed of all rights;

As a client of Renew Wellness, we expect the following from you as our client:

- **To be motivated for change. By contacting and scheduling appointments with us, we assume that you are prepared to make positive and transformative changes in your life on this journey to becoming your BEST SELF. We expect that you will make the commitment to attend your scheduled appointments. Our time is valuable, and we are here to work with you as you walk down this path of change. Repeated cancellations call into question your commitment to this process.**
    - **You will be charged a minimum amount of $30 for late cancellations or appointments cancelled without 24 hour notice**
    - **You will be charged the full fee of $150 for a NO SHOW counseling appointment.**

- We use a variety of communication to stay in contact with you including phone, text messaging, and email. If you choose to communicate with us through these methods, you acknowledge that there are limits to what can be kept confidential over the Internet. We are often not immediately available by telephone or outside of business hours. We encourage the use of your support system and coping strategies to manage stress outside of scheduled appointment times. If at any time you feel that you cannot wait for a return phone call or keep yourself safe, please contact 1) Netcare Access at 614-276-2273, 2) call 911, or 3) attend your nearest emergency department. We provide appointment reminders for counseling appointments, this service is a courtesy provided to you but you are ultimately responsible for your own appointment time.
- For counseling services, we schedule hourly appointments for 50 minute hours to allow us to have ample time to prepare in advance for our appointment with you. If you arrive late to your appointment, you will still have the same allotted time your appointment will end at ten minutes 'till the hour. We want to be respectful of everyone's time and make our best effort to keep our appointments on time.
- We use a variety of treatment modalities at Renew Wellness that are evidence based practices to help facilitate your process of change. We will provide you with as much information as you would like about these modalities and the evidence that supports our decision to utilize these in your treatment process. We recognize that every person is different, and we will develop a treatment plan appropriate to your needs and desired changes. We expect that you will participate in these treatments to the best of your ability and as appropriate by our recommendations.
- We have a therapy dog who is certified by Therapy Dog International and may be present in the building. If you are not comfortable with coming into contact with the therapy dog, please advise our office staff, and we will make necessary arrangements

Teletherapy Policies

Teletherapy is an option that we offer if appropriate with our clients. This is an option that will be determined on a case by case basis with your clinician.

- You understand that "teletherapy" includes consultation, treatment, transfer of medical data, emails, telephone conversations, and education using interactive audio, video, or data communications. You also understand that teletherapy also involves the communication of your medical/mental health information, both orally and visually.
- Unless we explicitly agree otherwise, our teletherapy exchange is strictly confidential. Any information you choose to share with me will be held in the strictest confidence. Just like my face-to-face clients, I will not release your information to anyone without your prior approval unless I am required to do so by law. In Ohio, we are required to notify authorities if we become convinced a client is about to physically harm someone, or if they are abusing or about to abuse children, the elderly, or the disabled.
- You understand that our teletherapy services are furnished in the state of Ohio, (USA), and the services I provide are governed by the laws of that state. In a manner of speaking, you are using this modality to visit me in my Ohio office, where we meet to do our work.
- You have the right to withdraw or withhold consent from teletherapy services at any time. You also have the right to terminate treatment at any time.
- You understand that there are risks and consequences with teletherapy services including, but not limited to, the possibility, despite reasonable efforts on my part, that: the transmission of your medical information could be disrupted or distorted by technical failures; the transmission of your information could be intercepted by unauthorized persons, and/or the electronic storage of your medical information could be accessed by unauthorized persons.
- In addition, you understand that teletherapy based services and care may not be as complete as traditional face-to-face services. While teletherapy is a great way to get help with many of life's problems, overwhelming and potentially dangerous challenges are best met with face-to-face professional support. You understand that teletherapy is neither a universal substitute, nor the same as face-to-face psychotherapy. If I believe that your needs would best be served by a local professional, you will be referred to a professional who can provide such services in your area. Finally, you understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts or the efforts of any such provider, your condition may not improve, and in some cases may even get worse.
- You understand that you may benefit from teletherapy, but that results cannot be guaranteed or assured.

- You understand and accept that teletherapy does not provide emergency services. If you are experiencing an emergency situation, you understand that the protocol would be to call 911 or proceed to the nearest hospital emergency room for help. If you are having suicidal thoughts or making plans to harm yourself, you may also call the National Suicide Prevention Lifeline at 1- 800-273-TALK (8255) for free 24 hour hotline support.
- You will be responsible for the following: (1) providing the computer and/or necessary telecommunications equipment and internet access for your teletherapy sessions, (2) securing or encrypting protected health information (PHI) transmitted to or stored on your computer/telecommunications device, (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for your teletherapy sessions, and (4) ensuring that teletherapy is covered by your insurance plan.
- You understand that while email may be used as a form of communication with me, that confidentiality of emails cannot be guaranteed due to complexities and abnormalities involved with the Internet, including, but not limited to, viruses, Trojans, worms, and other involuntary intrusions that have the ability to obtain and disseminate information you wish to keep private.
- You have the right to access your medical information and copies of your medical records in accordance with HIPAA privacy rules and applicable state law.

A copy of the CLIENT POLICIES will be distributed in written form to each client during the intake or assessment process and can be clarified or read orally if needed.

By signing the CLIENT POLICIES, you are also acknowledging receipt and acceptance of the CLIENT POLICIES.

_____ _____

Client/Guardian Signature Date

_____ _____

Witness Date

INFORMED CONSENT FOR COUNSELING SERVICES

Each treatment service that I receive has risks and benefits associated with it. The risks and benefits are outlined below and have been explained to me. My initials indicate that I wish to receive this treatment, and that I have had these benefits and risks explained to me as well as any others that may apply.

_____ Diagnostic Assessment: Diagnostic assessment is a means for your clinician to better understand you and the concerns that bring you to therapy. Your clinician may ask you questions regarding your past and present levels of functioning. This information will be helpful to your clinician in developing an individual treatment plan with you. Occasionally, your therapist or refer you for additional testing or services, that may include a practitioner at Renew Wellness or a collaborative practitioner.

_____ Counseling / Psychotherapy: I understand that therapy is a collaborative effort and that success or failure is a function of the efforts of both the therapist and myself. Specific benefits of effective therapy for me are outlined in my individual service plan. General benefits of therapy may include relief of symptoms, increased insight and confidence, improvement in interpersonal relationships, decreased anxiety, and a general improvement in daily functioning. The professional literature suggests that approximately 10% of therapy clients become more dysfunctional as a result of the stress of treatment.

_____ Confidentiality has been explained to me and I understand this concept.

_____ As a minor 14 years of age or older, I understand I am entitled to receive counseling services for not more than six sessions or thirty (30) days, whichever comes first, without the consent of my parent / guardian and without that person being informed. If services extend beyond that point, I will work with my therapist to involve my parent / guardian in my treatment

_____ I understand that I have the right to refuse any and all treatment. I also understand that my therapist may decline to provide services to me if I refuse or cannot comply with the necessary requirements of therapy. I understand that I have the right to withdraw my consent for any and all treatments at any time. If I refuse or withdraw consent for treatment, my therapist will make an effort to develop input or an alternative approach to therapy.

I consent to receive the services for which I have initialed and dated above or I consent for my child, who is under the age of eighteen- (18) to receive these services.

_____	_____	_____	_____
Client (Parent/Guardian)	Date	Witness	Date

I refuse consent for the treatment services provided for me (or my child,)

_____	_____	_____	_____
Client (Parent/Guardian)	Date	Witness	Date

COUNSELING FEE AGREEMENT

Fees for Service:

- **Psychotherapy Session: $150**
- **Late Cancel: $30**
- **No Show: $150**
- The payment for services is the responsibility of the patient or designated responsible party. For your convenience, we will submit your insurance forms for you.
- We expect prompt payment from you of any insurance payments made directly to you for counseling services.
- If your insurance company pays the total cost of services, Renew Wellness will reimburse you any excess amount you have paid us.
- Payment is expected on the day of service. If you choose to not submit an insurance claim, you will be expected to pay full cash fee.
- Your fee is:
  _____Full Cash Fee
  _____Insurance

  Primary Insurance Company: _____
  Co-Pay Amount: _____
  Contact Information: _____

  Secondary Insurance Company: _____
  Co-Pay Amount: _____
  Contact Information: _____

  Subscriber Information: Full Name: _____
  Relationship to Client: _____
  Subscriber Address if different than Client: _____
  _____
  Subscriber Social Security #: _____
  Subscriber Birth Date: _____

I understand I will be charged a minimum amount of $30 for late cancellations, appointments cancelled without 24 hour notice, and $110 for a no-show appointment. Clients who do not give a 24-hour notice for cancellations or who do not keep scheduled appointments may be terminated according to the agency cancellation policy.

Please review this agreement (previous page) before signing. By signing this form you agree to abide by the fee agreement. I also understand that you are financially responsible for the amount of charges not covered by your insurance.

AUTHORIZATION TO PERMIT PAYMENT OF MEDICAL BENEFITS

_____ _____

Client/Guardian Signature Date

AUTHORIZATION FOR RELEASE OF INFORMATION TO A THIRD PARTY PAYER

I hereby authorize Renew Wellness to release any information required in the course of evaluation or treatment to the Insurance carrier(s) and allow a photocopy of my signature to be used.

_____

Client/Guardian Signature

HIPPA NOTICE OF PRIVACY PRACTICES

This notice describes how medical/mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This information is effective as of January 1, 2016

Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes. All information released will be in accordance with state and federal laws and the ethics of the counseling profession. This notice describes our policies related to the use and disclosure of client health care information.

For the purposes of treatment we use and disclose health information to provide, manage and coordinate care. This may include case consultation.

To obtain payment we use and disclose health information to verify insurance coverage and to process claims and collect fees.

We use and disclose health information for healthcare operations such as reviews of treatment and business activities.

We will disclose client information to report child abuse, medical emergency and as required by law. This includes:
• Report of suspected physical, sexual or emotional abuse of a minor to appropriate authorities
• Report homicidal ideation to the identified victim(s) and local police department
• Report suicidal intentions if treatment recommendations are not followed

Client Signature _____ Date _____

Witness Signature _____ Date _____

Credit Card Authorization Form

Name on the Card _____

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

Other ☐ _____

Account Number _____

Expiration Date _____

Security Code _____

Billing Address _____

City, State, Zip _____

Phone Number _____

Order/Invoice Number _____

Item(s) Purchased _____

_____

Amount to be Charged _____

By signing this form, you authorize _____ to charge your card for the amount listed above.

Signature _____ Date _____