# RENOVARÉ WELLNESS, PLLC

**4209 Gateway Dr. Suite 200**
**Colleyville, TX 76034**

**12830 Hillcrest Dr. Suite D111**
**Dallas, TX 74230**

**CLIENT INFORMATION**

Today's Date _____

Name_____ Date of Birth_____

Home Address_____

City and State _____ Zip Code _____

Home Phone_____ Work _____Cell _____

Email: _____

Marital Status: _____ How Long: _____ Spouse Name: _____

Occupation (if student, what grade) _____ How long ____

Employer (Name and Address) _____

If Client is a minor: Name of Mother: _____

Name of Father: _____

Parents are: (Check one) Married _____ Divorced _____ Separated _____ Unmarried _____

Number of Children, names and ages: _____

_____

Brief Reason for Seeking Therapy: _____

_____

Medications, date prescribed, dosage, and MD/DO name: _____

_____

Previous Treatment - date(s) and therapist name: _____

Emergency Contact _____Phone # _____

Who Is Financially Responsible for the Account? _____

Who Referred You To Our Office? _____

_____ Date _____
Signature of Client or Legal Guardian (if minor)

**THIS SECTION TO BE COMPLETED ONLY IF PATIENT IS A MINOR (IF NOT A MINOR, PLEASE SKIP TO NEXT SECTION)**

| **MOTHERS INFO** | **FATHERS INFO** |
|---|---|
| _____ | _____ |
| Name | Name |
| _____ | _____ |
| Address (if different from patients) | Address (if different from patients) |
| _____ | _____ |
| City, State, Zip | City, State, Zip |
| _____ _____ | _____ _____ |
| Home Number Alt. Number (cell) | Home Number Alt. Number (cell) |
| _____ | _____ |
| Place of Employment | Place of Employment |
| _____ _____ | _____ _____ |
| Occupation Work Number | Occupation Work Number |

_____
If parents are divorced what is the custody arrangement? (Joint, sole, etc.)

# OFFICE PROCEDURES AND PATIENT CONTRACT

_____ Initial

1) Clients are seen by appointment only. Appointments are made according to the schedule of the client and the therapist and are usually 50 – 55 minutes in length. You will generally be seen within 10 minutes of your appointment time, although patient needs may, at times, result in a longer delay. Client calls, after hours, will be returned (emergencies only) by your therapist. Please be advised that telephone consultations are billed at the same rate as office appointments and may not be covered by insurance.

_____ Initial

2) Twenty-Four (24) hour notice for appointment changes or cancellations is required, otherwise the usual session fee will be charged. **This charge is the sole responsibility of the client**. If an emergency arises that prevents a 24- hour notice, these will be discussed and resolved on an individual basis with the therapist.

_____ Initial

3) In case of emergency, please go to the nearest emergency room or dial 911.

_____ Initial

4) All communications that occur between therapist and client are held in the strictest confidence. No information will be will be revealed to anyone without written authorization from the client (or parent/legal guardian if patient is a minor). Under most circumstance, evaluation results and notes from therapy sessions will remain completely confidential. However, under Texas Law, there are several exceptions to this rule of confidentiality. The attached forms will explain this further. The most common exceptions are:

1. Suspected abuse of a child, elderly or disabled person by you or anyone you report to your therapist.
2. You indicate an intention to harm yourself or another person
3. Sexual exploitation by a former or current therapist.
4. Cases before a court & law, which your mental health is an issue (i.e. child custody, divorce, personal injury cases).
5. Collection of past due charges or fees.

All Clients using third parties to provide partial or complete payment of fees should be aware that any and all of the information provided to the paying organization could be made available by that organization to: employers providing the insurance benefits, other insurance companies/agencies requesting the information, and other health care providers that have contact with the insurance company.

_____ Initial

5) I hereby give written permission to fax clinical data to managed care companies, other third party payers, and/or other mental health care professionals.

_____ Initial

6) I hereby give permission for treatment of the client. (Applies only if client is a minor; must be initiated by legal guardian or managing conservator).

_____ Initial

7) You have the right to withdraw from treatment at any time, unless treatment is court ordered. If you would like a referral to a different therapist; your therapist will gladly assist you in finding one.

_____ Initial

8) The ethical codes of therapists/psychologists prohibit dual relationships between therapists/psychologists and clients. This means that if you ever are a client, your therapist cannot meet with you for social occasions or be involved in any business activities with you other than providing psychological services.

_____ Initial

9) Often individuals seeking psychological services because they wish to change some aspect of their lives and/or behavior. Change in the patient frequently produces change in close personal relationships, work relationships, and other areas of the client's environment. It is important that you recognize the potential impact of any changes that you decide to make before you begin treatment.

_____ Initial

10) I hereby give written permission to RENOVARÉ WELLNESS, PLLC and Pamela Hafemann MA, LPC to send a referral acknowledgment to the doctor/person referring you to this office.

_____ Initial

11) If you cannot pay for services rendered and we need to terminate our relationship, we will give you a referral list.

**IF YOU HAVE QUESTIONS OR WOULD LIKE TO DISCUSS ANY OF THE INFORMATION ON THIS FORM, PLEASE WAIT TO SIGN THE CONSENT FORMS UNTIL YOU MEET WITH YOUR THERAPIST. I HAVE READ AND UNDERSTAND THE CURRENT PROCEDURES STATED ABOVE AND AGREE TO ABIDE BY THEM.**

_____ _____

Signature of Client (or parent/legal guardian if minor) Date

# RENOVARÉ WELLNESS, PLLC

**Pamela Hafemann, MA, LPC, LCDC**

## Financial Policy

Thank you for choosing **RENOVARÉ WELLNESS, PLLC** as your mental health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

**FULL PAYMENT FOR SERVICES RENDERED IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, AND MAJOR CREDIT CARDS. THERE IS A $35.00 FEE FOR ANY CHECKS RETURNED OR CREDIT CARD PAYMENTS THAT ARE REJECTED OR DENIED BY YOUR CREDIT CARD PROVIDER.**

When you agree to participate in counseling services, you also agree to pay for these services whether the outcome is successful or not. Mental health services cannot be guaranteed, although an attempt to provide high quality services at all times.

**Insurance**: Clinician will verify eligibility and file claims on behalf of client, but if your insurance company denies the claim you are responsible for the full amount of the session fee.

**Adult Patients:** Adult patients are responsible for payments or insurance co-payments at the time of service.

**Minor Patients:** The adult accompanying a minor and the parents (or guardians of the minor) are responsible for the payment at the time of service. For unaccompanied minors, non-emergency treatment will not be provided unless payment arrangements have been made prior to the appointment.

**Appointment confirmations, changes or cancellations/missed appointments.**

It is the policy of RENOVARÉ WELLNESS, PLLC and Pamela Hafemann MA, LPC to confirm, change or cancel appointments only for the client. This of course, does not apply to a parent/legal guardian calling on the behalf of a minor child. **Twenty-Four (24) hour notice for appointment changes is required; otherwise the usual session fee will apply. This charge is the sole responsibility of the patient.** If emergencies arise that prevent a 24-hour notice, they will be discussed and resolved on an individual basis with your therapist.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

**I have read the above and agree to the Financial Policy of RENOVARÉ WELLNESS, PLLC.**

_____ _____

Signature of Patient (or parent/legal guardian) Date

## RELEASE OF INFORMATION

I, authorize RENOVARÉ WELLNESS, PLLC or Pamela Hafemann MA, LPC, LCDC to release information as to my diagnosis and treatment to my insurance company for the sole purpose of validating my claim.

_____

Signature of Client (or legal guardian of minor patient) Date