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 _____

SSN _____ Drivers License Number _____

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

_____
Name

_____
Address (if different from patients)

_____
City, State, Zip

_____
Home Number Alt. Number (cell)

_____
Place of Employment

_____
Occupation Work Number

FATHERS INFO

_____
Name

_____
Address (if different from patients)

_____
City, State, Zip

_____
Home Number Alt. Number (cell)

_____
Place of Employment

_____
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 may be made by calling our office between the hours of 9:00a.m. and 5:00p.m. Appointments are made according to the schedule of the client and the therapist and are usually 50 – 60 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 our therapist. The office staff cannot resolve this issue. If the office is closed, please leave a message on the answering machine and we will return your call as soon as possible.

_____ Initial 3) In case of emergency, follow the "emergency" instructions on the answering machine. In case of a life-threatening 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 we shall attempt to provide high quality services at all times.

Insurance: We are and out-of-network provider. We do not accept insurance and we do not file insurance.

We must emphasize that as mental health care providers, our relationship is with you, not your insurance company. **All charges are your responsibility at the time the services are rendered.**

Adult Patients: Adult patients are responsible for 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. The office staff cannot resolve this. If the office is closed, please leave a message on the answering machine.

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 (any of the providers in that office) 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

NOTICE OF PRIVACY PRACTICES
RENOVARÉ WELLNESS, PLLC

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.

1. The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share this information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. **Our Legal Duty:**

   The Law Requires Us To:
   1. Keep your medical information private.
   2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
   3. Follow the terms of the notice that is now in effect.

   We have the Right To:
   1. Change our privacy practices and the terms of this notice at any time, provided that law permits the changes.
   2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.
   3. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. **Use and Disclosure of Your Medical Information:**

   The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. We will not use or disclose your medical information for any purpose not listed below, without your specific written permission. Any specific written authorization you provide may be revoked at any time by writing to us.

1. **For Treatment:** We may use medical information about you to provide you with treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other people who are taking care of you.
2. **For Payment:** We may use and disclose your medical information for payment purposes.
3. **For Health Care Operations**: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.
4. **Court Ordered and Judicial and Administrative Proceedings:** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person.
5. **Victims of Abuse, Neglect, or Domestic Violence:** We may disclose medical information to appropriate authorities if we reasonably believe that you are the possible victim of abuse, neglect, or domestic violence of the possible victim of other crimes. We may disclose information if we deem reasonable~ believe that a minor is the possible victim of abuse. We may also release information if we feel that there is a threat to your health and safety, or the health and safety of others.

4. YOUR INDIVIDUAL RIGHTS:

You have a right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical to do so. You must make your request in writing. You may request the form from a member of our staff. ***If you request copies, we will charge you $3.50 for each page and postage if you want your copies mailed to you.***
2. Request that we place additional restrictions on our use or disclosure of our medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in case of emergency).
3. Request that we change your medical information. We may deny your request if we did not create the information you wanted changed or in other certain reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
4. If you have any questions about this notice, please contact:

RENOVARÉ WELLNESS, PLLC
Pamela Hafemann MA, LPC, LCDC
4209 Gateway Dr. Colleyville, TX 76034
214-673-8546
Pamela@renovarewellness.com

If you feel that we have violated your privacy rights, please contact the person named above. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

Notice of Privacy Practices ***(keep pages 1 & 2 for your reference)***

Acknowledgment Form:

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Client Name:

_____

Signature of Client or Legal Guardian:

_____

Date: _____

Credit Card Authorization

RENOVARÉ WELLNESS, PLLC

Pamela Hafemann, MA, LPC, LCDC

I authorize: RENOVARÉ WELLNESS to keep my signature on file and to charge my credit card selected below for the following:

_____ All visits this calendar year

_____ All visits from _____ to _____

Charges for the following family members:

_____ _____

_____ _____

Check One: _____Visa _____MasterCard _____American Express _____Discover

I understand that this form is valid for one year unless I cancel the authorization through written form to the health care provider.

Client name _____

Card holder name _____

Cardholder Address _____

City:_____ State _____ Zip _____

Credit Card Number:_____

Expiration Date: _____ Security Code (last 3 digits on back) _____

Cardholder Signature: _____

Printed Name: _____

Date: _____