Renewed Hope Christian Counseling, Inc.

Name:_____

Address:_____

City:_____ State:_____ZIP:_____

Home Phone:_____

Work Phone:_____Cell Phone: _____

Date of Birth: _____

Marital Status: Single Married Divorced Widowed Separated

Emergency Contact:_____

Phone of Emergency Contact:_____

Employer:_____

Can you be contacted at work? Yes or No

Annual Family Income:_____

By Whom Were You Referred:_____

Renewed Hope Christian Counseling, Inc.

Findrenewedhope.com **866.739.HOPE**

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Suite 101
Shelby Twp., MI 48317
586.739.5450 or 1.866.739.HOPE

Disclosure and Consent Form

Welcome to Renewed Hope Christian Counseling. I want to inform you of several items as you begin the counseling process at RHCC. I want you to be aware of your rights as a client regarding confidentiality, office policy, consents, and the benefits and limitations of the counseling process.

Your Rights

As someone who is receiving counseling services, you should know your rights. The practice of licensed persons in the profession of psychotherapy is regulated by the State of Michigan. You are entitled to receive information regarding the methods of therapy, techniques used, and the approximate duration of treatment – if known. You may, at any time, seek a second opinion from another therapist or you can choose to terminate therapy at any time. You have the right to know how much my services cost. You have the right to participate in the development of your treatment plan. You have the right to refuse treatment and be told what will happen if you do so. You have the right to have information about you kept confidential. Confidentiality will be breached only under the following conditions: 1. if you give me written permission to release information, 2. if you are a danger to yourself or others, 3. if you disclose information suggesting possible neglect or abuse of a minor. You have the right to know a counseling relationship can be terminated if you do not participate in your treatment, pay for your services, or endanger the treatment process or therapist in any way. Lastly, you have the right to know about the professional governing agency that regulates social workers: Michigan Department of Consumer and Industry Services, P.O. Box 30246, Lansing, MI 48909.

Benefits and Risks of Therapy

As with any process that seeks to produce growth and change, there are some risks as well as benefits with therapy. You should think about both the benefits and risks when making any treatment considerations. For example, in therapy there is a risk that clients may, for a time, have uncomfortable levels of sadness, guilt, anxiety, anger, or other emotions. Clients may experience unpleasant memories, feelings, or anxieties. Friends and family members may not be supportive in your decision to receive treatment or in the personal changes you are making. Therapy may expose long-standing conflicts and problems in marital or other significant relationships and can therefore be disruptive in work or personal relationships. Lastly, a client's concerns may temporarily worsen after the beginning of treatment since issues are being more clearly identified. Most of these

risks are to be expected when people are making important life changes. Finally, even with the best efforts, there is a risk that therapy may not work out as you had expected or hoped. While you consider these risks, you should also know that the benefits of therapy have been repeatedly demonstrated in numerous research studies. In therapy, individuals and family members have the opportunity to talk issues through to the point of healthy resolve. Coping skills can be greatly improved. You may receive more satisfaction out of social and family relationships. Your personal goals may become clearer. Lastly, I hope that your relationship with God will grow to a deeper level of understanding and conviction as you discover His will for you.

Consultations and Referrals

If you can benefit from treatment services, which I cannot provide, appropriate referrals will be offered to you. Referrals may be made to medical doctors, psychiatrists, psychologist, testing services, groups, or possibly hospitalization. Also, a referral may be made to another therapist if I am not the best -suited professional to meet your needs.

Limits of Practice and Emergencies

Because RHCC is solely an outpatient therapeutic setting, I cannot provide 24-hour care and I cannot promise to be available at all times. I will generally try to return a phone call within 24 hours, except on weekends and holidays. I do not take calls when in session with clients. If you have any emergency and are unable to contact me, please leave a detailed message on my voice mail as to the nature of the emergency and how you can be reached. Also, if it is an emergency, you are encouraged to contact your physician, go to a local emergency room, or call Common Ground at 248.456.0909.

Payment Policy

Counseling services are to be rendered at the time of service, unless arrangements are made with this clinician prior to services. Fees are based on a fifty-minute session. The initial appointment is $95.00 and every appointment thereafter is $85.00.

Cancellation and Missed Appointments

Cancellations need to be made 24 hours prior to the appointment to avoid being charged for the time. Any missed appointments with no call received will be charged the regular fee per session.

Authorization for Treatment

I have read the preceding information and understand my rights as a client. I agree to receive counseling under these conditions. I understand that no specific promises have been made to me about the results of treatment, its effectiveness, or the number of sessions for therapy to be effective. I agree to enter into therapy with this therapist and will cooperate fully in the treatment process, as shown by my signature.

Signature of Client: _____ date: _____

Signature of Client: _____ date: _____

Signature of Therapist: _____ date: _____

CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I acknowledge that Renewed Hope Christian Counseling has provided a "Notice of Privacy Practices" to me.

I understand I have a right to review Renewed Hope's Notice of Privacy Practices prior to signing this document.

The Notice of Privacy Practices describes the types and uses and disclosures of my protected health information.

I am informed of what will occur in my treatment, payment of my bills, or in the performance of healthcare operations at RHCC.

The Notice of Privacy Practices for RHCC will also be provided on request.

This Notice of Privacy Practices also describes my rights and RHCC duties with respect to my protected health care information.

RHCC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by calling the office and requesting a revised copy be sent or given to me at the office.

_____ Date:_____

Signature of Patient

_____

Name of Patient

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquiries, note "Attention Privacy Officer".

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

PERSONAL INFORMATION RECORD - ADULT

Date: _____

Name: _____ Date of Birth: _____ Age: _____

Gender: ❑ Female ❑ Male Race: _____

Why have you come for counseling? _____

_____

_____

How long have you had this problem? ❑ Does not apply ❑ Several days ❑ Several weeks
❑ Several months ❑ Past year ❑ Past several years

Have you had counseling or psychiatric treatment before? ❑ No ❑ Yes, treatment was helpful
❑ Yes, treatment did not help

Name of treatment provider(s) and dates of treatment: _____

_____

SOCIAL HISTORY

Current Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Current Spouse's Name: _____ Length of Marriage: _____

Previous Spouse's Name: _____ Length of Marriage: _____

How many times have you been married? _____

Name of Children	Age

Please list any other adult/parent that are legally involved with your children but not living at your home:

Name	Phone Number

Who is the legal guardian of the children? _____

If separated/divorced, who has custody of the children? _____

Education
Circle highest level completed:

	Elementary	High School	College	Graduate or Technical School
Self	K through 8	9 10 11 12	1 2 3 4	_____
Father	K through 8	9 10 11 12	1 2 3 4	_____
Mother	K through 8	9 10 11 12	1 2 3 4	_____
Spouse	K through 8	9 10 11 12	1 2 3 4	_____

Describe any learning or academic problems you had in school: _____

_____

Occupation
State present or most recent occupation:

Self _____ Length of employment: _____

Father _____ Length of employment: _____

Mother _____ Length of employment: _____

Spouse _____ Length of employment: _____

Legal
Do you have any current or recent legal involvement? ❑ Yes ❑ No

Explain: _____

Have you ever been stopped for driving under the influence? ❑ Yes ❑ No
Have you ever received court ordered treatment? ❑ Yes ❑ No
Have you ever been convicted of a crime? ❑ Yes ❑ No

Military
Did you serve in the Military? ❑ Yes ❑ No

Please list branch, rank, type of discharge: _____

MEDICAL
Current primary care physician: _____

Date last seen: _____ Date of last physical: _____

Current prescription medications: _____

Purpose of medication: _____

Current non-prescription medications: _____

Describe current health problems: _____
Describe past health problems:

Nature of problem	Age	Outcome

Did you experience physical or sexual abuse as a child? ❑ Yes ❑ No

Have you experienced physical or sexual abuse as an adult? ❑ Yes ❑ No

DRUGS AND ALCOHOL

Do you use alcoholic beverages? ❑ Yes ❑ No

How often do you drink? ❑ Daily ❑ Weekly ❑ Monthly ❑ Holidays

Describe type of alcohol and amount used: _____

How long have you been drinking alcohol? _____

What previous drug or alcohol problems have you had? _____

_____

Do you currently use drugs (e.g., marijuana, cocaine, heroine, LSD) ❑ Yes ❑ No

When was the last time you used drugs? _____

Which drug(s) do you use? _____

Do you use alcohol and drugs in combination? _____

Substances used in the last 48 hours: _____

Please comment on any other issue that you feel is important for your therapist to be informed of:

_____

_____

_____

_____

_____ _____

Client's Signature Today's Date