Renew
Psychotherapy Group

Kristin Paige Thomson, M.A., LPC-S
Laura Hicks, M.A., LPC, LMFT
John Fontenot, M.A., LPC
Rosanne Scott, M.S., LPC
Dyana Robbins, M.Ed., LPC
Tania Lopez, M.A., LPC

Client Name: _____

Referred by: _____

Client Date of Birth: __/__/____

Sex: _____

Client Address:

_____

_____

Home Phone: _____

Cell Phone: _____

Email:_____

Emergency Contact/Relationship/Phone Number(s):

_____

Presenting Problem:

_____

Please check all that apply:

- ☐ Depressed Mood
- ☐ Grief/Loss
- ☐ Substance Abuse/ History of Substance Abuse
- ☐ Cutting/Self-Harm
- ☐ Suicidal/Homicidal Thoughts
- ☐ Relationship Problems
- ☐ School Related Problems
- ☐ Problems with Behavior
- ☐ Previous Psychiatric Hospitalization
- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Sleep Disturbance
- ☐ Hallucinations
- ☐ Recent Hospitalization
- ☐ Work-Related Problems
- ☐ Problems with Anger
- ☐ Parenting Issues
- ☐ History of Suicide Attempts

Name/Phone number of Psychiatrist if under the care of a psychiatrist:

_____

Members of your household and relationship to you:

_____

_____

PLEASE CHECK BELOW:

☐ I have received a copy of the Notice of Privacy Practice for this office:

DATE:_____**CLIENT/GUARDIAN SIGNATURE**:_____

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INSURANCE INFORMATION

Primary Insurance Company:

_____

Policy Holder:

_____

Policy Holder Date of Birth:

_____

Insurance ID#:

_____

Group#:

_____

Insurance Company Phone Number (for providers):

_____

Relationship to Policyholder:

_____

Client Name:

_____

Policy Holder Social Security Number:

_____

Client Date of Birth:

_____

Secondary Insurance Company:

_____

Policy Holder:_____

Insurance ID#:_____

Group#:_____

Insured Social Security #:_____

Insured Date of Birth:_____

Insurance Company Phone Number (for providers):_____

Relationship to Insured:_____

I, the undersigned, authorize the release of necessary information for the benefit of payment. I also authorize payment of insurance benefits otherwise payable directly to my therapist, Kristin Paige Thomson, M.A., LPC-S, or Laura Hicks, MA, LPC, LMFT or to Renew Psychotherapy Group, PLLC as required. I understand that I am responsible for co-payments, deductibles, and other charges whether or not paid by insurance. I authorize a copy of this release to be used in place of the original.

DATE:_____

CLIENT/GUARDIAN SIGNATURE:_____

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CREDIT CARD INFORMATION and CONSENT TO CHARGE:

Client Name:_____

Name on Card :_____

Phone Number:_____

Card Type:_____ Card Number:_____

Exp Date:_____ CCV Code:_____ Billing Zip Code:_____

**************************************PLEASE READ CAREFULLY**************************************

I agree to allow Renew Psychotherapy Group, PLLC, it's managing partners, and contracted associates to retain a copy of my credit card information and my signature on file, and to charge my credit card account for all insurance payments paid directly to me that were due to this office; for all missed appointment fees and any and all other balances owed to Renew Psychotherapy Group, PLLC, and it's managing partners and contracted associates.

*************If for any reason a scheduled appointment cannot be kept, I agree I must cancel within 24 BUSINESS HOURS before the appointment, or a standard office charge of $75 for the first two occurrences and $100 after two late cancellations or missed appointments. If your appointment is before/after hours (Before 8pm or 5pm & later, the late cancel/no show fee increases to $100. ******************

I understand this form is valid while I am a client of Renew Psychotherapy Group, PLLC, and it's managing partners or contracted associates unless I cancel this authorization through written notice to this office.

Printed Name:_____

Signature:_____

Date:_____

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Limits of Confidentiality

Contents of psychotherapy sessions are considered confidential and can usually be shared with another party only with written consent of the client or their legal guardian, or with a court order. Noted exceptions are as follows:

DUTY TO WARN OR PROTECT:

When a client discloses the intention to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the mental health professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

ABUSE OF CHILDREN AND VULNERABLE ADULTS:

If a client states or suggests that he or she is abusing or has recently abused a child or vulnerable adult, or either party is in danger of abuse, the mental health professional is required to report the information to the appropriate social service and/or legal authorities.

PARENTS AND GUARDIANSHIP:

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

INSURANCE PROVIDERS:

Insurance companies and other third party payers are given the requested information necessary to facilitate payment for services rendered.

I AGREE TO THE ABOVE LIMITS OF CONFIDENTIALITY AND UNDERSTAND THEIR MEANINGS AND RAMIFICATIONS

DATE:_____ Client/Guardian Signature:_____

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Practice Policies, Procedures, & Informed Consent

Welcome to Renew Psychotherapy Group, PLLC, the practice of Kristin Paige Thomson, M.A., LPC-S, Laura Hicks, MA, LPC, LMFT and John Fontenot, MA, LPC.. Here you will be provided with a quality counseling service. Please read the following policies that constitute the treatment agreement between you and Renew Psychotherapy Group, PLLC, it's managing partners and contracted associates and initial each section. Your signature at the bottom indicates that you have read and agree to these policies. If you have any questions, please speak with your therapist before signing this form.

PLEASE CHECK ALL BOXES AND INITIAL EACH SECTION TO INDICATE YOU HAVE READ AND UNDERSTAND THE FOLLOWING.

Office Hours:
☐ The business office hours are Monday-Thursday 8:00am to 5:00pm and Fridays 8:00am to 1:00pm. Messages and emails left before 3:00pm will be returned the same business day. However, if you are experiencing an emergency or are in crisis, please call 911 or go to your nearest emergency room.
INITIAL:_____

Appointments:
☐ Appointments are scheduled by either using your client portal to self-schedule or by calling our office to schedule your appointment. Having 3 or more no-shows or late cancellations may result in termination of treatment. You may be asked to reschedule your appointment if you are more than 15 minutes late for your session. **INITIAL:**__ ____

Cancellations and No-Shows:
☐ A 24 **BUSINESS** hour notice is required to cancel or reschedule an appointment. **Same day cancellations or missed appointments are charged an administration fee of $75 per occurrence. After 2 late cancel/missed appointments the fee will then be $100. For appointments before 8am and 5pm or later, the fee is $100.** Late cancel/missed appointments
are the responsibility of the client. If you fail to show up for your initial appointment or cancel/reschedule less than 24 business hours in advance, you may not be able to reschedule your appointment until the $75/$100 administrative fee is paid in full. As a courtesy, either a reminder email, phone call or text notification (if you have authorized in the client portal) is sent prior to your scheduled appointment. **This office is not responsible for appointments missed due to incorrect contact information or non-receipt of reminder text/email/phone call.** **INITIAL**:_____

Cancellation Policy for Couples/Double Appointments:
☐ For double (back to back appointments for couples or families) a 48 **BUSINESS** hour notice is required. If a 48 business hour notice is not provided, you will be charged $150 ($75 cancellation fee x 2).
INITIAL:_____

☐ The business office closes on Friday at 1:00pm. Monday appointments must be canceled before Friday at 1:00pm to avoid a late cancellation fee.
INITIAL_____

Payment of Services:

It is policy to collect payment and any balance owed due to late cancellations or no-shows prior to your session. You are responsible for all co-pays, deductibles, and co-insurance. If you are unable to make the required payment at the time of your appointment, you will be rescheduled. Returned check fee is $35.
INITIAL:_____

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(continued) Practice Policies, Procedures, & Informed Consent

☐ A copy of your insurance card and photo ID is required at your first appointment. If your provider is in-network with your insurance plan, we will file a claim on your behalf. Coverage varies widely from plan to plan and the exact amount your insurance provider will cover cannot always be determined in advance. In this case, we will file the claim and when that claim has been paid by your insurance provider we will then collect any balances owed to your therapist. If your insurance provider does not pay within 60 days of filing the claim, you will be responsible for the full payment of $125. **INITIAL:**_____

Please provide the office with any changes to your insurance at least 72 business hours before your scheduled appointment. Failure to do so will result in being charged full fee for your session or having your session rescheduled.

☐ If you do not have insurance, your insurance provider does not cover these services, or we are out of network with your insurance plan, you will be considered self-pay @ $125 per session and payment is due in full at the time of service. **INITIAL:**_____

Completion of Forms
☐ Due to the time involved for your provider, it is necessary to charge for all letters and forms. This is to be paid in advance and is not billed to your insurance provider. The cost for drafting letters and/or completing forms is $35. **INITIAL:**_____

Emergency Treatment
☐ I agree to call 911 in the event that I feel violent, suicidal, or homicidal in order to take the necessary steps to protect myself and the safety of others. Because your therapist does not provide 24-hour care, crisis intervention, or psychiatric services, they cannot provide appropriate care for individuals who are at risk for psychiatric emergencies. For example: Individuals with current or chronic thoughts of harming themselves or harming others may require emergency intervention at night, on weekends, or during holidays. Your therapist would not be able to respond to such a call. Clients in a psychiatric emergency or at risk of one will be referred to a hospital or other medical providers as needed to insure his or her safety and the safety of others. **INITIAL:**_____

Court Testimony
☐ For any court ordered/subpoenaed time, you will be billed at the self pay rate of $150 for each hour your therapist is required to be available, with a minimum of 3 hours, including travel and preparation time. Such fees are due in full prior to services being rendered. INITIAL:_____

Record Request
☐ For our client's protection, your provider does not release records to anyone unless subpoenaed by a judge. If your records are subpoenaed by a judge, you will be charged $35 and payment is due before records will be released. When it is in the best interest of the client, your therapist may provide a written or verbal summary of the client's case and progress. A release of information must be signed before any client information, written or verbal, will be released. **INITIAL:**____

I have read this agreement and understand that I am responsible for payment of the fee as described above. I acknowledge having received written descriptions of the NOTICE OF PRIVACY PRACTICES. I understand that my records will be accessible to the associates of Renew Psychotherapy Group, PLLC, who will be held responsible for maintaining strict confidentiality unless otherwise authorized.

By signing below, I give my consent for treatment.

Printed name:_____ Signature:_____Date:_____

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Client Bill of Rights

Client Rights

I have the right to efficient and effective care individualized to my needs. My provider will work with me to develop a treatment plan best suited for me. We will use the plan to help us deal with my issues as quickly and effectively as possible. I have the right to refuse treatment or discontinue treatment.

I have the right to be treated with dignity and respect at all times. I will report any misconduct by my provider including social invitations, suggestive remarks, or unwanted touching to the appropriate state agency.

My treatment provider will make every effort to meet with me at our scheduled appointment time. If my treatment provider is late, she will extend our session, if I am willing, or we will make other arrangements.

I have the right to privacy and confidentiality. All records and communications concerning my care will be treated confidentially and in compliance with applicable state and federal laws. These laws may obligate my treatment provider to report suspected abuse, neglect, or domestic violence and those who pose a danger to themselves or others.

Client Responsibilities

Scheduled appointments are commitments. I will make every effort to be on time for my appointment. If I am late for my scheduled appointment, I understand that time will be lost from my session. If I am more than 15 minutes late, I understand that my appointment may be rescheduled or I may be required to pay self-pay rates instead of billing insurance. If I miss an appointment and do not notify my provider at least 24 business hours in advance, I understand that I may be charged a missed appointment fee.

I am responsible for payment of services received. I am aware my insurance plan typically requires me to pay a copay or a percentage of my treatment fee at the time services are provided. My insurance plan may also have a deductible that is my responsibility. Additionally, certain services may be limited and/or not covered at all by my insurance plan. I understand that I am responsible for all copays, co-insurance amounts, deductibles, and all services not covered by my insurance plan. My provider, the office biller, and my insurance plan's representative will help me determine which services are covered. My health is my responsibility. I will contact my provider for any serious situation that arises. I will work with my provider to achieve my treatment goals and will advise my provider of any changes in my condition.

I have read or had read to me the above list of Rights and Responsibilities. I understand them and agree to them.

DATE:_____ CLIENT SIGNATURE_____

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Consent for Communication

Should this office (including my therapist and office staff) need to contact me and I am unable to be reached directly, I give my permission to leave office identity, appointment time, and provider information via voicemail, email, or text. I understand this office is not responsible for whomever retrieves the message.

Please list the phone number and email you prefer to be used below.

Check YES if you give permission for messages to be left via email, text, or voicemail.

☐ YES

Check NO if you do not give permission for messages to be left via email, text, or voicemail.

☐ NO

Please give phone number and email you prefer to be contacted on:

Phone:_____ Email:_____

If you have anyone who you would allow your therapist to communicate with, please list them below. Due to privacy laws, I cannot speak to anyone other than the client unless I have your written permission to do so.

I give Renew Psychotherapy Group, PLLC, Kristin Paige Thomson, MA, LPC-S and/or Laura Hicks, MA, LPC, LMFT my permission to speak with the following individuals regarding my care: If you prefer that we don't speak with anyone please type NO ONE.

Please give the name of the individual and their relationship to you along with a contact number of anyone authorized to discuss your care.

_____

_____

_____

DATE:_____ CLIENT SIGNATURE:_____

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Tania Lopez, M.A., LPC

Date:_____ **Client Name:**_____

Notice of Privacy Practices

This notice describes how your private health information (PHI) about you may be used and disclosed and how you can get access to this information. Please review carefully.

Uses and Disclosures

TREATMENT: Our staff may disclose you PHI to other health professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

PAYMENT: Your PHI may be used to seek payment from your insurance provider or from other sources such as credit card companies that you may use to pay for services.

HEALTH CARE OPERATIONS: Your PHI may be used as necessary to support the day-to-day activities such as in the case of students or supervisees working with Kristin Paige Thomson, M.A., LPC-S.

PUBLIC HEALTH REPORTING: We may disclose your PHI to public health agencies as required by law.

OTHER USES AND DISCLOSURES: Disclosure of your PHI or it's use for any purpose other than those listed above requires your written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. Your decision to revoke does not apply to disclosure of information that occurred prior to the revocation.

ADDITIONAL USES OF INFORMATION: Your PHI may be used to send you information on the treatment and management of your medical condition that you may find of some interest.

Individual Rights

You have certain rights under Federal Privacy Standards These include:

The right to request restrictions on the use of your PHI.
The right to receive confidential communications concerning your medical condition and treatment.
The right to inspect and copy your PHI (Client access is limited in regards to psychotherapy notes)
The right to amend or submit corrections to your PHI
The right to receive an accounting of how and whom your PHI has been disclosed.
The right to receive a printed copy of this notice.
We are required to maintain the privacy of your PHI and to provide you with this notice We are also required to abide by the privacy policies outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes may be required by changes in Federal or State Laws. Whatever the reason for the revisions, we will provide you a copy of the revised notice.

REQUESTS TO INSPECT PHI

As permitted by law, we require that the request to inspect or copy PHI must be submitted in writing. You may obtain a form to request your records by contacting the Privacy Officer.

If you would like to submit a comment or complaint about our privacy practices or if you feel your rights have been violated please send a letter addressing your concerns to:

Kristin Paige Thomson, M.A. LPC-S
1414 S. Friendswood Dr, Ste 430B
Friendswood, TX 77546

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Parental Consent for Minors

Client Name:_____

Parent/Legal Guardian Name:_____

I, being the legal parent/guardian of the above named client, hereby give my consent for my son/daughter to receive the counseling services of Renew Psychotherapy Group, PLLC and it's managing members and contracted associates. I further agree to allow my minor child to continue treatment until I notify his or her therapist of any other changes or plan to discontinue, or until their therapist determines that treatment is no longer necessary.

I understand that the information my son/daughter shares with the counselors confidential and can be shared with me only at the counselor's discretion. Furthermore, I am managing conservator and have the legal right to make the decision for the above named minor client to participate in counseling.

I also understand that if the parents of the above named client are divorced, State Law requires I provide a copy of the divorce decree to the therapist in order to prove that I am managing conservator.

Date:_____

Signature of Parent/Guardian:_____