

2020

**CONSENT FOR TREATMENT**

Please complete this entire form to ensure proper Insurance claim payment.

**RENAISSANCE  
CENTER, LLC**

**Patient Information:**

New Patient

New Insurance

Last Name		First		MI
Address		Suite#/Apt#	City	State Zip
Date of Birth ____/____/____	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____/____/____	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> Sep <input type="checkbox"/> Div <input type="checkbox"/> Other
Home Phone	Cell Phone	Work Phone	Email Address	
Employer Name				
Address		Suite#/Apt#	City	State Zip
Emergency Contact Person Name			Phone	Relationship

**Insurance Information:**

Primary Insurance		Policy ID#	Group#
Policy Holder's Last Name		First	Date of Birth
Policy Holder's Address		Suite#/Apt#	City State Zip
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Policy Holder's Employer	Patient's Relationship to Policy Holder? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	

\_\_\_ **•CONSENT FOR TREATMENT:** I hereby authorize The Renaissance Center, LLC to administer diagnostic and medical procedures which may be necessary for proper behavioral health care.

\_\_\_ **•AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize The Renaissance Center, LLC to release any medical information needed for insurance processing. Further, I authorize insurance benefits be paid to The Renaissance Center, LLC.

\_\_\_ **•INSURANCE POLICY:** I understand my insurance policy is between me and my insurance carrier. I have (or will) contact my insurance, agent or employer to fully understand my behavioral health benefits (i.e., required authorizations, deductibles, copays, pre-existing condition exclusions, etc.). I further understand that I am responsible for providing any updated or new insurance information prior to my appointment and I will provide a physical copy of my new insurance card or I will pay the full fee for my appointment.

\_\_\_ **•PAYMENT FOR SERVICES:** I agree to pay all fees incurred and/or not covered by insurance benefits paid to The Renaissance Center, LLC. I agree to pay at time of service for any deductibles, copays, coinsurance or balances not covered by my insurance policy.

\_\_\_ **•CANCELLATION POLICY:** I agree to provide a minimum of **24-hours notice for cancellation** of my scheduled appointment(s) to avoid a full fee charge for a therapy appointment. **A fee of \$150 will be charged for late cancellations or missed appointments with a physician. If the physician's appointment is rescheduled within the same week charge will be reduced to \$50.** I understand this charge is not covered by my insurance policy. **NOTE:** MD appointment reminder calls are a courtesy and not guaranteed depending on staff availability.

\_\_\_ **•MEDICATION MANAGEMENT:** I understand that all medication refills, questions or concerns must be made face-to-face with a physician at The Renaissance Center, LLC. An appointment is required to ensure adherence to ethical issues and is in the best interest of my mental health. I understand there is a \$25.00 charge for medication management handled between doctor visits, (i.e., medication prior authorizations, refills until my next appointment (if approved), medication documentation, etc.)

***I acknowledge I have received a copy of my Patient Rights and Responsibilities and the Financial Agreement which further outlines charges and services that are generally not covered by my insurance policy.***

\_\_\_\_\_  
Please Print: Client Name (or Parent/Guarantor)

\_\_\_\_\_  
Signature: Client/Parent/Guarantor

\_\_\_\_\_  
Date

## BACKGROUND QUESTIONNAIRE

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please give a brief explanation and history:

1. Present problem - List 3 main problem areas (anxiety, depression, stress, etc.) and what caused them.
  - A.
  - B.
  - C.
2. Symptoms (please circle all that apply):

A. Change in sleep pattern	E. Decreased concentration
B. Change in appetite	F. Increased anxiety
C. Decreased energy	G. Suicidal feelings
D. Decreased motivation	H. Other (please list):
3. Give at least one specific example of where or how you are having difficulties functioning:
4. List 2-3 of the most significant hurts in your life.
  - A.
  - B.
  - C.
5. What is/was your father like?

6. What is/was your mother like?
  
7. How many brother(s) and/or sister(s) do you have?  
  
What number child are you?  
  
What type of relationship do you have with them?
  
8. Describe your educational background.
  
9. Marriage/Significant Other History - What type of stresses are in your current relationship(s)?
  
10. How many children do you have, including ages.
  
11. Describe any types of previous consultations with a behavioral health physician and/or counselor.
  
12. Medical history - Please list any previous or existing medical problems:
  
13. Current interests (family, church, friends, hobbies, activities, etc.):
  
14. Job history:
  
15. Religious history:

## FINANCIAL POLICY

### Payment Methods

Payment or insurance co-payment is required at the time of service. Payments can be made in cash, check or credit card. Should your account remain unpaid for 30 days or more the clinician reserves the right to suspend or discontinue treatment until the charges are paid in full or until the client and clinician agree upon a suitable payment arrangement. If payment is not made and treatment is discontinued, the clinician will offer referral assistance to an appropriate municipal or non-profit mental health agency. If your account remains unpaid it will be turned over to a collection agency or for litigation. You will be responsible for any charges associated with the process of collection.

### Insurance

If you are utilizing insurance it is your responsibility to obtain initial primary care referrals and pre-authorizations as required. In addition, it is your responsibility to contact your insurance company directly to obtain information and understand your mental health/substance abuse benefit package including: deductibles, reimbursement rates/percentages, number of sessions covered, in-network and out-of-network provisions. Further, it is your responsibility to notify Renaissance Center LLC of any changes in your insurance coverage prior to your next scheduled appointment. **Failure to notify the Center of changes in your insurance coverage or Primary Care Physician of record will result in full fee charges for your sessions until insurance records, requirements and internal processing are updated and compliant with your insurance.** Insurance coverage and benefits may change during your treatment depending on your insurance company. A minimum of one week is required for processing of insurance changes. *No retro-active insurance claims or submissions will be filed.*

### Medication Management

The Renaissance Center, LLC is committed to providing outstanding medication management to its clients. Initially, when a new medication regimen is prescribed, psychiatrist visits may be required weekly, bi-weekly or monthly until medication efficacy and stability is obtained. Medication refills are handled at each of your scheduled follow-up appointments with the psychiatrist. You will be given enough medication to last until you are due to be seen for follow-up. A face-to-face office visit is required for all medication refills.

Appointments with the psychiatrist must be scheduled at least every 3 months for continuation of prescribed medication. Often life events or situations, as well as arising medical issues surface making it necessary to adjust medications appropriately. Prescription medications require ongoing monitoring for both medical and ethical concerns. Please review your medication renewals/prescriptions needs prior to your appointment time. If you have concerns or problems related to your medications you should schedule an appointment.

**Please allow 2-3 weeks for scheduling an appointment with the psychiatrist. In the event of an emergency please contact your primary care physician or go to your nearest emergency room.**

### Missed Appointments/Late Cancellations

If you are unable to keep a scheduled appointment it is your responsibility to cancel at least 24 hours in advance (more lead time would be appreciated). **Failure to provide less than 24 hours notice or not showing up for a scheduled appointment will result in being charged a full fee for a therapy appointment. A fee of \$150 will be charged for late cancellations or missed appointments with a physician. If the physician's appointment is rescheduled within the same week the charge will be reduced to \$50.** You may cancel by speaking to a member of the administrative staff, a clinician or by leaving a message in the voice mail system. Insurance companies will not pay or reimburse for missed appointments. Exceptions may be made in the event of an emergency, provided that your doctor or therapist is informed prior to the scheduled appointment.

**Your Rights As A Client**

As a client you have the right to:

- 1.) Be treated with dignity and respect.
- 2.) Ask questions regarding the therapeutic process or office procedures.
- 3.) Terminate therapy at any time. You may wish to see another clinician at Renaissance Center. Your therapist will also provide you with other referral sources upon request.
- 4.) Specify and negotiate therapeutic goals and be an active participant in therapy.
- 5.) Confidentiality, as described above.
- 6.) Be informed about fees and payment policies.

**Termination of Treatment**

You may decide to end treatment at any time without ethical, legal, or financial obligation beyond payment for sessions already rendered. We recommend that you discuss ending therapy with your clinician to enable a completion of the work in which you have engaged. If you cancel or miss a scheduled appointment and do not contact your clinician within 30 days, it will be assumed that you have ended your period of treatment. The therapist maintains no legal or professional obligations to the client after treatment has ended. You may contact your therapist at a later date if you wish to resume treatment.

**Emergency Calls**

In case of emergency you may reach your clinician during regular business hours (Mon.-Fri. 9:00 AM - 5:00 PM at 703-521-6004. Inform the receptionist that this is an emergency. After regular business hours you may call the Renaissance Center, LLC emergency number at 301-939-2081 and an on-call clinician will be contacted. **If you are having suicidal thoughts or are facing a medical or psychiatric emergency, you should go directly to the nearest hospital emergency room**

**Informed Consent**

By signing below, I agree that I understand the above information and agree to the terms of treatment stated. My therapist has adequately answered any questions I have at this point in time. My psychiatrist has informed me about the benefits and possible side effects of medications prescribed.

My signature indicates that I am giving my consent to be treated as a client at Renaissance Center, LLC.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician Signature

\_\_\_\_\_  
Date

**SERVICE FEE STRUCTURE**

The Renaissance Center, LLC is being faced with the challenge of increasing operational costs without corresponding reimbursements. Therefore, to keep our behavioral health practice viable, it has been necessary for us to implement fees for certain services.

**1. Medication Management**

It is the general policy of Renaissance Center, LLC that a face-to-face office visit with the doctor is required for all medication refills and lost prescriptions.

Additionally, there is a \$25.00 processing fee assessed for medication management services outside of your follow-up appointments which may include but is not limited to insurance pre-authorization, refills until your next appointment or medication documentation.

**2. Documentation/Forms Processing**

Documentation, letters or forms (i.e., for human resources, medical leave, disability, workers' compensation, school reports, correspondence, etc.) shall qualify for a processing fee of \$25-\$150.00 depending on the complexity and time needed to complete.

**3. Telephone Consultations**

Telephone consultations between sessions will be billed on a pro-rated basis according to your clinician's fee structure if you are unable to come in for an appointment. *This fee is not billable to your insurance company and will be due in full.*

You will need to approve phone contacts with family, friends or other professionals in advance and will be asked to sign a release of information except for those reasons defined by state law and professional ethics. *(See Agreement For Professional Services)*

**4. Release/Duplication of Records**

Charges for copying records is \$30.00 which includes postage and handling. A charge for releasing records under 20 pages by fax is \$10.00.

**5. Insurance Company Communications**

Communications and documentation, (i.e., required Treatment Plans, benefits resolutions, re-verification of benefits, authorizations, etc.) handled outside of a scheduled appointment shall qualify for a processing fee of \$25-150 depending on the complexity and time required to complete. Many times insurance cases require client participation, however, Renaissance Center, LLC will do everything possible to resolve insurance re-imburement disputes.

**Informed Consent**

By signing below, I acknowledge that I understand the above information and agree to the payment of these fees and understand that **these fees are not billable to my insurance.**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

## CLIENT-CLINICIAN AGREEMENT FOR PROFESSIONAL SERVICES

### Psychiatric and Psychotherapy Treatment

Psychotherapy is conducted using a number of different approaches, depending on your therapist and his or her training and orientation. Your therapist will inform you about his or her qualifications and approach. Psychotherapy is a collaborative effort. During the first few sessions the clinician will assess the nature of your concerns. The therapist will determine whether he or she is most qualified to treat you or whether referral to another clinician would be more appropriate. You and your clinician will agree upon goals you wish to work toward in therapy. Your progress will be periodically reviewed with your clinician. The length of therapy will vary depending upon the concerns you choose to work on. At times what is discussed in session and/or changes resulting from therapy may cause you discomfort or anxiety. These feelings often accompany behavioral and emotional change and are usually a sign of progress. It is important to discuss these experiences with your therapist.

Our psychiatrists are able to provide medical evaluation and prescribe psychotropic medication if and when this is needed. You will be informed about both the benefits and the possible side effects of medications prescribed. In our experience the most effective treatment for certain diagnoses often involves a combination of medication and psychotherapy.

### Confidentiality

As a client, one of your most important rights is that of confidentiality. Communications between client and clinician will be confidential and not disclosed to anyone outside Renaissance Center, LLC without your written consent. Your treatment may be discussed between Center professionals responsible for your treatment in order to ensure continuity and quality of care. If consultation takes place with professionals outside the Center, your identity will not be disclosed.

There are exceptions to confidentiality as defined by state law and professional ethics. Your therapist will be required to break confidentiality if one or more of the following conditions occur:

- 1.) Your clinician has reason to think that you may seriously harm yourself or another person.
- 2.) Your clinician has reason to suspect that abuse or neglect of a child, an elderly person, or a dependent adult has occurred.
- 3.) A court orders the release of information regarding your treatment.
- 4.) You are utilizing medical insurance which requires the disclosure of diagnostic and/or treatment information (your therapist will discuss the nature of this information request/release with you).
- 5.) You are asked to sign a release for psychotherapy records when involved in litigation. Think carefully and consult with an attorney before you sign away your rights. You can discuss this with your therapist.
- 6.) Clients under the age of 18 do not have full confidentiality from their parents or guardians.