Southern Connecticut Christian Counseling Center, Inc.
dba

RENEW COUNSELING ASSOCIATES

Christian therapists committed to serving you, your family, and your community

8 Wakeman Rd
Fairfield, CT 06824
(203) 255-5078

Welcome to Renew Counseling Associates! We're honored you have chosen us to help you with your current problems or concerns. We know how difficult it can be to share personal issues with someone you don't know, but you can be sure you will be treated with care and respect. All the information you share with us will be held in the strictest confidence allowed by ethical and legal regulations.

All of our therapists are committed to the core doctrines of the Christian faith. This influences their view of the world and the values they hold. Although they will not impose their beliefs on you, and are accustomed to helping people who hold very different beliefs, we think it is important for us to inform you about our perspective. If this is a concern for you, or if you would like more information about it, please address this with your therapist either before or during your first appointment.

We are committed to providing our clients with the highest quality of care. If at any point you believe you are not receiving the quality of care you anticipated, we would appreciate it if you would let your therapist know. If that does not result in positive changes, then you may communicate directly with our director, Dr. Duane Kellogg, or with the chair of our Board of Directors, pastor David DeVries of Trinity Baptist Church, 300 N. Benson Rd. Fairfield, CT.

Who referred you to Renew Counseling Associates?________________________________

May we contact that person to thank them for the referral? Yes No

Would you like to be placed on a Renew mailing list to notify you
about any upcoming workshops, classes, or groups led by Renew staff? Yes No

***The following pages of information are necessary to have in your personal file. Please respond to all questions that apply to you*.**

Personal Client Information

Name____Date____________________

Address____

City________________________________State____________Zip ___________________

Home phone______________________Work________________Cell __________________

Email address_____________________________ (this will be used to send reminders)

What is the best way to contact you during the day?______________Evening?__________

May we leave a message if you are not available? Yes No

Date of Birth ____________________ Age ________

Marital Status (circle) Single Married Separated Divorced Widowed

If married, date of marriage____________Name and age of spouse ___________________

If sep/divorced, date of marriage___________Date of sep/divorce ___________________

If widowed, date of marriage_____________Date of death of spouse _________________

Names and ages of children living with you:

____

____

Names and ages of children not living with you:

____

Name, age, and relationship of anyone else living with you:___________________________

____

Name of church you attend (if any):

____

In case of an emergency, I hereby grant permission to Renew Counseling Associates to contact the following person or persons on my behalf:

____

Relationship _________________________ Contact numbers _______________________

____

Office use only:
Dx:

Past Treatment for Psychological, Behavioral, or Emotional Difficulties

Inpatient Hospital Treatment (hospital, date, reason, length of stay)

____

____

Outpatient Treatment (therapist's name, date, reason, outcome)

____

____

____

Current Psychiatric Medications

Name__________________________Dosage__________Purpose ______________________

Name__________________________Dosage__________Purpose ______________________

Name__________________________Dosage__________Purpose ______________________

Who prescribes them? ____

May we request and release information to/from this prescriber? Yes No

Phone # ____

Relevant Medical History

Date of last physical exam __________________

Are you being treated for any medical problems? Yes No

If yes, what? ____

Current primary care provider ____

Address/phone number ____

Have you ever sustained a serious head injury? Is so, please indicate how/when

____

Are you taking any other prescription drugs other than those already noted? Yes No

If yes, Name of drug____________________Dosage__________Purpose _______________

Name of drug____________________Dosage__________Purpose _______________

Substance Use/Abuse History

In the past 3 months have you used any intoxicants? Yes No

If yes, please identify what type (example - alcohol, pot, cocaine)________________how much______________________and how often ______________________________________

Have you ever been treated for substance abuse or attended AA/NA? Yes No

Have you ever tried to stop or reduce your use on your own? Yes No

Occupational History

Employed (circle) full-time part-time

Unemployed Student Homemaker Retired Disabled

Current employer ____

Type of work you do ____

Date of hire _____________________________

Church Involvement

How often do you attend worship services? ________________________________

Name of pastor ____

Education

Highest grade completed____________College____________Grad School ______________

Were you ever diagnosed with a learning disability? Yes No

If yes, what was it? ____

Childhood

How would you describe your childhood? Happy Average Unusual Unhappy

Were you ever verbally, physically, or sexually abused as a child? Yes No

How many siblings did you have?______________Where were you in the birth order? (example - third of five or first of three) ____

Financial Responsibility for Services Rendered

I understand that I am financially responsible to Renew Counseling Associates for any professional services rendered to me (or my minor child). If I am using insurance or some other third party payor, I agree to pay any charges not covered by them. I realize that in many cases exact insurance benefits cannot be determined until the insurance company processes the claim. It is my responsibility to notify Renew Counseling Associates of any changes in my health care coverage.

I understand that my therapist is reserving time for my counseling sessions. Therefore, if I don't attend my session, I need to pay for my therapist's time (this is not covered by insurance). **If I fail to come to a session, (except for emergencies, illness, or inclement weather), I agree to pay one half of my therapist's normally charged fee unless I provide at least 48 hours notice of cancellation.**

Initials: ___________________

Method of Payment

Insurance (please fill out information below)

Self pay: Initial session fee: ___________

Regularly weekly session fee: __________

Note: Payments are due at time of session. A $5.00 fee may be assessed if payments are late (including co-payments for those using insurance or other third party payors).

Insurance Information

Primary insurance company ____

Policy holder's name if not patient ____

Relationship _____________________________

Date of birth _____________________________

Insurance I.D #_________________________________

Group # _______________________________________

Insurance phone # (for providers to call)____

Is there secondary insurance? If so please provide the same information as above.

____

____

Assignment of Benefits:

I authorize direct remittance and/or electronic payment of all insurance benefits to Renew Counseling Associates for all covered services provided to me during all courses of treatment. I understand and agree that this Assignment of Benefits will have continuing effect for as long as I am receiving treatment from Renew Counseling Associates.

Initials: __________

Authorization to Release Information:

I authorize the release of any medical, psychological, substance abuse, or otherwise relevant treatment information to Renew Counseling Associates, my insurance carrier(s) or other entity necessary to determine insurance benefits. A copy of this authorization will be sent to my insurance carrier(s) if requested. The original authorization will be kept on file at Renew Counseling Center.

Initials: __________

Confidentiality and Reporting Laws

Under current Connecticut statutes, communications between a client and a psychotherapist have the same privilege of confidentiality as that between an attorney and client except under specific, limited circumstances. You need to be aware of the following limitations between you and your therapist:

a. Disclosure of privileged communication can be required by a specific court order (not a subpoena).
b. Any form of suspected abuse (physical, sexual, and/or emotional) of children or elderly or incapacitated adults must be report to the proper authorities.
c. Any person who is a danger to him/herself or others must be reported to the proper authorities and if another individual is in danger, this person must also be informed.
d. Any threats by an individual regarding real estate property must be reported to the authorities and the owner of the property if possible.
e. If you utilize health insurance or any type of managed care/HMO/PPO, etc., you need to realize that more information than just your diagnosis may be required to secure benefits. This may include your psychological history, treatment plan, testing results, and treatment progress.

f. We consider supervision/consultation with other professional therapists to be in the best interest of our clients. Therefore, we want you to be aware that your case may be shared with other professionals for this purpose. However, in these situations, steps will be taken not to reveal you identity outside this agency.
g. In keeping with new federal regulations, all medical records must soon be stored electronically. This is to inform you that at Renew, we utilize a program called "TherapyNotes", a cloud based system that enables us to do this securely and in compliance with HIPPA regulations. Your name and demographic information are available to all therapist employed at Renew, but only your therapist, your therapist's supervisor (if he/she is under supervision), and Renew's director (for purposes of quality control and continuity of care) have access to your clinical records.

Be assured that we are committed to the ethical principle of confidentiality and that no material, other than that noted above will be knowingly communicated outside this agency without you specific written permission.

Initial: ____________

Privacy Practices

I acknowledge that I have seen or received a copy upon my request of the Notice of Privacy Practices for Renew Counseling Associates.

Initial: _______________

Consent for Treatment under Conditions Specified

By signing below, I hereby agree to treatment for me or my minor child by Renew Counseling Associates and accept full responsibility for any balance due on my account or that of a minor child. Further, I understand that in case of an emergency, I will try to contact my therapist by his/her cell phone. If my therapist is unable to respond, I will call 911 or go to the nearest hospital emergency room. I also certify that the information I have provided is true and correct to the best of my knowledge. I have read and agree to all the above described conditions and policies for counseling.

Signature(s) ____

____

Parent/guardian Signature (if minor)

____

Date __________________

Notice of Privacy Practices - Brief Version

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.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated and extensive, but we must give you this important information. This notice is a condensed version of the full, legally required notice of privacy practices (NPP) that you are welcome to read. It may be obtained by requesting a copy from your therapist. We can't cover all possible situations here so please talk to our Privacy Officer (see end of this notice) about any questions or problems about this policy.

We will use the information about your health that we get from you or from others mainly to provide you with treatment, to arrange payment for our services, and for other business activities that are called, in the law, health care operations. After you have read this brief NPP, we will ask you to sign a "Consent Form" to let us use and share your information. Please be advised that if you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes, we will discuss this with you and ask you to sign an "Authorization" form to allow this.

Of course, we will keep your health information private but there are some times when the laws require us to use or share it. Please refer to our "Contract for Services" form under the subheading, "Confidentiality and Reporting Laws" for more details.

Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. All medical records and notations made on your behalf by your therapist belong to the agency and, as has been stated in the contract for services, are available for inspection by your therapist, your therapist's supervisor (if any), and the agency's director.

4. You have the right to look at health information we have about you such as your medical and billing records.* You can even get a copy of these records but we may charge you. Contact our Privacy Officer to arrange how to see your records. (See below).

5. If you believe the information in our records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.

6. You have the right to a copy of this notice. If we change this NPP we will post the new version in our waiting area and you can always get a copy of the NPP from the Privacy Officer.

7. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer who is Dr. Duane Kellogg, Jr. He can be reached by phone at (203) 255-5078 or by mail at 8 Wakeman Rd. Fairfield, CT 06824

The effective date of this notice is July 1, 2009

* A summary of your psychotherapy sessions can be provided by your therapist at an additional charge.

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