59 Murray Guard Drive, Jackson, TN 38305 | 731-394-4109 | www.re-envisioncounseling.com

Client Information

Today's Date: _____

Full Name _____ **Preferred Name** _____

Date of Birth _____ **Age** _____

Gender/ Preferred Pronouns _____

Email _____

Address _____ **City/State/Zip** _____

Occupation _____ **Employer** _____

Are you a Student: Yes / No **School** _____

Grade _____ **Area of Study** _____

Relationship Status (please circle) Single / Engaged / Married / Widowed / Separated / Divorced / Remarried / Cohabitating

Partner's Name _____

Partner's Occupation _____

List members of your family and/ or all others:

Name	Gender	Age	Living with you?	Relationship to you

Contact Information

When you are contacted, we want to ensure your confidentiality and privacy.
Please indicate whether or not a detailed message may be left.

Primary Phone _____ **Message** Yes / No

Secondary Phone _____ **Message** Yes / No

Emergency Contact Name _____ **Relationship to Client** _____

Emergency Contact Phone _____ **Email** _____

If the client is under 18 years of age, or if the parent (s) will be responsible for payment, complete this section:

Parents' Marital Status Single / Engaged / Married / Widowed / Separated / Divorced

Mother's Name_____ **Primary Phone** _____

Work Phone _____ **Message** Yes / No

Address _____ **City, State, ZIP** _____

Employment _____

Father's Name _____ **Primary Phone** _____

Work Phone _____ **Message** Yes / No

Address _____ **City, State, ZIP** _____

Employment _____

If divorced, have parents remarried? Father: Yes / No Mother: Yes / No

Name of custodial/ primary residential party _____

If there are step-parents, please provide their names:

Step-Mother _____ **Step-Father** _____

Health Information

Please describe your primary reason for seeking therapy services.

_____

_____

How are your concerns affecting you at WORK or SCHOOL?

_____

_____

What are your goals for counseling?

_____

In what ways do you expect counseling to help you?

_____

Have you received counseling before? Yes ___ No ___
If yes, please give dates and with whom. _____

Have you ever been hospitalized for psychological/ psychiatric care? Yes ___ No ___
If yes, date(s) and reason: _____

Have you experienced a traumatic experience/ event? Yes ___ No___
If yes, please explain: _____

Current and Past Medication

Medication	Dose/ Freq	Start	Stop	Response	MD Prescribing

Please list any major medical illnesses or hospitalizations _____

Physician's Name _____ **Address** _____

City, State, ZIP _____ **Phone** _____

Psychiatrist Name _____ **Address** _____

Other Physicians _____

Have you ever been arrested or convicted of a crime? Yes ___ No ___

If yes, date(s) and reason for arrest(s) or conviction(s):

_____

Please check all that apply to you:

Present	**Past Only**	
☐	☐	Anxiety
☐	☐	Panic Attacks
☐	☐	Shyness/ Social Anxiety
☐	☐	Obsessive/ Compulsive Behaviors
☐	☐	Paranoid Thoughts
☐	☐	Hearing Voices
☐	☐	Depression
☐	☐	Irritability
☐	☐	Stress
☐	☐	Fatigue/ Low Energy
☐	☐	Difficulty Concentrating
☐	☐	Isolation from Others
☐	☐	Aggressive Behavior
☐	☐	Thoughts of Self-Harm
☐	☐	Thoughts of Harming Others
☐	☐	History of Self- Harm or Suicidal Thoughts
☐	☐	History of Harming Others

Present	**Past Only**	
☐	☐	Trauma
☐	☐	Problems at Work
☐	☐	Problems at School
☐	☐	Problems in Relationships
☐	☐	Problems in Parenting
☐	☐	Financial Concerns
☐	☐	Family of Origin Issues
☐	☐	Faith Concerns
☐	☐	Chronic Pain
☐	☐	Chronic Illness
☐	☐	Difficulty Sleeping
☐	☐	Poor Hygiene
☐	☐	Alcohol and/or Drug Use
☐	☐	Pornography Use
☐	☐	Excessive Video/ Online Game Use
☐	☐	Unwanted Sexual Experience
☐	☐	Patterns of Disordered Eating
☐	☐	Recent Death or Loss

FAMILY MENTAL HEALTH HISTORY: (Check any of the following that are/ were present in your family and who)

_____ Depression _____

_____ Anxiety _____

_____ Substance Abuse _____

_____ Suicide Attempt _____

_____ Sexual Abuse _____

_____ Eating Disorder _____

_____ Other Psychiatric/ Emotional Disturbance (explain) _____

_____

Adverse Childhood Experience Questionnaire for Adults

Our relationships and experiences- even those in childhood- can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below as this will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the *total number* at the bottom.

Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	
Did you lose a parent through divorce, abandonment, death, or other reason?	
Did you live with anyone who was depressed, mentally ill, or attempted suicide?	
Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	
Did your parents or adults in the home ever hit, punch, beat, or threaten to harm each other?	
Did you live with anyone who went to jail or prison?	
Did a parent or adult in your home ever swear at you, insult you, or put you down?	
Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	
Did you feel that no one in your family loved you or thought you were special?	
Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/ penetration)?	
Your ACE score is the total number of checked responses	

Please check the times when you are AVAILABLE for counseling:

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 am					
9:00 am					
10:00 am					
11:00 am					
12:00 pm					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					
6:00 pm					
7:00 pm					

Referral Information

How Did You Learn About Our Office?

_____

59 Murray Guard Drive, Jackson, TN 38305 | 731-394-4109 | www.re-envisioncounseling.com

INFORMED CONSENT AND HIPAA NOTIFICATION

Welcome to ReEnvision Counseling! We strive to provide the highest quality of care in a manner that is comfortable and convenient for our clients. Please do not hesitate to ask questions about any of these matters.
The following information is provided to assist clients in understanding ReEnvision Counseling's policies & procedures.

Appointments

Your first appointment will be the Intake Session, which is reserved with a credit card number once you've been assigned a therapist. After this initial assessment, you and your therapist will schedule additional sessions together. You are able to communicate directly with your therapist rather than going through a receptionist. When you arrive for your session, please help yourself to water, coffee and/or snacks, and your therapist will meet you in the waiting area. Please give your therapist at least 24 hours notice if you must cancel a session. Sometimes illnesses or other emergencies might prevent you from this, which is perfectly understandable. However, that time is reserved specifically for your session, so we must charge you **70% of the session fee if it is not cancelled at least 24 hours in advance.** This helps to offset the therapist's lost hour of work but also keeps you from having to pay the full session fee. We will bill the late cancellation fee to the credit card on file, unless you request us to do otherwise.

Emergencies and Telephone Calls

While you will be seen at a reserved time that fits your individual scheduling demands, there may arise situations when you feel as though you need to speak with your therapist between appointments. If you feel such a need, you may call during normal office hours and your therapist will get back with you as soon as they are able to do so. Emailing is also an excellent option for correspondence with your therapist. If the call will be longer than 5-10 minutes, your therapist might suggest a 25 minute phone session at half the price of a regular session.
If you are experiencing an emergency, you need to go immediately to the emergency room at the nearest hospital or call the crisis hotline at 855-274-7471.

Sessions

During a session, your therapist will do one or more of the following: (a) listen to your concerns and allow you to ventilate your feelings; (b) help you set goals and develop a plan of action to overcome your problems; (c) work with you in reviewing events/ thoughts/ feelings that are hindering you in reaching your goals; and (d) give you reading/ writing assignments designed to help you gain useful insights into your unique situation**.**

Risks Involved in Counseling

Counseling involves a degree of risk, usually in the form of feelings that may increase in discomfort for a temporary time. The therapist-client relationship often involves self-disclosure and confrontation, as well as encouragement and support. Sometimes counseling involves recalling unpleasant aspects of your history. Also, any change- even positive change- often disrupts a person's established system. You may meet resistance from other people in your life as a result of changes accomplished through therapy.

HIPAA Notification for Clients

ReEnvision Counseling is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 by informing clients of how they use and disclose personal health information (PHI).
What is PHI?
· Name; Address; Telephone Number; E-mail Address; Social Security Number; Medical Information (including initial assessment, progress notes, discharge summaries, treatment plans, etc. Any documentation related to your care)

Client Records of Disclosure
In general, the HIPAA privacy act gives individuals the right to request a restriction on uses and disclosures of their PHI. The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means such as sending correspondence to the individual's office instead of at the individual's home.

Square Inc.
If you and your therapist choose to utilize the Customers feature of Square, the other team members of ReEnvision Counseling may have access to a limited amount of your PHI (name, fee, email, last 4 digits of credit card & dates of service).

I wish to be contacted in the following manner (check all that apply):

Cell Phone: _____
__ Ok to leave a message with detailed information
__Leave a message with a call back number only

Email: _____
__ Ok to email to my personal email address
__ OK to email to my work email address

Work Phone: _____
__ OK to leave a message with detailed information
__ Leave a message with a call back number only

Other: _____

Issues of Confidentiality and Privileged Communications

What you talk about in your established relationship with your therapist is protected by privileged communication laws in the State of Tennessee. This means that no one is allowed to gain access to your personal information (PHI) without your express, written consent. All communications are kept private, confidential, and privileged. This is a key aspect of the counseling relationship and one that we work to protect in all situations.

Occasionally, however, for your safety and the safety of others, it becomes necessary for confidentiality to be broken.

The following is a list of serious events for which, by Tennessee State Law, your therapist is required to break confidentiality: (a) If there is imminent danger of serious harm to yourself and/or other people, a therapist may reveal such information to the intended victim and/ or agencies necessary to prevent such harm to yourself or another person; (b) If there is evidence revealed of physical and/or sexual abuse of children, the therapist must report this information to the appropriate authorities; (c) If a court of law issue a legitimate subpoena, ReEnvision Counseling is required by law to provide the information specifically described in the subpoena. (d) for therapists who are under a temporary license and receiving supervision from a licensed professional to collaborate and gain support. (e) for the purpose of pursuing professional excellence, we will occasionally collaborate with our team of professionals in staff meetings, but we always ask a client's permission before using any identifying information.

Telehealth Services Agreement

In the event that we cannot use our facilities for sessions or you are unable to come into the office due to temporary limitations such as medical conditions or distance due to travel, you have the option to participate in Telehealth Services.

"Telehealth" is defined as the use of electronic transmission to provide interactive real-time mental health services remotely, including consultation, assessment, diagnosis, treatment planning, counseling, psychotherapy, coaching, guidance, education, and transfer of medical information with an experienced psychotherapist. This can include both video and audio forms of communication, via the internet or telephone. Telehealth services do not include texting or e-mail. Telehealth is governed by all the same ethics and lows that cover in-office, in-person, face-to-face psychotherapy. Advantages and disadvantages exist in using this method as it offers a way to assist people to meet their mental health needs digitally; however, it may not provide the same level of comfort or seem as complete when talking about personal or private matters.

Emergencies

Just as with in-person services, if an emergency should occur during a telehealth session, the psychotherapist may consider taking any steps necessary to ensure the safety of the client or of others.

Scheduling

Just as with an in-person appointment, telehealth sessions are scheduled by prior arrangement.

Scheduling a telehealth appointment involves reserving time specifically for you. Just as with in-person appointments, you are responsible for keeping all telehealth appointments.

We should usually start and end on time. In all telehealth sessions, the therapist will initiate the telehealth session, unless other arrangements have been made. A window will remain open around the starting time of your appointment. Just as with an in-person session, if your psychotherapist doesn't hear from you, s/he will attempt to reach you but will discontinue after several attempts.

Cancellations and unkept appointments are treated just like in-person cancellations and unkept appointments. The psychotherapist is not responsible for the client's ability to participate in the session, including technological limitations.

Confidentiality

The laws that protect the confidentiality of your medical information in the office also apply to telehealth sessions, including mandatory and permissive exceptions to confidentiality.

The client and psychotherapist both agree to keep the same privacy safeguards as during an in-person session. The environment should be free from unexpected or unauthorized intrusions or disruptions to our communication. There is a risk of being overheard by a third party near you if you do not conduct the session in an enclosed private room, with reasonable sound barriers, and with no one else present or observing.

The client and psychotherapist both agree to not record the telehealth sessions without prior written consent of both parties.

Consent

You have the right to opt-in or opt-out of the methods of telehealth communication at any time, without affecting your right to future care or treatment.

It is your responsibility to discuss prior to the telehealth session which medium will be used, how to use it, and any necessary preparation.

Security

No electronic transmission system is considered completely safe from intrusion. Interception of communication by third parties remains technically possible. Due to the complexities of electronic media and the internet, risks of telehealth include the potential for the release of private information, including audio and images. So, your psychotherapist cannot fully guarantee the security of telehealth sessions. You are responsible for information security on your computer, laptop, tablet, or smartphone.

Telephone

Telehealth can include telephone sessions. When using the telephone, remember to be in a place you feel comfortable speaking about personal and private matters.

Video Conferencing

The client is responsible for his/her own hardware and software, audio and video peripherals, and connectivity and bandwidth considerations.

At the time of the telehealth appointment, it is your responsibility to have your electronic device on, video conferencing software launched, and be ready to start the session at the time of the scheduled telehealth appointment.

Payment

Just like in-person services, telehealth services are a professional service, and a fee is charged at the same rate as in-person services.

I have read and understood the information provided above. I have discussed it with my psychotherapist/mediator. All of my questions have been answered to my satisfaction. I hereby request and consent to telehealth services as a part of my treatment. I agree to abide by the terms of this agreement.

_____ _____

Client's Signature Date

_____ _____

Provider's Signature Date

Service Fees

All payments are due at the time services are rendered unless prior arrangements have been made and agreed upon between ReEnvision Counseling staff and the client.

Intake Appointment (50 minute session)	$150 with Dr. Britt $135 with Marci; Micah; Luke $125 with Hannah; Sarah $90 with Matthew; Kim; Morgan; Tori $40 with a graduate intern
Intake Appointment (80 minute session) *required for couples & families	$215 with Dr. Britt $175 with Marci; Micah; Luke $165 with Hannah; Sarah $125 with Matt; Kim; Morgan; Tori
Individual Therapy (50 minute session)	$125 with Dr. Britt $115 with Marci; Micah; Luke $100 with Hannah; Sarah $75 with Matt; Kim; Morgan; Tori $40 with a graduate intern
Individual/ Family/ Couples Therapy (80 minute session)	$185 with Dr. Britt $170 with Marci; Micah; Luke $150 Hannah; Sarah $115 with Matt; Kim; Morgan; Tori
Group Therapy	To be determined by the facilitator of the group

Subpoena to Court for Expert Testimony- Non-Refundable Up-Front Retainer fee:	$500/ one-time fee
Court Appearance and Preparation:	$250/ hour
Additional Expenses for Court/ Additional Practice Fees	TBD

Your Informed Consent to Receiving Care

We have provided this information in order to inform you of the ReEnvision Counseling policies and procedures. Mental health care offers no guarantees of success, and there are limitations to any form of care offered to a client. Please feel free to discuss any of these matters with your therapist in more detail. By signing below, you acknowledge having read, understood, and agreed to the ReEnvision Counseling policies and procedures. Your signature acknowledges your informed consent to receiving care.*

_____ _____

Signature of Client or Parent/ Guardian *Date*

The signature below indicates that I have explained the policies and procedures of ReEnvision Counseling to this client and that I have also offered the client a copy of this form.

_____ _____

Provider's Signature *Date*

**We reserve the right to update ReEnvision Counseling's policies and procedures as needed with these current rights and responsibilities being applicable, unless you receive a revision when you come in for a future appointment.*

FEE PAYMENT POLICY AND AUTHORIZATION FORM

Payment for service is expected at the time of the session unless you have made other arrangements with the therapist. **ReEnvision Counseling requires a credit card on file to be used only for missed appointments and late cancellation fees.** In addition, you can *choose* to authorize your therapist to charge you card automatically for sessions that you attend. Because there is an additional banking fee associated with using your credit or debit card, 4% per transaction will be charged when you choose this option.

Credit/ Debit Card Information

Name on Card _____ **Card Number** _____

Expiration Date _____ **CVV Number** _____

Billing ZIP Code _____ **Email Address** _____

Recurring Charge Authorization

The undersigned card member consents and permits ReEnvision Counseling to automatically charge the standard rate for counseling sessions that I attend. I understand there will be an additional (4%) fee for this convenience. I release my therapist, as applicable, from any and all claims arising from the use of this service.

_____ _____

Signature of Client or Parent/ Guardian *Date*

Insurance/ Third Party Billing

We will gladly create a superbill with the information needed to file an insurance claim. Coverage for therapy varies according to a client's plan and the insurance company. Full payment for the session is due at the time of service. We do not file insurance claims, and we are not on insurance panels.

Authorization

By signing below, I acknowledge that I have read, agreed to and understand the fee payment policy above. I also authorize the therapist to release necessary medical information to third parties, including organizations or individuals who are being invoiced for the client's services, for billing purposes and payment of medical benefits to the therapist.

_____ _____

Signature of Client or Parent/ Guardian *Date*

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Statement of Client Rights & Responsibilities

Statement of Client Rights

- Clients have the right to be treated with dignity and respect.
- Clients have the right to fair treatment in accordance with Title VI of the Civil Rights Acts of 1964 and to not be discriminated against. Services are offered to all eligible persons regardless of their race, religion, ethnicity, gender, sexual orientation, age, disability, income level, etc.
- Clients have the right for all their treatment and information to be kept private. Records may only be released by client's permission.
- Clients have the right to easily access timely care in a timely fashion.
- Clients have the right to know about their treatment choices, regardless of cost or coverage by a client's benefit plan.
- Clients have the right to share in developing their plan of care
- Clients have the right to information in a language they can understand.
- Clients have the rights to a clear explanation of their condition and treatment options.
- Clients have the right to ask their provider about their work history and training.
- Clients have the right to know about advocacy and community groups and prevention services.
- Clients have the right to give input on this Statement of Rights and Responsibilities.
- Clients have the right to freely voice concerns or complaints and to have those acted upon.
- Clients have the right to know of their rights and responsibilities in the treatment process.

**We reserve the right to change the ReEnvision Counseling Statement of Client Rights and Responsibilities as needed with these current rights and responsibilities being applicable, unless you receive a revision when you come in for a future appointment.*

Statement of Client Responsibilities

- Clients have the responsibility to treat those giving care to them with dignity and respect.
- Clients have the responsibility to give providers honest information so that providers can deliver the best care possible.
- Clients have the responsibility to ask questions about their care and/or treatment in order to better understand it.
- Clients have the responsibility to follow the treatment plan.
- Clients have the responsibility to tell their provider and primary care doctor about medication changes, including medications given to them by others.
- Clients have the responsibility to keep their appointments. Clients should call their providers as soon as they know they need to cancel visits.
- Clients have the responsibility to let their provider know when the treatment plan isn't working for them.
- Clients have the responsibility to let their provider know about problems with payment.
- Clients have the responsibility to report any abuse or fraud.
- Clients have the responsibility to openly share any concerns they may have about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities and that I understand this information.

_____

Client's Signature *Date*

_____

Legal Guardian of client (if under the age of 18) *Date*