Insight Renewal Center
2723 Foxcroft Road, Suite 202
Little Rock, AR 72227
Email: info@insightrenewalcenter.com
Phone: 501-414-0111 Fax: 501-222-1309

Consent for Treatment and Payment for Treatment

- ☐ I consent to mental health treatment for myself or for the client for whom I am the parent or legally authorized representative.
- ☐ I consent to the use of tele-therapy technologies (The use of video/audio connections to communicate) as an option for mental health treatment when both parties (Client and Therapist) agree.
- ☐ I understand that Insight Renewal Center will share client health information according to federal and state law for treatment, payment and health care operations.
- ☐ I understand that the client/client's parent/legally authorized representative is responsible for all charges incurred, regardless of the client's insurance status.
- ☐ The client/client's parent/legally authorized representative agrees to pay for services as the client incurs the charges and to pay copays at the time of services. I authorize the insurance provider to pay Insight Renewal Center for services rendered.

_____ _____
Client Signature Date

_____ _____
Guardian/Legal Representative Signature (if patient is under 18) Date

HIPAA Privacy Documentation Acknowledgment of Receipt of Notice of Privacy Practices

- The Notice of Privacy Practices tells me how Insight Renewal Center, LLC will use the client's health information for the purposes of treatment, payment for treatment, and health care operations.

- The Notice of Privacy Practices also explains in more detail how Insight Renewal Center, LLC may use and share the client's health information for purposes other than treatment, payment, and health care operations.

Insight Renewal Center, LLC also will use and share the client's health information as required or permitted by law.

☐ I acknowledge that I have received a copy of the Provider's Notice of Privacy Practices with the effective date of 5/15/2014.

☐ I understand and agree to the statements above.

_____ _____

Signature of Client Date

_____ _____

Printed Name of Client Date

_____ _____

Signature of Client's Legally Authorized Representative Date

_____

Printed Name of Client's Legally Authorized Representative

_____

Relationship of Legally Authorized Representative to Client

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Fee and Payment for Services

Fees are set based on the type of services provided. Each insurance company has a list of services that they allow to be provided to their members. As part of our service to our clients, we will contact insurance companies to verify benefits and eligibility. However, please know that it is ultimately the responsibility of the member to obtain the details of their eligibility, benefits, and coverage. Fees below are based on an hourly rate.

Fee Schedule	**Insurance Fees**	**Out of Pocket Fees**
Diagnostic Assessment:	$250.00	$200.00
Individual Therapy (per hour)	$200.00	$150.00
Family Therapy (per hour)	$200.00	$150.00
Group Therapy (per hour)	$75.00	$50.00
Crisis Intervention (per hour)	$200.00	$150.00
In Home Family Coaching (per hour)	$250.00	$250.00
Out of Office/Court Requests/Subpoena	$150.00	$150.00
Collaterals (per 15 minutes)	$25.00	$25.00
Text/Email Communication (per 15 minutes)	$25.00	$25.00

Fees are the set rates for the Clinic. The provider agrees to accept the fee set through their contract with set insurance companies. As stated above, our office will contact your insurance company to verify your coverage. We will utilize the information provided by your insurance company to process service claims. We recommend you contact them as well, to confirm the information provided to Insight Renewal Center. If coverage exists on more than one policy, insurance companies require that the primary policy is billed first. Please provide Insight Renewal Center with all active health policies. If all active insurance policies are not listed and verified, it could lead to a claim being denied and the insurance requiring payment out of pocket. It is important to contact your insurance company prior to your first appointment to ask the following:

- What services are covered?
- What is my deductible and copay for services?
- Is a prior authorization required for services to be provided?
- Is there a limit on the number of sessions I can have?
- Are there certain diagnosis codes that are not covered by my plan?

Accepted Forms of Payment

- Cash
- Credit Card

Payment Policy:

Payment is required at the time the services are rendered. Individuals who have insurance coverage are required to pay their copay amount, including any deductibles at the time of services.

Accounts past due will incur a $25 late fee for each 30 days they are overdue.

I understand if I have an unpaid balance to Insight Renewal Center, LLC and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for Insight Renewal Center, LLC or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Insight Renewal Center, LLC and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

Cancellation/DNKA Policy:

If an appointment needs to be canceled, please contact our office by phone to cancel an appointment. Please leave a message if after normal business hours. Cancellations that are made with less than 24-hour's notice will incur a $50 cancellation fee. If you miss or No Show to appointment, you will incur a $50 fee. Repeated instances will result in an incremental increase of $50 per occurrence (not to exceed the allowed amount billed to insurance for the encounter). Fees may also be incurred from late arrivals resulting in cancellation of the scheduled appointment. Insight Renewal Center reserves the right to waive these fees.

I understand the payment policy and cancellation/DNKA policy and agree to these terms.

_____ _____

Customer Signature Date

Credit card to place on file for payments:

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____ CVS: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize Insight Renewal Center to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

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Patient Information:

Date: _____

Name of Patient: _____

Patient Date of Birth: _____ Patient Age_____ Patient Sex_____

Patient Social Security Number: _____

Parent's Social Security Number (if patient is a minor): _____

Name Parent(s)/Guardians (if different than patient and patient is a minor):

_____

Address: _____

_____

Phone Numbers: (Home)_____ (Mobile) _____(Work)_____

Email Address: _____

Preferred Communication: Telephone/Voicemail ☐ Cell Phone ☐ Text ☐ Email ☐

Insurance Information:

Name of Employer: _____
Name of Insurance Company: _____
Insurance Company's Phone Number: _____
Insurance Company's Address: _____
Policy Holders Name: _____
Policy Holders Date of Birth: _____
Policy Holders Address: _____
Policy Holders Telephone Number: _____
Policy Holders Social Security: _____
Policy Holders Employer: _____
Policy Holders Insurance Card ID Number: _____
Policy Holders Insurance Card Group Number: _____

Secondary Insurance:

Name of Employer: _____
Name of Insurance Company: _____
Insurance Company's Phone Number: _____
Insurance Company's Address: _____
Policy Holders Name: _____
Policy Holders Date of Birth: _____
Policy Holders Address: _____
Policy Holders Telephone Number: _____
Policy Holders Social Security: _____
Policy Holders Employer: _____
Policy Holders Insurance Card ID Number: _____
Policy Holders Insurance Card Group Number: _____

Does the patient have a Secondary Insurance?(If there is a secondary insurance and it is not listed, it may cause your claims to "Deny", leaving patient responsible for all charges associated with the service)

Primary Care Physician Information:

Name: _____

Phone Number: _____

Emergency Contact:

Name: _____Relationship: _____Telephone Number:_____

Reason for Visit:

What is the reason you are seeking therapy/evaluation for yourself or your child?

_____
_
_____
_
_____
_ _____

What symptoms or behaviors are you or your child having due to these problems (i.e. anxious, angry, fighting, withdrawn, etc.) :

_____
_
_____
_
_____
_ _____

How long have these problems been going on?

_____

_____

_____

On a scale of 1 to 10 circle the score that best describes how bad the symptoms are?

1 2 3 4 5 6 7 8 9 10

Least Worst

Do you have thoughts about what causes these problems?

_____

_____

_____

Does the patient have a history of homicidal or suicidal behavior? No☐

Yes☐ Explain:

_____

_____

Does the patient have a history of Alcohol Problems? No☐ Yes☐

Drug Problems? _____No☐ Yes☐ Type of Drugs:_____

_____

Other addictions (gambling, pornography, gaming, etc? ☐ No ☐ Yes

If yes, Specify:_____

Is there additional information you think I should know about these problems?

_____

_____

_____

Has the patient participated in therapy before? _____Yes☐ No☐

If Yes, Name of Agency/Person?_____ Dates of Treatment:_____ - _____

Medical History:

List any major medical issues?

_____

_____

_____

Allergies:_____

Any significant changes in Weight (loss or gain of 10 or more pounds)?_____

Any pain?_____Yes_____No; If yes, rate pain on a scale of 1 to 10 with 1 being little to no pain and 10 being extreme pain?_____

Date of Last Physical Exam?_____ Were there any issues at that appointment?_____(it is recommended that patients have a physical every year)

Please list any medication that the patient is taking:

Medication	Dose	Frequency	Reason	Prescribing MD

(If patient is above age 18):

Marital Status

Patients Marital Status: Married _____Divorced _____Separated_____
Patients Work History:
Employed_____Fulltime/Part-time _____Unemployed _____
Occupation: _____

(If patient is a minor; NA if patient is over 18 years of Age):

Education

Patients Current Grade: _____Name of School: _____
Type of school Placement: Regular Ed _____Special Ed_____
504_____Alternative School or classroom placement_____
Socialization or Peer Issues? _____No _____Yes _____
If Yes Specify: _____

Family History:

Mother's Name: _____Age: _____Occupation:_____
Father's Name: _____ Age: _____Occupation:_____
Parent's Marital Status: Married _____Divorced _____Separated_____
Patients Siblings:
_____
_____
_____

Patient's Strengths:
_____

_____
_____
_____

Patient's Weaknesses:

_____
_____
_____
_____

Referred By:

Insurance Company: _____Internet/Website: (specify)_____

Person:_____