RENARI COUNSELING LLC

1468 Brice Rd., Reynoldsburg, OH 43068

CLIENT/RESPONSIBLE PARTY CONTRACT • ASSIGNMENT OF BENEFITS • CANCELLATION POLICY

This is a contract between me, _____, and Renari Counseling LLC (RENARI). I am seeking services from RENARI, and I understand that assessment, treatment, and/or consultation services will be provided by health care providers for my benefit, the benefit of my spouse, the benefit of those in guardianship, or any combination, and that any fees for those services will be charged to me directly. I understand that payment for these services is my responsibility. The fees for services have been explained to me, and I agree to the following:

Therapeutic Service Fees:	**Other Identified Fees:**
$225 Initial Assessment Interview	$35 Returned Check Fee
$150 Clinical Hour (per 45-60 minutes.)	$50-$100 Clinical Records or Letter Requests
$75 Clinical Half Hour (per 20-30 minutes.)	$250 (per 0-30 minutes) Court Appearance

If I am a member of, party to, or beneficiary of an insurance policy or contract, HMO, or other arrangement where a third party pays for, reimburses for, or provides health care benefits, then the party obligated to pay for, reimburse for, or provide the health care benefits is called the "third-party payor" in this agreement. As a convenience to me, RENARI or its billing agent will bill my primary third-party payor. I hereby assign all medical and/or mental health-related benefits to which I am entitled from any third-party payor to RENARI, and I hereby authorize RENARI to maintain my signature on file for use in filing any claims. RENARI maintains provider contracts with numerous insurance companies as a provider group. I understand this does not alter my responsibilities as agreed herein.

I understand it is my responsibility to determine the amount of and pay any deductible, co-insurance, and/or self-payment, less any amount paid by any third-party payor, at the time of each visit. If co-payment is not made at the time of service, there will be a $15 fee to offset billing costs. I agree that, under no circumstance, is the balance on my account to exceed $150 (including amounts expected to be my patient responsibility by any third-party payor). If that occurs, I will pay the balance in full, or make specific arrangements to pay it in full. I understand that I am financially responsible for all charges whether or not paid by any third-party payor. I understand that I may not be rescheduled if my account has an unpaid balance. **I agree not to let any fees remain unpaid for more than forty five (45) days**. I understand that my account may be sent to a collection agency if it is **forty five (45) days past due**.

The following cancellation policy for RENARI is in place out of respect for our therapists and our clients. When an appointment is scheduled, that time has been set aside for you. When it is missed, that time cannot be used to treat another client. By giving last-minute notice, or by giving no notice at all, you prevent someone else from being able to be scheduled into that time slot. This charge WILL NOT be paid by your insurance company. You will be personally responsible for this charge. If you accumulate a total of two (2) missed/late cancelled appointments within a two (2) month period, you may not be rescheduled for future appointments. If you cannot keep your appointment for any reason, please call us 24 hours prior to your appointment time.

If you **do not show** for your appointment, or if **you cancel with less than a 24-hour notice**, you will be charged as follows (please initial by each line):

$80.00 for all appointments with **less than 24-hour notice.** (_____)

I understand that, unless I provide RENARI with a 24-hour advance notice of cancellation, I may be charged for each missed/late cancelled appointment, and that any no-show or late-cancellation fees are my responsibility. I have read and understand the cancellation policy of Renari Counseling LLC, and I agree to be bound by its terms.

I authorize disclosure of portions of my records as deemed necessary by RENARI in order to obtain payment from any third-party payor, and to the extent necessary to determine liability for payment. I also authorize disclosure as necessary for consultation with other professionals and for quality assurance reviews when required by any third-party payor, or by professional standards. A photocopy of this assignment is to be considered as valid as the original.

Signature: _____

Print Name: _____ Date: _____

RENARI COUNSELING LLC

1468 Brice Rd., Reynoldsburg, OH 43068

(Client/Responsible Party) RENARI COUNSELING LLC (RENARI)

CONSENT TO ENTER INTO TREATMENT

TREATMENT/RIGHTS & RESPONSIBILITIES This is your consent for us to provide professional services, and a list of your rights and responsibilities as a client. This list represents our intent to comply with federal and state statutes, as well as professional standards and ethics. Please review any questions with your treating professional.

RIGHTS:

1. First and foremost, you have the right to be treated with dignity and respect.

2. You have the right to treatment. This right includes, but is not limited to:

   a) The right to a humane psychological and physical environment that is the least restrictive environment appropriate to your needs.
   b) The right to a current, written, individualized treatment plan, which you have participated in establishing, and to see and sign that plan.
   c) The right to be informed of alternative and additional treatment resources, and the right to request and receive aid in referral to another agency.
   d) The right to be informed of any contraindication(s) resulting from treatment.
   e) The right to be protected from abuse and/or neglect.
   f) The right to refuse medication and/or treatment of any type.

3. The right to have equitable access to treatment regardless of race, religion, sex, ethnicity, age, handicap, sexual orientation, or source of payment for services.

4. The right to confidentiality in accordance with federal and state law.

5. The right to full disclosure of all costs and fees.

6. You have the right to know that, under the following conditions, your rights to confidentiality may be limited, and that staff will (**please initial by each line**):

   a) Report suspected physical or sexual abuse to the appropriate authorities. (____)
   b) Report homicidal intentions to the identified victim(s) and your local police department. (____)
   c) Report suicidal intentions to your family, if you fail to follow treatment recommendations. (____)
   d) Report confidential information for peer and utilization review, and to insurance representatives for the purposes of utilization review and benefit determination. (____)

7. The right to express complaints and grievances through outlined channels, to have grievances heard and a response obtained.

8. The right to appeal any decisions made concerning treatment, complaints or grievances, and to obtain a response. a. Take your problem directly to any staff person, who will take it to the Manager for review.

RESPONSIBILITIES:

1. I have voluntarily chosen to receive mental health services, and I understand that I may terminate service at any time.

2. I understand that material may be discussed which might be upsetting or distressful in nature.

3. I understand that there is no assurance that services will provide desired results, and that evaluation and treatment is a cooperative effort between staff and myself, and I will work in a cooperative manner to resolve my difficulties.

4. I accept the financial responsibility to pay for services received, including all time for preparation, and/or travel for attorney consultations, depositions, or court appearances as an expert witness. I understand that prepayment may be required for expert witness services.

5. Some psychological symptoms have biological causes. I understand that it is my responsibility to obtain and maintain sufficient contact with a physician regarding my physical health and psychological symptoms.

6. I understand that there will be times when sensitive information will need to be discussed with representatives of my insurance company for the purposes of benefit determination, or with professional peers for review or consultation.

7. I agree that I may request information about my progress and satisfaction with services during and after completion of services.

I HAVE READ OR HAVE HAD THIS FORM READ TO ME. I FULLY UNDERSTAND ITS CONTENTS, AND I ACKNOWLEDGE THAT MY SIGNATURE BELOW INDICATES MY CONSENT TO RECEIVE SERVICES AS STIPULATED.

Signature: _____

Print Name: _____ Date: _____

RENARI COUNSELING LLC (RENARI) NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MUCH MEDICAL AND/OR MENTAL HEALTH INFORMATION THAT 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 medical and mental health information as part of providing professional care. We are also required, by law, to keep your information confidential. These laws are complicated, but we give you this important information. This is a shorter version of the full, legally required NOTICE OF PRIVACY PRACTICES (NPP). We will use the information about your health, which we get from you or from others, mainly to provide you with treatment, to arrange for payment for our services, and for some other business activities, which are called "health care operations" in the law. After you have read the NPP, we will ask you to sign a consent form to let us use and share your information. If you do not sign this form, we cannot treat you.

If we (or you) want to use or disclose (send, share, release) your information for any other purpose, 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 law requires us to use or share it. For example:

1. When there is a serious threat to your health and safety, or the health and safety of another individual, or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.

2. Some lawsuits, and legal or court proceedings.

3. If a law enforcement official requires us to do so.

4. For Workers' Compensation, or similar benefit program.

Your Rights Regarding Your Health Information:

1. You can ask us to communicate with you about our 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 divulge to people involved in your care, or the payment of our care, such as family members and friends. While we do not have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or if it is an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you, such as your medical and billing records. You can even receive a copy of these records, but there may be an administrative charge associated in copying this information.

4. If you believe the information in your record is incorrect – or if there is important information missing – you can ask us to make changes (called amending) to your health information. You must make this request in writing, and you must tell us the reason for any change.

5. You have the right to a copy of this notice.

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

The effective date of this notice is:

Signature: _____

Print Name: _____ Date: _____

(Client or Legal Representative)

Relationship to Client: _____ RENARI COUNSELING LLC (RENARI)