The Renaissance Centre, Inc.
506 N. Jackson Street, Albany, Georgia 31701
229-889-7200

I. New Client
Welcome and thank you for choosing The Renaissance Centre as your mental health provider.
Please read the following information regarding treatment, confidentiality, and office policies carefully, initial, date, and sign your name where indicated. Your initials and signature indicate that you have read, understood, and accept the terms of this agreement.

Minors: Georgia law states that when the client is a minor, any adult may bring in the minor for one visit. This must be on a fee-for-service basis and subsequent visits must have written consent of the minor's legal parent/guardian. In the event services are rendered for a minor of divorced or separated parents/guardians, the parent/guardian admitting the minor is responsible for the services incurred.

INDEPENDENT CONTRACTORS: Please note that while you are seeking services from the entity with the business name "Renaissance Centre," the actual clinical services you receive may be provided by individuals who are independent contractors and are NOT Renaissance Centre agents or employees. Independent contractors are responsible for their own actions and services and the Renaissance Centre will not be liable for the acts or omissions of any such independent contractors. Actual employees of the Renaissance Centre include the support staff and Dr. Nick Carden (owner). If you desire a list of independent contractors who utilize Renaissance Centre office space and its support services, please contact Dr. Nick Carden (owner).
_____//_____ (initial)

II. Aims and Goals:
The major goal is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This can be accomplished by:
1. Increasing personal awareness.
2. Increasing personal responsibility and acceptance to make changes necessary to attain your goals.
3. Identifying personal treatment goals.
4. Promoting wholeness through psychiatric treatment and/or psychological and spiritual healing and growth.

You are responsible for providing necessary information to facilitate effective treatment. You are expected to play an active role in your treatment, including working with your therapist to evaluate your needs and outline your treatment goals and assess your progress. Psychological testing may be a part of this process. There may also be negative consequences if you do not follow through with recommended treatment(s).

You may be asked to complete questionnaires or to do homework assignments. Your progress in therapy often depends as much or more on what you do between sessions as on what occurs in the session.

III. Appointments:
Appointments are usually scheduled for 45-50 minutes. The practice's hours are 8:00am-5:00pm. Patients are generally seen once every two weeks or more/less frequently depending on what you and your therapist agree upon. You may discontinue treatment at any time, but please discuss any decisions with your therapist. In the event of an emergency, your therapist may be reached by pager through our after hours answering service (dial the center's phone number). If you are unable to reach your therapist, you may call your primary care physician, go to the local emergency room, or call a crisis hotline (1-800-784-2433).

IV. Record Keeping:
A clinical chart is maintained describing your diagnosis, your treatment, and your progress in treatment, dates of and fees for sessions, as well as notes describing each therapy session. Current medical records are locked and kept on site. There will be a charge for copying and forwarding medical records to outside providers.

V. Fees and Payments:
Full payment is required for the first visit.

	Therapist	Psychiatrist
Initial Diagnostic Interview	$125.00	$225.00
Individual Therapy (45-55 minutes)	$110.00	Not Applicable
Individual Therapy (30-45 minutes)	$ 65.00	$110.00 (30 minutes)
Individual Therapy (12-30 minutes)	$ 45.00	$ 80.00 (15 minutes)
Psychological Testing (per hour)	$125.00	Not Applicable

Fees for services rendered by The Renaissance Centre may be paid in several ways:

1. Personal payment by you, the client
2. Predetermined payments may be accessed through your employer's Employee Assistance Program.
3. Your health insurance may pay a portion of your fee, however, your insurance company requires that we collect your co-pay at the time of the visit. As a service to you, our staff will file insurance claims with no more than two insurance companies. Any pre-certification required is the responsibility of the patient. Documents will be provided if you wish to file your own insurance. Please remember that the bill is your responsibility and not the insurance company's.

Other consultations and group services will be billed on a fee for service basis. Phone consultations (over 5 minutes) will be billed based on the fractional proportion of the hourly fee.

VI. Discharge:
Any remaining financial balance is due within 90 days of discharge or termination of treatment unless prior arrangements have been made with the business office or the individual therapist. We reserve the right to send accounts 90 days past due to a collection service.

VII. Cancellations and Missed appointments:
Our answering service accepts cancellations during non-office hours. Clients are charged half of their full fee for an appointment not kept or cancelled within 24 hours of the scheduled appointment. Insurance companies and some employer/churches will not pay this fee. Therefore, it is the client's responsibility.
A 24 HOUR CANCELLATION ADVANCED NOTICE IS REQUIRED except in the case of emergencies or sudden illness. If you do not show up for 2 appointments (late cancellation and/or no notification) you will be provided with a referral to another mental health agency. Missing two appointments without sufficient notice or communication with the service provider is considered self-termination of services.

My initials indicate that I have read and understand the above information regarding The Renaissance Centre policies and procedures:

Initials: _____ Date: _____ Revised March 2013

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CLIENT RIGHTS

You as the client (or parent/guardian of the child) have the following rights:

1) Respectful, individualized treatment, regardless of your race, religion, age, sex or disability.

2) To participate in the development of you or your child's treatment plan.

3) To request and receive specific information about your therapist's professional capabilities which include licensure, education, training, experience, membership in professional associations, as well as specialized areas of practice and limitations. You are also entitled to view verification of credentials (i.e. professional license, academic degree, special certifications, etc.).

4) To question your therapist regarding any phase of your therapy at any time.

5) Complete confidentiality of your treatment, as outlined in our Privacy Notice.

6) To review your treatment record as outlined in our Privacy Notice.

7) Written request release of your treatment record to other professionals. The request will be given to your therapist, who will authorize records to be released, which they assess to be in your best interest. No information regarding your treatment (verbal or written) will be shared without your written consent, except as described in our Privacy Notice.

8) Treatment will be understood to be terminated if:

(a) A client cancels an appointment and does not reschedule within one month.
(b) A client does not show up for a scheduled appointment without notification or does not reschedule.
(c) A client does not show up to a scheduled appointment, or fails to keep a rescheduled appointment.

Once therapy is terminated, a therapist is no longer obligated to be a treatment provider for any given client. Our office staff will notify each therapist, in writing, of any client who cancels an appointment and does not reschedule. This will become a part of the client's official record.

9) You have the right to initiate a complaint if you feel that your rights have been violated. We suggest that you first share your concern with your therapist. If not satisfied, please submit your complaint in writing. It will be presented to our supervising staff for review within one week (maximum). You are welcome to share your concerns in person with the supervising staff.

From time to time, various therapists make follow-up phone calls to past clients. These follow-up calls are to determine how you, our client, are doing and should not be construed as a request to resume treatment.

In the event of a clinical emergency, please call 229-889-7200 to contact an on-call therapist.

My initials indicate that I have read and understand the above client rights:

Initials: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This "Notice of Privacy Practices" describes how your PHI information may be used and disclosed in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice by posting a copy in our office, sending a copy to you by mail upon request, or providing one to you at your next scheduled appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU OR YOUR CHILD.

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordination, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization. We may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for the purposes of collection.

For Health Care Operations. We may disclose, as needed, your PHI in order to support our business activities, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As professionals licensed in this state and as members of our professional associations, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the professional code of ethics and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.

Medical Emergency. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a rime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not with your written authorizations specifically permitted by applicable law will be made only, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding you PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Margaret Beck, Renaissance Centre, 506 N. Jackson Street, Albany, Ga. 31701.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use of disclosures of our PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Complaints. If you believe that your privacy rights have been violated, you have the right to file a complaint in writing with our Privacy Officer at The Renaissance Centre, 506 N. Jackson Street, Albany, GA 31701 or with the Secretary of Health and Human Services at 200 Independence Avenue, SW, Washington, DC 20201, or by calling (202) 619-0257. **Your rights will be respected if you file a complaint and there will be no retaliation against you.**

My initials indicate that I have read and understand the above Notice of Privacy Practices:

Initials: _____ Date: _____ Revised March 2013

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CONSENT FOR TREATMENT

By signing below I acknowledge that I have read and understand the above information regarding The Renaissance Centre policies and procedures, client's rights and responsibilities, and notice of privacy practices (including protected health information). I also understand that I can end treatment at any time I wish and that I can refuse any requests or suggestions made by my treatment provider.

I am aware that the practice of medicine, psychiatry, clinical psychology, clinical social work, and other therapy by a licensed professional is not an exact science. I also acknowledge that no guarantees have been made as a result of evaluation or treatment.*

If I am consenting to treatment for another person, I certify that I am legally responsible for that person and am entitled to consent to treatment for them.

_____
Patient Name (printed)

_____ _____
Signature of Patient or Parent/Legal Guardian Date

_____
Relationship to Patient (if not self)

_____
If you are signing as a personal representative of an individual, describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

_____
Date of Birth of the Patient

☐ Patient/client refuses to acknowledge receipt

_____ _____
Treatment Provider/Witness Signature Date

_____
Treatment Provider Georgia License Number