NEW CLIENT INTAKE & INFORMED CONSENT FORM

We appreciate the confidence you have placed in us. This intake form is designed to help you understand our unique practice and office procedures. Each counselor listed on our website is an independent and separate legal entity. All of our associate and affiliate partners also operate as separate legal entities. We welcome you as you begin your journey of self-discovery in the counseling process.

Authorization for Treatment

Each licensed professional counselor sharing office space at the address of 11919 Grant Street, Suite 201; Omaha, NE 68164, OPERATE AS LEGAL SEPARATE BUSINESS ENTITIES.

PLEASE WRITE IN YOUR COUNSELOR'S NAME: ____

I, the undersigned consent for the afore named counselor as written above, to provide mental health counseling and therapy as may be necessary or advisable in my diagnosis and treatment. I understand that a positive outcome cannot be guaranteed. While I understand my afore named counselor will be providing certain therapy and/or counseling services, I acknowledge that numerous factors can affect the overall outcome and that such therapy and/or counseling services may not be effective in accomplishing the goals or other desired outcomes as discussed. I acknowledge and agree that there may be circumstances that presently, or in the future, require treatment or other health care services that are outside the scope of the services that can be provided by this counselor. With full knowledge of the risks and benefits of engaging in therapy and/or counseling services with any associates in this office, I give my informed consent by signing this document.

Appointments and Your Responsibility

Our therapists meet clients by appointment only. If for some reason you need to cancel an appointment, please give your therapist a **minimum of 24-hour notice.** If your counselor does not receive an advance notice from you, a **"no show" charge will be assessed to you in the full amount of the session.** Since insurance and EAP's do not cover the cost of an office visit that *you schedule - without providing a 24 hour notice for reschedule or cancellation,* **you will be responsible for payment *out of your pocket*. When you make your appointment, it will be your responsibility to write down your counselor's phone number** which is listed on the website. Your counselor may allow the use of texting as a courtesy and convenience for you in case you need to reschedule or cancel. Your counselor will respond to your call or text within 24 hours. Your counselor may opt to send you a text reminder of your appointment, but **it is not** their responsibility to remind you, it is your responsibility to communicate with them should you need to reschedule or cancel. Please be respectful of the time you have committed to as once you commit to a time slot other patients are declined for that time period. We hope you understand the importance and rationale behind a respectful agreement. It is important you DO NOT use text as a means for soliciting out of office counseling or for emergency assistance. ***Should you need emergency assistance, please call 911 or your nearest hospital.***

Financial Responsibility

Ultimate financial responsibility for our service rests with you and your family, regardless of insurance coverage. It is your responsibility to know what your insurance policy covers before you come to session by calling your insurance company and to determine if you need any precertification prior to being seen by the counselors. If your insurance company requires periodic prior authorization or prior notification after the initial one, ***it will be your responsibility to gain the appropriate approvals*** and give that information to your counselor. If your visit is denied by the insurance due to the lack of notification or authorization the patient is responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding covered charges, deductibles, etc. We will, of course, provide factual information; i.e., dates of service and diagnosis as necessary to assist you.

Your signature below signifies that you acknowledge the informed consent, authorization for treatment, financial responsibility and notification policy avoiding late cancellations or not showing up for a scheduled appointment.

Payments

Payment for counseling services is expected at the time of each visit if you do not have insurance. If you are coming to visit one of the counselors through an Employee Assistance Program (EAP) you may receive some initial sessions at no charge to you. Generally, however, the payment policy is as follows:

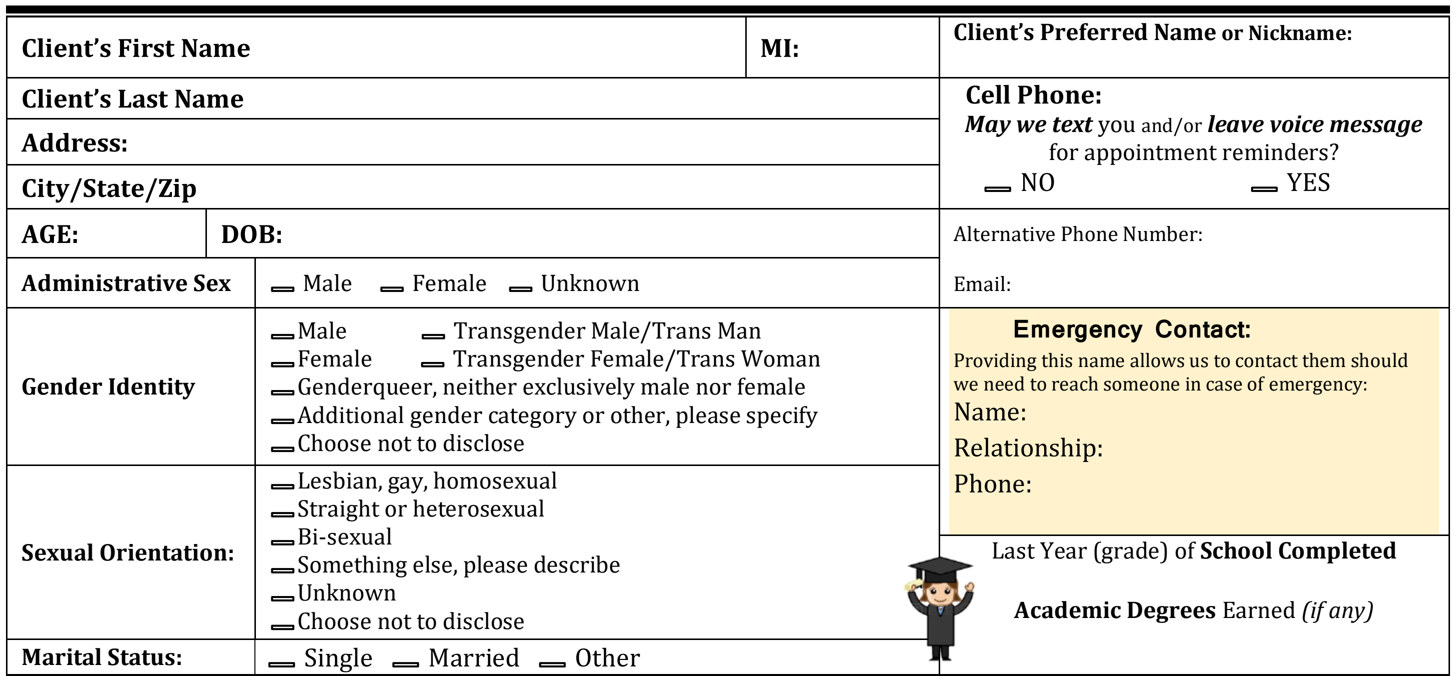
- At your request, we will file an insurance claim for you if you provide all the applicable information requested in this *Client Intake Form*. Please bring any required referral forms with you or you will be responsible for your charges.
- If you have copay, **it is due at each visit.** A statement will be sent for any balance due for your prompt payment.

Please sign below to acknowledge your responsibility in our office policy and procedures agreement

____ ____________________

Signature of Patient or Legal Representative: Date:

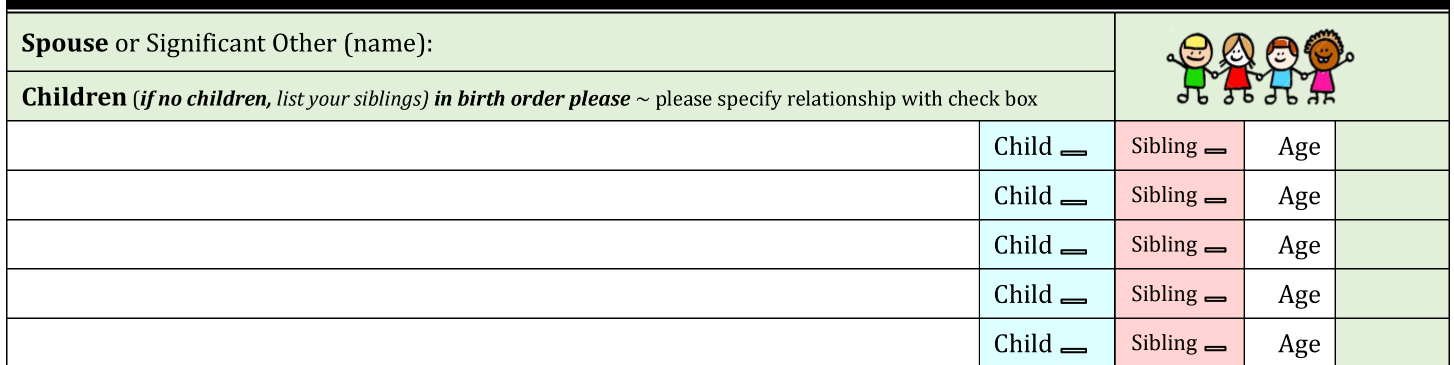
CLIENT INFORMATION INTAKE FORM



Client's First Name	MI:	Client's Preferred Name or Nickname:
Client's Last Name		**Cell Phone:** *May we text* you and/or *leave voice message* for appointment reminders? ☐ NO ☐ YES
Address:		
City/State/Zip		
AGE:	DOB:	Alternative Phone Number:
Administrative Sex	☐ Male ☐ Female ☐ Unknown	Email:
Gender Identity	☐ Male ☐ Transgender Male/Trans Man ☐ Female ☐ Transgender Female/Trans Woman ☐ Genderqueer, neither exclusively male nor female ☐ Additional gender category or other, please specify ☐ Choose not to disclose	**Emergency Contact:** Providing this name allows us to contact them should we need to reach someone in case of emergency: Name: Relationship: Phone:
Sexual Orientation:	☐ Lesbian, gay, homosexual ☐ Straight or heterosexual ☐ Bi-sexual ☐ Something else, please describe ☐ Unknown ☐ Choose not to disclose	Last Year (grade) of **School Completed** **Academic Degrees** Earned *(if any)*
Marital Status:	☐ Single ☐ Married ☐ Other	

EMPLOYER & IMMEDIATE FAMILY HISTORY AND REFERRAL RELATIONSHIPS

Employer		Occupation/Position/Title	
		Length of time at company	



Spouse or Significant Other (name):

Children *(if no children, list your siblings)* ***in birth order please*** ~ please specify relationship with check box

Name	Child	Sibling	Age	
	Child ☐	Sibling ☐	Age	
	Child ☐	Sibling ☐	Age	
	Child ☐	Sibling ☐	Age	
	Child ☐	Sibling ☐	Age	
	Child ☐	Sibling ☐	Age	

Please place "x" by all boxes that apply that brings you here today:

Relationships:

☐ Grief-Major Loss ☐ Relationship Concerns ☐ Marital Conflict ☐ Family Conflicts ☐ Workplace Relationships ☐ Divorce

Emotional:

☐ Stress Concerns ☐ Anxiety ☐ Depression ☐ Personal Mental Health Concerns ☐ Anger Issues ☐ Medical Concerns ☐ Self Esteem

Substance Abuse/Addiction:

☐ Alcohol Concerns ☐ Drug Concerns ☐ Gambling ☐ Co-Dependency ☐ Other Additional Concerns

Please provide more specific information for seeking counseling at this time?

Have you (the patient) been to counseling before? If so, when, where, and why?

How did you hear about us?

Please place "x" in boxes that apply:

Psychology Today ☐
Human Resources ☐
Spouse ☐
Employee Assistance ☐
Manager/Supervisor/Co-Worker ☐
Referral name optional: ____________________

MENTAL AND GENERAL HEALTH

CLIENT HISTORY

How would client rate current life stressors during the last month: Please "x" the appropriate rating:

Occupation/Education	None ▭	Mild ▭	Moderate ▭	Severe ▭
Marital/Family	None ▭	Mild ▭	Moderate ▭	Severe ▭
Interpersonal/Social	None ▭	Mild ▭	Moderate ▭	Severe ▭
Spiritual	None ▭	Mild ▭	Moderate ▭	Severe ▭

If the client is currently dealing with a **mental health** issue what, (if any) medications is the client currently taking for this problem?

Name of Prescription:	*For:*

Date of client's last visit to a doctor: Reason for visit:

Is the client currently pregnant or nursing? ▭ Yes ▭ No

What ***other medication*** (prescription or over the counter is the client currently taking)?

Name of Prescription	*For:*

Does the client ***smoke***? ▭ Yes (indicate how many packs: per day /or per week) ▭ None

Does the client ***drink***? ▭ Yes (indicate how many glasses: per day /or per week) ▭ None

Has the client or any family member ever experienced any of the following: (Please check all that apply)

▭ Drug or alcohol abuse ▭ Physical abuse ▭ Sexual abuse ▭ Attempted Suicide/Suicide

If you answered YES: *currently or past*, to any of the questions on this form, please explain briefly:

Client's immediate family members not living:	*Cause of death:*

Is there anything else that you would like for us to know that has not been asked?

BILLING INFORMATION

STOP and read carefully as we must have information about WHO *is* Responsible *for* Payment.

Responsible Party's Relationship to the Client ▭ Self ▭ Spouse ▭ Parent ▭ Other

- **IF you checked "self" - you may skip the purple section**
- **If you checked "Spouse" "Parent" "Other"** the **purple section must be filled out** with the information about the responsible party.

And **EVERYONE** must fill out ***either***
[The yellow section for private pay clients] or [The blue section for insurance clients]

First Name Of Responsible Party	MI:	Home Phone Of Responsible Party	
Last Name Of Responsible Party		Work Phone Of Responsible Party	
Address/PO Box Of Responsible Party		Cell Phone Of Responsible Party	
City/State/Zip Of Responsible Party		E-mail Address:	
Responsible Party's Employer: Company Name and title of employee			
Birth Date:			
Social Security#			
Gender	▭ Male ▭ Female		

This Section is for those utilizing PRIVATE PAY

This section can be discussed with your therapist.

Standard fee for **initial evaluation:** $ You have agreed to pay: $	Standard fee for **individual**: $ You have agreed to pay: $	Standard fee for **couples therapy** or **family:** $ You have agreed to pay $

Payment is due when service is rendered. You are responsible for payment and billed for missed appointments or cancellations. If we do not receive advance notice (24 hours) from you, unfortunately a "no show" charge is assessed to you in the full amount of the session. My signature below demonstrates that I have read, understand and have agreed to all the above. Credit card information can be retained for this purpose.

Signature: Date:

This Section is for those utilizing INSURANCE BENEFITS

Who is the policy holder?	▭ Client ▭ Responsible Party (named above)
Copay Amount:	Plan Type/Name/Number:

POLICY HOLDER'S AUHTORIZATIONS:

- As a courtesy our insurance processor will obtain deductible and co-pay information but it is your responsibility to call and verify for yourself.
- I hereby authorize my insurance benefits to be paid directly to my therapist for services rendered in my treatment, and I agree that I am financially responsible for all charges not covered by insurance.
- I **do understand that insurance will not cover late cancellations and/or "no show" sessions. I comply with the cancellation policy that a full session fee must be paid by the client in full with less than 24 hour notice or no a show will be applied. Credit card information can be retained for this purpose.**

PLEASE PRESENT THE POLICY HOLDER'S INSURANCE CARD and CREDIT CARD TO STAFF FOR COPYING.

Signature: ______________________________Date: ______________

Acknowledgment of Receipt of Notice of Privacy Practices

This form will be retained in your medical record

Notice to Patient

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

I acknowledge that I have received and had the opportunity to review the Notice of Privacy practices on the date below on behalf of counselors who practice at 11919 Grant Street, Suite 201; 68164

I understand that the Notice describes the uses and disclosures of my protected health information by the individual counselors at 11919 Grant Street, Suite 201; 68164 and informs me of my rights with respect to my protected health information.

The following two pages contain the Important Disclosure for Patients' Rights

Responsibility to Patient and Confidentiality Clarification & Consent to Treat -Notice of Privacy Practices
I acknowledge and understand my rights and how my information may be used.

Printed name of Patient: ______________________________

Patient Signature or *Legal Representative:* ______________________________**Date:** ______________

Blue Section for Office Use Only

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- *The patient refused to sign*
- *Due to an emergency situation it was not possible to obtain an acknowledgement*
- *Communications barriers prohibited obtaining the acknowledgement*
- *Other (please specify)*_

Counselor Name: Date:

PLEASE NOTE: Important Disclosure for Patient's Rights
Our responsibility to you as our valued client
Confidentiality Clarification & Consent to Treat - Notice of Privacy Practices

11919 Grant Street, Suite 201
Omaha, NE 68164
Effective Date: January 1, 2015

We understand the importance of privacy and are committed to maintaining the confidentiality of your counseling information. We make a record of your care and may receive such records from others. We use these records to provide or enable other health care providers to provide medical care, to obtain payment for services provided to you as allowed by your health plan and enable us to meet our professional and legal obligations to operate this counseling practice properly. We are required by law to maintain the privacy of protected health information and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this notice, please contact your counselor as they are the privacy officer of their own records.

The following two pages detail specifically how medical information about you may be used and disclosed as well as

YOUR RIGHTS AS A PATIENT

PLEASE REVIEW IT CAREFULLY. *Patient retains following two pages:*

Important Disclosure for Patient's Rights

Our responsibility to patient and Confidentiality Clarification & Consent to Treat

NOTICE OF PRIVACY PRACTICES

HOW the counselors at 11919 Grant Street, Suite 201, 68164, ***may*** USE OR DISCLOSE YOUR HEALTH INFORMATION.
It is possible that we may share your health information in the following ways:

1. **Treatment**
   We use medical information about you to provide your counseling care. We disclose medical information to others who are involved in providing the care you need. We may use your health information and share it with other professionals who are treating you who will provide services that we do not provide.
   Example: A counselor treating you for an issue asks another counselor, psychiatrist or psychologist for consultation.

2. **Payment for your services**
   We may use and share your health information to bill and get payment from health plans or other entities.
   Example: We give information about you to your health insurance plan so it will pay for your services.

3. **Required by Law – Public Health and Safety Issues**
   As mandated reporters, under some circumstances, we are allowed or required to use/disclose patient information without written authorization. We also make an effort to discuss such uses or disclosures with patients before information is released. We may share health information about you for certain situations such as:
   - Reporting suspected abuse, neglect, or domestic violence
   - Preventing or reducing a serious threat to anyone's health or safety including self-injury or suicide.
   - Should we notice a patient is intoxicated *by any substance* we will notify next of kin/significant other to drive patient home. If patient leaves premises while intoxicated we will call law enforcement for patient's safety as well as public safety.
   - Preventing disease (reportable diseases)
   - Law enforcement or governmental requests for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

   Respond to lawsuits and legal actions
   We can share health information about you in response to a court or administrative order, or in response to a subpoena.
   Share information in a disaster relief situation
   We may also share your information when needed to lessen a serious and imminent threat to health or safety. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

4. **Notification and Communication with Family**
   For certain health information, you can tell us your choices about what we share and with whom**.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do in writing and we will follow your instructions.

5. **Electronic Devices for personal correspondence, operations, and appointment reminders**
   RISKS INVOVLED for Text and Email: It is the policy of your counselor that any and all email and/or text messages sent or received that concern the diagnosis or treatment of a patient will become part of that patient's medical record. We take reasonable means to protect the security and confidentiality of email communication.
   There is no guaranteed privacy for email and none for texting. Thus, patients must consent to the use of email and/or text for confidential medical information after having been informed of the above risks. You are consenting to the use of email includes agreement with the following:
   - ✓ Your counselor may forward email correspondence within our office operations and vendors as necessary for diagnosis, treatment and reimbursement.
   - ✓ If the patient sends an email to their counselor, we will endeavor to read the email and respond to the email in the next session as time permits. ***Patients must <u>not</u> use email in an emergency.***
   - ✓ If a patient's email requires or invites a response and the recipient does not respond, the patient is responsible for following up to determine whether the intended recipient received the email.

   Text: Counselor may opt to text appointment reminders with your permission. There is a risk that an unintended recipient may forward messages without the senders permission or knowledge. The text reminders will not have information about your sessions. For example, *"Appointment reminder with "your counselor's name" – tomorrow at 10am, please confirm."*
   - ✓ Text will not be used to discuss sessions or personal issues rather it is for the purpose in setting appointments, making cancellations or changing appointment times etc.
   - ✓ Text will not be used to reach out for emergency - Patients ***must <u>not</u> use text in an emergency. Rather call 911.***

6. **Reception Area**
   We may call out your name when we are ready to see you but we are committed to discretion.

7. **Marketing**
   We may contact you to give you information about our products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, health care providers or settings of care that may be of interest to you. For example, we may wish to give you notification for our group workshops - we would share information with our inner office staff, including our counselors and educational leaders and/or life coach. We may also encourage you to maintain a healthy lifestyle and participate in extracurricular support groups or encourage you to purchase a book, tape or attend a seminar when we see you. Should we receive any compensation for any referrals we will notify you. However, it is not our practice to receive compensation for referrals nor do we receive kickbacks on any products that we recommend.

YOUR HEALTH INFORMATION RIGHTS

1. **Right to request us to limit what we use or share**
   - You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
   - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

2. **Right to request confidential communications**
   - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Please give that to us in writing on a new client intake form and we will update the record.
   - We will say "yes" to all reasonable requests.

3. **Professional Records**

You have the right to see your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it. We will charge a reasonable fee which covers our costs for labor, supplies, postage and if requested and agreed to in advance the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. I am required to keep records of the psychological services that I provide you. Although psychotherapy often includes discussions of sensitive and private information, I **keep very brief records** indicating whether or not you attended your session, noting themes and topics we discussed, and interventions used in session. You have the right to request that a copy of your file be made available to any other health care provider at your written request when you sign a written authorization form that meets certain legal requirements imposed by HIPAA.

4. **Right to receive for copy of this privacy notice – it is provided as part of your intake package.**

5. **Right to choose someone to act for you**
   - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
   - We will make sure the person has this authority and can act for you before we take any action.

6. **Right to file a complaint if you feel your rights are violated**
   - You have the right to complain to our office directly for resolution of any issue and/or the federal government.
   - Should you wish to contact the federal government; you can file a complaint with the U.S. Department of Health and Human Services Office.
   - We will not retaliate against you for filing a complaint.