

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 THIS NOTICE 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 and future physical or mental health or condition and related healthcare services is referred to as Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. 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 practice 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. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, 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.

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 purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, 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 you PHI. For training or teaching purposes, PHI will be disclosed only with your authorization. Your PHI will be provided to make 24-hour confirmation calls to remind you of your appointments. If this is a problem, please let our privacy officer know or indicate so on your initial paperwork

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 investigation or determining our compliance with the requirement of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

- Abuse and Neglect
- Judicial and Administrative Proceedings
- Deceased Persons
- Emergencies
- Family Involvement in Care
- Law Enforcement
- National Security
- Public Safety (Duty to Warn)

The following language addresses these categories to the extent consistent with the *NASW Code of Ethics*.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigation (such as the social work licensing board or the health department)
- Required by Court Order
- 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.

Verbal Permission. We may 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 specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Your Rights Regarding your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights please submit your request in writing to our Privacy Officer, at
Attn: Joni Reisinger, at 3532 W. Capital Ave, Grand Island, Nebraska 68803

- 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 may be 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 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 or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- 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 we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Joni Reisinger, 3532 W. Capital Ave, Grand Island, Nebraska 68803 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201, or by calling (202) 619-0257.

We will not retaliate against you for filing a complaint.

The effective date of this Notice is July 4, 2009.



Your Rights As a Client

- To be treated with dignity and respect
- To learn about the mental health and substance abuse services in your area
- To get information about your diagnosis and treatment
- To participate in decisions about your treatment
- To receive information on available treatment options and alternatives
- To change your service provider if you are unhappy with your current provider
- To ask questions and get answers before and during treatment
- To refuse treatment and get an explanation of what may happen if you don't get treatment
- To make a grievance about your services and get a timely answer
- To maintain privacy and confidentiality, including to allow or refuse the release of information, except when release is required by law
- To request and receive copies of your records and request that records be amended or corrected
- To freely exercise your rights without affecting how you're treated
- To get a second opinion when appropriate

Your Responsibilities

- To treat others with dignity and respect
- To inform Family Resources of Greater NE, P.C., of any changes in your benefits or personal information, such as address or phone number
- To learn about your mental health and substance abuse services
- To tell your service provider about the symptoms and to ask questions
- To be part of the treatment team
- To tell your service provider if you do not agree with recommendations
- To tell your therapist if you want to end treatment
- To tell your service provider about your medical doctor
- To be at appointments on time and to call ahead if you must cancel
- To take medication as prescribed and to tell your doctor if there is a problem
- To pay for any mental health or substance abuse services that are not covered under your insurance plan.

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

Patient Signature

Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

Provider Signature

Date



Notice of Privacy Practices

Receipt and Acknowledgement of Notice

Patient/Client Name: _____

Date of birth ____ / ____ / ____

SS#: ____ - ____ - ____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Family Resources of Greater Nebraska notice of Privacy Practices.

Signature of Patient/Client

Date

Signature of Parent, Guardian, or Personal Representative*

Date

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

Patient/Client Refuses to Acknowledge Receipt

Signature of Staff Member

Date

Serving Individuals, Families & Businesses

3532 West Capital Avenue • P.O. Box 5858 • Grand Island, NE 68803 • 308.381.748 7 • 888.381.7487 • fax 308.381.2712
www.family-resources.net



Consent to Treatment

Welcome to our practice

Family Resources offers services to people of all ages, including individual, group, family, and marital/couples therapy. We provide referrals for issues beyond our expertise as well. Except in an emergency, services are by appointment only.

We expect and encourage you to obtain knowledge of the procedures, goal(s), and possible side effects of psychotherapy and counseling. We will keep you informed about treatment alternatives available to you.

You have the right to refuse or question therapeutic procedures and methods at any time. You also have the right to receive information about the process and course of your therapy or counseling. Either you or your therapist may terminate treatment at any time. However, we encourage our clients to schedule a "closing" session.

There are some risks related to treatment. They may include intense and unwanted feelings, recollections of unpleasant life events, facing unpleasant thoughts, questioning values and personal beliefs, and changes in relationships. It is important to remember that these feelings and experiences may be natural and normal. Therapy and counseling may result in other major life decisions related to family living arrangements, employment, and lifestyles. These changes may result from closer examination of one's beliefs and values. They are legitimate outcomes of the therapy and counseling experience.

Confidentiality will be respected except in the following cases:

- In the event that a client reports intent to harm another person
- In the event a client reports a plan and intent to harm self
- In the event a client or family member reports neglect and/or physical-sexual abuse
- In the event a court subpoenas our records or the testimony of our therapists

Fees for services provided to you will be based upon our fee schedule in effect at the time those services are provided. Our fees are due and payable by you at the beginning of each session unless other arrangements are approved by us in advance of the session. Depositions or other court-related work are billed separately from therapy services. Payment arrangements must be made in advance of any court action.

Cancellation Policy. We reserve our time for you and therefore ask that you notify us at least 24 hours in advance of your scheduled appointment if you need to cancel. If you fail to do so, there will be a "no show" fee charged.

Emergency and after-hours services. We encourage you to call our office to speak to your therapist at any time if you need help dealing with an emergency or crisis situation. Our phones are staffed 24 hours a day, seven days a week and every reasonable effort will be made to reach your therapist. If however, your therapist cannot be reached, we will provide you with the option of talking to another therapist on staff. You will be charged for all phone consultations at rates described in our fee schedule. Email services are not available 24 hours a day. If you have an emergency, please call the 24 hour answering service.

Court Testimony and the Production of Records. In the event your therapist is required to testify at your request, or after receipt of a subpoena, you will be responsible for payment for the therapist's time and travel, at rates described in our fee schedule. If you request, or we are subpoenaed to produce your records, you will also be charged at rates described in our fee schedule.

By signing this document, you consent to treatment by Family Resources of Greater Nebraska, P.C. and agree that you are individually responsible for the payment of our fees unless we have approved other arrangements in advance. Married couples who both sign this form are each responsible for the payment of fees for services provided to either of them except for services provided by us after either of them notifies us in writing that he or she will no longer pay for services provided the other.

Name of Client(s) _____

Counselor reviewed & discussed with client: YES NO

Signature _____

Accepted for Family Resources of Greater NE

Signature _____

By: _____

Date: _____

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www.family-resources.net



Initial Visit Information

Client Information

Today's Date _____

Name _____ Social Security No. _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home#: _____ Cell#: _____

Email Address: _____

Would you like to receive our email newsletter? YES NO

As a courtesy, Family Resources will try to confirm your appointment the day before. If you are interested in this service, check YES or NO. If yes, do you prefer appointment reminders via:

Cell Home Email Text (check one).

If you want a text, please note type of service (example: Verizon) _____

Primary Occupation _____ Employer _____

Work Phone No. _____ May we contact you at work? YES NO

Highest Grade of Education Completed _____ Religious Preference _____

If client is a minor, please provide the following information

Family Information

Mother _____ Age _____ Residing in Home? YES NO

DOB: _____ Social Security No _____ Primary Occupation _____

Employer _____ Work Phone No _____ Contact at work? YES NO

Highest Grade of Education Completed _____ Religious Preference _____

Father _____ Age _____ Residing in Home? YES NO

DOB: _____ Social Security No _____ Primary Occupation _____

Employer _____ Work Phone No _____ Contact at work? YES NO

Highest Grade of Education Completed _____ Religious Preference _____

All Children

Name Date of Birth Residing in home? Y/N Male/Female

Others in your Home

Name Date of Birth Relationship to family

Concerns which caused you to seek our professional assistance

Briefly describe the issues and concerns that brought you to us. Please indicate when these issues and concerns first started.

Medical Information

Name of Primary Physician _____ Please initial _____ to give us permission to contact your Primary Physician.

Facilities Name _____ Address _____

Phone Number _____ Date of most recent physical or health check _____

Person to notify in case of an emergency _____ Relationship _____

Phone#: _____ days _____ evenings

Primary Client

Current Medical Conditions

Prescription Drugs/Dosage

Alcohol/Drug Dependency Past/Present Treatment. Please be specific: inpatient/outpatient, what hospital or clinic, type of drugs used, onset/duration dates, and current status.

Primary Client

Family Members

Counseling History

Have you been in counseling previously? YES NO

If so, how long ago, and who was the therapist or counselor? _____

Are you currently in counseling or therapy with any other therapist or counselor? YES NO

If so who is your psychiatrist? _____

Who referred you to our office? _____

May we thank them for referring you? YES NO

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Insurance Information

Name of Primary Insurance _____

Insured Name _____ Social Security No. _____

Group No. _____ Policy No. _____

Employer _____

Is the client covered by other insurance plans? YES NO If so please give us information on that insurance also.

Insured Name _____ Social Security No. _____

Group No. _____ Policy No. _____

Employer _____

Insured Name _____ Social Security No. _____

Group No. _____ Policy No. _____

Employer _____

Signature to extend authority and assign benefits

I request that payment of authorized insurance benefits be made to FAMILY RESOURCES OF GREATER NEBRASKA PC for any services furnished to me by its employees, contractors and/or agents. I authorize FAMILY RESOURCES OF GREATER NEBRASKA PC and its employees, contractors and/or agents to release to my health insurance company and its agents any information needed to determine these benefits or benefits payable for related services.

Signature of Client

Date

Signature of Insured and/or Legal Guardian

Date

Insurance

Medical insurance can be very confusing. Companies differ from one another and different plans within the same company are often quite different. It is in your best interest to become familiar with your insurance coverage. This can be found within the material provided with your policy or it can be obtained through representatives of your insurance company.

We are highly skilled in completing insurance forms and will gladly do so for you. It is our goal to help you receive the maximum coverage to which you are entitled. It is important for you to understand, however, that our professional services are rendered to you, not to an insurance company. The insurance company is responsible to you the client, and your responsibility for payment is to us.

Family Resources of Greater Nebraska, P.C.

Financial Policy

Our goal is to help you and your relationships so you can be healthy, happy and at your best. Psychotherapy is covered under many insurance plans. Regardless of your coverage, we will work together with you to develop a plan that we think will get you where you want to be. We invite you to ask questions to clarify anything you may not understand.

Clients Without Insurance

We ask that 100% of each visit be paid at the time of service. We take credit cards, debit cards, personal checks or cash. (Insufficient fund checks will be charged a fee of \$35.00). Private pay accounts will receive a 10% discount if paid in cash; this is excluding Drug and Alcohol Evaluations.

Group and Individual Insurance

Your insurance is an agreement between you and your insurance company. When possible we will call to verify your benefits on your insurance; however the benefits quoted to us by your insurance company are not guarantee of payment. As a courtesy to you as our valued client we will submit the necessary insurance forms at no extra charge. **It is to be understood and agreed that all services rendered are charged directly to you and you are personally responsible for any non-covered services, deductibles, co-pays and coinsurance. If services that you received are denied for any reason you are financially responsible.** Co-pays are expected at each time of service and it is expected that accounts are kept current. If not, services will not continue to be rendered. If the balance on an account is over 90 days due, other options may be necessary to pursue such as sending the account to a collections agency.

Medicaid

We accept Medicaid insurance in our office. Medicaid will pay your initial pre-treatment assessment. If a pre-treatment assessment has been completed by a provider not in our office within the past 12 months, you are required to release that assessment from the provider before services can be rendered. Medicaid requires that a Mental Status Exam be completed after the initial pre-treatment assessment before additional sessions are scheduled. This usually occurs within a week after the initial appointment. Medicaid requires that services cannot continue to be rendered if you do not complete the Mental Status Exam.

Medicare

Our office does not accept Medicare benefits.

No Shows and Late Cancellations

We require 24 hours' notice if you need to cancel an appointment. This time is reserved for you and unless there is an emergency, we honor our commitment to see you during your reserved time. Our time and your time is valuable. Therefore a no show and late cancellation fee of \$75.00 will be charged. Chronic no shows will not be allowed to reschedule. If you are using a Family Resources Employee Assistance Program session, a session will be forfeited for no showing.

Agreement

I have read and understand the financial policy of Family Resources of Greater Nebraska, P.C. I understand that my insurance is an agreement between myself and the insurance company, NOT between Family Resources and my insurance company. I request that Family Resources prepare the customary forms at no charge so that I may obtain my insurance benefits. I **also understand that if insurance does not pay within 60 days fees will be due and payable immediately.**

Printed Name

Signature

Date