

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



Statement of Understanding

The Employee Assistance Program (EAP) is provided by Your Employer without cost to you, to assist in clarification of personal problems and identification of appropriate resources or services in the community for resolution of the problems you discuss with the EAP personnel. The EAP will monitor that service to ensure that your needs are being met. It is your responsibility to pay for services provided by any outside resources. Your health insurance may defray some of the cost of services provided by outside resources. Consult your group insurance office if you have any questions on your insurance coverage.

LIMITED INFORMATION MAY BE SENT TO AN AUTHORIZED AGENCY TO PROVIDE NOTIFICATION TO YOUR HEALTH INSURANCE CARRIER OF POSSIBLE BENEFIT USAGE. IN ADDITION, STANDARD PRACTICE IS TO INFORM THE BENEFICIARY (I.E.: EMPLOYEE) OF BENEFIT USAGE THROUGH AN EOB (EXPLANATION OF BENEFITS).

CONFIDENTIALITY – The EAP will not reveal information that you disclose to EAP personnel to anyone outside the EAP except in the following circumstances: (1) you consent in writing; (2) the law requires disclosure (generally, the law does not require information to be released unless life or safety is seriously threatened); (3) the EAP discerns a threat to security of the employer or to national security; and/or (4) insurance verification/claims certification.

MANAGEMENT REFERRALS – The EAP will not advise your management of your participation in the EAP unless you are referred by your management because of a work performance problem. Should that be the case, the EAP will confidentially advise your management that you are coming to the EAP and are or are not in compliance with a plan to work on the problem.

VOLUNTARY PARTICIPATION – Participation in the EAP is solely at your discretion. In the event you have been offered EAP services, refusal to accept or utilize the EAP is not, in itself, a cause for disciplinary action. However, such refusal or failure to accept help may be taken into consideration when evaluating subsequent unsatisfactory performance or behavior. Furthermore, you are also advised that participation in the EAP does not constitute a waiver of your employer's right to take disciplinary measures in the event of unsatisfactory performance or behavior prior to, during or subsequent to your participation in the EAP.

CANCELLATIONS AND FAILURE TO APPEAR FOR APPOINTMENTS – If you need to cancel an appointment, please do so 24 hours prior to the appointment time. Failure to do so may count against your EAP sessions. If you fail to show for an appointment, it will be counted against your EAP sessions.

I hereby certify, to the best of my knowledge, I am not on an approved leave of absence, suspended, or terminated from employment with _____.

I have read this statement and understand its content.

Signature

Date

Signature

Date

Serving Individuals, Families & Businesses

3532 West Capital Avenue • P.O. Box 5858 • Grand Island, NE 68803 • 308.381.7487 • 888.381.7487 • fax 308.381.2712
www.family-resources.net



Initial Visit Information

Client Information:

Today's Date _____

Initial Intake Form Completed? Y/N Yes No
(Therapist to complete Initial Intake Form if not completed prior to Initial Visit and submit copy to EAP Coordinator with this completed Initial Visit Information Form within 24 hrs of Initial visit)

Authorization #: AFEAP- _____ FREAP- _____

Client Name _____ Social Security No. ____ - ____ - ____ Date of Birth _____

Employee Name: _____ Social Security No. ____ - ____ - ____
(if different than Client)

Employee's Employer _____ May we Contact you to at Work? Yes No
Employee's Employer Work-site _____ / _____ Work Phone No. _____
(City/State)

Would you like to receive our email newsletter? Yes No Email Address: _____

As a courtesy Family Resources will try to confirm your appointment the day before. If you are interested in this service circle 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) _____

Client's Relationship to Employee:

Self Spouse Dependent Parent
 Sibling Unmarried Partner Other

Client's Ethnicity:

Caucasian African-American Hispanic Arab-American
 Asian / Pacific Islander Native American Multi-Racial Other

Relationship Status:

Never Married Married Separated
 Divorced Widowed Cohabiting
 Single

Referral Source:

Self Co-Worker HR Family Member Supervisor (informal)
 Wellness Program Treatment Provider Supervisor (Job Performance)

Learned About EAP:

Self Spouse Dependent
 Word of Mouth Printed Materials Co. Representative
 Electronic Media Training / Health Fair Other

Client's Gender: Male Female

Client's Highest Level of Education:

Ged / High School 2 yr college 4 yr college
 Graduate School Doctorate No High School
 Current Elementary Current Secondary

Employment Data: (complete only if employee is client)

Employment Status:

Full-time Part-time Terminated Medical Leave
 Retired Disciplinary Leave Laid Off Disability

Job Dysfunction:

None Minimal Significant: No Job Jeopardy
 Moderate Significant: Job Jeopardy

Job Problem:

Absenteeism Fitness for Duty Safety Issue(s) Unpaid Leave Tardiness Positive Drug Screen None
 Productivity Issue (s) Co-worker Relationship Supervisor Relationship Aberrant Behavior Work Performance

Job Title Category:

Executive / Manager Professional Sales Office / Clerical Service Worker
 Technical Craft Work (skilled) Operative (semi-skilled) Laborer (unskilled)

Initial Visit Information

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 _____

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 _____

All Client's Children

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

Others in your Home

<i>Name</i>	<i>Date of Birth</i>	<i>Relationship to family</i>

Presenting and Assessed Problem: (choose only one Presenting problem (P) and one Assessed problem (A):

- | | | | |
|---|---|--|---|
| <p>P A</p> <p><input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> Drugs</p> <p><input type="checkbox"/> Mixed Alcohol / Drug Abuse</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Depression</p> | <p>P A</p> <p><input type="checkbox"/> Eating Disorder</p> <p><input type="checkbox"/> Hyperactivity</p> <p><input type="checkbox"/> Impulse control</p> <p><input type="checkbox"/> Thought disorder</p> <p><input type="checkbox"/> Grief / Loss</p> | <p>P A</p> <p><input type="checkbox"/> Child Care</p> <p><input type="checkbox"/> Adult / Elder Care</p> <p><input type="checkbox"/> Family Problem</p> <p><input type="checkbox"/> Financial Problem</p> | <p>P A</p> <p><input type="checkbox"/> Job / Occupational</p> <p><input type="checkbox"/> Legal</p> <p><input type="checkbox"/> Marital / Relationship</p> <p><input type="checkbox"/> Medical Problem</p> |
|---|---|--|---|

Counseling History

Have you been in counseling previously? Yes No

If so, how long ago and who was the provider? _____

Are you currently in counseling or therapy with any other provider? Yes No

If so who is your provider? _____

Initial Visit Information

Medical Information

Name of Client's 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

(EAP Clinician-Print / Sign)

(Date)

EAP CLINICIAN SUBMIT THIS FORM TO FRGN EAP COORDINATOR WITHIN 24 HRS OF CLIENT FIRST VISIT

For Office Use Only:

- Date rec'd by EAP Coordinator __/__/__ Date entered to EAP Database __/__/__
 entered by: _____ (initials)

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