Name: DOB: SS#:

INITIAL VISIT INFORMATION (1)

Client Information:

Today's Date_____

Client Name _____Social Security No._____-_____ -_____Date of Birth_____

Address _____ City_____ State _____ Zip _____

Home #: _____ Cell #:_____ Gender: Male or Female or NA

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 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)_____

Primary Occupation _____ Employer _____

Work #: _____ 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#_____ 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#_____ Contact at work? Yes □ No □

Highest Grade of Education Completed _____

All Client's Children (in home and out of home)

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

Name: DOB: SS#:

INITIAL VISIT INFORMATION (2)

Others Living in Client's Home (related and not)

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:

_____
_____
_____
_____
_____

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?_____

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*

Name: DOB: SS#:

INSURANCE INFORMATION

Client Information: **Today's Date_____**

Client Name _____Social Security No._____-_____ -_____Date of Birth_____

Does your insurance include mental health benefits?_____

Does your insurance need a pre-authorization for mental health benefits? _____ Do you have this authorization?_____

Does your insurance include a maximum number of sessions per year?_____ If yes, how many?_____

Name of Primary Insurance _____

Insured's Name:_____ _____

Insured's Date of Birth:_____ Insured's SS# _____

Group No. _____ Policy No. _____

Is client covered by other insurance plans? If so, please give us information on that insurance also.

Name of Secondary Insurance _____

Insured's Name:_____ _____

Insured's Date of Birth:_____ Insured's SS# _____

☐ Check here if you've given us a copy of the front and back of your insurance card.

Guarantor Name_____ Client Name _____

Address _____ City_____ State _____ Zip _____

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 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.

Name: DOB: SS#:

EAP CLIENT DEMOGRAPHICS

Client Information:

Today's Date_____

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

Employee Name _____ **Social Security No.**_____-_____-_____ **Date of Birth**_____

Employee's Employer _____ **May we Contact you at Work? Yes No**

Employee's Employer Worksite _____/____ **Work Phone No.** _____

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 □ Co-habitating
□ Single

Referral Source:
□ Self □ Co-Worker □ HR □ Family Member □ Supervisor (informal)
□ Wellness Program □ Treatment Provider □ Supervisor (Mandatory)

Learned about EAP:
□ Self □ Spouse □ Dependent
□ Word of Mouth □ Printed Materials □ Co. Representative
□ Electronic Media □ Training
□ Health Fair □ Other

Client's Gender: □ Male □ Female □ Choose Not to Respond

Client's Highest Level of Education:
□ GED □ High School Diploma □ 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 □ Medical Leave □ Disability
□ Disciplinary Leave □ Terminated (date) _____ □ Laid Off (date) _____ □ Retired (date) _____
(The date of termination, laid off or retired must have taken place within the most recent 3 months for EAP services to continue)

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

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

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Client Concerns: (check all that apply but circle the most important concern)

□ Alcohol	□ Eating Disorder	□ Job/Occupational	□ Health
□ Drugs	□ Hyperactivity	□ Parenting	□ Sleep
□ Mixed Substance Abuse	□ Impulse Control	□ Family Problem	□ Smoking Cessation
□ Anxiety	□ Behaviors	□ Marital/Relationship	□ Traumatic Experience
□ Depression	□ Grief/Loss		

For Office Use Only:
□ Date received by EAP Coordinator _____ □ Date entered into EAP Database _____
Entered by: _____ (initials)

Name: DOB: SS#:

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. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Denise Bredthauer.

_____ _____
Signature of Patient/Client Date

_____ _____
Signature of Parent, Guardian, or Personal Representative** Date

Relationship to Client: _____
***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

Name: DOB: SS#:

YOUR RIGHTS AS A CLIENT

- To be treated with dignity and respect
- To receive the behavioral services you need in convenient place at a time that works well for you
- To ask for a therapist who understands your language, culture, or who speaks American Sign Language (ASL)
- 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 ask for a fair hearing
- To 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 make an Advance Directive
- 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 by your insurance

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

_____ _____ _____

Patient Signature Date Parent/Guardian Signature (if client is minor)

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

_____ _____

Provider Signature Date

Name: DOB: SS#:

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 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

Trust and Confidentiality:

- Their child participates in therapeutic mental health services with the provider.
- Their child's trust in the provider is essential for maintaining a therapeutic relationship between the child and provider.
- Discussions between the child and provider are generally confidential with privacy limits discussed clearly at the beginning of therapy (e.g., mandatory to report suspensions of abuse against any child).
- Unless parental rights have been terminated or legally restricted, each parent of the child has access to information and therapeutic recommendations regarding the child. It is not within the scope of the provider's professional responsibilities or authority to adjudicate disputes between parents about success to information and therapeutic recommendations.
- Session records and therapy notes are confidential. A provider's duty to keep records and notes will not be shared with parents' representatives (e.g., attorneys) with rare exceptions (e.g., judge declines a provider's formal objection to a subpoena).
- In the case of a custody dispute or court-directed placement of a child, for the purposes of preserving trust and the integrity of therapeutic relationship between the child and provider, parents should not request the child's provider's testimony but seek an independent custody evaluation by someone specifically trained in forensic psychology.

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.

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 other therapists on staff. You will be charged for all phone consultations at rates described in our fee schedule.

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 _____

_____
Signature

_____
Parent Signature (if client is a minor)

Counselor reviewed & discussed with client: YES NO
Accepted for Family Resources of Greater NE

By:_____
Date:_____

Name: DOB: SS#:

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. (Nonsufficient fund checks will be charged a fee of $35.00).

Clients Using Outside EAP

As a client using outside EAP, it is your responsibility to call and secure any needed authorizations prior to your appointment. If your have not obtained an authorization prior to your appointment, your insurance will be billed. Further, you will be responsible for the amount not covered by insurance and/or assessed a private pay fee for the date of service.

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.**

Medicare

Medicare benefits for mental health therapy are only accepted when seeing our Licensed Social Worker or Licensed Psychologist.

No Shows and Late Cancellations

We require 24 hour 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.*

Late Fees

Effective 9.1.2017 there will be a $10.00 late fee charge for past due balances after 61 days, 91 days etc.

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.**

By signing below, I state that I understand my financial responsibility in seeking services.

Printed Name Signature Date

Name: DOB: SS#:

FRGN EAP
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 MAYBE 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) law requires disclosure; 3) EAP discerns a threat to security of the employer or national security; and/or 4) insurance verification/claims certification. For a more in-depth look at confidentiality, read the Consent to Treatment.

MANDATORY REFERRALS
Only in the event of a Mandatory Referral, will the therapist discuss sessions with specified HR or management personnel. ***You are asked to sign a release of information for mandatory referrals in order to facilitate the resolution of the workplace related issue for which you are referred.*** You can not be required to sign the release of information form or to attend mandatory sessions. However, HR or management personnel may view your refusal to participate as an indication of unwillingness to change problem behavior, increase work performance, or productivity. If you do consent to mandatory sessions it is important that you understand the therapist will only discuss the following items, confidentially, with designated personnel: that you cooperate with the intake process; that you openly discuss concerns; that you agree to work with therapist to define an appropriate treatment plan; and, that you agree to work on treatment plan. No personal information discussed in sessions will be disclosed.

VOLUNTARY PARTICIPATION
Participation in the EAP is solely at your discretion. No personal information is disclosed to your workplace unless you have signed the release of information form (refer to above paragraph). All sessions and identifying

CANCELLATIONS/FAILURE TO APPEAR FOR APPOINTMENTS
If you need to cancel an appointment, please do so 24 hours in advance. Failure to do so may count against your EAP sessions and you may be charged one EAP session.

I have read this statement and understand its content.

_____ _____ _____
Signature Date Parent/Guardian signature (if client is minor)

Counselor reviewed and discussed this statement with client: Yes No

_____ _____
Therapist Signature Date

Name: DOB: SS#:

PAPERWORK INSTRUCTIONS

Thank you for choosing Family Resources of Greater Nebraska, P.C. for your mental health needs. We want to make the paperwork process as smooth as possible. Below are instructions to assist you in this process. If something is unclear, please feel free to ask.

Please download and fill out the Initial Intake Questions on the website and bring it to your first session with this paperwork. This will allow you and your therapist to get started on the reason you are coming to counseling.

Page 1- Please fill out the information for the CLIENT (person being seen). If you are a parent/guardian, make sure the information is for the client. We also need a way to contact you. If you have a cellular provider and are asking to be contacted via text/cellphone, please be certain to include your cellular provider in the provided space.

Page 2- Please fill out this page. Note that we would like to contact your primary physician, especially if you are having medical issues and/or are taking medications. We ask you to initial the medical section. There is a formal release for you to sign on page 11. If you choose to decline this contact, do not initial that section of page 2 and please write "Declined" on page 11. If it is easier for you to bring a copy of your medications and dosages rather than filling in the bottom section, please do so.

Page 3- This section will help us bill appropriately for your sessions. You will need to contact your insurance carrier prior to the session to verify benefits, such as the number of sessions and copays. Please bring your insurance card with you to session (or a copy of the front/back of the card). Even though you are choosing to utilize EAP sessions first, we ask that you complete this page in the event that you choose to continue therapy after the EAP sessions are finished.

Page 4- This page is designed for statistical purposes and your private information is not released.

Page 5- This is your HIPAA confirmation. Should you wish to have a copy, we will be glad to provide one to you.

Page 6- Please read your rights and responsibilities and sign.

Page 7- Consent to treatment. Please read this carefully. Your **therapist** will also review it with you to ensure understanding.

Page 8- Please read over the financial policy. Once your EAP sessions are utilized, you can choose to continue therapy through insurance or private pay. Please note the session regarding no shows and late cancellations.

Page 9- Please read over and sign. Your **therapist** will review this with you to ensure understanding.

**** If there is anyone with whom your counselor will need to collaborate services, please ask your therapist for a Release of Information (Examples would include Goodwill, Region workers, spouse, teachers, lawyers, etc.) If you would like us to collaborate with your **doctor**, ask your therapist for a PHI Release.