**Vickie DeBuhr, MS, LMHP**

# CLIENT INFORMATION FORM

**NAME:** ____________________________________________ **M/F DOB:** ________________________**AGE**_______

IF MINOR (UNDER 19 AS OF TODAY) PARENT(S) NAME(s): __________________________________DOB_________________

PARENTS/LEGAL GUARDIAN (SOLE, JOINT, NON-CUSTODIAL) ___________________________ (PARENTING PLAN Y/N _______

ADDRESS: __________________________________________ CITY: _______________ ST: ______ Zip: ______________

PHONE: PRIMARY ( c h w )________________________ SECONDARY ( c h w ) ___________________________________

IS IT OK TO LEAVE VOICE/TEXT MESSAGE ON YOUR PHONE? Y/N SIGNATURE PLEASE__________________________________

Email address: ___________________________________________________________________________________

IS IT OK TO CONTACT YOU THROUGH YOUR EMAIL ADDRESS? Y/N SIGNATURE PLEASE__________________________________

**COUNSELING NEEDS:**

___________________________________________________________________________________________

HOW DID YOU HEAR ABOUT ME? ________________________________CAN I THANK THEM FOR THE REFERRAL? Y/N

MEDICAL CONDITIONS AND MEDICATIONS:

___________________________________________________________________________________________

___________________________________________________________________________________________

PRIMARY CARE PHYSICIAN: ________________________________ ADDRESS___________________________________

PHONE__________________________________ FAX__________________________________________

EMERGENCY CONTACT: ________________________________________PHONE ________________________________

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**ARE YOU USING EAP?** EMPLOYER: _____________________________EAP CO: _________________________________

Contact Info: __________________________________________Auth #: ________________________________________

Auth Dates: ____________________________________ Auth Visits: ___________________________________________

**ARE YOU USING HEALTH INSURANCE**?

Primary: _________________________________________ Secondary: _____________________________________

Primary Policy Holder: ________________________DOB______ Primary Policy Holder: ___________________ DOB________

PPH's PH#/ADD: ____________________________________ PPH's PH#/ADD: ___________________________________

Employer: ________________________________________ Employer: ______________________________________

Pol. #: ________________________________________ Pol. #: _________________________________________

Group/Plan Type: _______________________________ Group or Plan Type: __________________________

Deductible: _____________ Amt. Met: ____________ Deductible: _____________ Amt. Met: ___________
Copay: ________________ Coins.: ______________ Copay: _________________ Coins: ______________

**REQUIREMENTS: (credentials, medical necessity: covered/exclusions )_____________________________________**

**AUTHORIZATION NEEDED? Y/N** #: __________________________Dates: _____________________# visits: _____

**CLAIMS BILLING ADDRESS, and/or Payor ID: Please see copy of ID Card and or fill here_________________________________**

## Statement of Understanding and Consent to Treatment

I, the undersigned, understand and accept professional counseling services as provided by Vickie DeBuhr, MS, LMHP. I understand that rights of privacy and confidentiality are respected and that the information provided is protected under federal and state laws, with the following exceptions: if there is expressed intent to harm self or others, in cases of abuse and neglect, or a court order. I acknowledge that the policy manual which includes program descriptions, fees for services, and client's rights, including the right to terminate services at any time, has been made available to me. I understand and agree to the fees for service. And, I understand and agree to the fee of $45.00 for canceling an appointment less than 24 hours in advance and the fee of $55.00 for failing to appear for an appointment.
I also, hereby, authorize Vickie DeBuhr, MS, LMHP to release the information necessary to process this claim and authorize payment of benefits to Keystone Counseling Solutions LLC.

SIGNATURE OF CLIENT____________________________________________________________DATE________________________
SIGNATURE OF LEGAL GUARDIAN____________________________________________________DATE_______________________

PLEASE VERIFY BY SIGNATURE THAT I HAVE READ, UNDERSTAND, AND AGREE WITH INFORMATION INCLUDED IN EACH OF THE FOLLOWING DOCUMENTS. MY SIGNATURE VERIFIES THAT I HAVE BEEN GIVEN OPPORTUNITY TO THESE DOCUMENTS BY THE FORMS PAGE OF Vickie DeBuhr WEBSITE, DOCUMENT BOOK IN HER OFFICE, OR HARD COPIES FOR MYSELF AT MY REQUEST.

1. I am giving permission to contact my emergency contact person in the event of a medical emergency.
   SIGNATURE_________________________________________
2. I have been provided with information, and/or have read, policies relating to the privacy of my health records (HIPAA) and am aware that I may have a copy of this policy to take with me at my request.
   SIGNATURE_________________________________________
3. I have been informed and/or have read the FINANCIAL POLICY of Vickie DeBuhr, MS, LMHP and am aware that I may have a copy of this policy to take with me at my request.
   SIGNATURE_________________________________________
4. I have been informed and/or have read the ELECTRONIC COMMUNICATION POLICY and have AUTHORIZED USE of such devices. I am aware of possible privacy with such and that I may have a copy of this policy to take with me at my request.
   SIGNATURE_________________________________________
5. I have been given and/or have read the OUTPATIENT TREATMENT SERVICES CONTRACT regarding my treatment/sessions with Vickie DeBuhr, MS, LMHP, and consent to my treatment. I am aware that I may have a copy of this contract to take with me at my request.
6. SIGNATURE_________________________________________
7. If I am a parent or legal guardian of the above minor child, I have been given and/or read the CHILD THERAPY CONTRACT and consent to their treatment. I am aware that I may have a copy of this to take with me at my request.
   SIGNATURE_____________________________________________________

Keystone Counseling Solutions LLC

1406 Fort Crook Rd S., Bellevue NE 68005

(7/18)