DEMOGRAPHIC & INSURANCE INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Address for BILLING: _____Apt:_____Zip:_____

PHONE(S): _____ SS#:_____

Is voicemail ok? □ yes □ no Are text messages ok? □ yes □ no Is email ok? □ yes □ no

I consent to have billing statements sent to me by □ US mail □ email:_____ □ either way works

Emergency Contact (name, phone, relationship): _____

Does this person have a GUARDIAN?: □ no □ yes if yes, name and phone:_____

INSURANCE INFORMATION & PAYMENT FOR SERVICES

a. □ (initial) _____ please **file claims with the following insurance** company.

Insurance Company: _____

Person Insured: _____Their DOB: _____

Their address: _____zip: _____

Member ID: _____ Group ID:_____

Their Phone: _____

Relationship of Policy Holder to client: □ self □ spouse □ child or step-child of.

□ check if a SECONDARY INSURANCE is applicable and add that information to back of this form.

b. □ (initial) _____ I will pay for services and **do not wish for my claims to be sent to an insurance** company. As discussed, a fee of $_____ per_____ payable at time of service.

FINANCIAL CONTRACT

I, the undersigned, understand that the practitioners associated with Lincoln Therapy use a billing company and administrative support individuals which/whom upholds HIPAA regulations. I also authorize the insurance company to directly pay the provider benefits payments that would otherwise be paid to the insured for reimbursements. I understand that I am responsible for all charges incurred, whether or not they are paid by the insurance company. I understand that I must contact my insurance provider prior to receiving services to become aware of services covered. I am responsible as well for any deductible and copays that are part of my insurance contract. My insurance company is not responsible for missed appointment charges, I am. Balances should be paid in full within 30 days of receipt of statement. Copays must be paid at time of visit. I understand that in the event that my account is more than 90 days overdue, interest of 3%/billing cycle may accrue/a collections agency may be utilized. If I need to reschedule or cancel a scheduled appointment, I understand that I am responsible for contacting the number given to me by my provider at least 24 hours in advance or be charged a fee of $50. A bounced check will be charged a fee of $50. Private pay, copays and balances will go directly to the provider. Lincoln Therapy is a group of practitioners associated only by common ground and common address. They are independent contractors.

X_____ Date:_____

NAME: _____

INFORMED CONSENT FOR TREATMENT

□ Michelle Miller, LIMHP, CPC □ Kelly Rook, LIMHP □ Katie Sturdevant, APRN, BC

I am **my own guardian** and I consent to participate in services provided by the above noted practitioner **or I am the legal or appointed temporary guardian** of the identified client/patient in which these forms are being filled out for. I /the person I am guardian for am voluntarily entering a therapeutic relationship with above noted practitioner. I understand that **I am consenting** and agreeing only **to those services that the above named provider is qualified to provide within the scope of the provider's license, certification, and training.** I understand that I may revoke this consent at any time. A range of services are available from the practitioners. An initial assessment will be made prior to beginning treatment to determine which services are appropriate. I understand that I can expect regular review of progress and treatment goals. I agree to be actively involved in the treatment and in the review process. The results of this treatment are not guaranteed as participation, motivation to change, active involvement, follow through and canceling appointments all contribute to outcomes. I may discontinue treatment at any time and agree to discuss discontinuation, without judgment, with my practitioner prior to doing so.

X_____ Date:_____

HIPAA POLICY STATEMENT

The practitioners **will not release information** without prior written or verbal indication to release PHI information. In certain circumstances, this confidentiality must be broken in order to follow ethical and legal guidelines: if a court of law supersedes, if a subpoena is presented, or when risk of imminent danger to self is presented, a danger to another person is presented, or when there is suspicion that a child or elder is being sexually or physically abused. I have been offered a copy of the HIPAA, The Health Insurance Portability and Accountability Act/I have been told that a copy can be found on lincolntherapy.com. I understand that all information shared with the practitioners that practice at Lincoln Therapy is confidential and information will not be released without my knowledge. If I have any questions regarding this consent form or about the services offered by the practitioners at Lincoln Therapy, I may discuss them with my provider. I have read and understand the above.

X_____ Date:_____

ADVANCED DIRECTIVES

The state of Nebraska allows you to make an "advance directive" for mental health decision making. *An advance directive is a legal form.* It talks about how you want to be treated if you are not able to speak for yourself. Providers look at this form if you are too sick to decide about your care. You can use an advance directive to: • Tell a doctor, hospital or judge what types of treatment you want or do not want. • **Name a friend or family member who can make mental health care decisions for you.** They can do this **if you are not able to make decisions for yourself**. You can get more information and sample forms from the National Resource Center on Psychiatric Advance Directives, www.nrc-pad.org. Tell your family and providers if you have an advance directive. Give copies to: • All providers caring for you. This includes your primary care doctor. • People you name as a medical or mental health power of attorney. • Family members or trusted friends. They can help your providers make choices for you. Even after you make an advance directive, a provider may not want to follow it "as a matter of conscience." This is when the provider does not agree with the directive. This does not happen often. If it does happen, the provider must give you written policies that: • State why the facility and/or providers object to the directive. • State the law that allows the objections. • Describe the medical conditions involved. Listing someone below provides a TEMPORARY ADVANCED DIRECTIVE.

WOULD YOU LIKE TO NAME SOMEONE? □ **yes**, Name & Phone: _____

□ **no**, thank you.

X_____ Date:_____

NAME: _____

AREAS OF CONCERN/SYMPTOMS/PROBLEMS

Change in environment: (yes) (no): _____

Change in family: (yes) (no):_____

Change in friends: (yes) (no): _____

Problems in relationships/problems relating: (yes)(no): _____

Communication problems: (yes)(no): _____

Mood swings: (yes) (no): _____

Anger: (yes) (no): _____

Sadness: (yes) (no): _____

Agitation/irritability: (yes) (no): _____

Hopelessness: (yes) (no): _____

Problems focusing/concentrating: (yes) (no): _____

Anxiety: (yes) (no): _____

Panic attacks: (yes) (no): _____

Obsessions: (yes) (no): _____

Repetitive activities: (yes) (no): _____

Problems with sleep: (yes) (no): _____

Problems with food: (yes) (no): _____

Seeing/hearing things that others do not: (yes) (no): _____

Legal problems: (yes) (no): _____

History of trauma: (yes) (no):_____

Abuse: (yes) (no): _____

Feelings of low or no self-esteem: (yes) (no): _____

Child Protective/Adult Protective Services Involved: (yes) (no):_____

Actions that could be considered dangerous: (yes) (no): _____

Thoughts of wanting to hurt self or die: (yes) (no):_____

Thoughts of wanting to hurt or kill others: (yes) (no): _____

Problems with alcohol: (yes) (no): _____

Problems with prescription or other drugs: (yes) (no): _____

Other areas of concern: _____

NAME: _____

COORDINATION OF TREATMENT

Communication between your health care providers can offer you a higher level of care. In order to do so your permission is needed in writing. Can we release/obtain information from your PCP (Primary Care Provider), and other medication providers or therapeutic professionals for coordination of care purposes?

□ Yes, I'd like my therapist and PCP or other professionals to communicate. I will sign a release and/or releases.

□ No, I do not wish to sign or release my PERSONAL HEALTH INFORMATION.

□ The **PCP** or **General Practitioner** that I am currently seeing is: □ I do not have one

NAME: _____ PHONE: _____

ADDRESS: _____

NAME OF PRACTICE: _____

I began seeing the practitioner approximately: _____

MEDICATIONS PRESCRIBED by this practitioner are the following. Please include name of medications, dosages,

Start and Stop dates, and purpose/issues the medication has been prescribed to address: _____

_____

_____

I have the following MEDICAL CONDITIONS: _____

□ The **PSYCHIATRIST** or **APRN** that I am currently seeing is/saw in the past is: □ I do/did not have one at this time

NAME: _____ PHONE: _____

ADDRESS: _____

NAME OF PRACTICE: _____

I began seeing the practitioner approximately: _____

MEDICATIONS PRESCRIBED by this practitioner are the following. Please include name of medications, dosages,

Start and Stop dates, and purpose/issues the medication has been prescribed to address: _____

_____

_____

_____

□ I have NOT received mental health treatment (hospitalizations, therapy, psychiatric medication) in the past.

□ I have received mental health treatment in the past to include: _____

_____

_____

How did you become aware of Lincoln Therapy/Your practitioner? _____

NAME: _____

RIGHTS AND RESPONSIBILITIES

You have rights and responsibilities. Your rights are important. Providers must explain your rights at your first visit. You have the right to: • Be treated carefully, with respect, dignity and privacy. • You may not be subject to discrimination on the basis of race, gender, national origin, age, handicap, religious or political beliefs • Have your treatment and other information kept private and confidential: we share treatment records without your written or verbal consent only when the law mandates it. • Get care easily and when you need it. • Learn about treatment options in a way that: − respects you and that you can understand. − fits your needs, and allows for information about any risks and benefits of said treatment • Take part in making your plan of care and to make informed decisions about whether or not you will receive treatment. • Get information in a language you can understand and translated at our cost. • Get information in other ways if you ask for it. • Participate in the treatment planning process. • Get information about clinical rules followed in your care. • Ask your providers about their work history and training. • Not be kept alone or forced to do something you do not want to do: this is based on a federal law. • Give your thoughts on the Rights and Responsibilities policy. • Ask for a certain type of provider. • Have your provider make care decisions based on the treatment you need. • Get healthcare services that obey state and federal laws about your rights. • Help make decisions about your healthcare: this includes the right to get a second medical opinion and to refuse treatment. This is your right unless the court says otherwise. • File a complaint about: − a provider or the care you receive. • Get help from your insurance carrier/contact whomever you wish to file a complaint, grievance or appeal. • Get a copy of your medical records. You can ask that they be changed or corrected. • Use your rights. This will not affect the way your practitioner treats you. • Get written information on advance directives and your rights under state law. (An advance directive tells doctors the kind of care you would want if you become too sick to decide.) • Talk with your provider about the types of treatment that are right for you. The cost or benefit coverage does not affect this. Your right to information: You have the right to get information about your treatment, diagnosis, and any disorders that you may have at any time • You have the right to inquire about your providers and to ask and obtain pertinent Information about providers. • You have the right to obtain information about your health plan benefits as well as have an explanation of this information • The process for getting services. This includes getting approvals. • A description of after-hours and emergency coverage and how to get these services. • A description of emergency medical conditions. • A description of “post-stabilization” services. • How to get a ride to services. Receive care in a timely manner• Grievance, appeal and state fair hearing procedures. This includes their timeframes. • Share your worries about the quality of your care. • Tell someone if you suspect abuse and fraud. (This is someone not being honest.) If you believe that your rights have been violated, you may submit a complaint with the Federal Government. Filing a complaint will not affect your right to further treatment or future treatment. To file a complaint with the federal government, contact, Secretary of US Department of Health and Human Services 200 Independence Ave, SW Washington, D.C. 20201 (202)619-0257.

Your responsibilities are important. You have the responsibility to: • Get treatment you need from a provider. • To treat anyone providing care with respect. • Give providers and your insurance carriers/ if one is being used for services the information they need including informing us of all insurances that you carry. This helps providers give you quality care. It helps us give you the right service. • Ask questions about your care. This helps you and your providers understand your health problems. It helps create treatment goals and plans you agree on. • Follow your treatment plan. You and your provider should agree on this plan. • Follow the plan for taking your medicine. You and your provider should agree on the plan. • Tell your providers and primary care doctor about changes in your medicine. This includes medicines other doctors give you. • Come to all your provider visits. You should call your provider as soon as you know you need to cancel a visit. • Tell your provider when you think the treatment plan is not working. • Tell your provider if you have problems paying copayments and make payments as agreed upon with your provider.

X_____ Date:_____

NAME: _____