

**LIFE RESOURCES, LLC & THE INSIGHT PROGRAM, PC**

**New Client Information**

Legal First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ SSN: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_

Email: \_\_\_\_\_ Pronouns preferred: \_\_\_\_\_ Gender: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Marital Status: Married /Single /Widowed /Divorced /Separated

Contact Preference (Please label 1-4 in order of how you would prefer to be contacted):

\_\_\_\_ Cell Phone \_\_\_\_ Email \_\_\_\_ Text \_\_\_\_ Home Phone \_\_\_\_ Work Phone

**Emergency Contact** Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell Phone :(\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Phone :(\_\_\_\_) \_\_\_\_ - \_\_\_\_

**Only If Client is a Minor Complete Below:**

I acknowledge I have legal authority to permit \_\_\_\_\_ to receive counseling services. As parent or legal guardian I can request information concerning the above person's evaluation and treatment.

Parent/ Guardian Signature X \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

➤ **Person Financially Responsible** Initial if same as client listed above \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell Phone :(\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Phone :(\_\_\_\_) \_\_\_\_ - \_\_\_\_

SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Relationship to Client: \_\_\_\_\_

**Work Information**

Employer: \_\_\_\_\_ Employee: \_\_\_\_\_ Employee DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

## **EAP**

EAP Company: \_\_\_\_\_ Authorization #: \_\_\_\_\_

Phone Number: \_\_\_\_\_ # Sessions authorized: \_\_\_\_\_

### **Insurance Information:** (please provide the front desk with a copy of the insurance card(s))

**Primary Insurance:** \_\_\_\_\_ Phone Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Client: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Co-payment: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Phone Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Client: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Co-payment: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

### **Brief Medical History**

Are you currently taking any medication, prescription or over the counter? (YES or NO)

If so, please list:

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Do you have any medical conditions? (YES or NO)

If so, please list:

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Have you been hospitalized for mental illness? (YES or NO)

If so, please describe:

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Have you ever been seen by a mental health provider? (YES or NO)

If so, please list the provider's name: \_\_\_\_\_

# Demographic Information

(The following are to be used solely for demographic purposes.)

## Highest Level of Education

- 3. HS Graduate
- 4. Some College
- Certificate/Associates Degree
- 5. College Graduate
- 6. Advanced Degree

## Ethnic Background

- 1. Native American
- 2. Asian
- 3. African American
- 4. Hispanic
- 5. Pacific Islander
- 6. Two or More Races
- 7. White
- 8. Other

## Referral Source

- 1. Supervisor Requirement
- 2. Supervisor Recommendation
- 3. Medical Dept. or Employee Health
- 4. Self

## Work Status

- 1. Full Time
- 2. Part Time
- 3. As Needed
- 4. Temporary
- 5. Other \_\_\_\_\_
- 6. NA: Family Member

## Job Location

\_\_\_\_\_

## Length of Service

\_\_\_\_\_

## Current Shift

- 1. Days
- 2. Evenings
- 3. Nights
- 4. Rotating
- 5. Other \_\_\_\_\_
- 6. NA: Family Member

## Work Performance Problems

- 1. Absenteeism
- 2. Tardiness
- 3. Safety Violations
- 4. Issues Relating to Other Employees
- 5. Quality/Quantity of Work Decreased
- 6. Concentration
- 7. Alcohol/Drugs Suspected on Job
- 8. Theft
- 9. DOT Violation
- 10. DOT Consultation
- 11. Other
- 12. N/A: Family Members
- 13. NO Problems

## Have you lost work due to injury in the past 12 months?

- 1. Yes
- 2. No
- 3. N/A: Family Member

## Any missed work due to presenting issue?

\_\_\_\_\_

## Previous EAP

- 1. No
- 2. Once
- 3. Twice
- 4. Three Times
- 5. Four Times
- 6. Five or More

## Personnel Actions

- 1. Employee Counseled
- 2. Verbal/Written Warning
- 3. Suspension
- 4. Demotion
- 5. Termination
- 6. Resignation
- 7. NO Action
- 8. N/A: Family Member

## Urgency of Care

- 1. Suicidal Ideation
- 2. Homicidal Ideation
- 3. Sexual Abuse
- 4. Physical Abuse
- 5. Psychosis
- 6. Combination of the Above
- 7. None of the Above

## Aware of EAP Through

- 1. Prior participation
- 2. Newsletter Article
- 3. Poster
- 4. Payroll Insert
- 5. Brochures
- 6. Supervisor Suggested
- 7. Co-Worker Suggested
- 8. Family Suggested
- 9. In-Service Training/Orientation

# Personal Issues

(Please check those that are most concerning to you.)

### Abuse/Addiction by Client

- 1. Alcohol
- 2. Drugs
- 3. Gambling
- 4. Internet
- 5. Sexual
- 6. Other \_\_\_\_\_

### Family Issues

- 7. Family conflict
- 8. Concerns about child(ren)
- 10. Parent/Child Relationship
- Custody Concerns
- 11. Domestic Violence
- 12. Reaction to Illness
- 13. Living w/ Abuse or Addiction
- 14. Living with Emotional Problems
- 15. Other \_\_\_\_\_

### 16. Marital/Relationship

- Current
- Previous

### Emotional Problem

- 17. Depression
- 18. Anxiety
- 19. Other \_\_\_\_\_

### Trauma and Abuse

- 20. Physical Abuse
- 21. Sexual Abuse
- 22. Emotional Abuse
- 23. Post-Traumatic Stress
- 24. Grief/ Major Loss
- 25. Other \_\_\_\_\_

### Work Related

- 26. Relationship with Co-Workers
- 27. Relationship with Supervisor
- 28. Workplace Violence
- 29. Harassment
- 30. Job Performance
- 31. DOT Consultation
- 32. DOT Violation
- 33. SAP Evaluation
- 34. Other \_\_\_\_\_

### 35. Medical Condition

### 38. Financial Issues

### 39. Legal Issues

### Work/Life Stressors

- Work/Life Balance
- 41. Older Adult Services
- 42. Lifestyle/Wellness
- 47. Education
- 48. Other \_\_\_\_\_

### Other

- 50. Eating Disorder
- 51. Stress
- 52. \_\_\_\_\_

**Insight Staff Only:**

**Staff Name:** \_\_\_\_\_

**Open Date:** \_\_\_\_\_

**Client ID:** \_\_\_\_\_

1. Employee Only
2. Employee & Family Member
3. Family Member Only
4. Other

**Please feel free to use the space below to describe the primary reason for your visit.**

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# Statement of Understanding

Please Initial that you have read, reviewed, asked all questions and understand the following documents:

- **Informed Consent for Mental Health Treatments** \_\_\_\_\_

- **My Responsibilities to You as Your Therapist** \_\_\_\_\_

- i. Confidentiality \_\_\_\_\_

- ii. Other Rights

- iii. Your Responsibilities as a Therapy Client

- **Acknowledgement of Insurance Processing** \_\_\_\_\_

- **Receipt of Notice of Privacy Practices (HIPAA)** \_\_\_\_\_

Under the Health Insurance Portability and  
Accessibility Act of 1996, I have a right to review the  
privacy practices of Life Resources, LLC & The Insight  
Program. I have received, read, and understand the  
Notice of Privacy Practice.

- **No-Show Agreement** \_\_\_\_\_

Life Resources, LLC and the Insight Program reserves the  
right to charge \$50 for the allotted time. This fee is not  
covered by any insurance plan.

I have reviewed carefully, asked any questions that I needed to, and understand this consent to receive mental health services. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process. I agree to pay the session fee. I understand my rights and responsibilities as a client, and my therapist’s responsibilities to me. I agree to undertake therapy with Life Resources, LLC and The Insight Program, PC. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions.

Patient Signature X \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness Signature X \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## **INFORMED CONSENT FOR MENTAL HEALTH TREATMENT**

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy, whose goal is your well-being. There are also certain limitations to those rights that you should be aware of. As therapists, we have corresponding responsibilities to you.

### **My Responsibilities to You as Your Therapist**

#### **I. Confidentiality**

With only a few specific exceptions outlined below, you have the absolute right to the confidentiality of your therapy. We cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, we may legally speak to another health care provider or a member of your family about you without your prior consent, but we will not do so unless the situation is an emergency. We will always act to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you.

If you elect to communicate with me electronically at some point in our work together, please be aware that these services are not completely confidential. All electronic records are retained in the logs of your or my internet service or cellular provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service or cellular provider.

Correspondence we receive from you, and any responses that I send to you, may be printed out and kept in your treatment record.

The following are legal exceptions to your right to confidentiality. We will attempt to inform you of any time when we think we will have to put these into effect.

1. If supervision occurs, your confidential information may be shared.
2. If we have concerns about child and/or elder abuse or neglect.
3. If we are concerned you may harm yourself or someone else.
4. Under court order.

## **II. Other Rights**

We are always willing to discuss how and why we've decided to do what we do, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

## **III. Your Responsibilities as a Therapy Client**

You are responsible for coming to your session on time and at the time we have scheduled. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than twenty-four hours' notice, you must pay for that session at our next regularly scheduled meeting. The answering machine has a time and date stamp which will keep track of the time that you called me to cancel. We cannot bill these sessions to your insurance. The only exception to this rule about cancellation is if you would endanger yourself by attempting to come (for instance, driving on icy roads), or if you or someone whose caregiver you are has fallen ill suddenly. If you no-show for two sessions in a row and do not respond to my attempts to reschedule, I will assume that you have dropped out of therapy and will make the space available to another individual.

• Psychiatric Diagnostic Evaluation \$200	• Individual Psychotherapy 45 min \$150
• Individual Psychotherapy 60 min \$200	• Family Psychotherapy \$200
• No Call/ No Show \$50 (not covered by insurance)	

You are responsible for paying for your session weekly unless we have made other firm arrangements in advance. Co-pays are due at the time of the appointment.

## **Acknowledgement of Insurance Processing**

In order to process claims and receive payment from insurance carriers, it is helpful for each client to be aware of the certain processes mental health services require. Most insurance plans require prior authorization for a service such as therapy. Please contact your carrier by calling the customer help line located on the back of your card to ensure that your plan does not require prior authorization or a referral from your primary care physician. If you have any questions, please feel free to contact our billing department.

Life Resources, LLC and The Insight Program, PC will complete and mail an insurance claim of your behalf. However, you are responsible for all pre-authorization requirements, insurance claim follow up, and all charges not covered by your insurance. Life Resources, LLC and The Insight Program, PC reserves the right to charge the patient the full amount of the visit if there is no response from the insurance company within 45 days.

Please be aware that all clients that have co-pays or co-insurances must pay them at the time of service. If you are unable to make the payment at that time, a statement will be mailed to you and payable within 10 days of receipt. If necessary, a payment plan can be made with our billing department. In the event that we have not received payment within 90 days of service, a collection process will commence. Please keep our office up-to-date with any change of address to avoid any complications with statements.

## **Notice of Privacy Practices**

**This notice describes how medical information may be used and disclosed and how you may access this information. Please review it carefully.**

This notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementing regulations (HIPAA). It is designed to tell you how we may, under federal law, use or disclose your Health Information.

1. We may use or disclose your health information for purposes of treatment, payment or healthcare operations without obtaining your prior authorization. Here is an example: Our billing department may access your information and send relevant parts to other insurance companies to allow us to be paid for the services we render to you.
2. We may also use or disclose your Health Information under the following circumstances without obtaining your prior authorization:
  - a. To notify and/or communicate with your family. Unless you tell us you object, we may use or disclose your Health Information in order to notify your family or assist in notifying your family, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in any communications with your family and others.
  - b. To coordinate or manage services with other health care providers, including third parties. (attending physician, consulting physician, nurses, technicians, health profession students, or other facility or health care personnel who have a legitimate need for such information in order to take care of you.
  - c. For Health Oversight Activities. We may use or disclose your Health Information to health agencies during audits, investigations, certification and other proceedings.



- d. In response to Subpoenas or for Judicial and Administrative Proceedings. We may use or disclose your Health Information in the course of any administrative or judicial proceeding. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person.
  - e. For Concerns of Abuse or Neglect. We may disclose your Health Information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your Health Information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
  - f. To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to identify or locate a suspect, fugitive, material witness or missing person, comply with a court order or subpoena and other law enforcement purposes.
  - g. To Coroners and Funeral Directors. We may use or disclose your Health Information for purposes of communicating with coroners, medical examiners and funeral directors.
  - h. To Aid Specialized Government Functions. If necessary, we may use or disclose your Health Information for military or national security purposes.
  - i. For Worker's Compensation. We may use or disclose your Health Information to company with worker's compensation laws.
  - j. To Correctional Institutions or Law Enforcement Officials, if you are an inmate.
3. For all other circumstances, we may only use or disclose your Health Information after you have signed an authorization.
    - a. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.
  4. You should be advised that we may also use or disclose your Health Information for the following purposes:
    - a. Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about treatments or health-related benefits and services that may be of interest to you.
    - b. Change of Ownership. In the event that our entity is sold or merged with another organization, your Health Information/record will become the property of the new owner.

- c. Providing Information to our plan sponsor (if a health plan). We may disclose your Health Information to our plan sponsor.

## 5. Your Rights

- a. You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with your request.
- b. You have the right to receive your Health Information through confidential means through a reasonable alternative means or at an alternative location.
- c. You have the right to inspect and copy your Health Information made by use, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, healthcare operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with family; and/or for certain government functions, to name a few.
- d. You have a right to a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one of more of these rights, contact Susan Meyerle, 402-477-0651.

## 6. Our Duties

- a. We are required by law to maintain the privacy of your Health Information (and to provide you with a copy of this Notice).
- b. We are also required to abide by the terms of this Notice.
- c. We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health Information even if it was created prior to the change in the Notice. If such amendment is made, we will immediately display the revised Notice at our office and provide you with a copy of the amended Notice. We will also provide you with a copy, at any time, upon request.

## 7. Complaints to the Government

You may make complaints to the Secretary of the Department of Health and Human Services if you believe your rights have been violated. We promise not to retaliate against you for any complaint you make to the government about our privacy practices.

## **Definitions**

**-Notice of Privacy Practices-** A written notice in compliance with the requirements of Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009, made available from The Insight Program, PC and Life Resources, LLC to an individual or the individual's personal representative at the first delivery of service, or at the individual's next visit following a revision to the Notice, that describes the uses and disclosures of protected health information that may be made by The Insight Program, PC and Life Resources, LLC and the individual's rights and The Insight Program, PC and Life Resources, LLC's legal duties with respect to protected health information.

**-Protected Health Information (PHI)-** Individually identifiable health information that is transmitted or maintained in any form or medium, including electronic media. Protected health information does not include employment records held by The Insight Program, PC and Life Resources, LLC in its role as an employer.

## **Contact Information**

You may contact us about our privacy practices by calling the Privacy Officer, Susan Meyerle at:

Life Resources, LLC and the Insight Program, PC

P.O. Box 57235, Lincoln, NE 68505-7235

Telephone: 402-477-0651 or 402-488-1032

**OR** You may contact the DHHS at:

US Department of Health and Human Services

200 Independence Avenue, SW, Washington DC, 20201

Telephone: 202-619-0257, Toll Free: 1-877-696-6775