

Moving Forward Therapy Services LLC
Tara L. Thomsen, MS, LIMHP, LPC
11060 Oak Street, STE 2 Omaha, NE 68144
Ph. 402-933-8998 Fax 402-933-9091

Client Information

(Please complete all 12 pages)

Child's Name: _____
Child's Sex: Male Female Age: _____ Date of Birth: _____ SS#: (Only last 4) _____
Address: _____ City: _____ State: _____ Zip: _____
School or daycare: _____ What grade? _____

Parent #1/Guardian

Name: _____
Sex: Male Female Not applicable Age: _____ Date of Birth: _____
Email: _____ OK to contact you via this email address? Yes No
Phone: Home :(____) _____ Is it OK to leave a detailed message on this number? Yes No
Work: (____) _____ Is it OK to leave a detailed message on this number? Yes No
Cell: (____) _____ Is it OK to leave a detailed message on this number? Yes No
Is it OK to text you on this cell phone? Yes No
Primary Occupation: _____ Employer: _____

Parent #2/2nd Guardian

Name: _____
Sex: Male Female Not applicable Age: _____ Date of Birth: _____
Email: _____ OK to contact you via this email address? Yes No
Phone: Home :(____) _____ Is it OK to leave a detailed message on this number? Yes No
Work: (____) _____ Is it OK to leave a detailed message on this number? Yes No
Cell: (____) _____ Is it OK to leave a detailed message on this number? Yes No
Is it OK to text you on this cell phone? Yes No
Primary Occupation: _____ Employer: _____

Emergency Contact: _____

Their phone: Home: (____) _____ Work: (____) _____ Cell: (____) _____ I
agree for this person to be contacted in an emergency (**initial**) _____

Name(s) of Siblings

	Age	Sex	School/College/Employed	Living with the child?
1. _____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. _____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. _____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. _____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

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CHILD'S INFORMATION - Page 2

Reason for Seeking Services Today: _____

Current Primary Care Physician or Pediatrician: _____ Phone #: (____) _____

Location Child visits _____

Child's Medical History & Current Medical/Surgical Problems: _____

Child's Current Medications or supplements:

_____ Dose _____

_____ Dose _____

_____ Dose _____

_____ Dose _____

Do they take their medications as prescribed? Yes No

Is anyone in the immediate family currently involved in the legal system? Yes No

If Yes, Please give details: _____

Are you or anyone in the immediate family, currently seeing a Mental Health Professional? Yes No

Therapist/ Psychiatrist: _____ Phone #: (____) _____

Therapist/ Psychiatrist: _____ Phone #: (____) _____

Have you, or anyone in the immediate family, seen a Mental Health Professional in the past? Yes No

If Yes, please list who? Symptoms, Diagnosis, and Treatment received: _____

Referred here by: Physician Therapist Google search Other Internet ABA Therapy Company Other

Name of Referral Person/Agency: _____ Phone#(____) _____

Signature of Parent or Legal Guardian): _____

Date: _____

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CONTRACT FOR PAYMENT OF SERVICES

I understand that Ms. Thomsen’s current rates are \$195 per 52+ minute individual, couple or family session, and \$230 for the initial evaluation session where a diagnostic interview is required for insurance purposes.

By signing below, I understand that I am assuming responsibility for payment of my bill at the time of the session, unless other arrangements are made and herein specified. I also understand that should the Child’s account balance remain outstanding that *Moving Forward Therapy Services LLC* and Ms. Thomsen do utilize the services of a collection agency and I agree that Ms. Thomsen’s office may release my name to any necessary party in the course of obtaining payment. Self-pay fees and insurance co-pays are expected at the time of service and paid at the beginning of each session.

Section 1: Please choose one of the following options and complete the information requested.

Option A: I/we wish to self-pay and not use any insurance benefits. I/we **do not** give permission for any confidential information about me (or my partner) and my/our treatment to be released to any third-party payer, employer or insurance company. Self-payments may be made from an HSA or FSA account via check or credit card. (If you select this option, Skip to section 2)

Option B: I/we wish to use insurance to help pay for services; Blue Cross Blue Shield, Tri-care Military and Family, Nebraska Medicaid, Iowa Medicaid or Midland’s Choice insurance plans (including some Cigna plans) only. Please complete all of the following: for clients wishing to use their health insurance for treatment, it is the Parent or guardian’s responsibility to ensure they have current mental health benefits for outpatient office visits. Insurance companies only quote benefits and do not guarantee payment over the phone. Any disagreement regarding payment of a claim by insurance is between the Parent and the insurance company. Ultimately, payment of the bill is the Parent’s responsibility.

Name of Primary Insurance: _____

Member # _____ (if TRICARE, this is the DoD # for the service member)

Insured’s Name: _____ SS# : _____

Insured’s Date of Birth: _____ Insured’s Employer _____

Name of Secondary Insurance: _____

Member # _____ (if TRICARE, this is the DoD # for the service member)

Insured’s Name: _____ SS#: _____

Insured’s Date of Birth: _____ Insured’s Employer _____

Signature of Responsible Party for Billing _____

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****This section is not required for children covered by Medicaid programs in Nebraska.**

CONTRACT FOR PAYMENT OF SERVICES - continued

I have spoken to my insurance company and confirm I have current mental health benefits for outpatient office visits, and I understand my insurance co-pay is \$_____ per office visit. (Or co-insurance is _____%).

My insurance company requires pre-authorization: Yes No, if yes, the authorization # is: _____ I

believe I have already met my insurance deductible for this year: Yes No. If not, my remaining deductible is

\$ _____ as of _____ (date).

Assignment of Insurance Benefits

Signature of this contract authorizes payment of medical benefits to Tara Thomsen for services rendered (assignment of benefits). I understand my insurance company (if applicable) may be billed the full amount for the session and that aside from my co-pay (if applicable) and providing that Tara L. Thomsen is considered "in-network" for my insurance plan, I am not liable for any difference between the billed amount and the reimbursement amount previously contracted between the insurer and Tara L. Thomsen and/or Moving Forward Therapy Services.

I/we the undersigned acknowledge that my/our insurance company may request clinical information, including diagnosis, prognosis and treatment plans and hereby authorize the release of any appropriate information relating to payment of claims submitted to insurance on behalf of myself/us and/or dependents. I/we further expressly agree and acknowledge that signature of this document authorizes Tara Thomsen and/or Moving Forward Therapy Services to submit claims for insurance benefits, for services rendered, or for services to be rendered, including treatment plans, without obtaining my/our signature to each and every claim submitted for myself/us and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I/we therefore authorize the insurance company to pay and hereby assign directly to Tara L. Thomsen and/or Moving Forward Therapy Services all insurance benefits, if any, otherwise payable to me for services described on the attached forms. I understand that I am financially responsible for all charges incurred whether or not paid by insurance. I further acknowledge that any insurance benefits, when received by and paid to Tara L. Thomsen and/or Moving Forward Therapy Services will be credited to my account, in accordance with the above said assignment.

Section 2: All Clients

I understand that it is important that I provide at least 24-hours' notice of cancellation of a scheduled appointment, and in not doing so I will be liable for a charge of **\$50.00** for this scheduled time. This charge will be the responsibility of the Parents and insurance does not pay for these charges.

Moving Forward Therapy Services LLC

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****This section is not required for children covered by Medicaid programs in Nebraska.**

It is usual practice, and preferable, to provide payment for the session (or insurance co-pay if applicable) at the start of each session by cash, check, or credit card, however I agree for Tara Thomsen (*Moving Forward Therapy Services LLC*) to keep my credit card details on file to pay the balance of any outstanding insurance co-pay amounts, self-pay fees, or cancellation fees not previously paid at the time of service.

Card type: Visa MasterCard

Card Number: _____

Expiration date: ____/____ Security Code (3 digits on the back): _____

Name as it appears on the card: _____ Billing ZIP: _____

I authorize Tara Thomsen to charge my account for any outstanding amounts owed.

Card holder's signature: _____ Date: _____

I/we acknowledge understanding of and agree to the terms of this contract for payment of services;

Parent(s): _____ Date: _____

CONSENT FOR TREATMENT

I/we authorize the provision of outpatient therapy treatment for my child; _____
This treatment may include such services as a pre-treatment assessment, the use of specific assessment instruments, treatment planning, and individual or, family therapy. I understand that my active participation and compliance with psychotherapeutic treatment and recommendations are an important component of a successful outcome of the treatment, and that treatment does not necessarily guarantee successful outcome. I/we understand that it is reasonable and customary to arrive to appointments on time, to end appointments at the scheduled finish time, and to provide 24hour notice if I need to cancel a scheduled appointment. I understand that should a pattern of canceling appointments or not showing for appointments develop, that Tara Thomsen reserves the right to refer me (or my child) to another practitioner. I/we understand that all information and records generated and obtained in the course of treatment will remain confidential within Tara L. Thomsen's practice and any State mandated supervision processes and will not be released to other parties without my written consent. This confidentiality will be followed according to the Health Information Portability and Accountability Act (HIPAA) and a separate HIPAA Notice will be reviewed and signed by me and placed in the file. I/we understand that the confidential information may be released under the following specific circumstances:

1. If a Child's states intention to harm him or herself, or others, it is the Practitioner's legal duty to warn authorities and the person or persons at risk of harm or who have been threatened harm.
2. If a Child's reveals intent to harm him or herself, it is the Practitioner's duty to take whatever action is necessary and possible to protect that individual. Such action may include notifying the spouse, family, or the appropriate authorities.
3. If a Child becomes involved in certain legal processes, medical and behavioral health records may be subpoenaed. The Practitioner's ability to protect a Child's confidentiality will be dependent on the legal situation. Records are usually subject to release in these circumstances.
4. If a Child or parent/guardian, during the course of treatment or assessment, informs the practitioner or an office staff member that a child, or elderly, or disabled individual is either currently being abused or neglected, or has been abused or neglected in the past, it is the practitioner's legal and ethical responsibility to advise the authorities.
5. If the Child or parent/guardian is using insurance benefits to pay for services rendered and the insurer requests clinical information to support claims.
6. If the child has been referred for an assessment to begin Applied Behavioral Analysis services with an outside agency, the information from this assessment will be automatically released to them.

I/we understand that psychotherapy and working towards change may involve experiencing difficult and intense feelings, some of which may be painful in order to reach therapeutic goals. I/we accept that such changes can have both negative and positive effects, and I/we agree to evaluate and clarify the potential effects of changes before I/we undertake them. I/we understand that the psychotherapy process does not guarantee a therapeutic outcome.

I/we understand that staff members and billing personnel may have access to my records. I/we agree to pay for Tara Thomsen's and/or Moving Forward Therapy services as an agreed upon fee for service.

I/we have read and understand the contents of this consent form and accept the conditions of this agreement.

Signature of Parent (or Legal Guardian):

_____ Date: _____

Client Orientation

As a professional psychotherapist, providing you with whatever assistance you need is important. I am committed to the highest ethical standards of my profession and invite you to discuss any questions related to your therapy or the policies of my practice. In seeking services through my office, I want you to know you have the right:

1. To ask questions at any time.
2. To be fully informed of the therapist's qualifications to practice, including training and credentials, years of experience, etc.
3. To be fully informed regarding the therapist's therapeutic orientation, areas of specialization, and limitations.
4. To ask questions relevant to your therapy, such as therapist's values, background and attitudes, and to be provided thoughtful, respectful answers.
5. To be fully informed of the extent of written or taped records of therapy and their accessibility.
6. To be fully informed of your diagnosis (if the therapist uses one).
7. To specify or negotiate therapeutic goals and to renegotiate these goals when necessary.
8. To be fully informed regarding the therapist's estimation of length of treatment to meet your agreed upon goals.
9. To be fully informed regarding specific treatment strategies employed by the therapist.
10. To refuse any intervention or treatment strategy.
11. To request that the therapist evaluate the progress of therapy.
12. To discuss any aspect of your treatment with others, including consulting another mental health professional.
13. To be provided with written summaries of written records at your request.
14. To require the therapist to send a written report regarding services rendered to a qualified mental health practitioner or mental health organization at your request.
15. To give or refuse permission for the therapist to use aspects of your case for a presentation or publication.
16. To refuse to answer any questions.
17. To know the ethics code to which the therapist adheres.
18. To solicit help from the ethics committee of the appropriate professional organization in the event of doubt or grievance regarding the therapist's conduct.
19. To terminate therapy at any time.

CONFIDENTIALITY

Records of the identity, prognosis or treatment of any client are confidential and will be disclosed *only* with the written consent of the Child's legal guardian, by order of the court of competent jurisdiction, or as otherwise required by law. It should be noted that we are required by law to report any information which we receive pertaining to child or elder abuse or neglect. In addition, if we become aware that a Child's is acutely suicidal or is intending to harm another individual, we are required to take the steps necessary to prevent this action, including notification of the police or the threatened party. Therapy notes are typically NOT shared with parents or guardians.

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OFFICE/FINANCIAL PROCEDURES

Therapy sessions are 50 minutes in length, unless otherwise arranged or circumstances warrant. Following the first session, an attempt is made to establish a regularly scheduled appointment time consistent with the frequency of appointments needed. Please provide at least 24 hours of notice of a canceled appointment to avoid incurring a cancellation fee of \$50.

There is generally no charge for one brief (5 minute) telephone consultation between sessions with your therapist, unless the contact is occurring on a regular basis (typically more than once a week). For extended or frequent emergency contacts between sessions, additional charges will be assessed to the patient at the rate normally charged. Please note, Tara Thomsen, only returns messages during office hours, and does not provide an after-hour's emergency service. Messages left outside of office hours are usually returned the next working day.

If you are experiencing a mental health emergency, please call the Boys Town 24-hour Crisis Line at (800)448-3000, text VOICE to 20121 or call 911, or go to the nearest emergency room.

Additional charges may also be made for the administration and scoring of tests, writing reports, scheduled consultations with a psychiatrist, other professionals or family members, or involvement of a co-therapist.

The Parent/guardian is responsible for payment of the fee for each session at the time of the session, unless other arrangements are made in advance. We will submit claims to your insurance company for you. Responsibility for payment of the bill remains with the parent/guardian and not an insurance company. You will receive a statement as long as a balance exists regardless of your insurance company status. There is a \$35.00 charge for returned checks, this will cover bank charges and additional paperwork required in the office.

NOTICE OF PRIVACY PRACTICES

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to Tara Thomsen and her staff.

Our Legal Duty

Tara L. Thomsen and her staff at Moving Forward Therapy Services LLC. are required by applicable federal and state law to maintain the privacy of your health information. We are also required to provide you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

This Notice takes effect (02-1-2012) and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy, we will change this Notice and make it available to you upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Use and Disclosure of Health Information We use and disclose health information about you for treatment, payment for services, and healthcare operations. For example:

Treatment:

We may use or disclose your health information to a physician, psychologist, or other healthcare provider providing treatment to you (with your permission).

Payment:

We may use and disclose your health information to obtain payment for services we provided you. If your payment balance is outstanding and unresolved, we utilize the services of a collection agency.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conduct training programs, licensing or credentialing activities.

Your Authorization:

In addition to our use of your health information for treatment, payment of services provided, or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it *was* in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Your Family and Friends: We must disclose your health information to you, as described in the clients' rights section of this Notice. We may disclose your health information to a family member or friend, but **only** if you agree we may do so.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

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Required by Law We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of some other crime. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counter-intelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate clients under certain circumstances. **Appointment Reminders:** We may use or disclose health information to provide you with appointment reminders such as voicemail messages, emails, SMS texts, or letters. We may use password protected online services such as Google Voice, Gmail, and a remotely hosted Microsoft Exchange Server.

Clients Rights to Access:

You have the right to look at or obtain copies of your health information, with limited exceptions. You may request we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access. If you request copies, we will charge \$0.50 for each page and \$20.00 per hour for staff time to locate and copy your health information, and postage if you want the health information mailed to you. If you request an alternative format, we will charge a cost-based fee for providing health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure. Records pertaining to couples therapy can only be released with the permission of both partners.

Disclosure Accounting:

You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other operations, for the last 6 years, but not before November 1, 2006. If you request this accounting more than once in a 12- month period, we may charge you a reasonable, cost-based fee for reasonable, cost-based fee for responding to these additional requests.

Restrictions:

You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in an emergency.

Alternative Communication:

You have the right to request that we communicate with you about your health information by alternative means or alternative locations. You must make this request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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Amendment:

You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice:

If you receive this Notice on our website or by electronic mail (e-mail, digital, audio file), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about your access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer:

Tara Thomsen

Telephone: (402) 933-8998 Fax: (402) 933-9091

Address: 11060 Oak Street #2, Omaha NE 68144

Moving Forward Therapy Services LLC

Tara L. Thomsen, MS, LIMHP, LPC

I have been given a copy of Tara Thomsen's Client Orientation and Notice of Privacy Practices which covers topics including, but not limited to, treatment, financial procedures, healthcare operations, disclosure accounting, health information amendment, and concepts of confidentiality and privilege.

Child's Printed Name: _____

Child's Signature: (if over age 12)

_____ Date: _____

Parent's Printed Name: _____

Signature(s) below confirms receipt of the (above) listed information

Parent Signature(s) (or legal guardian)

_____ Date: _____