Great Oaks
COUNSELING LLC

FOR OFFICE USE ONLY:
Date:
ID #:
Provider:
EAP Authorization:

Client Information:

Last Name: _____ Date of Birth: _____

First Name: _____ M.I.____ Marital Status: _____

Address: _____ Social Security # _____

City/State/Zip: _____ Gender: Male ( ) Female ( )

I MAY CALL YOU AT: **Is it ok to leave a message at the following?**

		Yes	NO
Home Phone	_____	( )	( )
Cell Phone	_____	( )	( )
Work	_____	( )	( )
Email (optional)	_____	( )	( )

If you would have an emergency, who would you want contacted?

Name: _____ Relationship: _____

Phone Number: _____

IF CLIENT YOUNGER THAN 19 YEARS OLD:

Parent's Name(s): _____

If parents are separated/divorced, who is the custodial parent? Or check here if joint custody ( )

Name: _____

Address if not same as the client: _____

City/State/Zip: _____ Phone Number: _____

FINANCIALLY RESPONSIBLE PARTY
(if not client)

Name: _____
Address: _____
City/State/Zip: _____
Date of Birth: _____
Preferred Phone: _____
Social Security # _____
Relationship to Client: _____

Primary Card Holder:
Check here if same as Responsible Party ( )

Name: _____
Address: _____
City/State/Zip: _____
Date of Birth: _____
Preferred Phone:_____
Social Security # _____
Relationship to Client: _____

REFERRAL: Who referred you to Great Oaks Counseling, LLC? _____

May we thank who referred you? If yes, please initial here: _____

GREAT OAKS COUNSELING, LLC

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the Great Oaks Counseling Client Policies. I have had all my questions answered fully.

I do hereby seek and consent to take part treatment at Great Oaks Counseling. I understand that discussing treatment goals and regularly reviewing our work toward meeting those goals are in my best interest. I agree to play an active role in this process.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. For example, if my appointment is at 9am, I am aware that I need to call by 9 am the day prior to my scheduled appointment. If I do not cancel and do not attend the appointment, I may be charged a fee for that appointment.

I hereby authorize release of information by Great Oaks Counseling, LLC to my insurance company and also authorize my insurance benefits to be paid directly to Great Oaks Counseling, LLC for services rendered. I agree that I am financially responsible for all charges not covered by my insurance. Further, I grant release of all information in my file to Methodist Health Partners, a third party organization which contracts with certain insurance companies to provide for quality assurance in providers such as Great Oaks Counseling, LLC., for the purpose of record keeping audits. Further, I grant release of information to third parties involved in the billing and collection of fees for services rendered by Great Oaks Counseling, LLC sufficient to perform that function.

My signature below shows that I understand and agree with all of these statements.

Signature of Client Date

Signature of parent, legal guardian or power of attorney Date
(if Client is under the age of 19)

Printed name Relationship to Client

GREAT OAKS COUNSELING, LLC
CLIENT POLICIES

About Psychotherapy

Because you will be putting a good deal of time, money and energy into therapy, you should choose a therapist carefully. You should feel comfortable with the therapist you choose and hopeful about your work together. When you feel this way, therapy is more likely to be helpful to you.

The therapists at Great Oaks have a variety of methods in practicing therapy. They also have a variety of credentials, treatment styles and educational backgrounds. We encourage you to consult the Great Oaks web site or discuss in person the methods and credentials of the therapist with whom you wish to work.

Psychotherapy requires your best efforts to change thoughts, feelings, and behaviors. For example, your therapist will want you to tell about important experiences, what they mean to you, and what strong feelings are involved. This is one of the ways you are an active partner in therapy.

The Benefits and Risks of Therapy

The benefits of therapy have been shown by scientists in hundreds of well designed studies. People who are depressed may find their mood lifting. Others may no longer feel afraid, angry or anxious. In therapy, people have a chance to fully talk things out until their feelings are relieved or the problem solved. Clients' relationships and coping skills may improve greatly. They may get more satisfaction out of social and family relationships. They may grow in many directions- as individuals, in their relationships, in their work and in the ability to enjoy their lives.

As with any powerful treatment, there are some risks as well as many benefits with therapy. You should think about the benefits and risks when making any treatment decisions. For example, in therapy there is a risk that clients will, for a time, have uncomfortable levels of sadness, guilt, anxiety, anger or other unpleasant emotions. Also, clients in therapy may have problems with people important to them. Family secrets may be told, relationships may change. Sometimes, too, a client's problems may temporarily worsen after beginning treatment. Most of these risks are to be expected when people are making important changes in their lives. Finally even with our best efforts there is a risk that therapy may not work out well for you.

About Confidentiality and Ethics

It would be unethical for your therapist to have any other role in your life. He/She cannot be a close friend or socialize with any of his/her clients. He/she cannot be a therapist to someone who is already a friend. He/she can not have a romantic relationship with any client during, or after, the course of therapy. He/she cannot have a business relationship with clients, other than the therapy relationship.

Your therapist will treat with great care all the information you share with him/her. It is your legal right that your sessions and therapy records about you be kept private. That is why your therapist will ask you to sign a “release-of-records” form before he/she can talk about you or send their records about you to anyone else. In general, he/she will tell no one what you discuss with him/her. He/she will not even reveal that you are receiving treatment from Great Oaks Counseling, LLC.

In all but a few rare situations, your privacy is protected by state law and by the rules of the counseling profession. Here are the most common cases in which confidentiality ***is not*** protected:

1. If you were sent to therapy by a court or an employer for evaluation or treatment, the court or employer may expect a report from your therapist. Your therapist will be happy to discuss the reporting procedure if you request.

2. Are you suing someone or being sued? Are you being charged with a crime? If so, and you tell the court that you are seeing a therapist, your therapist may then be ordered to show the court his/her records. Please consult your lawyer about these issues.

3. If your therapist decides that you are a serious threat to yourself or to others, the law requires him/her to try to protect you or that other person. This usually means telling others about the potential threat. Your therapist cannot promise never to tell others about threats you make.

4. If your therapist believes a child or vulnerable adult (elderly or handicapped) has been or is being abused or neglected, he/she is legally required to report this to the authorities.

If the client being treated is a child under the age of majority (19 in Nebraska), you should know that the rules of confidentiality change somewhat. For example, parents and guardians have the legal right to general information, including how therapy is going and if the sessions are being attended. This would not require permission from the client.

In cases where families are being treated, or the therapist works individually with several members of the same family, the confidentially situation can become very complicated. Your therapist may have different duties to different family members. At the start of treatment your family members and your therapist must all have a clear understanding as to what the limits of confidentiality may be in your situation.

In cases where the client is a couple being seen with the goal of creating a healthier relationship, the rules of confidentiality change as well. If you tell your therapist something your partner/spouse does not know and not knowing this can harm them or the relationship, your therapist cannot promise to keep that information confidential. It may not be in your best interest or the best interest of your relationship to keep some information confidential. Your therapist will work with you to decide the best way to handle the situation.

If your records need to be seen by another professional (a psychiatrist or primary care doctor for example) or anyone else, you will need to sign a release form. This form states exactly what information is to be shared, with whom, and why, and it also sets time limits.

Client records are kept in a safe, secured and locked place as long as required by law. After that it is our policy to destroy client records.

If you choose to have insurance cover the cost of your sessions, there are some compromises to your confidentially. Insurance companies will sometimes ask for more information on symptoms, diagnoses and treatment methods. Your therapist's answers will become part of your permanent medical records. Please understand that your therapist has no control over how these records are handled at the insurance company. Great Oaks policy is to provide only as much information as the insurance company will need to pay your benefits. Please understand that this compromise of your privacy is the cost of having your insurance pay for your sessions.

About Our Appointments

You can expect that we will usually meet for a minimum of 45-minutes per session. **Please note, Great Oaks Counseling requires a 24 hour notice for canceled appointments. You (not your insurance company) may be charged a cancellation fee for sessions canceled with less than 24 hours notice**, for other than the most serious reasons. Your therapist, in turn, will afford you as much time as possible if he/she ever needs to cancel an appointment.

If thirty days pass and you have not successfully attended a session, then your file will be closed by your therapist. This simply means that you are no longer receiving our services or under our care. If you desire to return for treatment you can do so per mutual agreement with your therapist and your file can be reopened.

Fees, Payments, and Billing

Payment for services is an important part of any professional relationship.

Regular therapy services: If you choose to pay "out of pocket" for counseling services, please plan to pay for each session at your appointment check in. If you are utilizing your insurance benefits, your portion (or co-pay) is due at check in time as well.

Telephone consultations: Telephone consultations may be suitable or even needed at times in your therapy. If your therapist needs to have long telephone conferences with other professionals as part of your treatment, you will be billed for these at the same rate as for regular therapy services. If you are concerned about this, please be sure to discuss it with your therapist in advance so a policy can be set that is comfortable for both of you. Of course, there is no charge for calls about appointments or similar business. However, if the call lasts beyond 10 minutes you will likely be charged accordingly as insurance does not cover this service.

Email contact: Your therapist may use email as a means to communicate with clients between sessions. The type of communication that is appropriate consists of "business" topics including: insurance issues, changing, confirming or making appointments, arrangement of payment, etc. He/she will not conduct therapy/counseling over email/computer and any communications in this venue should not be construed as such unless specific arrangements are made and agreed to in advance.

Other services: Charges for other services, such as hospital visits, consultations with other therapists, or any court-related services (such as consultations with lawyers, depositions, or attendance at courtroom proceedings) will be based on the time involved in providing the service at our regular fee schedule.

Your agreed-upon fee-paying relationship with Great Oaks Counseling, LLC will continue as long as your therapist provides services to you. He/she will assume this until you tell them in person, by telephone, or by certified mail that you wish to terminate therapy services. You have a responsibility to pay for, or make arrangements for, fees you have incurred for any services you have received upon ending the therapeutic relationship.

If you think you may have trouble paying your bills on time, please discuss this with your therapist. Nonpayment may alter your ability to continue receiving therapy services. Fees that continue unpaid may be turned over to a collection service.

If there is any problem with charges, billing, insurance, or any other money-related issues, please bring it to your therapist's attention. He/She will do the same with you. Such problems can interfere greatly with our work. They must be worked out openly and quickly.

If You Need to Contact Me

Great Oaks Counseling does not have a 24 hour answering service and therefore your therapist may not be available at all times. You can always leave a message on his/her voice mail. Generally, calls are not returned on weekends or holidays. If you are the kind of person who feels they may need frequent contact between sessions, then you should discuss this with your therapist.

If I Need to Contact Someone about You

If there is an emergency during our work together, or your therapist becomes concerned about your personal safety, your therapist is required by law and by the rules of their profession to contact someone close to you—perhaps a relative, spouse, or close friend. They are also required to contact this person, or the authorities, if they become concerned about your harming someone else. This is why we asked for this information on your intake form.

Other Points

If you ever become involved in a divorce or custody dispute, your therapist may want you to understand and agree that they will not provide evaluations or expert testimony in court. You may be asked to hire a different mental health professional for any evaluations or testimony you require. This position is based on two reasons: (1) Your therapists' statements will be seen as biased in your favor because you have an ongoing therapy relationship; and (2) the testimony might affect your therapy relationship and your therapist must put this relationship first.

Complaint Procedures

Problems can arise in the relationship with your therapist, just as in any other relationship. If you are not satisfied with any area of work with your therapist, please raise your concerns with them at once. Your work together will be slower and harder if your concerns with them are not worked out. Your therapist will make every effort to hear any complaints you have and to seek solutions to them. If you feel that your therapist has treated you unfairly or has broken a professional rule, please talk to them about it.You can also contact the Nebraska State Department of Health and Human Services at 402-595-3400 and speak to someone in the ethics department, he or she can help clarify your concerns or tell you how to file a complaint.

Our Agreement

Your signature below indicates that you have read and discussed this agreement. If at any time during your treatment you have questions about any of the subjects discussed in this document, you can talk with your therapist about them, and he/she will do his/her best to answer them.

You understand that after therapy begins you have the right to withdraw your consent to therapy at any time, for any reason. However, you will make every effort to discuss your concerns about your progress with your therapist before ending therapy.

You understand that your therapist will treat you with professionalism, integrity and skill. Nonetheless, you understand that no specific promises have been made to you by your therapist about the results of treatment, the effectiveness of the procedures used by your therapist, or the number of sessions necessary for therapy to be effective.

I _____ hereby agree to enter into therapy (or to have the client enter therapy), and to cooperate to the best of my ability, as shown by my signature here.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent if Client is under age of 19 Date

_____ _____
Signature of therapist* Date

*My signature indicates that I have provided the opportunity to discuss questions or concerns about the policies of Great Oaks Counseling.

Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/Information

As part of your counseling healthcare here, a record will be made of each visit and any other important exchange of information on your behalf. This record may include your symptoms, diagnosis, treatment plan and other impressions. Your information is used by insurance companies to verify that the services billed were actually provided. Although your health record belongs to the healthcare provider, you do have certain rights with regard to your health information.

Your Rights:

- You have a right to expect that your health information will be kept secure and used only for legitimate purposes.
- You have a right to understand how your health information may be used and disclosed by Great Oaks Counseling, LLC
- You have a right to receive this privacy notice that tells you how your health information may be used or disclosed.
- You have a right to ask questions about any healthcare privacy issue and have those questions clearly and promptly answered.
- You have a (limited) right to know who has seen your health information, and for what purpose.
- You have a right to see, and to keep a copy of, all of your health records (except psychotherapy notes). Your request for a copy of your record must be in writing. We may charge you a reasonable, cost-based, copying fee.
- You have a right to ask for correction—or inclusion of a statement of disagreement—for anything in your records that you feel is in error. Your request must be in writing and include supporting documentation.
- You have a right to authorize—or refuse—additional uses of your health information, such as for fundraising, marketing, or research.
- You have a right to request extra protections for health information you consider especially sensitive, and to request that we communicate with you by alternative means.
-

Our Responsibilities:

We also have certain responsibilities. These include:

- Maintaining the privacy of your health record;
- Providing you with a copy of this Notice;
- Abiding by the terms of this Notice;
- Notifying you if we are unable to agree to a requested amendment or restriction; and
- Accommodating reasonable requests you may have to communicate health information by alternative means or at alternative locations.

If our information practices change, we may change this Notice. If we do so, the change will be effective for information gathered both before and after the effective date of such change. The effective date of our Notice will always appear at the end of the Notice.

We will not use or disclose your health information without your authorization, except as described in this Notice.

Disclosures for Treatment, Payment and Healthcare Operations:

We may use or disclose your information for treatment, payment, and healthcare operations without your permission. However, if state law requires us to obtain your written permission to use or disclose your health information for treatment, payment, or healthcare operations, we will do so.

We will use or disclose your health information for payment.
For example: We may send your bill to you or your insurance company. Your bill may contain information that identifies you, as well as your diagnosis, treatment plan and procedures. Further, your billing may be processed through a third party billing service and similar information may be disclosed to that service. This billing service must use appropriate safeguards to protect your health information.

Other Disclosures That May be Made Without Your Authorization:

Unless we are otherwise restricted from doing so, we may also use or disclose your information for the following purposes without your authorization:

Great Oaks Counseling, LLC: We may use your information to provide you with information regarding a health-related product or service provided by Great Oaks Counseling, LLC or information regarding your treatment of care, such as appointment reminders or information about treatment alternatives. In addition, your health information may be used in face-to-face encounters or to provide you with gifts of nominal value.

Workers Compensation: We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Specialized Governmental Functions: We may disclose your health information for military and veterans activities, national security and intelligence activities, and similar special governmental functions as required or permitted by law.

Correctional Institution: If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Notification: As permitted or required by law, we may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care about your location and general condition.

Law Enforcement: We may disclose your health information for law enforcement purposes as required or permitted by law or in response to a valid subpoena, court order or other binding authority.

Disclosures Required by Law: We may use or disclose your health information as required by law provided such use or disclosure complies with and is limited to the relevant requirements of such law. For example, this may include involvement in abuse, neglect, violence, or to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Health Oversight Agencies: We may disclose your health information to an appropriate health oversight agency, public health authority or attorney involved in health oversight activities.

Judicial and Administrative Proceedings: We may disclose your health information for judicial or administrative proceedings as required or permitted by law or in response to a valid subpoena, court order or other binding authority.

THIS NOTICE SERVES AS THE JOINT NOTICE OF PRIVACY PRACTICES FOR ALL COUNSELORS AT GREAT OAKS COUNSELING, LLC.

For More Information or to Report a Problem:

If you have questions or would like additional information, you may contact the Privacy Officer, Michael A. Harsh, LPC, at Great Oaks Counseling, LLC. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer, at 402-932-6500, or with the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

Effective Date: December 15, 2013

I acknowledge I have received a copy of this Privacy Notice:

_____

Signature

_____ _____

Please print your name Date

Great Oaks Counseling, LLC

Health History Form

NAME _____ DOB_____ AGE_____ Date Form Completed_____

Please fill out this form to the best of your knowledge. Information provided will be held in strictest confidence.

Why are you seeking services today? _____

_____

Have you ever been treated as an outpatient by a mental health therapist, psychologist, or psychiatrist?……. ☐Yes ☐ No

If yes, please list prior diagnosis, provider, and dates:_____

_____

Have you ever been treated in the following settings for mental health or alcohol / substance use problems?

(if yes, please provide dates and reason for treatment)

Inpatient Psychiatric Hospital: □ Yes □ No _____

_____

Partial Hospital / Day Treatment / Intensive Outpatient: □ Yes □ No _____

Rehabilitation Center: □ Yes □ No _____

Residential Treatment Facility: □ Yes □ No _____

LIST CURRENT MEDICATIONS AND OVER THE COUNTER SUPPLEMENTS

Medication	Dosage	Date Began	Reason Prescribed

LIST ANY MEDICATION ALLERGIES OR SENSITIVITIES: _____

List any medical conditions you have been diagnosed with or suffered from, including high blood pressure, elevated cholesterol, diabetes, thyroid condition, seizures, head injury, or migraines, etc, if applicable:_____

_____

_____

List any significant surgeries and/or hospitalizations for a medical reason you have had in the last five years:_____

_____

Please list any FAMILY HISTORY of mental health disorders? _____

_____

In regard to your safety, do you have access to weapons? □ Yes □ No

Have you ever been abused or experienced significant trauma? □ Yes □ No

Have you ever been a regular user of tobacco products? □Yes □ No ; Do you currently use tobacco products? □Yes □ No

Have you ever been a regular user of cannabis? □Yes □ No ; Do you currently use cannabis? □Yes □ No

Categorize your alcohol consumption? □Never □ Rare □ Social □ Frequent □ In Recovery

Currently, or in the past, have you ever considered yourself to have a problem with any of the following? □Yes □ No

If yes, please circle:	Alcohol	Marijuana	Inhalants (glue, gas, duster…)
Pain Pills (oxy, codeine, etc)	PCP	Amphetamines	Cocaine
Over the counter pills	Sleeping Pills	LSD, Mescaline, Hallucinogens	Solvents (rubbing alcohol…)
Opiates, Heroin Morphine…	Barbiturates or Sedatives	Tranquilizers (valium, xanax…)	Other: _____

(TURN PAGE OVER)

Have you ever been prescribed the following medications? (please circle)

Prozac / Fluoxetine	Celexa / Citalopram	Lexapro / Escitalopram	Zoloft / Sertraline	Paxil / Paroxetine	Effexor / Venlafaxine	Cymbalta / Duloxetine
Luvox / Fluvoxamine	Viibryd / Vilazodone	Remeron / Mirtazaline	Wellbutrin / Bupropion	Desyrel / Trazodone	Pristiq / Desvenlafaxine	Nardil / Phenelzine
Pamelor / Nortriptyline	Elavil / Amitriptyline	Fetzima / Milnacipran	Trintellix / Vortioxetine	Emsam / Selegiline	Marplan / Isocarboxazid	Parnate / Tranylcypromine
Anafranil / Clomipramine		Imipramine				

Lithium	Carbamazepine / Tegretol	Oxcarbamazepine / Trileptal	Lamictal / Lamotrigine	Depakote / Valprioc Acid	Prolixin / Fluphenazine	Mellaril / Thioridazine
Abilify Aripiprazole	Seroquel / Quitiapine	Invega / Paliperidone	Risperdal/ Risperidone	Olanzapine / Zyprexa	Vraylar / Cariprazine	Geodon / Ziprasidone
Saphris / Asenapine	Clozaril / Clozapine	Latuda / Lurasidone	Rexulti / Brexpiprazole	Holdol / Haloperidol	Chlorpromazine / Thorazine	Orap / Pimozine

Valium / Diazepam	Klonopin / Clonazepam	Ativan / Lorazepam	Xanax / Alprazolam	Librium	Atarax / Hydroxyzine	Melatonin
Ambien / Zolpidem	Lunesta	Rozarem	Belsomra	Sonata	Restoril / Temazepam	Triazolam

Strattera	Ritalin / Methylphenidate	Focalin	Concerta	Adderall	Vyvanse	
Clonidine	Guanfacine/ Intuniv		Cylert	Metadate		

Campral / Acamprosate	Antabuse / Disulfiram	Naltrexone / Revia / Vivitrol	Methadone	Buprenorphine+noloxone / Suboxone

From the following list, mark each item which has concerned you in the past month with a rating of severity	NONE	MILD	MODERATE	SEVERE		NONE	MILD	MODERATE	SEVERE
Unable to concentrate					Phobias				
Feeling mind play tricks					Forgetfulness/memory problems				
Thoughts racing					Anger				
Restless/unable to sit still					Verbal fighting with others				
Too much energy					Worried about your weight or appearance				
Anxious or nervous					Compulsions				
Sad or depressed					Obsessions				
Crying spells					Loss of interests				
Gambling					Thoughts of suicide				
Thoughts of harming others					Physical fighting with others				
Stealing					Self-mutilator				
Tension					Defies authority				
Lying					Extreme sibling rivalry				
Social withdrawal					Fire setting				
Destruction of property					Overly sensitive				
Truancy					Sexual acting out				
Overly dependent					Runaway history				
Cruelty to people					Shyness				
Do you see things other people do not see?					Do you think people are spying on you?				
Cruelty to animals					Mood swings				
Bed-wetting					Soiling problems				
Do you hear voices when no one is there?					Sexual problems				
Trouble with sleep					Low energy				

SIGNATURE: _____ DATE: _____