Great Oaks Counseling, LLC
13906 Gold Circle, Suite 202
Omaha, NE 68144

Client Information:

Last Name:_____ Date of Birth:_____

First Name: _____ Marital Status:_____

Address:_____ Social Security# _____

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

Home Phone:_____ Banking Institution:_____

Cell Phone:_____ Employer:_____

Work Phone:_____ Employer Address:_____

Email:_____

Spouse, Parent, Other relationship to patient_____

Name:_____ DOB:_____

Address:_____ City:_____State:_____Zip:_____

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

Name:_____ Relationship:_____

Phone number:_____

If client is a minor or has a legal representative/guardian

Name:_____ Relationship:_____

Phone number:_____

Financially Responsible Party Check here if you are 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?_____

Great Oaks Counseling, LLC
13906 Gold Circle, Ste. 202
Omaha, NE 68144

CONSENT FOR TREATMENT

I hereby authorize my provider at Great Oaks Counseling to conduct an evaluation and provide services for myself and/or the person under my legal guardianship with regard to psychiatric or behavioral health problems. These services may include medication, psychotherapy, laboratory tests, diagnostic procedures and other appropriate alternative therapies.

I understand that I have the right to be informed of and participate in the selection of treatment modalities, receive a copy of this consent, and to withdraw this consent at any time to the extent that my providers have taken action in reliance upon this consent. I acknowledge that no guarantees have been made as to the result of treatments or evaluations.

CLIENT POLICIES AND CONDITIONS OF TREATMENT

Financial Responsibility: I understand that I am financially responsible for all charges incurred for services received from my provider, regardless of insurance coverage. This includes, but is not limited to charges that are denied by my insurer, charges for non-covered services (as listed below), and fees for no-show or late cancellation appointments. I understand that it is my responsibility to understand my mental health benefits and insurance network. I agree to supply all insurance information at or before my first appointment, and in a timely manner agree to notify the office of any change of address, guarantor status, employment or insurance coverage thereafter.

I understand that Great Oaks Counseling, LLC is contractually obligated to collect any copay or coinsurance at the time of service. If I have not met my deductible, I understand that I will be charged the full visit fee at the time of service.

I understand that if insurance is not being filed, or if I am not able to use in-network insurance benefits, the full session fee is due at the time of service. I understand that any account balance is due in full at my next appointment, or within 30 days of my statement date, whichever occurs first. I further understand that it is the financial policy of your provider to refer any account over 90 days in arrears to a professional collection agency.

Release of Information: I have been informed that my insurance company may request copies of my medical records in order to make payment or authorize further visits. My signature below gives my permission to release this information when requested. Further, I grant release of my information 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. Furthermore, Great Oaks Counseling, LLC may disclose my name, demographic and insurance information and/or financial record to third parties involved in the billing and collection of fees for services rendered by Great Oaks Counseling, LLC sufficient to perform that function.

Assignment of Benefits: I understand that if my provider is contracted with my insurance plan, or is otherwise able to accept assignment of my insurance benefits, that Great Oaks Counseling, LLC will file claims with my insurance company as a courtesy to me. In this circumstance, I hereby assign all benefits otherwise payable to me to Great Oaks Counseling, LLC as payment toward the balance due for psychiatric services rendered to me.

I understand that if I have an out of network insurance plan, my provider may not accept assignment of my insurance benefits. Instead, I will be provided with a superbill (receipt for services) and given information about how to personally submit the out of network claim for any reimbursement due to me.

Payment: I understand that I may pay via cash, check, debit or credit card in person, by mail or over the phone. I understand that petty cash is not available to make change. I understand that I can leave a secure credit card on file with my provider. I understand that checks returned for lack of funds (NSF) will be subject to a $35 administration fee.

Missed appointments and cancellation policy: Appointment reminder calls are provided to me as a courtesy, however, I understand that it remains my responsibility to remember the time and date of my appointment.

I understand that a 'late cancellation' fee of $75 is charged for all appointments cancelled with less than 24 hours advanced notice. I understand that a 'no show' fee of $100 is charged for appointments that were not attended, where no notice of cancellation was given prior to the scheduled appointment time. I understand that if I arrive late to my appointment (exceeding 10 minutes), I will be rescheduled and a late cancellation fee assessed.

I understand that I may be discharged from my provider's care after three missed or late cancellation appointments.

Prescriptions: I understand that I should contact my pharmacy directly to request refills of prescriptions and that the pharmacy will contact my provider for approval. I will allow 3 business days for approval of prescriptions. I understand that changes in medication or addition of new medications requires an appointment. I understand that I must follow up with my provider at recommended intervals to be eligible for prescription refills.

Phone calls: I understand that Great Oaks Counseling, LLC does not have a 24-hour answering service and therefore my provider may not be available at all times. I understand that I can leave a voicemail for my provider at any time, but that calls are not generally returned on weekends or holidays. I understand that my provider will attempt to respond to all requests for return communication within 2 business days.

I understand it may be necessary for the office to contact me. I consent to allow my provider, a covering provider, or administrative staff to utilize the phone numbers and/or email addresses I provide on the patient demographic sheet to leave me a discreet message on my answering machine, voicemail, text or email. I agree to hold these persons harmless for all such disclosures in compliance with this policy. I understand that I can notify my provider in writing of any request to restrict or limit the means by which the office communicates with me so that they can best meet my privacy and communication preferences.

I understand that in the case of a psychiatric emergency requiring IMMEDIATE attention, regardless of time and date, that I should go to the nearest hospital emergency department or call 911.

Non-Covered Services may incur an additional charge, including, but not limited to:
-Paperwork: letters, reports, FMLA, disability, or other forms not completed during a visit. Minimum fee: -$25.00.
-Phone calls requiring extensive counseling. Most medication management services will require an appointment.
-Court ordered and legal related services. - Duplication of your medical records.

Office Closures: In the case of inclement weather, our office will typically be closed if Millard Public Schools are closed. Please call the office and listen to your providers voice message for information in the case of inclement weather.

Recordings: I understand that recording of patient sessions is NOT allowed.

_____

My signature below indicates that I have read and fully understood this two-page document which includes my consent for treatment, financial responsibility, release of information and understanding of office policies. I acknowledge that I was given a copy of the Great Oaks Counseling LLC Notice of Health Information (Privacy) Practices.

Patient Name (print)_____ Date of Birth_____

Signature of Patient or Legal Representative: _____ Date _____

Name of Legal Representative if different than Patient Name (print) _____

State Legal Representative's Relationship and Authority Over the Patient _____

Great Oaks
COUNSELING LLC

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

Please Keep This Copy For Your Files

Privacy Notice

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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.

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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: _____