BEHAVIORAL PEDIATRIC AND FAMILY THERAPY PROGRAM

Account # _____

Patient Last Name | First | MI | Birthdate | Gender

Street Address/Apt # | City | State | Zip | Best Contact Phone

Only a patient or his/her legal guardian can be the responsible party unless someone else gives their written consent

RESPONSIBLE PARTY'S NAME_____
Last Name First MI

Birthdate _____ SSN _____

Address _____ City _____ State _____ Zip _____

E-Mail Address _____ Employer Name _____

Cellular Phone _____ Work Phone _____ Home Phone _____

SPOUSE or
OTHER PARENT _____Birthdate _____

Address _____ City _____ State _____ Zip _____

Employer _____ Cellular Phone _____ Work Phone _____

OTHER _____ Birthdate _____
(partner, noncustodial parent, step-parent, or foster parent, etc.)

Address _____ City _____ State _____ Zip _____ Home Phone _____

Employer _____ Cellular Phone _____ Work Phone _____

Emergency Contact other than parent or spouse
Name _____ Relationship _____ Phone _____

PRIMARY INSURANCE COMPANY
Insurance Company _____

Name of Policy Holder _____

Member ID Number _____

Group Number (if any) _____

SECONDARY INSURANCE COMPANY
Insurance Company _____

Name of Policy Holder _____

Member ID Number _____

Group Number (if any) _____

LIST ALL SIBLINGS OR CHILDREN OF PATIENT STARTING WITH FIRST BORN

NAME	BIRTHDATE	SEX	DIAGNOSIS (FOR OFFICE USE ONLY)

I hereby authorize Behavioral Pediatric and Family Therapy Program to release any information acquired in the course of treatment to my insurance carrier. This authorization shall remain valid until written notice is given by me revoking said authorization. I further authorize payments directly to the psychologist/therapist. Pursuant to any applicable provider relations' agreement, I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Signature _____ Date _____

Behavioral Pediatric & Family Therapy Program
Office Policy

The information in this packet is provided to assure that you have a full understanding of our office policies. Please read this carefully, ask any questions you may have, and sign where indicated. The following signatures must be secured before you can be treated in our clinic.

Financial Agreements and Authorizations for Treatment

I authorize treatment for the named person and agree to pay all fees for such treatment. I agree to pay for members of my family and for myself at the time of service unless other credit arrangements are agreed upon in writing. Charges shown on statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date.

Your signature below indicates you have received and read the information included on the following pages regarding the Behavioral Pediatric and Family Therapy Program office policies, informed consent and confidentiality statement and agree to abide by the stated terms during our professional relationship. Please read and review the following pages and keep them for your reference. Thank you for your attention to these matters.

_____ _____ _____

(Patient Name) (Signature of Parent or Guardian) (Date)

Confirmation Telephone Calls

It is our practice to remind you of an upcoming scheduled appointment. Please respond to the following questions related to these automated contacts:

Please choose **ONE**: ❑ Call ❑ Text ❑ E-Mail ❑ No reminder

(Note: If no option is selected, a reminder will be made via automated telephone call)

Telephone number for reminder calls _____

Telephone number for reminder text messages _____

E-Mail address for reminder e-mails _____

Communication with Physician

In order to provide the highest level of care, we request permission to release relevant aspects of the patient's case to the primary care physician and/or medication prescriber. Please complete the following and checkmark the appropriate choice. If you have any questions, please discuss them with your physician or therapist.

_____

(Patient's Primary Care Physician Name)

❑ Yes, you may release relevant aspects of the patient's case to the physician named above.
(PLEASE COMPLETE RELEASE OF INFORMATION FORM)

❑ No, I do not want the patient's case released to the physician, pediatrician, or medication prescriber.

Behavioral Pediatric & Family Therapy Program

Client Consent Form

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you as described in our Notice of Privacy Practices. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

_____	_____	_____
Patient Name	Signature of Patient or Legal Guardian	Date

Behavioral Pediatric & Family Therapy Program
Office Policies and Informed Consent

The information in this document is provided to assure that you have a full understanding of our office policies. Please read carefully, initial each section, and sign the bottom of page 3.

_____ Fees

If you have eligible health insurance, we will submit the following charges to your insurance company:
Fee for the initial diagnostic session is **$345.00**. Fee for each subsequent therapy session is **$280.00**. An additional **$30.00** fee may be added to sessions that meet national current procedural terminology criterion for complex sessions. Fee for school meetings and observation is **$280.00**. Fees for testing and evaluation are **$275.00** for the first hour and **$220.00** for each subsequent hour. Testing time may include direct patient contact plus administrative time (e.g., scoring, interpretation, report writing, etc.). Provider-directed telephone calls regarding patients are typically included as a part of the fees for therapy or assessment with your providers, unless other arrangements are made with the provider.

If, for any reason, your provider is required to speak with attorneys or appear in court, reimbursement is expected from the party responsible for the provider's participation. Your insurance carrier will not pay for these charges. The rate is $**275.00** per hour for review of records, preparing letters/reports, and phone calls. The rate is **$440.00** per hour for a deposition or court testimony, including travel time. If you have any questions about fees for your sessions, please discuss these with your provider.

_____ Additional Paperwork

It is your responsibility to notify our office as soon as possible of any changes in insurance, address, or telephone numbers. You will be expected to complete updated paperwork when there has been a break in services for six months or longer.

_____ Payment Policy

Our policy requires payment in full at the time services are rendered unless other arrangements have been made in advance. If you have arranged a payment plan with our billing office, we ask that your balance not exceed **$280.00**. If this should occur, you will be asked to pay your balance in full, or at least a large percentage, before any additional appointments are scheduled. Unpaid balances of 90 days or longer may be assessed a re-billing charge of 1% per month until the balance is paid. If no payment is received within a reasonable period of time, we reserve the right to begin collection procedures.

Please note, the individual who initiates therapy is responsible for payment and will receive billing notices from our office. Nebraska law indicates that the custodial parent has ultimate financial responsibility for payment regardless of the divorce decree. This individual, not our office, is responsible for settling any financial obligations with the noncustodial parent.

_____ Insurance

Pursuant to any applicable provider relations agreement, your insurance is a contract between you and your insurance company. Your account with this office is your responsibility. Insurance cannot be filed without the signature of the responsible party on our initial paperwork. Please contact your health insurance carrier if you have questions regarding your insurance coverage. Payment of account balances will be requested at the time of check in.

_____ Cancellations / Missed Appointments

We understand that, at times, it may be necessary to cancel an appointment. To help us schedule our time most efficiently, we ask that any changes or cancellations be made at least 24 hours in advance. If cancellations are not made at least 24 hours in advance, or if an appointment is missed without a call, **you may be subject to a $30.00 fee.** This fee is your responsibility and is not covered by your insurance policy. If a pattern of missed appointments with late or no notice develops, further sessions with your provider may be declined and referral to a different group recommended.

_____ Evaluations / Home Visits / School Meetings and Observations

Fees for psychological and neuropsychological testing and school evaluations will vary and may not be covered by your insurance policy. If you do not fully understand what fees will be incurred, please discuss this issue with your psychologist. Fees for home visits, school meetings, and observations are determined by the amount of time spent in the home or school, as well as distance traveled. Payment of these fees is your responsibility if these services are not covered by your insurance company.

_____ Child Psychotherapy with Separated / Divorced Parents

Unless a parent/legal guardian has sole legal/medical custody (our office requires a copy of the custody agreement), both parents/legal guardians must consent to treatment in order for your child to be seen in our clinic. Psychotherapy for children when parents are separated or divorced can present unique circumstances. Psychotherapy is most successful when parents are involved in the therapy process. The best outcomes occur when the provider has a working relationship with both parents built upon collaboration and a desire to promote your child's best interest. The provider will work with each parent to achieve successful co-parenting, as this is one of the best predictors of children's adjustment and psychological health when parents are separated or divorced. It is not a provider's role to provide custody evaluations or opinions about parental fitness. Your provider will discourage the release of your child's mental health records to your attorneys. Please inform your attorneys not to subponena your child's provider or child's mental health records. Any requests for release of information to either parents or a third party must be signed by both parents. If there is a court-appointed evaluator, your provider will provide the evaluator with general information about your child, but will not include opinions about custody or parental fitness.

_____ Minors and Parents

Patients under 19 years of age who are not emancipated should be aware that the law may allow parents to examine their child's treatment records. Because privacy in therapy is often crucial to successful progress, your provider will provide only general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Before giving parents any information, your provider will discuss the matter with the child and do his/her best to handle any objections he/she may have. Any other communication will require the child's authorization, unless your provider feels the child is in danger or is a danger to someone else, in which case, your provider will notify the parents of their concerns.

_____ Records

Our office is required to maintain records for seven (7) years following the discontinuation of services, or for seven (7) years past the age of majority (19 years) in Nebraska.

_____ Confidentiality

In general, the confidentiality of all communications between a patient and provider is protected by law, and your provider can only release information about our work to others with your written permission. However, there are a number of exceptions.

In most judicial proceedings, you have the right to prevent your provider from providing information about your treatment. However, in some circumstances, such as child custody proceedings and proceedings where your emotional condition is an important element, a judge may require your provider to testify if he/she determines that resolution of the issues before him/her demands it.

There are some situations in which your provider is legally required to take action to protect others from harm, even though revealing some information about a patient's treatment. For example, if your provider believes that a child, an elderly person, or a person with a disability is being abused, he/she may be required to file a report with the appropriate state agency. If your provider believes that a patient is threatening serious bodily harm to another, he/she may be required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a patient threatens to harm him/herself, your provider may be required to seek hospitalization for the patient, notify police, or to contact family members or others who can help provide protection. These situations rarely occur. However, if such a situation develops, your provider will make every effort to fully discuss it with you before taking action.

You should be aware that, pursuant to HIPAA, your provider keeps Protected Health Information about you/your child as part of their professional records. It includes information about you/your child's reasons for seeking therapy, a description of the ways in which you/your child's problem impacts on your life, diagnosis, treatment goals, progress toward these goals, medical and social history, treatment history, past treatment records (if applicable), professional consultations, billing records and any reports or requests that have been sent to anyone, including reports to your insurance carrier.

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that your record be amended; requesting restriction on what information from your Clinical Records is disclosed to others, requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policy and procedures. The Office is also required by HIPAA to inform you if we become aware of or suspect a breach of your Protected Health Information.

Your provider may occasionally find it helpful to consult about a case with other professionals. In these consultations, he/she will make every effort to avoid revealing the identity of the patient. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, your provider will not tell you about these consultations unless he/she feels it is important to your work together. Providers for the Behavioral Pediatric and Family Therapy Program are independent providers and share no joint liability.

_____ Risk Assessment

You should be aware that your contract with your insurance company requires that we provide it with information relevant to the services that we provide to your child and/or you. We are required to provide a clinical diagnosis. Sometimes, we are required to provide additional clinical information, such as treatment plans or summaries, or copies of your entire clinical record. By signing this Agreement, you agree that we can provide requested information to your insurance carrier.

_____ Communication via Text Message

You should be aware that text messages are not HIPAA-compliant; therefore, your provider will not respond to a text message sent to his/her cellular telephone.

While this written summary of policies and exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns with your provider. The laws governing these issues are quite complex and your provider is not an attorney. While he/she may be happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable. If you request, your provider will provide you with relevant portions of summaries of the applicable state laws governing these issues.

By signing below, you indicate that you have read, understand, and agree to comply with the policies described above. You are also consenting to treatment and acknowledge that you have received consent (either verbally or in writing) from the noncustodial parent/legal guardian.

_____

Patient Name

_____ _____

Signature Date

Behavioral Pediatric & Family Therapy Program
Adult Family Inventory

Name _____ Telephone _____ DOB _____

Address _____ Marital Status _____ Age _____

Employment _____ Position _____

Work Phone _____ Length of Employment _____ Work Hours _____

Education Completed _____ Where _____

Partner's Name _____Telephone _____ DOB _____

Address _____ Marital Status _____ Age _____

Employment _____ Position _____

Work Phone _____ Length of Employment _____ Work Hours _____

Education Completed _____ Where _____

Names of Children/Step-Children DOB Age School Attended Grade

_____

_____

_____

Have you (or spouse) even been involved in therapy or any other type of counseling program?
Yes ____ No ____

If Yes, When _____ Where _____

Reasons _____

_____

Reasons for considering counseling at this time _____

_____

_____

Who referred you?_____

(Continued on back)

Are you currently taking a psychiatric medication? Yes _____ No _____

If yes, list medication, dosage, and start date _____

_____

Name of physician _____

Have you ever been hospitalized for any mental health reasons? Yes _____ No _____

If yes, When? _____ Where? _____

Have you ever, or are you now being treated for any type of chemical dependency abuse?
Yes _____ No _____

If yes, When? _____Where? _____ Length of treatment _____

Did you participate in follow-up counseling? Yes ____ No ____ With Whom? _____

Are you presently under a physician's care for physical health problems? Yes _____ No _____

If yes, please list conditions and any medications _____

_____

Name of Family Physician _____

Address _____ Telephone _____

Have you ever been arrested and/or commited a crime? Yes _____ No _____

If yes, When _____ Please describe _____

Outcome of situation _____

Please list anyone else with whom you presently live (other than partner or children):

_____ _____

_____ _____

If need be, would other relatives be willing to come to therapy sessions? Yes _____ No _____

If no, please indicate reason _____