***Initial Health History Packet***

***Filling out this packet***

* Completing this paperwork will help Leta understand your background to best help you.
* If you need help filling out any of these forms:
	+ Bring the form(s) with you to your first appointment and Leta will help you complete the form(s). Remember to fill out the front and back page of each form.

***Bring to your appointment****:*

* This Initial Health History Packet and any other important medical records
* Your insurance card/information and your co-payment (if applicable) to ***EVERY*** appointment
* Billing questions need to be addressed with our office manager, our receptionist does not handle the billing issues, she only collects co-pays

The office is located at 407 Black Hills Ave., located in the Alliance Physical Therapy building. Our office hours are Monday thru Wednesday 8 am to 5pm. We are closed daily from noon to 1pm for lunch. We are closed for all major holidays. If you call outside of our regular business hours, please leave a message with your name, the reason for your call, and a contact number and we will get back to you the next business day. Due to the nature of our business your call may not be returned immediately but will be returned the therapists’ earliest convenience. Our office staff strives to provide you with a positive experience outside of the therapeutic setting, it is important that you bring your co-payment with you and that you treat all office staff with the same respect that you expect. Thank you.

**Parents/Legal Guardians:**

It is imperative that ***you*** or an adult you appoint to bring your child(ren) to their counseling sessions. It is against policy for children to attend counseling without a parent/guardian or adult. It is also important to remember that your involvement in their therapy will provide success and to teach them the necessary tools for support system building and maintaining.

If your child arrives at the Fair Winds Counseling office without an adult, or should an adult **not** remain in the waiting room during your child’s session, that session will be rescheduled, and you will be charged an appropriate fee. Your insurance does not cover these fees, so this will be billed to you.

Thank you.

Leta Voigt

 **Fair Winds Counseling Intake Form**

**Note: This information is confidential.**

**Demographic Information:**

|  |  |
| --- | --- |
| Name:  | Date:  |
| Date of Birth:  | Relationship Status:  |
| Age: | SSN: |
| # of Dependents: | Gender: M / F  |
| Home/Mobile Phone:  | Is it ok to leave a message for you at this number? Y / N |
| Work Phone:  | Is it ok to leave a message for you at this number? Y / N |
| Email:  | Is it ok to email you? Y / N  |
| Mailing Address:  |  |
| Current Employer: | Position Title:  |
| Current Occupational Status: (i.e., F/T, P/T, self-employed, student, returning to work): |
| Emergency Contact Name: | Emergency Contact Phone: |
| ER Contact Relationship:  |  |
| **Primary Insurance:** | ID #: |
| Subscriber Name: | Group #: |
| Insurance Phone: | Subscriber DOB: |
| Subscriber Address: | City, State, Zip |
| Emergency Contact:What is your primary language? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you speak any other languages? Yes NoRace: African American Caucasian Hispanic Native American Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Religious preference: Atheist Catholic Christian No Preference Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you a ward of the state? Yes, No If Yes, who is your case worker? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you have Medicare? Yes, No If yes, what is your Medicare ID number? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you have Medicaid? Yes, No If yes, what is your Medicaid ID number? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you have insurance Coverage? Yes No | Subscriber SSN#: |

|  |  |
| --- | --- |
| **Secondary Insurance:**  | ID #: |
| Subscriber Name:  | Group #: |
| Insurance Phone:  | Subscriber DOB:  |
| Emergency Contact Name:  | Subscriber SSN:  |
| ER Contact Relationship:  | Emergency Contact Phone: |
| Subscriber Address:  | City, State, Zip:  |
| Subscriber Phone:  | Alternate Phone: |

**Current Concerns:**

What concern brings you in?

When did this concern begin (give dates)?

Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of this concern:

Are you having any difficulties/stressors in your current job? If so, please briefly describe those difficulties.

What do you hope to accomplish in counseling?

What kind of obstacles could get in the way?

Have you been in therapy before or received any prior professional assistance for your concerns? If so, please give name of provider, dates of treatments and results:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***IF YOU DO NOT HAVE INSURANCE COVERAGE, PLEASE ANSWER THE FOLLOWING QUESTIONS***

1. Do you or have you ever lived or worked on a farm or a ranch? Yes No

1. What is your annual household income? $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* We do offer discounted service fees based upon your household income, be prepared to provide proof of income (tax returns, or other proof of income) upon request.

**PAYMENT AGREEMENT**

If you do not have insurance coverage your account is considered “Self-Pay” and you are responsible for all charges. Late payments or a lack of payment on your account ***may*** result in additional late fees, finance charges, refusal of services, and possible collection charges being assessed to your account.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am aware that since I have not provided insurance information, I am responsible for all charges on my account. I understand that my signature on this form makes it a binding contract and I agree to the terms listed above. I also understand that if my circumstances change (i.e., income changes, obtain insurance coverage, get disability, etc.) that this contract can be renegotiated if I present proper documentation (i.e., tax return, copy of insurance card, etc.) to the office in a timely manner. Any changes to this contract must be signed by both myself and either Leta Voigt or a member of her office staff.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient (or Guardian) Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Member Signature Date

FOR OFFICE USE ONLY:

Pt. Income level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fee for Intake: \_\_\_\_\_\_\_\_\_\_\_\_\_ Fee for follow-up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Behavior – circle any of the following behaviors that apply to you:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Overeat | Suicidal attempts | Cannot keep a job | Take drugs | Compulsions |
| Insomnia | Vomiting | Smoke | Take too many risks | Odd behavior |
| Withdrawal | Lack of motivation | Drink too much | Nervous tics | Eating problems |
| Work too hard | Procrastination | Sleep disturbance | Crying | Impulsive reactions |
| Phobic avoidance | Outbursts of temper | Loss of control | Aggressive behavior | Concentration difficulties |

Are there any specific behaviors, actions, habits that you would like to change?

**Feelings – circle any of the following feelings that apply to you:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Angry | Guilty | Unhappy | Annoyed | Happy | Bored | Sad |
| Conflicted | Restless | Depressed | Regretful | Lonely | Anxious | Hopeless |
| Contented | Fearful | Hopeful | Excited | Panicky | Helpless | Optimistic |
| Energetic | Relaxed | Tense | Envious | Jealous | Others: |  |

**Physical – circle any of the following symptoms that apply to you:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Headaches | Stomach trouble | Skin problems | Dizziness | Tics |
| Dry mouth | Palpitations | Fatigue | Burning or itchy skin | Muscle spasms |
| Twitches | Chest pains | Tension | Back pain | Rapid heartbeat |
| Sexual disturbances | Tremors | Unable to relax | Fainting spells | Blackouts |
| Bowel disturbances | Hear things | Excessive sweating | Tingling | Watery eyes |
| Visual disturbances | Numbness | Flushes | Hearing problems | Do not like being touched |

**Biological Factors:**

Do you have any current concerns about your physical health? Please specify:

Please list medicines you are currently taking, or have taken during the past 6 months (include any medicines that were prescribed or taken over the counter):

Do you get regular exercise? If so, what type and how often?

**Check any of the following that apply to you:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Never** | **Rarely** | **Frequently** | **Very Often** |  | **Never** | **Rarely** | **Frequently** | **Very Often** |
| Marijuana |  |  |  |  | Heart problems |  |  |  |  |
| Tranquilizers |  |  |  |  | Nausea |  |  |  |  |
| Sedatives |  |  |  |  | Vomiting |  |  |  |  |
| Aspirin |  |  |  |  | Insomnia |  |  |  |  |
| Cocaine |  |  |  |  | Headaches |  |  |  |  |
| Painkillers |  |  |  |  | Backaches |  |  |  |  |
| Alcohol |  |  |  |  | Early morning awakening |  |  |  |  |
| Coffee |  |  |  |  | Fitful sleep |  |  |  |  |
| Cigarettes |  |  |  |  | Binge / Purge |  |  |  |  |
| Narcotics |  |  |  |  | Poor appetite |  |  |  |  |
| Stimulants |  |  |  |  | Eat “junk foods” |  |  |  |  |
| Hallucinogens |  |  |  |  | Lack of interest in activities  |  |  |  |  |
| Diarrhea |  |  |  |  | Constipation |  |  |  |  |
| Compulsive Exercise |  |  |  |  | High blood pressure |  |  |  |  |
| Use Laxatives |  |  |  |  | Allergies |  |  |  |  |

**Counseling Service Agreement**

Please be aware that this Agreement will be in effect for one year from the date of signing unless you specifically request that it remain in effect for a shorter time.

**Introduction**

Our first few visits/sessions will involve a discussion of your needs. By the end of the discussion, we will be able to offer you some first impressions of what we will cover in counseling and a treatment plan will begin to be developed. We will schedule visits/sessions at times that work for you and your needs. If you have any questions about this, please speak with me.

**Contacting Fair Winds Counseling**

When I am unavailable, my office telephone (308) 761-1519 is answered by our office manager or voicemail that I monitor frequently. I will make every effort to return your call on the same day that you made it, except for weekends and holidays. If you are difficult to reach, please inform me of sometimes when you will be available. You can also reach us at fairwindscounseling@gmail.com . In emergencies, contact your family physician or the nearest emergency room and ask for the psychologist and/or psychiatrist on call.

**Limits on Confidentiality**

The law and/or Board of Psychology protect the privacy of all communications between a patient and a psychologist, therapist, and/or counselor. In most situations, **we can** **only release information about your treatment to others if you sign this written Authorization form that meets certain legal requirements imposed by the Health Insurance Portability and Accountability Act (HIPAA).** A separate HIPAA form will also be given to you for your consent and signature.

**Client’s Bill of Rights**

You have the right to privacy. The counseling relationship is confidential and no information you disclose in a counseling session will be given out without your written consent. State law and ethical standards of psychology mandate the following exceptions:

1. If there is a clear and imminent danger to an individual or to society, your therapist must inform appropriate individuals
2. If there is suspected or confirmed abuse of children or vulnerable adults, your therapist must report it to the appropriate state agencies
3. If a record is court ordered by proper legal authority, your therapist must submit that record
4. If you are a minor, your therapist may be obligated to share some information about you with your parent(s) or legal guardian. You will be informed about all such disclosures
5. You have the right to see all the records about yourself. Your therapist will be available to assist you in explaining written material and to answer your questions.

You have the right to be free from discrimination based on race, religion, gender, sexual preference, age, or any other legally designated category while receiving counseling services.

You have the right to expect courteous treatment and to be free from verbal, physical, or sexual abuse by your therapist.

You have the right to assert these rights without retaliation.

**Grievance**

A grievance under this procedure is a claim brought by any client that there has been a complaint about the service provided by Fair Winds Counseling. Every effort will first be made to resolve an alleged grievance informally between Fair Winds Counseling and the client. If a resolution is not reached, a written statement will be submitted jointly by the client and Fair Winds Counseling to the appropriate service Director.

**Therapy for a minor**

By signing below, you are also giving authorization to provide therapy to a minor.

Names of Minor(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Counselor Date

**Fair Winds Counseling**

**RELEASE OF INFORMATION**

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize and give my permission for Fair Winds Counseling, to exchange, release, disclose or obtain information and/or copies of pertinent reports:

 To Dates of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 From

Organization and/or Name of contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason Requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Educational Transcripts, test results, student assistance team plans, behavior intervention team plans

\_\_\_Special Education records, Speech-Language Evaluations, Multidisciplinary reports, Individual Education Plans

\_\_\_Chemical Dependency Evaluation and Treatment \_\_\_Neuropsychological Evaluation

\_\_\_Pre-treatment Assessment \_\_\_Medical Discharge Summary

\_\_\_Psychological Evaluation \_\_\_Dates of Hospitalization/Treatment \_\_\_Progress Notes \_\_\_Psychiatric Assessment and/or notes

 \_\_\_Verbal Communication \_\_\_Other, Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information will be used for the following purposes:

\_\_\_Planning appropriate treatment or program

\_\_\_Case Coordination

\_\_\_Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that this information may be protected by the HIPAA privacy rule. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and no longer protected by the HIPAA privacy rule.

I understand that I may revoke this consent upon written notice, and after ***one year from date of signature this authorization will expire.*** Any revocation will not be effective to the extent that our office has acted in reliance with this authorization. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. I understand that services will not be denied to me if I do not sign this form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Legal Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Youth Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Counselor/Witness Date

Acknowledgment of Receipt of Notice of Financial Policy

By my signature below, I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ print Name of Client or Parent/Guardian if minor

acknowledge that I have received a copy of the Notice of Financial Policy for Fair Winds Counseling.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature Date

**For Office Use Only**

I attempted to obtain a written acknowledgement of receipt of my Notice of Financial Policy, but acknowledgement could not be obtained because:

\_\_Individual refused to sign

\_\_Communications barriers prohibited obtaining the acknowledgement

\_\_An emergency prevented me from obtaining acknowledgement

\_\_Other (please specify):

Attempt was made by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explanation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name Signature

Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This form will be retained in your case file.**

**About our Notice of Privacy Practices**

We are committed to protecting health information in compliance with the law. The attached Notice of Privacy Practices states:

* Our obligations under the law with respect to your personal health information.
* How we may use and disclose the health information that we keep about you.
* Your rights relating to your personal health information.
* Our rights to change our Notice of Privacy Practices.
* How to file a complaint if you believe your privacy rights have been violated.
* The conditions that apply to uses and disclosures not described in the Notice.
* The person to contact for further information about our privacy practices.

We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

**Client Acknowledgement of Receipt**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Fair Winds Counseling.**

**Client’s signature Date**

**Office Policies**

**Insurance:** As a courtesy, I will bill your insurance company, but ultimately you will be held liable for any costs that the insurance company does not pay (up to either the amount I am contracted with them or my fee of $\_\_\_\_\_\_ if I am not contracted with them).  **Please call your insurance company before your scheduled appointment to see how your policy pays for Behavioral Health, In-Network, and for Out-of-Network therapy. Also find out what your co-pay is for Behavioral Health sessions and/or if you have a deductible.** Please know that if you are using your insurance to pay for sessions, they assume the right to know your diagnosis, determine how many sessions you can have as well as the right to request additional information from the therapist to justify continued payment for your treatment. This information is given a summary form as your confidentiality is important to me.

**Cancellation or late arrival:** Since an appointment reserves time specifically for you, ***24-hour notice is required for rescheduling or canceling of an appointment.*** Outside of an agreed upon emergency or accident, you will be charged a fee equal to your insurance company’s contracted fee with me or our agreed upon session fee if you are not using insurance. Most insurance companies do not reimburse for missed sessions, so you will be responsible for the bill. Additionally, if you are late, we will meet for whatever amount of your time remains and you will be charged for the full session. ***If you are more than 10 minutes late, our office will consider this a no show and bill you accordingly.*** If a client cancels or no-shows for ***two consecutive appointments, another client may be scheduled in your time slot***. We strive to place you on an on-going or reoccurring schedule to benefit you, if you are not able to make those appointments, it is important that you know that they may be scheduled to another client when necessary. **Two consecutive missed appointments remove you from reoccurring schedule.**

**Telephone Calls and Text Messaging:** You are welcome to leave a message on the office phone. If you need to speak to me regarding a ***therapeutic issue***, I will call you back within **24 hours if it is an emergency**. If you need to speak with me immediately, please call the Box Butte General Hospital at 308-762-6660 and ask to speak to the Behavioral Health person on call, you will need to follow their instructions from that point, as there may be a short waiting period for someone to call you back. In some cases, you may be asked to come to the ER to speak with the On-call BH Therapist. **If it is not an emergency I will contact, you within 48 hours of your message**. Please ***leave a brief message*** with your name, stating the nature of your call. If you require extended time (15 minutes or more) on the phone, I will bill you for my time. Most insurance companies do not cover telephone counseling, so you will be charged a fee equal to your regular session fee. **I will not correspond with you through texting for any reason.**

**24-Hour Clean and Sober Policy:** Therapy can only be effective with a willing and able client. Clients are expected to be sober during our sessions. I assert the right to terminate any session if I believe that a client is under the influence or has used substances within the past 24 hours that impairs his/her ability to participate in treatment. If a session is terminated due to substance use, this is considered a no-show and the client will be charged the fee equal to your regular session.

**Court Preparation and Testifying:** I strive for your records and sessions to be confidential. From time to time there is a need for my records or for me to personally attend court for you. I will only do this when there is a subpoena for my services and when there is no other alternative for court satisfaction (i.e., letters, or phone conversations) Fees for court preparation are $150 per hour. Court testifying is at $200 per hour, travel time$75 per hour. Court fees are not payable by your insurance and will be billed by our office. Signing this agreement holds you responsible for those fees and will be billed out to you by our office. A subpoena does not change your financial obligation to court fees. Please talk to me about Court issues in advance as you the client are responsible for these fees.

**Payment for Services:** Fees are $\_\_\_\_\_\_for intake and $\_\_\_\_\_\_, or a fee that I have contracted with your insurance company, per therapeutic hour (50 minutes). You are expected to pay for services (full fee or co-pay) at the time they are rendered unless other arrangements have been made. Please notify me ahead of time if any problem arises regarding your ability to make timely payment. See Financial Policy.

**I accept cash, check, or credit card (Visa, MasterCard or Discover).**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree to be legally responsible for any charges that said persons listed below may incur during (please print name of responsible party)

therapy with Leta Voigt. \_\_\_\_\_ (initial here)

I understand that I, personally, will be billed for any missed or cancelled appointment (without 24-hour notice) as insurance companies do not typically reimburse for missed sessions. \_\_\_\_\_ (initial here)

Consent for Treatment: I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

 (Please print all names of any person or persons participating in therapy then have each member sign below)

Authorize and request that Leta Voigt, MA LIMHP, carry out therapeutic examinations, diagnostic procedures, and/or treatment for me while I am her client. I understand that the purpose of any procedure will be fully explained and be subject to my agreement. **I have read, understand, and fully agree with the “Office Policies” and the “Therapeutic Contract.”**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s signature Date Client’s signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Counselor’s signature Date

***Financial Policy***

The terms and conditions of this policy are reflected below. If you have questions or concerns about this policy and how it affects you, please discuss this with a member of our staff.

* You must present your insurance card(s) at ***every*** appointment. This will help us to keep current information on file and be aware of any changes to your insurance coverage without any unnecessary fees being charged to your account.
* Your eligibility will be checked before each appointment, and you will be informed of the outcome.
* If you do not have insurance or provide correct insurance information, you will be responsible for **ALL** charges on your account until you bring us the correct information.
* If you do not have insurance, you will be required to sign a Self-Pay contract and be prepared to provide proof of your annual (yearly) household income.
* If you do not show for your appointment, you will be charged after your 2nd no-show. The fee for a ***no show*** is **$25.00** **and is not paid or reimbursed by your insurance**. I ask that you bring this fee with you at your next session.
* If you have an overdue balance on your account, you ***MUST*** make a payment on that balance at the time of your appointment.
* You must pay your co-payment at the time of your appointment.
* If you do not pay on your account or pay your co-payment at the time of your appointment, you will be required to reschedule your appointment.
* If you refuse to pay your balance, you will be discharged from our care and will have to find a new provider. You will also be turned over to a collection agency if your account balance is not taken care of within 30 days of your discharge.
* If your account is **30 days past due with no attempts to pay the balance**, you will receive a warning letter stating that you need to take care of the balance due.
* If your account is ***60 days past due with no attempts to pay the balance***, you will receive a letter stating that if you do not pay on your account within 30 days, your account will be turned over to collections.
* If your account is ***90+ days past due with no attempts to pay the balance***, your account will be turned over to collections and you will no longer be able to receive services at this office. You will have to find a new provider.
* If you are making regular payments on your account, you balance will not be turned over to collections.
* You will be reminded of any co-payment or balance due when you receive your reminder call for your appointment.
* If you are covered under Nebraska Medicaid, you will not receive a bill from us, what Medicaid pays we accept as payment in full.
* Unless you have extenuating circumstances that you discuss with a member of the staff or Leta, there are no exceptions to this policy.

The methods of payment that we accept in the office are cash, check (made payable to Leta Voigt), and money order. If you feel that you are unable abide by this policy, we can provide a list of other providers in the area. We apologize for any inconvenience or delay in care this might cause. If you do transfer to another provider, upon the receipt of a signed release of information, we will transfer your records to your new provider for you. You will still be responsible for any unpaid charges on your account upon termination of services with this office.

Scheduling and Payment information

**Payment for providers in this office are due at the time of service**. This includes self-payments for

those without insurance as well as patients who will be paying co-payment amounts and deductible

amounts.

Under the Health Insurance Portability Act of 1996 (HIPAA), it is now a federal crime to defraud private insurance companies. Failure to collect co-pays is also a violation of the False Claims Act. Violations can result in fines and criminal prosecution for providers.

According to the law, we cannot routinely waive co-insurance or co-payment fees. If you feel that you are unable to pay the full amount, you must speak with the billing manager to see if there are

arrangements that can be made for payment following a payment schedule. You must do this ***BEFORE*** your first appointment.

As providers, we are responsible for collecting all payments due from the patient, after which we file with your insurance company to receive the amount to be paid by insurance. If we do not collect co- insurance payments at the time of service, and a patient subsequently refuses to pay, we can be held

accountable for that, and could potentially face criminal charges, and be deactivated from that

insurance company as a provider for anyone using that insurance.

We are obligated to report to your insurance company any refusal of payments or delinquent payments.

For the patient, not paying your co-payments could result in losing your insurance.

**If you believe you will not be able to pay in full for an appointment, you must decide**

**with the billing manager in advance of the appointment.**

***If you do not decide in advance and cannot pay for your appointment, we will assist you***

***with contacting the billing manager and may reschedule your appointment.***

I acknowledge that I have received a copy of the payment information for your provider.

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Signature Date