PERSPECTIVES PROFESSIONAL COUNSELING

303 Burlington Avenue, Suite C ♦ Hastings, NE 68901 ♦ Office (402) 834-0884 ♦ www.perspectivespc.com

YOUTH CLIENT REGISTRATION (under age 19)

	Today's Date:
Client's Legal Name:	Preferred Name:
(First) (Middle) (Last)	
Sex: ❑M ❑F ❑Other / Relationship Status: ❑Married ❑Separated ❑Divorced ❑Single ❑Partnered ❑Widowed	
Address:	City/ State/ Zip:
Birth Date: Age:	Social Security #:
Home Phone:	Cell Phone:
Email Address:	
May we contact you at home? ❑Yes ❑No Work? ❑Yes ❑No Cell? ❑Yes ❑No Email: ❑Yes ❑No	
Emergency Contact:	Phone:
(Name) (Relationship)	
Guardian / Power of Attorney:	Phone:
(Name) (Relationship)	
Medical Doctor:	Phone:
Employer:	Work Phone:
Employer Address:	
Employment Status: ❑Full-time ❑Part-time ❑Retired ❑Unemployed ❑Disabled	
Primary Insurance	
Policy Holder Name:	
Policy Holder Social Security#:	Policy Holder Date of Birth:
Insurance Company Name:	
Insurance ID#	Group #:
Secondary Insurance: *(If applicable)*	
Policy Holder Name:	
Policy Holder Social Security#:	Policy Holder Date of Birth:
Insurance Company Name:	
Insurance ID#	Group #:
Referred By / How did you hear about us?	
❑ I am a former client ❑Yellow Pages ❑Friend/ Family ❑Internet Search ❑ Website ❑School ❑Pastor/ Priest	
❑ Employee Assistance Program ❑ Dr. ____________________ ❑Other ________________________________	

Parent / Guardian Signature: ________________________________ **Date:** ____________________

Relationship to the Client: ____

CONSENT TO TREATMENT

Perspectives Professional Counseling offers counseling services to people of all ages, including individual, group, family and marital/couples therapy. We provide referrals for issues beyond our expertise as well.

We expect and encourage you to obtain knowledge of the procedures, goal and possible side effects of psychotherapy and counseling. We will keep you informed about treatment alternatives available to you. You have the right to refuse or question therapeutic procedures and methods at any time. You also have the right to receive information about the process and course of your therapy or counseling. Either you or your therapist may terminate treatment at any time. However, we encourage our clients to schedule a “closing” session.

There are some risks related to treatment. They may include: intense and unwanted feelings, recollections of unpleasant life events, facing unpleasant thoughts, questioning values and personal beliefs and changes in relationships. It is important to remember that these feelings and experiences may be natural and normal.

Confidentiality: will be respected except in the following cases: in the event that a client reports intent to harm another person; in the event a client reports a plan and intent to harm self; in the event a client or family member reports neglect and/or physical-sexual abuse; in the event a court subpoenas our records or the testimony of our therapists.

Mental Health Emergency and after-hours services: Your therapist will provide you with their emergency and/or after-hours contact information. If in an emergency situation for which you feel immediate attention is necessary please contact your therapist. If however, your therapist cannot be reached please dial 911. National Suicide Prevention Hotline at 1-800-273-8255

Coordination of Treatment: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Please understand that you have the right to revoke this authorization at any time. If you prefer to decline consent no information will be shared.

If consent is granted, please complete the following form:

Confidential Exchange Of Information with
Primary Care Physician or other Behavioral Health Clinician/Facility.

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Confidential Exchange Of Information with
Primary Care Physician or other Behavioral Health Clinician/Facility

Patient/ Client	
Patient Name:	DOB:
Primary Care Physician or other Behavioral Health Clinician/Facility	
Provider Name:	
Office or Facility:	
Address:	
Phone:	Fax:
Consent to Release Information	
Communication between behavioral health providers and your primary care physicians or other behavioral health providers is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary. My signature below indicates that I authorize Perspectives Professional Counseling to release information related to my evaluation and treatment to the physician/clinician named above. This consent will last one year from the date signed and I understand that I may revoke my consent at any time.	
Responsible Party's Signature:	Date:
Printed Name of Signee:	Relationship to Client:

Dear Dr. ____;

I'm writing to notify you that your above named patient was seen by me for a mental health evaluation and therapy. I look forward to working with you in the care of this client during their on-going therapy. Please let me know if you would like further information. I can be reached during my office hours or by confidential voicemail, if you prefer to leave a message.

Specific Information or Concerns:

Thank you for your assistance in coordinating care for this client.

Sincerely,

Primary Therapist: ____ Date Sent: ___________

PLEASE DO NOT SEND MEDICAL RECORDS UNLESS SPECIFICALLY REQUESTED.

CONSENT TO TREATMENT

I ______________________________ (name of client), agree and consent to participate in behavioral health care services offered and provided at Perspectives Professional Counseling, a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient.

PARENTAL CONSENT FOR MENTAL HEALTH TREATMENT OF A MINOR

If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

By signing this document, you consent to treatment by Perspectives Professional Counseling.

Name of Client: ____

____ ___________

Client Signature: **Date:**

____ ___________

Parent/ Guardian Signature **Date**

FINANCIAL POLICY

As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you. We ask that at each session you pay your co-payment or coinsurance amount. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. **If your balance exceeds $300.00 we will need to ask that you pay for services when rendered.** In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Perspectives Professional Counseling. You may put a credit card on file to pay for charges not covered by your insurance.

Policy on Non-Covered Services: In order to offer you consistent quality care and to coordinate this care with other providers or organizations, we may need to charge for services that are not typically covered or reimbursed by your insurance company. A list of these services is provided below. These services are billed at the standard hourly rate for your therapist. The following are a list of some of the services not covered by insurance companies: Court ordered and legal related services; preparing reports or letters for other providers or organizations; completing documents (for disability claims, insurance reviews, workers' compensation, etc.); consultations by telephone or e-mail; evaluating, testing or treatment services not covered by your insurance .

We sincerely appreciate your cooperation and at any time you have questions regarding insurance, fees, balances or payments please feel free to ask one of our billing staff.

Missed Appointment Cancellation Policy: We consider it an honor and privilege to be of service. We do understand that there may be extenuating circumstances; however, we request that any cancellation or rescheduling of your appointment be made at least **24 hours in advance**. You will be charged a **$50.00** fee for missed appointments or appointments not cancelled at least 24 hours in advance of the scheduled visit. We provide text and email reminders before your appointment as a courtesy. We have a **3 cancel/no-show policy**. If you cancel 3 consecutive appointments or no show for 3 appointments, you will not be rescheduled. We appreciate your consideration of our time and will express the same consideration for yours.

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Financial Policy Agreement

I have read and understand the **Financial Policy** of Perspectives Professional Counseling. I understand that my insurance is an agreement between myself and the insurance company, NOT between PPC and my insurance company. I request that PPC prepare the customary forms at no charge so that I may obtain my insurance benefits. I also understand that if insurance does not pay within 60 days fees will be due.

By signing below, I state that I understand my financial responsibility in seeking services.

____
Name of Client

____________________________________ __________
Parent/ Guardian Signature **Date**

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PATIENTS RIGHT AND RESPONSIBILITIES

Patients have the right to:

- Be treated with dignity and respect.
- Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have your treatment kept confidential.
- Easily access care in a timely fashion.
- Know about your treatment choices regardless of cost or coverage.
- Share in developing your plan of care.
- Receive information in a language you can understand, and free of charge.
- Receive a clear explanation of your condition and treatment options.
- Receive information about Perspectives Professional Counseling its providers, programs, services and role in the treatment process.
- Receive information about clinical guidelines used in providing and managing your care.
- Ask your provider about their work history, training and qualifications.
- Know about advocacy, community groups and prevention services in your area.
- Freely file a complaint or appeal and to learn how to do so.
- Know of your rights and responsibilities in the treatment process.
- Request certain preferences in a provider.
- Have provider decisions about your care made on the basis of treatment needs.
- Decline participation or withdraw from services.

Patients have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers the information that they need. This is so providers can deliver quality care and appropriate services.
- Provide the necessary information for insurance processing, and to ask questions you may have concerning your bill, and make appropriate payment arrangements.
- Ask questions about your care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Follow the agreed upon medication plan.
- Tell your provider and primary care physician about medication changes, including medications given to them by others.
- Keep your appointments. Call PPC as soon you know you need to cancel visits.
- Let your counselor know when the treatment plan is not working for them.
- Let your counselor know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care you receive.
- Let your counselor know if you decide to withdraw from services.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

Client Signature:____ **Date:**____________

Parent/Guardian Signature:__________________________________ **Date:**____________

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NOTICE OF PRIVACY PRACTICES

Notice of Policies and Practices to Protect the Privacy of Our Patient's Health Information
THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you. "Treatment, Payment, and Health Care Operations"
- Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
- Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within our [office, clinic, practice group, etc.], such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

<u>II. Uses and Disclosures Requiring Authorization:</u>

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures.
In those instances when we are asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

<u>III. Uses and Disclosures with Neither Consent nor Authorization</u>
We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse** – When we have reasonable cause to believe that a child has been subjected to abuse or neglect, or if we observe a child being subjected to conditions which would reasonably result in abuse or neglect, we must report this to the proper law enforcement agency or to the Nebraska Department of Health and Human Services.
- **Adult Abuse** – When we have reasonable cause to believe that a vulnerable adult has been subjected to abuse or if we observe such an adult being subjected to conditions which would reasonably result in abuse, we must report this to the appropriate law enforcement agency or the Nebraska Department of Health and Human Services."Vulnerable adult" shall mean any person eighteen years of age or older who has a substantial mental or functional impairment or for whom a guardian has been appointed under the Nebraska Probate Code.
- **Health Oversight Activities** – For the purpose of any investigation, the Director of Health and Human Services or the Director of Regulation and Licensure (the board which licenses us to practice) may subpoena relevant records from us.

NOTICE OF PRIVACY PRACTICES Continued…

- **Judicial and Administrative Proceedings** – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information without the written authorization from you or your personal or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party (e.g. state agency) or where the evaluation is court-ordered. We will inform you in advance if this is the case.
- **Serious Threat to Health or Safety** – If you communicate to us a serious threat of physical violence against a reasonably identifiable victim or victims, we must communicate such threat to the victim or victims and to a law enforcement agency.
- **Worker's Compensation** – If you file a worker's compensation claim, we must, on demand, make available records relevant to that claim to your employer, the insurance carrier, the worker's compensation court, and to you.

IV. Patient's Rights and Therapist's Duties:

Patients Rights:

- ***Right to Request Restrictions*** –You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. On your request, we will send your bills to another address.)

Patient's Rights Continued…

- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in all cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- ***Right to Amend*** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process. (as of April 14, 2003)
- ***Right to a Paper Copy*** – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI. We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the PPC Practice Administrator at 402-984-9754 or send a written complaint to P.O. Box 1542, Hastings, NE 68902-1542

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy This notice will go into effect on 4-14-03

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by U.S. mail or electronically

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NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGEMENT OF NOTICE

Client Name:____

By signing this form I hereby acknowledge that I have received and have been given an opportunity to read a copy of

PERSPECTIVES PROFESSIONAL COUNSELING's

Notice of Privacy Practices and agree to the policies described therein.

____ _____________

Signature of Client Date

____ _____________

Signature of Parent, Guardian, or Personal Representative Date**

Relationship to Client: ____

**If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

Patient/Client Refuses to Acknowledge Receipt:

Staff Member Initials: _____________ Date: _____________

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YOUTH BACKGROUND INFORMATION

CLIENT NAME: ____

DATE OF BIRTH: _______________AGE:___________ TODAY'S DATE:__________________________

REASON FOR SEEKING COUNSELING:____

____

____

RACE/ETHNICITY: _________________ **RELIGIOUS/ SPIRITUAL ORIENTATION**:_________________

GENDER: _________________________**SEXUAL ORIENTATION:**___________________________

FAMILY OF ORIGIN:

PLACE OF BIRTH: ____________________OTHER PLACES CLIENT HAS LIVED?___________________________

PARENT STATUS (CIRCLE): MARRIED DIVORCED/SEPARATED WIDOWED IN A RELATIONSHIP SINGLE

PARENT/ GUARDIAN (NAMES/AGES):____

CUSTODY STATUS (IF APPLICABLE):____

LIST SIBLINGS/ OTHER CHILDREN IN THE HOME:

NAME:	AGE:	MALE/ FEMALE:	LIVING IN YOUR HOME: YES/NO	RELATIONSHIP:

LIST ANY OTHER INDIVIDUALS LIVING IN YOUR HOME:____

LIST ANY OTHER SIGNIFICANT OTHERS NOT IN THE HOME:____

EMPLOYMENT HISTORY (for youth who are employed):

EMPLOYMENT STATUS (CIRCLE): FULL-TIME PART-TIME STUDENT UNEMPLOYED

PLACE OF EMPLOYMENT: ______________________________________POSITION: __________________________

HOW LONG HAVE YOU WORKED THERE? _______________

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ACADEMIC HISTORY:

HIGHEST LEVEL OF EDUCATION: ____

NAME OF SCHOOL: ___________________________________ ANY DIAGNOSED LEARNING DISABILITIES: YES / NO

ANY HISTORY OF ATTENTION OR BEHAVIOR PROBLEMS (CIRCLE): YES / NO ______________________________

LIST ANY SPECIFIC SCHOOL RELATED CONCERNS:____

MEDICAL HISTORY:

PHYSICIAN'S NAME AND LOCATION: ____

CURRENT MEDICATIONS, DOSAGE, REASON FOR TAKING: ____

____

____

ANY PAST/PRESENT MEDICAL CONDITIONS/CONCERNS?____

____

SURGERIES/ INJURIES, DATES: ____

____ ALLERGIES: ______________________

COMPLICATIONS AT BIRTH? YES / NO NORMAL CHILDHOOD DEVELOPMENT? YES / NO

PSYCHIATRIC HISTORY:

PRIOR COUNSELING, PREVIOUS COUNSELOR: ____

CURRENT OR PAST PSYCHOTROPIC MEDICATIONS: ____

MEDICATION PROVIDER / LOCATION: ____

HOSPITALIZATIONS/ TREATMENT STAYS (DATE, LOCATION): ____

PAST DIAGNOSES: ____

PAST SUICIDE ATTEMPTS? YES / NO WHEN?____________________SELF-HARM? YES / NO

FAMILY HISTORY OF MENTAL HEALTH DIAGNOSIS (DESCRIBE)?____

LEGAL HISTORY:

PAST LEGAL CHARGES/CONVICTIONS: YES / NO PENDING CHARGES: YES / NO

CURRENT DIVORCE / CUSTODY ACTIONS: YES / NO CHILDHOOD LEGAL DIFFICULTY: YES / NO

ADDITIONAL INFO: ____

SUBSTANCE USE HISTORY (PLEASE CIRCLE THE SUBSTANCES YOU HAVE USED OR CURRENTLY USE):

ALCOHOL	NICOTINE	MARIJUANA	HALLUCINOGENS	METHAMPHETAMINES
ECTASY	TRANQUILIZERS	PAIN KILLERS	METHADONE	STIMULANTS (PILLS)
HEROIN	COCAINE	CAFFIENE	OTHER	

IF YES TO ANY, PLEASE LIST DATE OF FIRST USE, LAST USE, HOW MUCH, HOW OFTEN, AND HOW LONG YOU HAVE USED THIS SUBSTANCE:

____

____

HAVE YOU EVER BEEN TREATED FOR DRUG/ALCOHOL ABUSE? YES / NO IF YES, WHEN? ________________________

HAVE YOU EVER MISUSED PRESCRIPTION DRUGS? YES / NO IF YES, WHEN? ________________________

STRENGTHS AND LIMITATIONS:

WHAT ARE YOU TALENTS, SKILLS, ABILITIES AND ACHIEVEMENTS:____

WHAT DO YOU CONSIDER YOUR STRENGTHS:____

WHAT DO YOU CONSIDER LIMITATIONS:____

OTHER INFORMATION YOU WANT YOUR COUNSELOR TO BE AWARE OF:

____

____

____

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YOUTH SYMPTOM CHECKLIST

Please place a check mark next to the symptoms that you are experiencing.

For EACH symptom checked note the severity (Mild 1 to 10 Severe) and how long you have been experiencing this.

CLIENT'S NAME: ____________________ **TODAY'S DATE**: __________

PERSON COMPLETING FORM/ RELATIONSHIP TO CLIENT: ____________________

SYMPTOM	☑	RATE SEVERITY Mild 1 to 10 Severe	DURATION (How long?)	SYMPTOM	☑	RATE SEVERITY Mild 1 to 10 Severe	DURATION (How long?)
Depressed Mood				Irritability / Anger			
Feeling Hopeless				Mood Swings			
Feeling Helpless				Communication Problems			
Withdrawing from others				Restless, "keyed up"			
Lack of Interest in things once enjoyed				Impulsive (acts without thinking first)			
Change in Sleep Patterns (too much, too little)				Difficulty concentrating			
Nightmares				Problems Remembering			
Change in appetite				Obsessive thoughts			
Weight Gain or Loss				Feeling nervous/ shaky			
Low Self-esteem				Anxiety / worry			
Feeling Guilty				Fear / Panic			
Feeling Worthless				Poor attention to details			
Feeling Lonely				Difficulty organizing			
Crying more				Avoid effortful tasks			
Difficulty making decisions				Easily Distracted			
Feel people are picking on you				Hyper/ Too much energy			
Fatigue/ low energy				Mind Racing/ Rapid Thoughts			
Headaches / Stomach Aches/ Physical Pain				Repeated Actions/ Compulsive Behavior			
Self-harm (cutting, self- mutilation)				Disturbing Thoughts			
Suicidal Thoughts				Feeling dizzy, faint, lightheaded			
Suicide Attempts				Muscle Tension			
Shyness				Taking too many risks			
Flashbacks of traumatic events				Difficulty following instructions			

ADDITIONAL AREAS OF CONCERN/ DIFFICULTY (PLEASE CIRCLE **ALL** AREAS THAT APPLY):

LEGAL	FINANCIAL	BEHAVIORAL	EATING DISORDER	GAMBLING	PHYSICAL ABUSE HISTORY	SEXUAL ABUSE HISTORY
DEATH OF A LOVED ONE	ALCOHOL/ DRUG USE	RELATIONSHIP PROBLEMS	PARENT/CHILD CONFLICT	DIFFICULT CHANGES	VIOLENCE IN FAMILY	SCHOOL PROBLEMS

OTHER SYMPTOMS NOT NOTED ABOVE:

____