8101 O St. STE 300 Lincoln, NE 68510
Phone: 402.261.3714 Fax: 1.888.959.0716

Demographics for Independent Adults

Name: _____DOB: _____Today's Date:_____

Current Age: _____Gender:_____ SS#:_____SS# of Insured_____

Address: _____City:_____ State:_____ Zip:_____

Contact Information:

Phone numbers and the type of number (i.e. home, work number, etc)

Type:_____ (_____) _____-_____ May a message be left? Y N

Type:_____ (_____) _____-_____ May a message be left? Y N

Type:_____ (_____) _____-_____ May a message be left? Y N

Is texting ok? Y N If yes, which number is best? _____

Email address: _____

Is this email address ok to receive reminders/updates/etc. regarding your session? Y N

Emergency Contact:_____
Name *Relationship to you* *Phone Number*

Employer/School: _____
Name *Position held*

How did you hear about us? _____

Payment for Services information (please choose **ONE** of the following two options):

1. _____(initial) I would like my provider to file claims on my behalf through this **insurance** company:

Insurance Co. & Phone #: _____

Name of Policy Holder: _____Relationship: _____DOB:_____

Address: _____City: _____State: _____ Zip: _____

Member ID: _____Employer:_____

If a Secondary Insurance is applicable, please put the same information on the backside of this form

2. _____(initial) I would like to **private pay** for services. _____ Initials of therapist in agreement

Individual Session (45-50 minutes) $_____Family Session (60 minutes) $_____

*I understand that having insurance coverage does not guarantee payment for therapeutic services and assume financial responsibility for all changes by my signature below. My signature below authorizes the insurance company to pay for therapeutic services and is binding as a **financial contract**. If I have opted to Private Pay, payment will be made directly to my therapist.*

Signature: _____ Date:_____

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Outpatient Therapeutic Services Contract/Adult Consent for Treatment

Informed Consent Signature: I, _____ (please print your name), agree voluntarily to enter a therapeutic and professional relationship with:

Therapist: _____ of Lincoln Wellness Group.
Name *Credentials*

The purpose of this contract is my desire to participate in mental health therapy, behavioral health care and/or consultation. I understand that I have the right to question any evaluation and/or treatment procedure and refuse or accept services as an informed client at Lincoln Wellness Group. Consultation with other parties often facilitates treatment but will only be done with my written permission. I understand that I have the right to revoke consent for treatment in writing or orally at any time and that subsequent disclosure of protected health information will only be released with my signature via a "Release of Information" form. I understand that I am consenting and agreeing only to those services that the above checked provider(s) is qualified to provide within: 1) the scope of the provider's license, certification, and training; or 2) the scope of the license, certification, and training of the behavioral health care providers directly supervising the services received by this patient.

Signature:_____ Date:_____

HIPAA Policy Statement: I have received Lincoln Wellness Group's HIPAA Policy Statement. I understand that a copy of the Records Amendment form is available upon my request. My signature below confirms receipt of this information. _____ *I prefer to waive my right to the HIPAA Policy Statement*

Signature:_____ Date:_____

Bill My Insurance: I, the undersigned, understand that Lincoln Wellness Group uses a billing agency that upholds HIPAA regulations. I also understand that only the minimum amount of information necessary will be shared with the billing agency and my insurance company. I further authorize the provider to release any medical information necessary to process claims. The provider will notify the insured if information being requested is beyond typical. Typical information includes demographic information, diagnosis code, service dates, treatment plan, and progress information. I also authorize the insurance company to directly pay the provider benefits payments that would otherwise be paid to the insured for mental health services. I understand I am responsible for all charges incurred whether or not paid by the insurance company. The signature below authorizes this office to release the least amount of health information possible (e.g. client name, dates of service, types of service, diagnosis) to ensure payment.

Signature:_____ Date:_____

Magellan Behavioral Health Client Contract:
1). I authorize the release of any medical information necessary to process this/these claim(s). I also request payment of government benefits to myself or to the party who accepts assignment.
2). I authorize payment of medical benefits to the provider of services or supplier for services rendered.

Signature:_____ Date:_____

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HIPAA

Policy Regarding Protection of Mental Health Records

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA) regarding procedures protecting client's rights related to health records, including mental health. The "**transaction rule**" refers to adoption of consistent standards for electronically submitting health claims to insurance companies for reimbursement. At this time, therapists at Lincoln Wellness Group (Ryan W. Tenopir, Sue Outson, John Odell, Seth Brown, Patty Kimberly-Martinez, Erica J.W. Sullivan, Lindsey Sanny, Nicole Trevena, Jennifer Manche, Gillian Jenkins, Elissa McGill, Rachel Meier, Ashlee Reed, Luke Meier, Tracy Schaaf, & Kristal Flaming) do submission. The "**privacy rule**" relates to use of health information, release of health information to people/agencies, and client rights to view and amend their health records. The "**security rule**" relates to maintenance and storage of records and office policies regarding records. Protected Health Information (PHI) under HIPAA refers to any information that identifies the client. As related to the practices of Lincoln Wellness Group, this information includes Diagnostic Interviews, Pretreatment Assessments, Psychological Evaluations, Family Assessments, Attachment/Bonding Assessments, Sexual Acting Out Risk Assessments, Therapy Summaries, Claim Forms, Insurance EOBs, Client Intake Forms, Treatment Plan, and Correspondence with persons/agencies with written client consent. Records received from other persons/agencies become part of the patient's PHI and will only be released by consent of the client/client's guardian. In situations where the client is a ward of the state of Nebraska, the caseworker is presumed to be the legal guardian. Information provided to Lincoln Wellness Group's therapists by a caseworker becomes the patient's PHI and can be forwarded by our therapists to agencies needing the material for treatment decisions (e.g., Magellan Managed Care Company).

Lincoln Wellness Group's therapists obtain their own federal tax identification numbers. Each therapist maintains responsibility for implementing procedures regarding protection of client records as seen fit. In order to provide the best possible care for clients, it is sometimes helpful to consult with other mental health professionals. When this is done, Lincoln Wellness Group therapists will discuss the case without using names and in a manner protecting the identity of the client. For purposes of supervision, Ashlee Reed utilizes the services of Ryan W. Tenopir, MA, LIMHP and John Odell, MA, LIMHP. Rachel Meier, Gillian Jenkins, and Luke Meier utilize the services of Ryan W. Tenopir, MA, LIMHP. Nicole Trevena Flores and Kristal Flaming utilize the services of Seth Brown, MA, LIMHP. These supervisors will be informed of all client information necessary to initiate and maintain proper standards of treatment; therefore a release of information is not necessary to communicate with them. They adhere to the same HIPAA guidelines set forth in this policy. Ryan W. Tenopir, John Odell, Seth Brown, Patty Kimberly-Martinez, Erica J.W. Sullivan, Lindsey Sanny, Jennifer Manche, Elissa McGill, and Tracy Schaaf are independently licensed and do not utilize a supervisor.

Lincoln Wellness Group therapists will only release a client's health information with a signed release from the client or client's guardian in the case of a minor. Only information specifically identified on the signed release will be sent from this office. A copy of the signed release becomes part of the patient's file. The release allows the client to restrict the information disclosed by identifying it on the form. Lincoln Wellness Group, of course, has no control over information once it is released. If the client uses commercial insurance to managed care benefits to pay for services, it is our policy to release the least amount of information possible that will allow claims to be paid. Information typically includes dates of service, length and type of treatment provided, address, social security number, and diagnosis. If companies request more information, our therapists will consult with you, our client, before sending information.

Lincoln Wellness Group uses a billing agency that only has access to demographic and diagnostic information necessary for processing claims with insurance companies. Social Security numbers are obtained as per office policy as collecting payments often requires this information. Lincoln Wellness Group maintains responsibility for amending policies and procedures related to client records as laws change. The person to contact if a client has a complaint about his/her health record, is his or her therapist. Complaints will be documented and saved in a locked file indicating the action taken.

Lincoln Wellness Group therapists will honor client requests to have copies of their health records but are encouraged to sit down with their therapist to discuss them, as some information in the file needs interpretation and can be misunderstood if taken out of context. Clients of Lincoln Wellness Group have the right to request that information in their file be amended or changed if they feel it is incorrect. This topic will be discussed upon the request, with the client, and changes will be made in the form of an amendment if the information provided by the client was misinterpreted or if the client has data to suggest that a wrong assumption was made by our therapists. A form has been developed to document this discussion and will become part of the patient file. The personal computers of our therapists are password protected. Storage devices with patient data on them are stored in locked enclosures. The medical files of all clients are locked inside file cabinets and in a room that is double locked when the premises are vacant.

My signature indicates I have read and understand the above information.

_____ _____

Signature Date

LINCOLN WELLNESS GROUP

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Concerns for Seeking Therapy

*Please **Circle Yes** or **No** on each of the following. Please comment as necessary for clarification.*

Change in environment: Yes No _____

Change in family: Yes No _____

Change in friends: Yes No _____

Relationship problems: Yes No _____

Communication problems: Yes No _____

Feelings of little or no self-worth: Yes No _____

Unexplainable mood swings: Yes No _____

Anger: Yes No _____

Sadness: Yes No _____

Problems focusing: Yes No _____

Possible/undocumented abuse: Yes No _____

Child/Adult Protective Services involvement: Yes No _____

Problems with food: Yes No _____

Problems with sleep: Yes No _____

Thoughts of wanting to hurt or kill self: Yes No _____

Thoughts of wanting to hurt others: Yes No _____

Actions that some would consider dangerous: Yes No _____

Panic attacks: Yes No _____

Manic feelings: Yes No _____

Feelings of panic: Yes No _____

Intrusive thoughts: Yes No _____

Rituals: Yes No _____

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Hallucinations: Yes No _____

Legal Problems: Yes No _____

Problems with alcohol and/or drugs: Yes No _____

Misuse of Prescription drugs, and/or use Street drugs: Yes No _____

Other areas of concern: : _____

Current General Medical Practitioner:

- Name:_____
- Address: _____
- Phone Number: _____
- When did you begin seeing this practitioner? _____

Current Psychiatrist:

- Name:_____
- Address: _____
- Phone Number: _____
- When did you begin seeing this practitioner? _____

Has client received mental health treatment in the past? Y N

- If yes, please list, with names and dates, any mental health practitioners, therapists, counselors, psychiatrists, etc. that have provided any treatment or prescribed any mental health medications in the past. Please also list the diagnosis given. If you need more room to write, please continue on the reverse side of this page.

_____
_____
_____
_____
_____

Medication History

Date (Start & stop)	Medication	Dosage	Purpose of Medication	Doctor

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Magellan Health Services
Members' Rights and Responsibilities Statement
Members' Rights and Responsibilities Statement 2009/Approved June 24, 2009

Statement of Members' Rights

Members 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 their treatment and other member information kept confidential. Only where permitted by law may records be released without the member's permission.

~Easily access care in a timely fashion.

~Know about their treatment choices. This is regardless of cost or coverage by their benefit plan.

~Share in developing their plan of care.

~Receive information in a language they can understand.

~Receive a clear explanation of their condition and treatment options.

~Receive information about Magellan, its providers, programs, services and role in the treatment process.

~Receive information about clinical guidelines used in providing and managing their care.

~Ask their provider about their work history and training.

~Give input on the Members' Rights and Responsibilities policy.

~Know about advocacy and community groups and prevention services.

~If asked, Magellan will act on the member's behalf as an advocate.*

~Freely file a complaint or appeal and to learn how to do so.

~Know of their rights and responsibilities in the treatment process.

~Request certain preferences in a provider.

~Have provider decisions about their care made on the basis of treatment needs.

~Receive information about Magellan's staff qualifications and any organization Magellan has contracted with to provide services.*

~Decline participation or withdraw from programs and services.*

~Know which staff members are responsible for managing their services and from whom to request a change in services.*

Statement of Members' Responsibilities

Members have the responsibility to:

~Treat those giving them care with dignity and respect.

~Give providers and Magellan information that they need. This is so providers can deliver quality care and Magellan can deliver appropriate services.

~Ask questions about their care. This is to help them understand their 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 their provider and primary care physician about medication changes, including medications given to them by others.

~Keep their appointments. Members should call their provider(s) as soon they know they need to cancel visits.

~Let their provider know when the treatment plan is not working for them.

~Let their provider know about problems with paying fees.

~Report abuse and fraud.

~Openly report concerns about the quality of care they receive.

~Let Magellan and their provider know if they decide to withdraw from the program.*

* This standard is required for our *Condition Care Management* (CCM) products.

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

_____

Member Signature Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

_____

Provider Signature Date