THE Counseling & Enrichment CENTER

O'Neill Office
614 N. 4th St., Ste 105 & 106
O'Neill NE 68763

Norfolk Office
105 S. 5th Street
Norfolk NE 68701

Kearney Office
2315 W. 39th Street, Ste 109
Kearney NE 68845

Phone – 402.992.1512 / Fax: 402.246.6252
Fax: 308.237.0720

Offering Hope ***Recognizing the Cause*** ***Resolving the Symptoms***

Client Information & Payment for Services Agreement

Client: _____ DOB: ____/____/____ Male / Female

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: ____-____-____ Phone: _____ Cell: _____

Email: _____

Responsible Party: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Relationship to Client: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

How did you become aware of our agency? _____

Method of Payment

☐ Medicaid – NTC/ UHC/ Healthy Blue ID # _____

☐ Insurance: Company Name: _____ Phone: _____

Policy/ID #: _____ Group #: _____ Co-Pay $ _____

☐ EAP: _____ (Company Name) ☐ Private Pay

I agree to pay for services at Counseling & Enrichment Center in the manner specified above. I am aware that I am responsible for paying any fees not covered by my insurance company. If I am covered by Medicaid and I become ineligible for Medicaid benefits, I will be responsible for payment of any charges incurred while not eligible.
I understand that if I no show/no call for a session prior to the start time, I agree to pay the fee of $35.

_____ ____/____/____

Signature of Client or Personal Representative Date

The confidentiality of this information is protected by Federal Law (42CFRII). No further disclosure of this information is allowed without the above-named person's written consent specifying release of information in accord with Federal regulations.

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CLIENT CONTRACT

Time of Sessions: Each therapy session is scheduled to last 45 to 50 minutes. We encourage you to arrive punctually at your scheduled time. Please notify the therapist in advance if you are unable to keep your appointment. You may be subject to a $35.00 no-show fee if you do not alert your therapist before missing a scheduled session.

Cost: The standard fees are available for review in the business office. You will be notified of any changes. A deduction of $10.00 will be made if you are able to pay on the date of service.

Payment: You may pay by cash, check, credit card or money order. We will be happy to submit any charges to your insurance carrier and then bill you for the deductible and unpaid claims. If you are on Medicaid and as long as you remain eligible, your charges will be covered. If, at any time, you are unable to make your payment in full, payment arrangements should be made with the counselor or office manager.

Confidentiality: Our professional ethics require us to keep everything you discuss during our sessions in the strictest of confidence. At times, we consult with other mental health professionals regarding clients with whom we are working. This allows for perspectives and ideas to be shared to help you reach your goals and bring healing. Such consultations are performed in such a manner that confidentiality is maintained, and these professionals are bound by the same code of ethics. Information will not be released about you without your permission unless we are required to by law.

Legal Exceptions to Confidentiality

**If there are situations in which you are at serious risk to harm either yourself or others, we are required to take action to prevent that harm from occurring. This includes alerting the person or persons being threatened and/or alerting the authorities.*

**We are required to report any suspected child abuse or neglect. If this should occur, you will be alerted to any testimony we may be compelled to present.*

**In rare circumstances, our office may be subpoenaed to testify about you in court. This could happen if there was reason to believe we knew of certain types of criminal activity.*

**If you should ever bring legal action against this office, we would be authorized to release any information in court.*

Couples Therapy Confidentiality: When working with a couple, at times, there are instances in which one partner wants to relate something to the therapist without the other partner knowing. Please be aware that anything you choose to tell the therapist that is important to the work with both partners may come out in therapy. Please do not expect your therapist to keep secrets where doing so jeopardizes the therapeutic work.

Physical Problems: Because our therapists are not physicians, they cannot know if you have physical conditions that may affect your well-being. Your therapist may request that you get a physical examination or that information be exchanged with your physician as is deemed important to your wellness.

Termination of Treatment: Your treatment may be for an established length of time determined by you and the therapist, or it may be on an "as needed" basis. You may terminate treatment at any time for any reason. It is preferred that you notify your therapist of your intent to terminate before your final session so that in your final session, you and your therapist can bring therapy to a close.

Risks: Counseling is intended to help you feel better, but may make you feel guilty, frustrated, lonely and helpless at times. As part of your therapy, you may recall unpleasant memories from the past. In some instances, your condition may get worse before it gets better. In regard to couples' counseling, there is the possibility of separation just as there is the possibility of reconciliation.

Grievances/Complaints: Conflicts with your therapist may arise during the course of treatment. If this occurs, please discuss them with your therapist. If this is uncomfortable for you, or if the problem persists, you are welcome to speak with the Chief Operations Officer. If you still do not get satisfactory results, you are advised to contact your insurance carrier or the agency that is paying for your services.

AGREEMENT

We, the undersigned, have read this contract, understand it, and agree to the terms it contains. We will comply with all parts of this contract on our personal and professional honor. It is understood that therapy maybe discontinued if these terms are not fulfilled by either of us.

By signing this agreement, I authorize information to be released to my insurance company and agree to assign all insurance benefits to The Counseling & Enrichment Center.

_____

Signature of Client/Caregiver/Guardian

Date: _____

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NOTICE OF
PRIVACY PRACTICES
RIGHTS AND RESPONSIBILITIES

The Counseling and Enrichment Center provides each client with a copy of the *Notice of Privacy Practices* which describes how medical information about you may be used and disclosed and how you can get access to this information.

Your signature below verifies that you have received a copy of *Notice of Privacy Practices* and agree to the information contained within.

_____ _____

Client/Responsible Party Printed Name

_____ _____

Client/Responsible Party Signature Date

_____

Client Name (If a minor)

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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

Client: _____ DOB: ____/____/____ Date: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

I, _____, ☐ the individual named above, or ☐ a personal representative because the patient is a minor or incapacitated, authorize the Counseling & Enrichment Center to:

☐ release information to: ☐ obtain information from: ☐ exchange information with:

Name/Agency/Clinic/School: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

For the following information pertaining to the above individual:

_____ Medical Diagnosis/Treatment/Medication Interventions/Lab Information
_____ Psychological/Mental Health Evaluation/Diagnosis
_____ Educational/School Information
_____ Substance Abuse Evaluations/Treatments
_____ Psychiatric Evaluation/Medication/Discharge History
_____ Other: _____

for evaluation/assessment and/or coordinating treatment interventions.

This consent will automatically expire one (1) year after the date of my signature as it appears below. I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ ____/____/____
Signature of Client or Personal Representative Date

The confidentiality of this information is protected by Federal Law (42CFRII). No further disclosure of this information is allowed without the above-named person's written consent specifying release of information in accord with Federal regulations.

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Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between Behavioral Health Providers and your Primary Care Physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow y our Behavioral Health Provider to share Protected Health Information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, and medication if necessary.

I, the undersigned understand that I may revoke this consent at any time. I have read and understand the information and give my authorization:

Patient Authorization

☐ I agree to release any applicable mental health/substance abuse information to my PCP

My Primary Care Physician is _____

Address _____

Telephone Number: _____

☐ I agree to release information to my PCP

☐ I WAIVE NOTIFICATION of my PCP that I am seeking or receiving mental health services, and I direct you NOT to so notify him/her.

☐ I do not have a PCP and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a PCP that I am seeking or receiving mental health services.

_____

Patient Signature Date

Patient Rights:

- You can end this authorization (permission to use or disclose information) any time by contacting:_____
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- You have a right to a copy of this signed authorization. Please keep a copy for your records.
- You do not have to agree to this request to use of disclose information

Information to be completed by Behavioral Health Provider

I saw _____ on _____ for _____

(Patient Name) (Date) (Reason/Diagnosis)

Summary: _____

_____

_____

_____

_____

_____

_____

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PARENTAL CONSENT FOR TREATMENT OF A MINOR

I, _____ as the parent/responsible party of _____, consent to participate in behavioral health care provided by The Counseling and Enrichment Center. I understand that I am consenting to participate in services the counselor is qualified to provide within the scope of his/her licensure, certification and training.

I understand and agree that at times the services may be performed via live, interactive video telehealth services.

I understand that:

a. I retain the right to refuse telehealth consultations at any time without affecting my right to future care or treatment.
b. All existing confidentiality protections shall apply to my telehealth consultation.
c. Information from the telehealth service (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my written consent.
d. If I decline telehealth services, other alternative options are available to me, including in-person services.
e. I will be informed whether the telehealth consultation will be or will not be recorded.
f. I will be informed of all people who will be present.
g. I will be informed of all people who will be present at all sites during my service.
h. I retain the right to exclude anyone from my service.

_____ _____
Parent/Responsible Party Signature Date

_____ _____
Relationship to Client Date

_____ _____
Counselor Signature Date

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MEDICATIONS

NAME: _____ DOB: _____

Current Medications	Dosage	Who Prescribed?	Compliant? Y / N	Reason for **not taking** Prescribed medication

Current "Over the Counter" Medications/Supplements	Dosage	Who Prescribed?	Compliant? Y / N	Reason for **taking** the Medication/Supplement

Counseling & Enrichment Center, 118 N. 5th St., O'Neill, Ne 68763 P: 800.689.0945 Fax: 402.336.4640

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

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Finding Your ACE Score

Name:_____
DOB: _____
Date: _____

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**...
   Swear at your, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes or No — If yes, enter 1 _____

2. Did a parent or other adult in your household **often or very often**...
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes or No — If yes, enter 1 _____

3. Did an adult or person at least 5 years older than you ever...
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes or No — If yes, enter 1 _____

4. Did you often or very often feel that...
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes or No — If yes, enter 1 _____

5. Did you often or very often feel that...
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes or No — If yes, enter 1 _____

6. Were your parents ever separated or divorced?
   Yes or No — If yes, enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   Or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes or No — If yes, enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes or No — If yes, enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes or No — If yes, enter 1 _____

10. Did a household member go to prison?
    Yes or No — If yes, enter 1 _____

Now add up your "Yes" answers: _____ **This is your ACE score.**