COMPLETE BEHAVIORAL HEALTH
4565 S. 133rd St. Omaha, NE 68137
p: (402) 590 - 2947 | f: (402) 590 - 2030
www.cbhomaha.com

Intake

Information you provide here is protected as confidential information. Please complete these forms and bring to your first session.

Personal Information

Client First Name: _____ Last Name: _____Nickname: _____

DOB: _____ Age: _____ SS#: _____ Gender: _____

Address: _____

City:_____ State:_____ ZIP:_____

Home Phone: _____ May we leave a message? ☐ Yes ☐ No

Cell: _____ May we leave a message? ☐ Yes ☐ No

Work Phone: _____ May we leave a message? ☐ Yes ☐ No

E-Mail: _____ May we email you? ☐ Yes ☐ No
*Please note: E-mail correspondence is not considered a confidential medium of communication.

Referred by (if any):

_____

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list any children/age:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Emergency Contact

Name: _____ Relationship:_____ PH: (H) _____ (C) _____

Name: _____ Relationship:_____ PH: (H) _____ (C) _____

Name: _____ Relationship:_____ PH: (H) _____ (C) _____

Insurance Information

Insurance Company: _____ Benefits Phone #: (____) _____-_____

Subscriber Name: _____ DOB: _____ / _____ / _____

ID #: _____ Group #: _____

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Consent For Outpatient Treatment

Client Name (Print): _____

I, the undersigned Patient, parent, or legal guardian hereby give my consent for and acknowledgment of the following items which are initialed: I understand that I am consenting and agreeing only to those services that the 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. 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.

_____ Receipt of Rights

_____ I understand the possible psychological risks involved in counseling. I am hereby forewarned and cautioned, that engaging in psychotherapy may involve discussing uncomfortable past traumatic events, and/or experiencing depression, anger, and other difficult, intense emotions.

_____ I understand that I cannot attend any session or group while I am under the influence of illegal drugs and/or alcohol.

_____ I understand that my therapist may work with practicum students, supervisors, and case managers regarding my treatment and/or clinical file.

_____ I understand that case consultation occurs with providers for the sake of learning and improving clinical practice and that my confidential information will not be disclosed.

_____ I understand that certified alcohol and drug abuse counselors, practicum students/interns, and unlicensed professionals do not have privileged communication and may be required if court ordered to testify regarding my treatment.

_____ I understand that audio or video recording of sessions is strictly prohibited unless explicitly agreed upon in writing by both the client and the therapist. Unauthorized recording may result in termination of services and legal consequences.

_____ I understand that I have the right to receive Telehealth services which are available for most insurance plans and are offered through HIPAA compliant, confidential software.

_____ I understand that I need to communicate any concerns or problems to my therapist regarding my treatment and that I am responsible to make change occur. I am also responsible for completing homework assigned by my therapist.

I have read and understand the above initialed items and received an explanation of the information.

Date: _____ Person Served: _____

Personal Representative: _____

Date: _____ Witness: _____

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Official Financial Policy and Billing Agreement

Client Name (print): _____

Insurance Coverage:

- Client agrees to contact Insurance Company to verify benefits for services rendered. You pay for your Insurance. **It is your responsibility to know the benefits of your policy.** _____ (*Initial)*
- Should a dispute arise on a claim, **it is generally the clients' responsibility to clarify and resolve the dispute with the insurance company.** _____ (*Initial)*
- If Insurance is being filed, **any deductible not yet met is due at the time of service as well as any co-pay**. _____ *(Initial)*

Payment:

- **Payment is expected at the time of service** unless other arrangements have been made. _____ *(Initial)*
- **I agree to provide at least 24 hours' notice to cancel or reschedule an appointment.** If I provide less than 24 hours' notice, or do not attend the scheduled appointment, late-cancel and/or no-show charges may apply. Fees are as shown:
  - Initial late cancellation fee $75 and then $100 for all subsequent late cancellations
  - Initial no show fee $100 and then $150 for all subsequent no shows

  I also understand that late cancellation fees or no show fees **MUST** be paid prior to the next scheduled session._____ *(Initial)*
- A Service requested by the client, but not covered by the client's Insurance Plan may be arranged under a separate written agreement with the provider. _____ *(Initial)*
- Our self-pay fees are $150/session and are subject to change at the discretion of the practice. _____ *(Initial)*
- Questions regarding your account should be directed to the Billing service at (402) 590 - 2947. _____ *(Initial)*
- **All clients must keep a debit or credit card on file** for our office to run copays and other outstanding balances after insurance claims are processed. All clients with balances over $100 will be notified via phone call before a card is run. Please discuss payment plans with your provider. _____ *(Initial)*

I certify that I have read, understand and agree to the foregoing. The undersigned is the client or is duly authorized by and on behalf of the client to execute the above and accept its term.

Date: _____ Person Served Signature: _____

Personal Representative: _____

Date: _____ Witness: _____

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Authorization for Disclosure of Information

☐ Mental Health ☐ Drug/Alcohol ☐ Other

Name (Print):	SSN/DOB:

Authorization is hereby given to exchange information in written, verbal or electronic form regarding the above-named individual between the following agencies and/or individuals to be used for the purpose(s) of:

☐ Assessment ☐ Coordination of Services ☐ Individual Request ☐ Insurance ☐ Legal ☐ Other _____

All information requested is covered by federal regulation 45 C.F.R the Health Insurance and Portability Act (HIPAA) Parts 160 and 164. Drug and alcohol information is covered by federal regulation 42 C.F.R Part 2.

I authorize the following agency or individual (please include address):	To release and/or receive information from the following agency or individual (please include address):

The specific information to be exchanged is as follows:

_____ Aftercare/Discharge Plan
_____ Current Medications
_____ Discharge Summary
_____ Drug/Alcohol Summary
_____ Financial Resources & Eligibility
_____ Individual Education Plan
_____ Medical History
_____ Progress Reports/Summary of Treatment
_____ Psychiatric History and Diagnosis
_____ Psychological Testing Information
_____ Social History
_____ Treatment/Service Plan
_____ Other _____
_____ Intelligence Testing Results
_____ Psychotherapy Notes
_____ Determining Eligibility for Benefits or Program

If requested records including drug and alcohol information, I understand that my alcohol and drug treatment records are protected under the federal regulation governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand this Authorization may be revoked at any time, except to the extent that action has already been taken in reliance on this Authorization. I understand if I wish to revoke this authorization, I must do so in writing and present my written revocation to the Family Foundations.

Unless otherwise revoked, this Authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this Authorization will expire six (6) months from the date below.
I understand this authorization is voluntary. I can refuse to sign this Authorization. I need not sign this Authorization in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 C.F.R. 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may no longer be protected by federal confidentiality laws.

Date: _____ Person Served Signature: _____

Personal Representative: _____

Authority of Personal Representative: _____

Date: _____ Witness: _____

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HIPAA Notice of Privacy and Practices

I have reviewed the HIPAA Notice of Privacy Practices information and agree. At my request I am entitled to receive a copy of my rights to privacy.

Date: _____ Person Served Signature: _____

Personal Representative: _____

Date: _____ Witness: _____