FAMILY ENRICHMENT, INC.
CLIENT INFORMATION SHEET
PLEASE PRINT – FILL OUT COMPLETELY

Therapist _____

Date _____

Client's Name			
Address	City	State	Zip Code
Home Phone Number	Work Phone Number - If Child, Parent	Cell Phone Number - If Child, Parent	

Is it OK to contact you at home? ❑ Yes ❑ No Is it OK to contact you on your cell? ❑ Yes ❑ No

Is it OK to contact you at work? ❑ Yes ❑ No

Gender M F	Age	Date of Birth	Check One: ❑ Single ❑ Divorced ❑ Married ❑ Separated ❑ Widowed ❑ Living Together

Client's Employer or School	Client's Social Security Number
Name of Spouse (or Custodial Parent) / Date of Birth	Client's Highest Level of Education
Spouse or Parents' Employers	Work Phone (Spouse or Parents)
Physician Name	Medication Client is Taking
Major Medical Conditions	

Names of Children	Date of Birth	Age	Lives With You?
			❑ Yes
			❑ Yes
			❑ Yes
			❑ Yes

Referred By	In Case of Emergency Notify
Religion Preference	Relationship to Client and Phone Number
Is Client or anyone else in family receiving counseling?	
Reason for seeking service	

CONSENT TO TREATMENT Both parents must sign if divorced and have joint legal custody of minor.

I, _____, consent to treatment for therapy/counseling for
Your Name

( ) myself or ( ) minor _____
Minor's Name

by _____.
Therapist / Dr.

I grant this psychologist / therapist / physician to perform those procedures and treatment necessary for my condition that are generally used in this and similar settings.

_____ _____
Signature of Client or Responsible Party Date

_____ _____
Signature of Co-responsible Party Date

INSURANCE INFORMATION FORM

INSURANCE POLICY HOLDER_____
BIRTH DATE_____ SEX___ SS#___-___-___
RELATIONSHIP TO CLIENT _____
ADDRESS IF DIFFERENT FROM CLIENT_____
CITY_____STATE___ ZIP CODE_____

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of the necessary client records. If my insurance company requests information, I understand that I will be notified by my therapist.
I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and other health plans to be paid to FAMILY ENRICHMENT, INC.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance, and I also understand that Family Enrichment is not responsible for my insurance company's decision about payment. I hereby authorize said assignee to release all information necessary to secure the payment.
I have read the above statements and agree to their terms.

_____ _____
CLIENT'S SIGNATURE/RESPONSIBLE PARTY (IF MINOR) DATE

FINANCIAL POLICY

Thank you for choosing us as your mental health care provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we required you to read and sign prior to treatment. You much complete our Insurance Information form prior to treatment or provide a valid insurance card.

1. If your insurance deductible has not been met, we will expect payment in full each visit. After that, we will expect that you pay your co-pay at the time of each visit. We must have these payments in order to continue to provide you with service. Method of Payment-Cash, Checks, Visa or MasterCard are accepted. If you wish to have a receipt, please request it at the time of payment.
2. Adult clients are always responsible for either full payment or co-payment at time of service. The adult accompanying a minor is responsible for payment also at the time of service. If the minor is unaccompanied, payment by cash, check or credit card is expected.

CANCELLATION POLICY

I agree to A MINIMUM OF 24 HOURS NOTIFICATION OF CANCELLATION for appointments. I understand that I WILL BE CHARGED FOR THE SESSION FOR MISSED APPOINTMENTS without the minimum notification. I understand that my therapist will discuss repeated missed appointments with me.

Please let us know if you have questions or concerns about this Financial Policy. I have read the Financial Policy. I understand and agree to the terms in this Financial Policy.

_____ _____
Signature of Client or Responsible Party Date

I have received a copy of this agreement_____

HIPAA NOTICE OF PRIVACE PRACTICES
FAMILY ENRICHMENT, INC.

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice. Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in our office.

III. HOW WILL I USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:

1. For treatment. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you I may disclose your PHI to her/him in order to coordinate your care.

2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control-I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I cold also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHII.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example, I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.

2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.

3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.

4. If disclosure is compelled by the patient or the patient's representative pursuant to Nebraska Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.

5. To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.

6. If disclosure is compelled or permitted by the face that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.

7. If disclosure is mandated by the Nebraska Child Abuse and Neglect Reporting Law. For example, if I have a reasonable suspicion of child abuse or neglect.

8. If disclosure is mandated by the Nebraska Elder/Dependent Adult Abuse Reporting Law. For example, if I have reasonable suspicion of elder abuse or dependent adult abuse.

9. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.

10. For public health activities. Example, In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.

11. For health oversight activities. Example, I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.

12. For specific government functions. Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.

13. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.

14. For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.

15. Appointment reminders and health related benefits or services. Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer.

16. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.

17. I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that my be of interest to you.
18. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
19. If disclosure is otherwise specifically required by law.
C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.
1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.
D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.
IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.
These are your rights with respect to your PHI:
A. The Right to See and Get Copies of your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI but I know who does, I will advise you how you can get it. You will receive a response form me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.
B. The Right to Request Limits on Uses and Disclosures of your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the sues and disclosures that I am legally required or permitted to make.
C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.
D. The Right to Get a List of the Disclosures I have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, I.e., those for treatment payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or dsclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.
I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.
E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, © not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change (s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.
F. The Right to Get This Notice by Email. You have the right to get this notice by email. You have the right to request a paper copy of it, as well.
V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES.
If, in your opinion, I may have violated your privacy rights, of if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section IV below. You may also send a written compliant to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.
VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES.
If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact Scotti Thralls, Security Officer at Family Enrichment, Inc. 820 S 75th Street, Omaha, NE 68114-4623 or email at familyenrichment@gmail.com.
VII. EFFECTIVE DATE OF THIS NOTICE
This notice went into effect on April 14, 2003.
I acknowledge receipt of this notice.

Patient Name: _____ **Date:** _____ **Signature:** _____

CONSENT TO TREATMENT

I, _____ , consent to treatment for therapy/counseling for
Your Name

( ) myself or ( ) minor _____
Minor's Name

by _____ .
Therapist / Dr.

I grant this psychologist / therapist / physician to perform those procedures and treatment necessary for my condition that are generally used in this and similar settings.

_____ _____
Signature of Client or Responsible Party Date

_____ _____
Signature of Co-responsible Party Date

Family Enrichment, Inc.

820 South 75th Street
Omaha, Nebraska 68114
(402) 391-2477
Fax (402) 397-4268
e-mail: familyenrichment@gmail.com

Authorization for Release of Information

I, _____ hereby authorize _____ to disclose and/or
(Patient Name)
receive the following protected health information to/from: _____

Patient's DOB: _____ Address: _____

Patient's SS#: _____ _____

- ☐ Treatment Summary
- ☐ Psychological Evaluation
- ☐ Discharge Summary
- ☐ All available information
- ☐ Other _____
- ☐ HIV/Addiction- Federal Law 42 CFR Chapter 1 Part 2
- ☐ Substance Abuse and/or Addiction

_____

(Specifically describe the information to be disclosed, including, but not limited to, meaningful descriptions such as date of service, type of service provided, level of detail to be released, origin of information, etc.)

This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations of Family Enrichment, Inc. in the following manner:

_____

(Describe how protected health information will be used to carry out treatment, payment, and/or health care operations of Family Enrichment, Inc.)

This authorization shall be in force and effect until (date) _____ at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time, by sending such written notification to Family Enrichment, Inc. at 820 South 75th Street, Omaha, NE 68114. I understand that a revocation is not effective to the extent that Family Enrichment, Inc. has relied on the use or disclosure of the protected health information.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Family Enrichment, Inc. will not condition my treatment, payment enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Description of Personal Representative's Authority

_____ _____
Signature of Parent/Guardian (if under 19 years) Date