CLIENT INFORMATION

Therapist: _____ Date: _____

CLIENT INFORMATION

Legal Name: _____ Preferred Name: _____

DOB: _____ AGE: _____ Gender: _____

Address: _____

City / State / ZIP: _____

Phone: (home) _____ (cell) _____ (work) _____

Personal Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Partnered ☐ Widowed

Employment Status: ☐ Employed ☐ Unemployed ☐ Stay-at-Home ☐ Disability

Occupation/Employer Name: _____

Spouse/Partner's Name: _____ DOB: _____

Spouse/Partner's Occupation / Name of Employer: _____

APPOINTMENT REMINDERS – I would like to receive appointment reminders via the following method(s):

Phone Call: _____ Text Message to PH#: _____

Email: _____

INDIVIDUAL RESPONSIBLE FOR INSURANCE: (POLICY HOLDER/SUBSCRIBER INFORMATION)

Relationship to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: _____ DOB_____

Employer Name: _____

OTHER INFORMATION:

Emergency Contact: _____ Relationship to Client: _____

PH#: _____ Address: _____

How did you hear about us? _____

Primary Care Provider/Clinic: _____ PH#: _____

Psychiatrist/Clinic: _____ PH#: _____

FOR MINOR CLIENT:

Name of Parent/Guardian: _____

Home/Cell Phone: _____ Work Phone: _____

REV 10.2019

CONFIDENTIALITY CLARIFICATION & CONSENT TO TREAT

It is important that you fully understand the nature of confidentiality in the context of your relationship with The Attachment and Trauma Center of Nebraska, LLC, here forth referred to as ATCN. ATCN, its therapists, partners, interns, and employees will keep confidential any information disclosed by you in the course of our relationship and this information will not be disclosed to other parties without a written release signed by you. There may be exceptions, however, and it is important that you are aware of the exceptions to this policy.

- Disclosure of Child Abuse, Endangerment, and/or Neglect: If the client discloses information that a child is being abused, endangered or neglected, ATCN therapists, interns, and employees, ***are required by law to report this information to Child Protective Services (CPS).***

- Duty to Warn: If the therapist believes that a client poses a threat to themselves or others, the ***therapist is ethically bound to disclose this information to the appropriate person or agency.***

- Court Subpoena of Records: ***It is within the power of the Court System to subpoena client records*** for a therapist or agency.

- Any Insurance Agent/Company covering a client's mental health treatment will have access to any information necessary for the completion of insurance forms for the determination of benefits.

- All cases may be reviewed during Team Consultation. Treatment is provided with the understanding that case review may be brought to the team for discussion.

- Exchange of information with psychiatrists, therapists, CPS case managers, probation officers, or other persons outside ATCN regarding the client's case with the express written permission by the client (See Consent to Release Form).

- Research Participation: If asked and you agree to participate in therapeutic outcomes research, express written permission which defines the project will be obtained.

If you have any questions regarding confidentiality, please ask. Your therapist will provide you with a copy of this clarification sheet if requested.

I have read, understand, and agree to the above limitations of confidentiality. _____ (Initial)

INFORMED CONSENT: We ask that clients sign the below as a Consent to Treatment. The client may decline specific recommendations during the therapy process at any time**.**

I give my consent for services with the Attachment & Trauma Center of Nebraska, (ATCN) to include evaluation, therapy, education, testing (if applicable) and involvement in the treatment planning processes.

_____ _____ _____

Identified Client or Legal Guardian Signature Witness Date

I would like a copy of this consent □ YES □ NO

REV 10.2019

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF HIPAA PRIVACY POLICIES

I certify that I have received a copy of Notice of HIPAA Privacy Policies. The Notice of HIPAA Privacy Policies describes the types of uses and disclosures of my protected health information (PHI) that might occur in my treatment, payment of my bills, or in the performance of The Attachment and Trauma Center of Nebraska's (ATCN) health care operations. The Notice of HIPAA Privacy Policies also describes my rights and ATCN's duties with respect to my PHI. The Notice of HIPAA Privacy Policies is posted in the corridor near the front door.

The Attachment and Trauma Center of Nebraska reserves the right to change the privacy policies that are described in the Notice of HIPAA Privacy Policies. I may obtain a revised Notice of Privacy Policies by calling the office and requesting a revised copy be sent in the mail, asking for one at my next appointment, or through e-mail.

_____

Printed Identified Client Name

_____

Signature of Patient or Personal Representative

_____ _____

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

_____

Date

Rev1.2019

ASSIGNMENT OF INSURANCE BENEFITS

Signature of this contract authorizes payment of medical benefits to The Attachment and Trauma Center, LLC (ATCN) for services rendered (assignment of benefits). I understand my insurance company (if applicable) may be billed the full amount for the session and that aside from my co-pay (if applicable), and providing that ATCN is considered "In Network" with my insurance plan, I am not liable for any difference between the billed amount and the reimbursement amount previously contracted between the insurer and ATCN.

I / We the undersigned acknowledge the my / our insurance company may request clinical information including diagnosis, prognosis and treatment plans and hereby authorize the release of any appropriate information relating to payment of claims submitted to insurance on behalf of myself / us and or dependents. I/we further expressly agree and acknowledge that signature of this document authorizes ATCN to submit claims for insurance benefits, for services rendered, or for services to be rendered, including treatment plans, without obtaining my / our signature as though the undersigned had personally signed the particular claim. I /we therefore authorize the insurance company to pay and hereby assign directly to ATCN all insurance benefits, if any, otherwise payable to me / us for services described on the attached forms. I /we are financially responsible for all charges incurred, whether they are paid by insurance or not. I / we further acknowledge that any insurance benefits, when received and paid to ATCN, will be credited to my / our account, in accordance with the above said statement.

I understand that it is important that I provide at least a 24-hour notice of cancellation of a scheduled appointment, and in not doing so, I will be liable for up to the full amount normally charged for this scheduled time. This charge will be the responsibility of the client. _____
Initial

It is usual practice, and preferable, to provide payment for the session (or insurance co-pay, deductible if applicable) at the time of check-in before the session begins. Cash, check or credit card are accepted: _____
Initial

☐ If preferred, and at your request, your credit/debit card information may be maintained within your secure, encrypted EHR (Electronic Health Record) for future co-payments. You may change this at any time. _____
Initial

☐ I understand that I will be charged a $35 service handling fee for any returned form of payment. _____
Initial

CARD HOLDERS SIGNATURE: _____ Date: _____

☐ ***I/We acknowledge understanding of and agree to the terms of this contract for payment of services.***

_____ _____
Client/Guardian Signature Date

ATCN

638 N 109TH Plaza, Omaha NE 68154 * 402.403.0190 * FAX 402.932.4121

CONTRACT FOR PAYMENT OF SERVICES

I understand that I am assuming responsibility for payment of my / legal dependent / minor child's legal bill at this time of the session, unless other arrangements are made and herein specified. I also understand that should the client account balance remain outstanding, that The Attachment and Trauma Center of Nebraska, LLC (ATCN) utilizes the services of a collection agency and I agree that ATCN may release my name to any necessary party in the course of obtaining payment.

*****

SELF-PAY FEES AND INSURANCE CO-PAYS ARE EXPECTED AT THE TIME OF SERVICE AND SHOULD BE MADE BEFORE EACH SESSION AT THE TIME OF CHECK-IN WITH THE BUSINESS OFFICE

*****

☐ ***Option A:*** I/We wish to self-pay and NOT use insurance benefits. I/We do not give permission for any confidential information about me (or my partner) and my/our treatment to be released to any third-party payor, employer, or insurance company. Self-payments may be made from a HAS or FSA account via check or credit.

☐ ***Option B:*** I/We wish to use insurance to help pay for services.

☐ Copy of my insurance card will be given to the Business Office or therapist for billing purposes at check-in. _____
Initial

For clients choosing to use health insurance for treatment, it is client's responsibility to ensure you have current mental health benefits for outpatient office visits. Insurance companies only quote benefits and do not guarantee payment over the phone. Any disagreement regarding payment of a claim by insurance is between the client and his/her insurance company.

ULTIMATELY, PAYMENT OF THE BILL IS THE CLIENTS RESPONSIBILITY AND IT IS EXPECTED THAT PAYMENT BE MADE WITHIN 30 DAYS UNLESS YOU HAVE A PAYMENT PLAN ARRANGEMENT IN PLACE WITH YOUR THERAPIST AND THE BUSINESS OFFICE. _____
Initial

Name of Primary Insurance: _____ Member #: _____

Subscriber (Policy Holder): _____ Subscriber DOB: _____

Name of Secondary Insurance: _____ Member #:_____

Subscriber (Policy Holder): _____ Subscriber DOB: _____

☐ ***I/We acknowledge understanding of and agree to the terms of this contract for payment of services.***

_____ _____
Client/Guardian Signature Date

ATCN * 638 N 109TH Plaza, Omaha NE 68154 * 402.403.0190 * FAX 402.932.4121

Academic and Social History

CLIENT NAME: _____

Academic Performance

Highest grade on last report card: _____ Lowest grade on last report card: _____

Favorite subject in school: _____ Least Favorite subject: _____

Has your child had special testing in school: ☐ Yes ☐ No Describe:_____

Psychological: ☐ Yes ☐ No Learning: ☐ Yes ☐ No Vocational: ☐ Yes ☐ No

What would your child like to do about school at this time:

☐ Quit School ☐ Graduate from High School ☐ Go to College

In school, how many friends does your child have: ☐ A lot ☐ A few ☐ None

Does child have friends in the neighborhood or close contacts they play with regularly? ☐ Yes ☐ No

Describe: _____

How does your child handle anger with peers and family: _____

_____

What are your child's interests, hobbies and regular activities: _____

_____

_____

How much time does your child play on the computer, watch tv, play video games or other electronic devices: _____

Has your child ever had difficulty with the Police: ☐ Yes ☐ No

Describe: _____

_____

Has your child ever been on Probation: ☐ Yes ☐ No

Dates	Reason	Probation Officer
_____	_____	_____
_____	_____	_____

Has your child ever been employed: ☐ Yes ☐ No

Dates	Employer	Job
_____	_____	_____

Child Developmental and Family History

CLIENT NAME: _____

In the first two years of life, did your child experience:

☐ Separation from mother ☐ Out of home care ☐ Disruption in bonding ☐ Depression of mother

☐ Abuse ☐ Neglect ☐ Chronic pain ☐ Chronic illness ☐ Parental stress ☐ Unknown

Reached developmental milestones: ☐ On time ☐ Early ☐ Late

How many times has the child moved homes? _____

BIOLOGICAL FAMILY HISTORY IF KNOWN

Biological Dad: _____DOB:_____ Biological Mom: _____DOB:_____

Marriage: _____ Separated: _____ Divorced: _____

Siblings first Name(s) & Age: _____

Siblings first Name(s) & Age: _____

Siblings first Name(s) & Age: _____

Siblings first Name(s) & Age: _____

Siblings first Name(s) & Age: _____

CUSTODIAL ADULTS/PARENTS/GUAIDIAN HISTORY (if not biological parents):

Who is the primary caretaker: _____ Date became caretaker: _____

Who is the Legal Custodial Parent/Guardian: _____

Dad: _____DOB:_____ Mom: _____DOB:_____

People in the household if different from above: _____

_____

Does father work outside the home: ☐ Yes ☐ No Occupation: _____ Hours: _____

Highest Level of education: _____

Does mother work outside the home: ☐ Yes ☐ No Occupation: _____ Hours: _____

Highest Level of education: _____

If separated or divorced, visitation schedule: _____

Does either parent have legal issues: ☐ Yes ☐ No If yes, describe: _____

Does your family have any specific spiritual or religious beliefs? ☐ Yes ☐ No

If yes, describe: _____

List any mental illness or addiction in immediate or extended family, (for example: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, eating disorders, ADHD, Schizophrenia):

_____
_____
_____

Has your child witnessed domestic violence? ☐ Yes ☐ No

If yes, describe: _____

How is your child disciplined? Please list each method and frequency of use:

_____
_____
_____

REV 10.2019

Child & Teen Medical History

CLIENT NAME: _____ DATE of 1st Appointment: _____ TIME:_____

DOB: _____ Age: _____ Gender: ☐ Male ☐ Female

School: _____ Grade: _____ Key Teacher: _____

School Counselor: _____ Therapist: _____

MEDICAL HISTORY

Name of Primary Care Physician (PCP): _____ Clinic: _____

Address: _____ Phone #:_____

Many Managed Care companies require that we have interaction with the client's PCP to coordinate care. Do you give us consent to discuss your care with the above-named doctor? ☐ Yes ☐ No

Please Sign here for either answer above: _____

Date of last medical evaluation: _____ Date of next appointment: _____

Current medications being taken:

- Medication: _____ Dose: _____

Diagnosis/Purpose: _____ How Long on Rx:_____

Side Effects: _____Cautions: _____

Prescribing Physician: _____ Ph #:_____

Pharmacy: _____ Ph#:_____

- Medication: _____ Dose: _____

Diagnosis/Purpose: _____ How Long on Rx:_____

Side Effects: _____Cautions: _____

Prescribing Physician: _____ Ph #:_____

Pharmacy: _____ Ph#:_____

- Medication: _____ Dose: _____

Diagnosis/Purpose: _____ How Long on Rx:_____

Side Effects: _____Cautions: _____

Prescribing Physician: _____ Ph #:_____

Pharmacy: _____ Ph#:_____

- Medication: _____ Dose: _____

Diagnosis/Purpose: _____ How Long on Rx:_____

Side Effects: _____Cautions: _____

Prescribing Physician: _____ Ph #:_____

Pharmacy: _____ Ph#:_____

Has your child ever been hospitalized for medical or psychiatric reasons? ☐ Yes ☐ No
Hospital/ Month/Year/Reason

_____
_____
_____

Describe any important medical history, chronic ailments, or other health problems your child experiences:

_____
_____
_____

Does your child have a learning or physical disability? ☐ Yes ☐ No ☐ Maybe
Describe:

_____
_____

Does your child have a mental health diagnosis? ☐ Yes ☐ No ☐ Maybe
Describe:

_____
_____

Describe any other health problems or important medical history about your child's immediate family members and close relatives, including chronic ailments:_____

_____
_____

Does your child have any close relatives (father, mother, sibling, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please List: _____

_____

Trauma History

Has your child been verbally abused: ☐ Yes ☐ No ☐ Suspected Describe: _____

_____

Has your child been physically abused: ☐ Yes ☐ No ☐ Suspected Describe: _____

_____

Has your child been sexually abused: ☐ Yes ☐ No ☐ Suspected Describe: _____

_____

Other stressors or trauma: _____

Concerns, Strengths and Goals

Check the symptoms your child displays and list the number of times per week the symptom is displayed.

☐ Anger _____ ☐ Anxiety _____ ☐ Bedwetting _____ ☐ Acts out sexually _____

☐ Controlling _____ ☐ Conduct problems _____ ☐ Day Defecation _____ ☐ Unusual Sexual Knowledge _____

☐ Day Wetting _____ ☐ Defiance _____ ☐ Depression _____ ☐ Homicidal thoughts/actions _____

☐ Disassociates _____ ☐ Drug/Alcohol Use _____ ☐ Hyperactivity _____ ☐ Excessive Masturbation _____

☐ Hyper Vigilance _____ ☐ Impaired Conscience _____ ☐ Isolation _____ ☐ Lack of empathy_____

☐ Lethargy _____ ☐ Lying _____ ☐ Nightmares _____ ☐ Obsesses _____

☐ Phobias _____ ☐ Shy _____ ☐ Self Mutilating _____ ☐ Peer Problems _____

☐ Running Away _____ ☐ Lack of motivation _____ ☐ Stealing_____ ☐ Low self-esteem_____

☐ Tantrums _____ ☐ Low impulse control _____ ☐ Plays out violent themes _____

☐ Suicide talk _____ ☐ Plays out sexual themes _____ ☐ Sleeping problems _____

☐ Somatic Symptoms (headaches, stomachs, etc)

☐ Other Concerns: _____

_____

_____

Has the child experienced any significant loss: ☐ Yes ☐ No Describe: _____

What do you view as your child's major strengths and positive traits: _____

_____

_____

Describe your goals for your child's therapy: _____

_____

What else is important for your therapist to know about your child and your family:

_____

_____

_____

_____

_____

Parent Signature_____ Date _____

REV 10.2019