NEBRASKA MENTAL HEALTH CENTERS - Confidential Intake Form

Name (First, Middle Initial, Last):		Gender M F	Birthdate (mm/dd/yyyy)
Street Address:	City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:	
Social Security Number:	Marital Status: S M W D	Email Address:	
Employer:	Full-time Part-time	Employer Address:	
Education Level (highest grade completed):	Student Now? Yes No	School:	
Have you (patient) had previous counseling? Yes No	If yes, please tell us when and with whom:		
Emergency Contact (name, relationship, phone):		Intitial here for permission to contact in case of emergency: _____	
How did you hear about us:			

Parent / Legal Guardian Information **(for patients under 19yrs of age, elderly, mentally disabled, etc)**

Parent/Guardian Name (First, Middle Initial, Last):		Relationship to Patient:	
Street Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	
Parent/Guardian Name (First, Middle Initial, Last):		Relationship to Patient:	
Street Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	

Insurance Plan Information

Primary Plan Name:	Phone #:	Policy #:	Group #:
Policy Holder Name:	Birthdate (mm/dd/yyyy):	Social Security Number:	
Policy Holder's Employer:		Relationship to patient:	
Secondary Plan Name:	Phone #:	Policy #:	Group #:
Policy Holder Name:	Birthdate (mm/dd/yyyy):	Social Security Number:	
Policy Holder's Employer:		Relationship to patient:	

Patient Rights:

1. To receive quality, considerate, and respectful care.
2. To receive treatment without regard to age, race, color, sex or sexual orientation, religion, marital status, national origin, economic status or source of payment;
3. To be treated with respect and recognition of your dignity and right to privacy.
4. To receive information about services, staff, and hours of operation.
5. To receive a clear explanation of their condition and treatment options.
6. To be informed and to participate in the decisions about your treatment.
7. Information in a language they can understand.
8. To be provided a way in which to make a complaint or a grievance about services without discrimination or reprisal, and get a timely answer.
9. To have treatment and other member information kept private. Only where permitted by law will records be released without members' permission.
10. To have access to your medical records as permitted by Nebraska State las.
11. To have your psychiatric/mental health advance directive followed, should you have one. Check one below.
    _____ I have a psychiatric/mental health advance directive.
    _____ I want information about having a psychiatric/mental health advance directive developed
    _____ I do not want to have a psychiatric/mental health advance directive developed.
12. To be provided an on-call crisis line manned by clinical personnel to assist patients after normal business hours. Call the Emergency Assistance On-Call Crisis Line at 402-483-6990 and leave a voice message with his/her name and phone number. The on-call clinician returns calls as clinically necessary.

_____ Patient/Guardian Initials

Permission to Observe Sessions and Discuss Case Information

We would also like to inform you that as a group practice and training facility for a Psychology Internship and Residency Programs, professionals work together to consult on patient care issues. It is possible your material could be used in teaching, supervision, and consultation with other therapists or, on occasion, an intern or a supervisor may observe your session. Your therapist will, on these occasions, ask prior to the beginning of the session if someone can join for observation and/or provide assistance. You may decline at that time. All professionals within NMHC are bound by confidentiality agreements and HIPAA regulations.

_____ Patient/Guardian Initials

CONSENT FOR TREATMENT

I hereby consent to mental healthcare to be provided by Nebraska Mental Health Centers. This includes assessment and treatment procedures as appropriate. I understand that treatment options will be discussed with me and that I have a right to participate in decisions about treatment.

Patient Name: _____ Patient Signature:_____

Parent/Guardian Name_____ Parent/Guardian Signature: _____

Date: _____ Staff Initials _____

Financial Policy and Patient Responsibility

Patient Responsibilities

- Provide a photo ID for your confidential patient chart (16 years and older).
- Provide NMHC with your current insurance and policy holder information.
- Know their insurance policy. Patients should be aware of their benefit coverage including which providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and costs share information such as deductibles, co-insurance, and co-pays. If you are not familiar with your plan coverage for mental health services, we recommend you contact your carrier directly.
- Pay their co-pay amount at the time of service.
- Pay for their visit in full at the time of service if a self-pay patient.
- Pay any Medicare deductible and co-insurance amounts not covered by their supplemental insurance.
- Promptly pay any patient responsibility indicated by their insurance carrier. A late charge of 1.5% per month on unpaid patient balances will be added to accounts not paid within 90 days of receipt of insurance payment.
- In the case of a divorce, the custodial parent is responsible for all payments. NMHC is not involved in disagreements between the parties in a divorce situation.
- Inform the front office of any change of personal information (e.g., phone #, address, insurance information)
- Keep all appointments. If needing to cancel an appointment, provide office notification at least 24 hours in advance. Any No Show or Late Cancel appointments may be charged as follows:
  First Time – No Charge Second Time – Half price of the Session scheduled.
  Third Time – Full Price of the Session scheduled.

NMHC will bill your insurance company in a timely manner, be as accurate as possible with our billing procedures, and will efficiently answer any billing questions you may have. We will send you a monthly statement so that you know the amount you are responsible to pay. Payment is due upon receipt of the monthly billing statement.

Account balance past 30 days must be paid prior to the next visit. If you cannot pay, other options may be discussed. Please speak to the accounts manager. If your account balance remains past due after 90 days, we will notify you that without a response from you, we may use a collection agency or our attorneys to obtain payment in full.

Financial Policy Acknowledgement

I have read and understand the above financial policy. I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered. I understand that payments can be made by cash, check or credit card. I agree that if my account is referred to a collection agency or attorney I will be responsible for all costs of collection on my account including attorney's fees, and any interest on money due.

Patient Name: _____ Signature:_____ Date _____

Patient's Guardian Name: _____ Signature:_____ Date:_____

NMHC Staff Signature:_____ Date:_____

Nebraska Mental Health Centers

Lincoln Beatrice Fremont

Authorization to Exchange Confidential Information with Medical Primary Care Provider

Patient Name: _____ Date of Birth: _____

The Purpose of the Authorization: To release behavioral health evaluation and/or treatment information to the Medical Primary Care Provider listed below to ensure quality and coordination of care and to request applicable medical/health information in accordance with the Federal and State statutory requirements concerning confidentiality of records

_____ I hereby authorize that confidential information be exchanged with my Medical Primary Care Provider listed below.

Doctor Name: _____

Doctor Phone Number: _____

Doctor Fax Number: _____

_____ I decline to authorize the exchange of confidential information with my Medical Primary Care Provider.

_____ I do not have a Medical Primary Care Provider.

Signature of Patient: _____ Date: _____

OR

Signature of Responsible Party: _____ Date: _____

Name of Responsible Party: _____

NMHC Staff Signature: _____ Date: _____

Important Rights and Other Required Statements You Should Know:

- You can revoke this authorization at any time by writing to the providers named above. If you revoke this authorization it will not apply to the information that has already been released.
- The information disclosed based on this authorization may be re-disclosed by the recipient and may no longer be protected by Federal or State privacy laws. Not all persons or entities have to follow these laws.
- You do not need to sign this form in order to obtain enrollment, eligibility, payment or treatment for services. This authorization is completely voluntary.
- You have a right to a copy of this authorization once you have signed it.
- A photocopy or fax of this release is as good as the original. NMHC will not condition treatment, payment, enrollment, or eligibility for benefits on this authorization. NMHC notifies you of the potential that this information, once forwarded to the other party, could be re-disclosed and no longer protected by the rule.

Jill Zlomke McPherson, MA, LIMHP, Executive Director **Dr. Lee C. Zlomke, Clinical Director**

4545 South 86th Street • Lincoln, NE 68526

Phone: 402-483-6990 or 1-888-210-8064 • Fax: 402-483-7045

Visit us online at www.nmhc-clinics.com

Nebraska Mental Health Centers

Consent for Use/Disclosure of Protected Health Information (PHI) for Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by Nebraska Mental Health Centers (NMHC) for the purpose of diagnosing or providing treatment to me, obtain payment for my health care bills, or to conduct health care operations of NMHC. I understand that diagnosis or treatment of me by NMHC may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my health care provider, a health care professional, a health plan, my employer, or a healthcare clearinghouse. This protected health information related to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the following rights with regard to my protected health information:

- Right to request restrictions on certain uses and disclosures of PHI. However, NMHC is not required to agree to a restriction you request.
- Right to receive confidential communications by alternative means and at alternative locations.
- Right to inspect and copy PHI and psychotherapy notes in NMHC mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. NMHC may deny your access to PHI under certain circumstances, but in all cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- Right to amend PHI for as long as the PHI is maintained in the record. NMHC may deny your request. On your request, we will discuss with you the details of the amendment process.
- Right to a paper copy of the notice from NMHC upon request.

I understand I have a right to review NMHC's Notice of Privacy Practices prior to signing this document. A copy of the NMHC's Notice of Privacy Practices is available in the waiting room. A copy of the afore-mentioned documents will also be provided to me upon my request. The Notice of Privacy Practices describes the types of uses and disclosures of my "protected health information" (PHI) that will occur in my treatment, payment of my bills, or the performance of healthcare operation of NMHC. NMHC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I have the right to revoke this consent in writing, at any time, except to the extent that NMHC has taken action in reliance on this consent.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature:_____

NMHC Staff Signature: _____ Date: _____

Nebraska Mental Health Centers

Intake Questionnaire

Family/Self Psycho-social History

Have you and/or anyone in your birth family experienced or been diagnosed with the following? Check all that apply.

Self	Family	
☐	☐	Mental Retardation
☐	☐	Speech or Communication Disorder
☐	☐	Attention-Deficit/Hyperactivity Disorder
☐	☐	Learning Problems/Disabilities
☐	☐	Pervasive Developmental Disorder
☐	☐	Autism Spectrum Disorder
☐	☐	Sleep Disorders
☐	☐	Eating Disorders
☐	☐	Anxiety Disorders (Panic, Phobias, Social Anxiety)
☐	☐	Post-Traumatic Stress
☐	☐	Obsessive-Compulsive Disorder
☐	☐	Depression
☐	☐	Manic-Depression/Bipolar Disorder
☐	☐	Sexual Disorders
☐	☐	Personality Disorders
☐	☐	Schizophrenia or other Psychosis

Self	Family	
☐	☐	Seizures or other Neurological Disorder
☐	☐	Genetic Disorder (e.g. Down Syndrome)
☐	☐	Dementia
☐	☐	Neglect
☐	☐	Emotional abuse
☐	☐	Physical abuse
☐	☐	Sexual abuse
☐	☐	Domestic violence
☐	☐	Legal problems
☐	☐	Financial problems
☐	☐	Alcohol/Substance Abuse
☐	☐	Serious illness
☐	☐	Accident or injury
☐	☐	Frequent/Multiple moves
☐	☐	Homelessness
☐	☐	Other: _____

Current Psychological Difficulties

Please check any that apply to you at this time

- ☐ Generalized Anxiety
- ☐ Specific fears/phobias
- ☐ Panic Attacks
- ☐ Obsessive thinking/repetitive behaviors
- ☐ Sadness/Depression
- ☐ Frequent crying
- ☐ Loss of energy
- ☐ Loss of pleasure in life
- ☐ Trouble waking up
- ☐ Fatigue/tiredness during the day
- ☐ Nightmares/Night terrors
- ☐ Memory problems
- ☐ Paranoia
- ☐ Problems with attention/concentration
- ☐ Racing thoughts
- ☐ Problems making/keeping friends
- ☐ Problems controlling temper
- ☐ Relationship/Marriage problems
- ☐ Problems with intimacy
- ☐ Problems with job
- ☐ Alcohol/drug use/abuse
- ☐ Financial problems
- ☐ Legal situation
- ☐ Mood swings
- ☐ Hallucinations
- ☐ Frequent body complaints
- ☐ Body image issues
- ☐ Other: _____

Have you ever or are you currently contemplating suicide?
☐ No ☐ Yes (Currently) ☐ Yes (Past)

Has anyone close to you (family/friends) ever attempted/committed suicide?
☐ Yes ☐ No

Have you ever or are you currently contemplating harming another person?
☐ No ☐ Yes (Currently) ☐ Yes (Past)

Health and Social Information

How is your health at present? (Select one)
☐ Poor
☐ Unsatisfactory
☐ Good
☐ Very Good

Please list any persistent physical symptoms or health concerns (e.g., chronic pain, headaches, hypertension, diabetes, etc.)

_____

_____

How many times per week do you exercise?
☐ 1 or less
☐ 2
☐ 3
☐ 4 or more

Rate the overall level of stress in your life.
☐ Very Low
☐ Low
☐ None
☐ High
☐ Very High

List any sources of stress in your life: _____

_____

_____

Are you having any problems with your sleep habits?
☐ Yes
☐ No

If yes, check where applicable:
☐ Sleeping too little
☐ Sleeping too much
☐ Poor quality sleep
☐ Disturbing dreams
☐ Other: _____

Have you ever or are you currently engaging in self-harm?
☐ No
☐ Yes (Currently)
☐ Yes (Past)

Are you having any difficulty with appetite or eating habits?
☐ Yes
☐ No

If yes, check where applicable:
☐ Eating less
☐ Eating more
☐ Binging
☐ Restricting

Have you experienced significant weight change in the last 2 months?
☐ Yes (gain)
☐ Yes (loss)
☐ No

Are you currently in a relationship?
☐ Yes
☐ No
If yes, please list status: _____

Number of marriages: _____
Number of divorces: _____
If widowed, your age at death of spouse: _____

Do you have children?
☐ Yes
☐ No
If yes please list below:

Medical Information

Do you now have, or have you had in the past, any of the following?

Now	Past		Now	Past		Now	Past	
☐	☐	Concussion/Loss of Consciousness	☐	☐	Allergies	☐	☐	Seizures
☐	☐	Asthma	☐	☐	Epilepsy	☐	☐	Diabetes
☐	☐	Brain Injury	☐	☐	Cancer	☐	☐	Heart Disease
☐	☐	Digestive Disorders	☐	☐	Immune System Problems	☐	☐	Hearing Problems
☐	☐	Breathing Problems	☐	☐	Vision Problems	☐	☐	Tuberculosis
☐	☐	High Blood Pressure	☐	☐	Urinary Disorders	☐	☐	Chronic Fatigue Syndrome
☐	☐	Arthritis	☐	☐	Multiple Sclerosis	☐	☐	Miscarriage (how many)
☐	☐	Thyroid Disorder	☐	☐	Pregnancy (how many)	☐	☐	Sleep Disorder
☐	☐	Fibromyalgia	☐	☐	Sexually Transmitted Disease	☐	☐	Other: _____
☐	☐	Abortion (how many)						
☐	☐	Serious Accident	☐	☐	Headaches			

List all medications you take, including prescription, psychotropics, over-the-counter, vitamins, drops, and topicals

List medications to which you are allergic

List any operations/medical procedures and the dates they took place

List any other hospitalizations and/or major injuries

Legal history

Have you ever been the victim of a crime?

☐ Yes
☐ No

Have you ever been convicted of a misdemeanor or felony?

☐ Yes
☐ No

Substances History

Please indicate substances currently used (over the past 6 months), how much at one time, how many times per day/week, age of first use, past use history, and length of time used.

Substance	Usage	Amount	Frequency	Age (of first use)
Caffeine	☐Current ☐Past			
Alcohol	☐Current ☐Past			
Tobacco	☐Current ☐Past			
Marijuana	☐Current ☐Past			
Ecstasy	☐Current ☐Past			
Cocaine/Crack	☐Current ☐Past			
Heroin	☐Current ☐Past			
Methamphetamines	☐Current ☐Past			
PCP/LSD/Mushrooms	☐Current ☐Past			
Painkillers	☐Current ☐Past			
Steroids	☐Current ☐Past			
Tranquilizers	☐Current ☐Past			
Sleeping pills	☐Current ☐Past			
Diet pills	☐Current ☐Past			

Have you ever believed your substance use was a problem for you?
☐ Yes
☐ No

Has anyone ever told you they believed your substance use was a problem?
☐ Yes
☐ No

Have you ever had withdrawal symptoms when trying to stop using any substances?
☐ Yes
☐ No

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use?
☐ Yes
☐ No
If yes, please describe: _____

Have you ever participated in drug/alcohol treatment?
☐ Yes
☐ No

If yes please list type, length, dates, and age at the time you received these services: _____
_____

Do you currently or have you ever attended Alcoholics or Narcotics Anonymous?
☐ Yes
☐ No

If yes, please list length of time sober and number of meetings you attend per week: _____
_____

OQ-45.11

Name:_____ Date:_____

Provider:_____

INSTRUCTIONS:

Looking back over the last week, including today, help us understand how you have been feeling. Read each item and mark the answer that best describes your current situation. Work is defined as employment, school, housework, volunteer work, etc.

1. I get along well with others
   [] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

2. I am easily fatigued
   [] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

3. I feel little interest in life
   [] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

4. I feel stressed at work/school
   [] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

5. I blame myself for things
   [] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

6. I feel irritated
   [] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

7. I feel unhappy in my marriage/significant relationship
   [] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

8. I have thoughts of ending my life
   [] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

9. I feel weak
   [] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

10. I feel fearful
    [] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

11. After heavy drinking, I need a drink the next morning to get going (if you do not drink, mark 'never')
    [] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

12. I find my work/school satisfying
    [] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

13. I am a happy person
    [] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

14. I work/study too much
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

15. I feel worthless
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

16. I am concerned about family troubles
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

17. I have an unfulfilling sex life
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

18. I feel lonely
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

19. I have frequent arguments
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

20. I feel loved and wanted
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

21. I enjoy my spare time
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

22. I have difficulty concentrating
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

23. I feel hopeless about the future
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

24. I like myself
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

25. I am not able to keep disturbing thoughts out of my mind
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

26. I feel annoyed by people who criticize my drinking or drug use
(if not applicable, mark 'never')
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

27. I have an upset stomach
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

28. I am not working/studying as well as I used to
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

29. My heart pounds too much
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

30. I have trouble getting along with friends and close acquaintances
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

31. I am satisfied with my life
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

32. I have trouble at work because of drinking or drug use
(if not applicable, mark 'never')
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

33. I feel that something bad is going to happen
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

34. I have sore muscles
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

35. I feel afraid of open spaces, of driving, or being on buses, subways,etc.
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

36. I feel nervous
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

37. I feel my love relationships are full and complete
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

38. I feel that I am not doing well at work/school
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

39. I have too many disagreements at work/school
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

40. I feel that something is wrong with my mind
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

41. I have trouble falling asleep or staying asleep
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

42. I feel blue
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

43. I am satisfied with my relationships with others
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

44. I feel angry enough at work/school to do something I might regret
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always

45. I have headaches
[] Never [] Rarely [] Sometimes [] Frequently [] Almost Always