New Patient Intake Packet

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

Social Security Number: _____

Emergency Contact (name, relationship, phone): _____

2. Primary Insurance

Primary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name _____ Insured Phone # _____ Insured Date of Birth _____

Insured Gender
○ Female ○ Male

Insured Street Address _____ Insured City _____ Insured State _____ Zip Code _____

3. Secondary Insurance

Secondary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name _____ Insured Phone # _____ Insured Date of Birth _____

Insured Gender
○ Female ○ Male

Insured Street Address _____ Insured City _____ Insured State _____ Zip Code _____

4. Please describe what has led you to seek Counseling now. How long has this been a problem for you and what other help have you had with it? How do your current difficulties affect you?

5. Have you dealt with any of the following emotional / behavioural problems? Check all that apply:

- ☐ Alcohol abuse
- ☐ Chronic lying
- ☐ Distrustful
- ☐ Drug use
- ☐ Extreme worrier
- ☐ Hostile/angry mood
- ☐ Immaturity
- ☐ Impusivity
- ☐ Indecisiveness
- ☐ Not trustworthy
- ☐ Repeats words of others
- ☐ Self-injurious acts
- ☐ Stealing
- ☐ Violent temper
- ☐ Other(s)

If "other(s)", please specify

6. Have you ever or are you currently contemplating suicide?

- ○ No
- ○ Yes (Currently)
- ○ Yes (Past)

7. Has anyone close to you ever attempted/committed suicide?

- ○ Yes
- ○ No

8. Are you having any problems with your sleep habits?

- ○ Sleeping too much
- ○ Sleepting too little
- ○ Poor quality sleep
- ○ Disturbing dreams
- ○ Pain

9. Have you ever or are you currently engaging in self-harm?

- ○ No
- ○ Yes (Currently)
- ○ Yes (Past)

10. Who suggested that you see a Counselor?

- ☐ No-one (self-referral)
- ☐ Friend
- ☐ Family member
- ☐ Partner
- ☐ Co-worker
- ☐ Other

If "other", please specify

11. What would you like to gain from Counseling now? How would things be different if the difficulties were resolved?

12. How have you been coping with this problem until now?

13. What support do you have in your life (Family / Friends / School / Work / Social activities, etc)?

14. Do you have any difficulties with alcohol, drugs or food? If yes, please describe about such difficulties.

15. Regarding your childhood, which - if any - of the following conditions did you suffer from? Please use the boxes to indicate the approximate age when affected by such conditions and/or to further specify them:

- ☐ Allergies to _ _____
- ☐ Asthma _____
- ☐ Autism _____
- ☐ Chicken pox _____
- ☐ Chronic, serious health problems __ _____
- ☐ Diphyheria _____
- ☐ Ear infection _____
- ☐ German measles _____
- ☐ Lead poisoning _____
- ☐ Mental retardation _____
- ☐ Mumps _____
- ☐ Pneumonia _____
- ☐ Poliomyelitis _____
- ☐ Red measles _____
- ☐ Rheumatic fever _____
- ☐ Scarlet fever _____
- ☐ Significant injuries __ _____
- ☐ Tuberculosis _____
- ☐ Whooping cough _____
- ☐ Other(s) _____

If "other(s)", please specify

_____

16. As a child, did you experience dificulty with any of the following? You may use the boxes to further specify the behaviors. Check all that apply:

- ☐ Animal cruelty _____
- ☐ Assaults to others _____
- ☐ Bizarre behavior _____
- ☐ Breaking things _____
- ☐ Controlling bladder _____
- ☐ Disobedience _____
- ☐ Feeding self _____
- ☐ Fire-setting _____
- ☐ Frequently daydreams _____
- ☐ Fraquently tearful _____
- ☐ Hyperactivity _____
- ☐ Lack of attachment _____
- ☐ Often sad _____
- ☐ Unable to play cooperatively _____
- ☐ Poor concentration _____
- ☐ Riding bycicle _____
- ☐ Riding tricycle _____
- ☐ Self-injurious threats _____
- ☐ Speaking sentences _____
- ☐ Speaking words _____
- ☐ Tolerating separation _____
- ☐ Other(s) _____

If "other(s)", please specify

_____

17. Please describe any serious hospitalizations or accidents you went through:

	Date	Age	Reason
1			
2			

18. Have you received psychotherapy or counseling in the past? If yes, when was that? Please list the mental health care providers (Counselor / Psychologist / Psychiatrist)' names and phone numbers:

_____

_____

_____

_____

19. In case you have received psychotherapy or counseling in the past, please dissert about the problems you were having:

_____

_____

_____

_____

20. Which - if any - of these substances do you currently use or have used in the past? Please use the box to indicate your age at first use and age at last use. (E.g.: Alcohol - 16, 30)

☐ Alcohol	☐ Amphetemines	☐ Barbiturates/Owners
_____	_____	_____
☐ Caffeine	☐ Cocaine	☐ Crack cocaine
_____	_____	_____
☐ Hallucinogens (e.g., LSD)	☐ Inhalants (e.g., glue, gas)	☐ Marijuana or hashish
_____	_____	_____
☐ Nicotine/cigaretters	☐ PCP	☐ Other(s)
_____	_____	_____

If "other(s)", please specify

_____

21. If any, which have been the consequences of substance abuse in your life? Please use the box below to dissert about such consequences:

- ☐ Arrests
- ☐ Assaults
- ☐ Binges
- ☐ Blackouts
- ☐ Hangovers
- ☐ Job loss
- ☐ Loss of control
- ☐ Medical conditions
- ☐ Overdose
- ☐ Relationship conflicts
- ☐ Seizures
- ☐ Sleep disturbance
- ☐ Suicidal impulse
- ☐ Tolerance changes
- ☐ Withdrawal symptoms
- ☐ Other(s)

If "other(s)", please specify

_____

22. Substance usage status:

- ○ No history of abuse
- ○ Active abuse
- ○ Early partial remission
- ○ Early full remission
- ○ Sustained partial remission
- ○ Sustained full remission

23. Presence of family during your childhood:

	Present entire childhood	Present part of childhood	Not present at all	Don't have
Mother				
Father				
Stepmother				
Stepfather				
Brother(s)				
Sister(s)				

24. Please describe your childhood family experience:

- ○ Outstanding home environment
- ○ Normal home environment
- ○ Chaotic home environment
- ○ Witnessed physical/verbal/sexual abuse toward others
- ○ Experienced physical/verbal/sexual abuse from others
- ○ Other (please specify)

If "other", please specify

_____

25. Is there a history of alcohol/drug abuse in your family? Please use the box below to indicate the type of drugs and if the abuse is active or in remission:

- ☐ No-one
- ☐ Father
- ☐ Mother
- ☐ Sibling(s)
- ☐ Granparent(s)
- ☐ Stepparent (live-in)
- ☐ Uncle(s)/Aunts
- ☐ Spouse/Significant other
- ☐ Children
- ☐ Other(s)

If "other(s)", please specify

_____

26. Is there a history of any of the following in the family? Please tick the boxes that apply and specify relationship to patient:

- ☐ Alzheimer's disease/Dementia _____
- ☐ Behavior problems _____
- ☐ Birth defects _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Emotional problems _____
- ☐ Heart disease _____
- ☐ High blood pressure _____
- ☐ Mental retardation _____
- ☐ Stroke _____
- ☐ Thyroid problems _____
- ☐ Tuberculosis _____
- ☐ Other chronic or serious health problems _____

If "other", please specify

_____

27. Describe your current physical health:

- ○ Good
- ○ Fair
- ○ Poor

28. If you are currently under care of a Physician, please specify:

	Physician	Condition	Treatment
1			

29. Which medications (psychotropic or not) are you currently taking?

	Medication	Dosage	Since when?	Adverse effects
1				
2				

30. Marital Status Please check and specify when applicable:

- ☐ Single, never married
- ☐ Engaged for how long? _____
- ☐ Married for how long? _____
- ☐ Separated for how long? _____
- ☐ Divorced for how long? _____
- ☐ Divorce in process for how long? _____
- ☐ Live-in partner for how long? _____
- ☐ __ prior marriages (self) _____
- ☐ __ prior marriages (partner) _____
- ☐ Never been in a long term relationship _____

31. Relationship satisfaction:

- ○ Very satisfied
- ○ Satisfied
- ○ Somewhat satisfied
- ○ Dissatisfied
- ○ Very dissatisfied

32. Describe any past or current significant issues in your intimate relationships:

_____

_____

_____

_____

33. Describe any past or current significant issues in your immediate family relationships:

_____

_____

_____

_____

34. Parents' current marital status. If a parent is no longer alive, please indicate the parent's marital status before passing:

- ☐ Married to each other
- ☐ Separated for __ years _____
- ☐ Divorced for __ years _____
- ☐ Mother remarried __ times _____
- ☐ Father remarried __ times _____
- ☐ Mother involved with someone _____
- ☐ Father involved with someone _____

Additional info

_____

35. What is your current living situation? Check all that apply:

- ☐ Housing adequate
- ☐ Homeless
- ☐ Housing overcrowded
- ☐ Dependent on others for housing
- ☐ Housing dangerous/deteriorating
- ☐ Living companions dysfunctional
- ☐ Other

If "other", please specify

_____

36. List all persons currently living in your household:

	Name	Age	Sex	Relationship to you
1				
2				
3				

37. List children (yours / your partner's) not living in the same household as you:

	Name	Age	Sex	Relationship to you
1				
2				

38. Your habits Please describe, when applicable:

	How much?
Smoking	
Alcohol	
Recreational drugs	
Coffee	
Sleeping pills	
Laxatives / Purgatives	

39. What is your current employment situation? Check all that apply:

- ☐ Employed and satisfied
- ☐ Employed but dissatisfied
- ☐ Unemployed
- ☐ Coworker conflicts
- ☐ Supervisor conflicts
- ☐ Unstable work history
- ☐ Disabled
- ☐ Other

If "other", please specify

_____

40. If currently employed:

What is your occupation?

Do you enjoy your work?

How many hours a day do you work?

Do you take work home with you?

41. How is your social interaction? Check all that apply:

- ☐ Normal social interaction
- ☐ Isolates self
- ☐ Very shy
- ☐ Alienates self
- ☐ Inappropriate sex play
- ☐ Dominates others
- ☐ Associates with acting-out peers
- ☐ Other

If "other", please specify

42. What is your current financial situation? Check all that apply:

- ☐ No current financial problems
- ☐ Large indebtedness
- ☐ Poverty or below-poverty income
- ☐ Impulsive spending
- ☐ Relationship conflicts over finances
- ☐ Other (please specify)
- ☐ Other

If "other", please specify

43. What is your legal situation? Check all that apply:

- ☐ No legal problems
- ☐ Now on parole / probation
- ☐ Arrest(s) not substance-related
- ☐ Arrest(s) substance-related
- ☐ Court ordered this treatment
- ☐ Jail/prison (specify how many times and total time imprisoned)
- ☐ Jail/prison (specify how many times and total time spent)
- ☐ Other

If "other", please specify

44. How is your intellectual / academic functioning? Check all that apply:

- ☐ Normal intelligence
- ☐ High intelligence
- ☐ Learning problems
- ☐ Authority conflicts
- ☐ Attention problems
- ☐ Underachieving
- ☐ Mild retardation
- ☐ Moderate retardation
- ☐ Severe retardation
- ☐ Other

If "other", please specify

45. How have your sexual experiences been? Check all that apply:

- ☐ Heterosexual orientation
- ☐ Homosexual orientation
- ☐ Bisexual orientation
- ☐ Transgender
- ☐ Assexual
- ☐ Currently sexually satisfied
- ☐ Currently sexually dissatisfied
- ☐ Age at first sex experience?
- ☐ Age at first pregnancy/fatherhood?
- ☐ History of prosmicuity. From age __ to __?
- ☐ History of unsafe sex. From age __ to __?
- ☐ Currently sexually active
- ☐ Currently sexually inactive
- ☐ Never had sex
- ☐ Other

If "other", please specify

_____

46. What is your stress level?

- ○ Low
- ○ Average
- ○ Considerable
- ○ Unbearable

47. What are the major causes of your stress? (Marital / Financial / Career / Family / Health / Unfulfilled expectations, etc)

_____

_____

_____

_____

48. How do you cope with stress?

_____

_____

_____

_____

49. What are your passions and leisure pursuits?

_____

_____

_____

_____

50. Do you exercise? If yes, what type of exercise, how often and for how long, in average?

_____

_____

_____

_____

51. Current symptoms checklist. Rate intensity of symptoms currently present:

	None	Mild	Moderate	Severe
Aggressive Behaviors				

Agitation				
Anorexia				
Appetite Disturbance				
Bingeing / Purging				
Circumstantial Symptoms				
Concomitant Medical Condition				
Conduct Problems				
Delusions				
Depressed Mood				
Dissociative States				
Elevated Mood				
Elimination Disturbance				
Emotional Trauma Perpetrator				
Emotional Trauma Victim				
Emotionality				
Fatigue / Low energy				
Generalized Anxiety				
Grief				
Guilt				
Hallucinations				
Hopelessness				
Hyperactivity				
Irritability				
Laxative / Diuretic abuse				
Loose associations				
Mood swings				
Obsessions / Compulsions				
Oppositional behavior				
Panic attacks				
Paranoid ideation				
Phobias				
Physical trauma perpetrator				
Physical trauma victim				
Poor concentration				

Poor grooming				
Psychomotor retardation				
Self-multilation				
Sexual dysfunction				
Sexual trauma perpetrator				
Sexual trauma victim				
Significant weight gain/loss				
Sleep disturbance				
Social isolation				
Somatic complaints				
Substance abuse				
Worthlessness				
Other				

If "other", please specify

_____

52. Feel free to use the space below to provide your health care provider with any extra information pertinent to your health analysis and care:

_____

_____

_____

_____

Nebraska Mental Health Centers

CONSENT FOR TREATMENT

Client 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. To inform staff of a complaint or a grievance about services without discrimination or reprisal, and get a timely answer.
8. To have treatment and other information kept private, except where permitted by law.
9. To have access to your medical records as permitted by Nebraska State laws.
10. 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.
11. To be provided an on-call consultation line manned by clinical personnel to assist clients after normal business hours. Call the Consultation Line at 402-483-6990 and leave a voice message with your name and phone number. The on-call clinician returns calls as clinically necessary.

___ Client/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 new clinicians and Psychology Internship and Residency Programs, professionals work together to consult on client 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.

___ Client/Guardian Initials

Custodial Parent Notification (if Client is a Minor)

If client is a minor and parents are divorced or separated, we require consent from both parents **OR** a copy of the custody agreement that delineates Medical Power of Attorney.

Please also see our Financial Policy and Client Responsibility form regarding insurance and bill payment.

___ Client/Guardian Initials

I hereby consent to mental health care 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.

Client Name	Client Signature
Parent/Guardian Name	Parent/Guardian Signature

Date _____ Staff Initials _____ Custody PPW Needed ? Yes or No Received? Yes or No

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.

Client Name	Client Signature
Parent/Guardian Name	Parent/Guardian Signature

Date _____ Staff Initials _____

Nebraska Mental Health Centers

Client Name _____

Financial Policy and Client Responsibility

Client Responsibilities

- Provide NMHC with your photo ID and your current insurance and policy holder information.
- Know your insurance policy. If you are not familiar with your plan coverage for mental health services, we recommend you contact your carrier directly.
- Co-pays are the client's responsibility and are required to be paid at the time of service. Clients are also responsible for any deductible, co-insurance, and/or out-of-pocket balances remaining after insurance benefits have been applied.
- Uninsured clients or self-pay clients are required to pay for services in full before they can be seen.
- A late charge of 1.5% per month on unpaid client balances will be added to accounts not paid within 90 days of receipt of insurance payment.
- In the case of multiple caregivers, the guardian completing the consents is responsible for all payments. NMHC is not involved in disagreements between the parties. If an additional party is responsible for payment, please have them complete consent forms as well.
- 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.
- NMHC has the following court and/or letter request fees:
    - Preparation time/Letter writing/phone calls (including submission of records): $150/hour
    - Depositions, time required in giving testimony: $250/hour
    - Missed practice hours not included above: $100/hour
    - All attorney fees and costs incurred by the therapist as a result of the legal action.
    - Mileage: $1/mile

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.

NMHC requires a form of payment on file. Any outstanding charges after 90 days will be charged unless a payment plan has been agreed to previously. The client will be notified in advance of the transaction. If you need assistance with your balance, please speak to the accounts manager to discuss.

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 consent to having a card on file and outstanding balances to be charged. 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.

Card Holder Name			
Account Number	**Expiration Date**	**Security Code**	**Billing ZIP Code**
Client/Guardian Name	**Signature**		**Date**

Date _____ Staff Initials _____

Nebraska Mental Health Centers

Lincoln Fremont Beatrice

Authorization to Exchange Confidential Information with Medical Primary Care Provider

Client 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

PLEASE READ CAREFULLY AND CHECK ONE OF THE THREE OPTIONS BELOW

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

Doctor/Provider Name	
Phone	Fax

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

☐ I do not have a Medical Primary Care Provider.

Client Name	Client Signature
Parent/Guardian Name	Parent/Guardian Signature

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.

Staff Signature	Date