

MIDWEST BEHAVIORAL HEALTH FAMILY INVENTORY

Account Number _____

Patient Last Name	First Name	MI	Date of Birth	Sex
Street Address / Apt. #	City	State	Zip	Best Phone Number

Only a patient or patient's legal guardian can be the responsible party except with specific written consent

RESPONSIBLE PARTY _____				
Date of Birth	SSN		_____	
Address	City/State	Zip		
E-Mail	Employer			
Cell	Work Phone	Home Phone		

SPOUSE or OTHER PARENT _____ Date of Birth _____

Address _____ City/State _____ Zip _____
Employer _____ Cell _____ Work Phone _____

OTHER _____ Date of Birth _____

(Partner, Non-custodial parent, Step-parent, Foster Parent, Guardian, etc.)

Address _____ City/State _____ Zip _____
Employer _____ Cell _____ Work Phone _____

EMERGENCY CONTACT (Other than parent or spouse)

Name _____ Relationship _____ Phone _____

PRIMARY INSURANCE

Company _____
Policy Holder _____
Member ID _____
Group Number _____

SECONDARY INSURANCE

Company _____
Policy Holder _____
Member ID _____
Group Number _____

LIST ALL SIBLINGS OR CHILDREN OF THE PATIENT STARTING WITH FIRST BORN

Name	Date of Birth	Sex	Diagnosis (For Office Use Only)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I hereby authorize MidWest Behavioral Health to release any information acquired in the course of treatment to my insurance carrier. This authorization shall remain in effect until I submit written notice revoking this authorization. I further authorize payments to my MidWest provider. Pursuant to any applicable provider relations agreement, I understand that I am financially responsible for all charges whether or not they are covered by my insurance.

Signature _____ Date _____



1530 S 70th Street, Suite 200
Lincoln, Nebraska 68506
Phone: 402.327.0073
Fax: 402.327.0204

OFFICE POLICY

The information in this packet is provided to assure that you have been fully informed of our office policies. Please read this carefully, ask any questions you may have and, if you are satisfied with your understanding of the material presented, sign where indicated. Valid signatures of the client or guardian must be secured before you can be treated in our clinic.

Financial Agreements and Authorizations for Treatment

I authorize treatment for the named person and agree to pay all fees for such treatment. I agree to pay for members of my family and for myself at the time of service unless other credit arrangements are agreed upon in writing. Charges shown on statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date.

I have received and read the information included on this and the following pages regarding the MidWest Neurofeedback office policies, informed consent and confidentiality statement and agree to abide by the stated terms during our professional relationship. I have been offered a copy of the policy statement for my records.

Client Name

Signature of Patient or Legal Guardian

Date

Medication Refill Policies and Procedures:

- Requests for refills will be accepted only if appointments have been scheduled and kept as directed by my prescriber
- Requests for refills should be called in to my pharmacy who will contact the MidWest office
- Requests for medication sent by text or email will not be accepted
- I should expect to wait 48 hours or more for routine refills
- I should expect to wait 72 hours or more for prescriptions requiring prior authorization from my insurance provider
- I understand that medication refill orders will not be made on weekends, legal holidays or after business hours and that requests requiring refills during these times or on a same day basis may be assessed an additional fee.

Confirmation Contacts

It is our practice to make reminder contacts prior to each scheduled appointment. Please indicate your preference:

May we contact you and leave reminder messages? Yes No

Please indicate your preferred method of contact: Phone Text Message E-mail

What phone number or e-mail do you wish us to use for reminders? _____

Communication with Physician

In order to provide the highest level of care, we request permission to discuss (i.e., in person, by telephone, and/or in writing) relevant aspects of your case with the client's physician(s). Please complete the following and *initial* the appropriate choice. If you have any questions, please discuss them with your physician psychologist/therapist or psychiatric provider.

Name of Client's Primary Care Physician

_____ Yes, you may discuss relevant aspects of my or my child's case with my or my child's primary care physician

_____ No, I do not want my or my child's case discussed with my or my child's primary care physician (Please note that refusing to allow contact with your primary care physician may influence whether or not you are accepted or maintained as a client at MidWest Behavioral Health)

**MidWest Neurofeedback, LLC
(DBA MidWest Behavioral Health)
Office Policy and Informed Consent**

As of July 1, 2023, the fee for the initial psychological or psychiatric diagnostic session in the clinic is **\$340.00**. Fees for subsequent Psychotherapy and/or Family Therapy sessions are **\$250.00** for a visit of 45-50 minutes. An additional **\$25.00** fee may be added to sessions that meet national current procedural terminology criteria for complex sessions. Fees for brief medication checks are **\$140.00, \$200 or \$280**, depending on the length of the visit. An additional fee of **\$40** may be added for sessions involving multiple participants and interactive complexity. Fees for school meetings or observation are **\$240.00** per hour. Fees for testing and evaluation are **\$240.00** per hour. Testing time may include direct patient contact plus administrative time (e.g., scoring, interpretation, report writing, etc.). Provider-directed telephone calls regarding patients are typically included as a part of the fees for therapy or assessment with your providers, unless other arrangements are made with the provider. If, for any reason, your provider is required to speak with attorneys or appear in court, reimbursement is expected from the party responsible for the provider's participation, usually the attorney who requests or compels the provider's participation. The rate is **\$250** per hour for review of records, preparation of letters/reports, and phone calls. The rate is **\$450** per hour for a deposition or court testimony, including travel time. If you have any questions about fees for your sessions or other services, please discuss these with your provider. Please be aware that these fees are subject to change without notice.

Family Inventory

You will be expected to complete a new Family Inventory for our office on an annual basis and when there is any change in your family or living situation or insurance. It is your responsibility to notify the office of any changes that need to be documented for insurance coverage and treatment in our office.

Payment Policy

Our policy requires payment in full at the time services are rendered unless other arrangements have been made in advance. If you have arranged a payment plan with our billing office, we ask that your balance not exceed **\$250.00**. If this should occur, you will be asked to pay your balance in full, or at least a large percentage, before any additional appointments are scheduled. Unpaid balances of 90 days or longer will be assessed a re-billing charge of 1% per month until the balance is paid. If no payment is received within a reasonable period of time, we reserve the right to begin collection procedures.

Please note: the individual who initiates treatment is responsible for payment and will receive billing notices from our office. Nebraska law dictates that the custodial parent has ultimate financial responsibility for payment regardless of the divorce decree. This individual, not our office, is responsible for settling any financial obligations with the noncustodial parent.

Insurance

Pursuant to any applicable provider relations agreement, your insurance is a contract between you and your insurance company. Your account with this office is your responsibility. Insurance cannot be filed without the signature of the responsible party on our Family Inventory form. Please feel free to call our office if you have questions regarding your insurance coverage before the next visit. It is your responsibility to inform the office as soon as possible of any change in your insurance coverage and/or insurance provider.

Insurance PPO's

If we are listed as a Preferred Provider in your PPO directory, please consult your policy or insurer to determine coverage. Please note that there are different requirements for each company. All copayments, coinsurance, and deductibles are due at time of service.

United Behavioral Health/MHNet

Each visit may require preauthorization by your insurance company. It is your responsibility to see that proper authorization has been received by our office prior to each visit. All copayments, coinsurance, and deductibles are due at time of service.

Cancellations/Missed Appointments

We understand that at times it may be necessary to cancel an appointment. To help us schedule our time most efficiently, we ask that any changes or cancellations be made at least 24 hours in advance. If cancellations are not made at least 24 hours in advance, or if an appointment is missed without a call, **you may be subject to a \$25.00 fee**. This fee is your responsibility and is not covered by your insurance policy. If a pattern of missed appointments with

late or no notice develops, further sessions with your psychologist/therapist/medication provider may be declined and referral to a different provider recommended.

Evaluations/Home Visits/ School Meetings and Observations

Fees for psychological and testing and school evaluations will vary and may not be covered by your insurance policy. If you do not fully understand what fees will be incurred, please discuss this issue with your psychologist/therapist/medication provider. Fees for home visits, school meetings, and observations are determined by the amount of time spent in the home or school as well as distance traveled. Payment of these fees is your responsibility if these services are not covered by your insurance company.

Child Psychotherapy with Divorced Parents

Psychotherapy for children when parents are divorced or separated often presents complex circumstances. Psychotherapy is most successful when all parents are involved in the therapy process. The best outcomes occur when the therapist has a working relationship with both parents built upon collaboration and a desire to promote your child's best interest. A copy of the custody agreement is required. Further, we require consent from both parents or guardians before your child can be seen in our clinic unless one parent has been granted sole legal/medical custody. The therapist will work with each parent to achieve successful co-parenting, as this is one of the best predictors of children's adjustment and psychological health when parents are divorced. It is not a therapist's role to provide custody evaluations or opinions about parental fitness. Your therapist will discourage the release of your child's mental health records to your attorneys. Please inform your attorneys not to subpoena your child's therapist or child's mental health records. Any requests for release of information to either parents or a third party must be signed by both parents. If there is a court-appointed evaluator, your therapist will provide the evaluator with general information about your child, but will not include opinions about custody or parental fitness.

Minors and Parents

Patients under 19 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in therapy is often crucial to successful progress, your psychologist/therapist will provide only general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Before giving parents any information, your psychologist/therapist will discuss the matter with the child and do his/her best to handle any objections he/she may have. Any other communication will require the child's authorization, unless your psychologist/therapist feels the child is in danger or is a danger to someone else, in which case, your psychologist/therapist will notify the parents of their concerns.

Records

Our office is required to maintain records for seven (7) years following the discontinuation of services, or for seven (7) years past the age of majority (19 years) in Nebraska. Records may be maintained in physical form or stored electronically. Records which are scanned and stored electronically are deemed equally valid as physical or paper records.

Confidentiality

In general, the confidentiality of all communications between a patient and psychologist/therapist is protected by law, and your psychologist/therapist can release information about our work to others only with your written permission. However, there are a number of exceptions.

In most judicial proceedings, you have the right to prevent your psychologist/therapist/medication provider from providing information about your treatment. However, in some circumstances such as child custody proceedings and proceedings where your emotional condition is an important element, a judge may require your psychologist/therapist/medication provider to testify if he/she determines that resolution of the issues before him/her demands it.

There are some situations in which your psychologist/therapist/medication provider is legally required to take action to protect others from harm, even though revealing some information about a patient's treatment. For example, if your psychologist/therapist/medication provider believes that a child, an elderly person, or a person with a disability is being abused, he/she may be required to file a report with the appropriate state agency. If your psychologist/therapist/psychiatric provider believes that a patient is threatening serious bodily harm to another, he/she may be required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a patient threatens to harm him/herself, your psychologist/therapist/psychiatric provider may be required to seek hospitalization for the patient, notify police, or to contact family members or others who can help provide protection. These situations rarely occur. However, if such a situation develops, your psychologist/therapist will make every effort to fully discuss it with you before taking action.

You should be aware that, pursuant to HIPAA, your psychologist/therapist/psychiatric provider keeps Protected Health Information about you/your child as part of their professional records. It includes information about you/your child's reasons for seeking therapy, a description of the ways in which you/your child's problem impacts on your life, diagnosis, treatment goals, progress toward these goals, medical and social history, treatment history, past treatment records (if applicable), professional consultations, billing records and any reports or requests that have been sent to anyone, including reports to your insurance carrier.

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that your record be amended; requesting restriction on what information from your Clinical Records is disclosed to others, requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policy and procedures. The Office is also required by HIPAA to inform you if we become aware of or suspect a breach of your Protected Health Information.

Your psychologist/therapist/psychiatric provider may occasionally find it helpful to consult about a case with other professionals. In these consultations, he/she will make every effort to avoid revealing the identity of the patient. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, your psychologist/therapist/psychiatric provider will not tell you about these consultations unless he/she feels it is important to your work together. Providers for MidWest Neurofeedback are independent contractors and share no joint liability.

Risk Assessment

You should also be aware that your contract with your insurance company requires that we provide information relevant to the services provided to your child and/or you. We are required to provide a clinical diagnosis and, at times, may be required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. By signing this Agreement, you agree that your psychologist/therapist/psychiatric provider can provide requested information to your insurance carrier.

While this written summary of policies and exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns which you may have at your next session. The laws governing these issues are quite complex and your psychologist/therapist/psychiatric provider is not an attorney. While he/she may be happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable. If you request, your psychologist/therapist will provide you with relevant portions of summaries of the applicable state laws governing these issues.

**MidWest Behavioral Health
Client Consent Form**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you or your child. You have the right to review this Notice before signing this consent. The terms of our Notice may change. If changes are made, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you or your child is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to such a restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you as described in our Notice of Privacy Practices. You have the right to revoke this consent in writing, except to the extent that we already have made disclosures in reliance on your prior consent.

Signature of Patient or Responsible Party	Date
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Reason Patient/Responsible Party is unable to sign (if applicable)

Signature of Office Staff or Other Witness	Date
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NEW PATIENT: ADULT

Date _____

Name _____ DOB _____ Age _____

Address _____ Best Phone _____

Marital Status _____ Employer _____

Length of Employment _____ Work Hours _____ Work Phone _____

Education Completed _____ Where _____

Spouse/Partner Name _____ Age _____

Address _____ Best Phone _____

Marital Status _____ Employment/Position _____

Length of Employment _____ Work Hours _____ Work Phone _____

Educated Completed _____ Where _____

<u>Names of Children/Step-Children</u>	<u>DOB</u>	<u>Age</u>	<u>School</u>	<u>Grade</u>
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Have you (or partner) ever been involved in therapy or other counseling program? Yes No

If Yes: When _____ Where _____

For what reason? _____

Reasons for considering counseling at this time _____

Who referred you? _____

Are you currently taking psychiatric medication? Yes No

If Yes, list medication, dosage and start date _____

Who prescribes the medication? _____

Have you ever been hospitalized for mental health reasons? Yes No

If Yes: When? _____ Where? _____ How long? _____

Have you ever participated in substance abuse or chemical dependency treatment? Yes No

If Yes: When _____ Where _____

Did you attend follow up counseling? Yes _____ No _____ If Yes, with whom _____

Are you currently under medical care for physical health problems? Yes No

If Yes, please list conditions and any medications _____

Name of Family Physician _____ Phone _____

Address _____

Have you ever been arrested? Yes No

If Yes: When _____ Please elaborate _____

Outcome or resolution _____

Please list anyone with whom you live currently (other than partner or children):

If required, would other family members be willing to participate in therapy? Yes No

If No, please indicate reason _____
