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_____________

MidWest BEHAVIORAL HEALTH
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? ________________________________

Contact 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 **$125.00** for a visit of approximately 20-30 minutes, **$180.00** for 40-50 minutes, and **$250.00** for a visit of 53 minutes or more. An additional **$40.00** 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. 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 subponena 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

Reason Patient/Responsible Party is unable to sign (if applicable)
____

____

____ _______________
Signature of MWBH Office Staff or Other Witness Date

NEW PATIENT: CHILD / ADOLESCENT

DATE ______________________

I. PATIENT INFORMATION:

Patient's Name____Nickname_______________________

Age ___________________ Birth date ____________________________ Sex _______________________

Address ____ Phone ______________________

Father's Name ____ Age _____________

Mother's Name ____ Age _____________

Relationship to Patient (circle one)

Father: Natural Adoptive Foster Step Married _____________ Divorced ____________
Date Date

Mother: Natural Adoptive Foster Step Married _____________ Divorced ____________
Date Date

Guardian: (Explain)____

____

Siblings' Names	Age	Sex

Who Referred You? ________________________________ Patient's Physician ______________________

Reason for Referral? ____

____

____

II. PATIENT ASSESSMENT:

Growth and Development:

General impression of infant development: (circle one) Poor Fair Good

Note the month the patient achieved the following activities:

Sat Alone ________ Crawled _________ Walked ________ Feed Self ________ Spoke Words _________

(Typical: Sit, 6-8 months; Crawl, 9 months, Walk, 12-18 months; Feed, 10-12 months; Speak, 10 months)

General Appearance ____

Weight ______________ Height ______________

Physical Assessment of Vision, Hearing, and Speech:

Vision	Normal _______	Abnormal _______	Corrected _______
Hearing	Normal _______	Abnormal _______	Corrected _______
Speech	Normal _______	Abnormal ________	Corrected _______

Does the patient have a physical health problem which interferes with normal functioning:

☐ Yes ☐ No If yes, please describe:____

____

____

<u>Behavioral and Emotional Status</u>:

Does the patient have a behavioral or emotional problem that concerns you? Yes _______ No _______

If yes, please describe: ____

____

____

Has the patient ever received medications, counseling, or therapy? Yes _______ No _______

If yes, describe problems, medication, therapist, and dates: ______________________________

____

____

____

Is the relationship between this patient and the father good? Yes _______ No _______

If no, elaborate: ____

Is the relationship between this patient and the mother good? Yes _______ No _______

If no, elaborate: ____

Is the relationship between this patient and the siblings good? Yes _______ No _______

If no, elaborate: ____

Which of the following have been or are now problems with this patient?

	Yes	No	Sometimes		Yes	No	Sometimes
Won't Mind	_______	_______	_______	Soiling	_______	_______	_______
Too Active	_______	_______	_______	Bedwetting	_______	_______	_______
Bad Temper	_______	_______	_______	Cries Too Much	_______	_______	_______
High Strung/Nervous	_______	_______	_______	Clings to Parents	_______	_______	_______
Breath holding	_______	_______	_______	Toilet Training	_______	_______	_______
Easily Upset	_______	_______	_______	Lying	_______	_______	_______
Clumsy	_______	_______	_______	Too Shy	_______	_______	_______
Night Terrors	_______	_______	_______	Siblings	_______	_______	_______
Destructive	_______	_______	_______	Hyperactive	_______	_______	_______
Head banging	_______	_______	_______	Other	_______	_______	_______

III. SCHOOL ASSESSMENT:

What type, if any, of school does the patient attend? (circle one)

Preschool Kindergarten Elementary School Middle School High School

What grade is the patient in: _______

Describe school progress (circle one) Poor Fair Good Very Good

School Name ______________________________________ Principal's Name _____________________________

School Address ____________________________________ Teacher's Name ____________________________

Phone ____ Hours in Attendance __________________________

According to the teacher, the patient:	Yes	No	Sometimes
Has difficulty following instructions	_________	_________	_________
Completing assignments	_________	_________	_________
Talks out of turn	_________	_________	_________
Is a slow learner	_________	_________	_________
Has a short attention span	_________	_________	_________
Has trouble finishing work	_________	_________	_________
Does not get along with other children	_________	_________	_________
Has poor school attendance	_________	_________	_________

Have you had special or extra conferences with teacher or school authorities for the behavior or learning problems? Yes __________ No _________

Does the patient receive any Special Education Services or has he/she ever been tested for learning, behavior, or speech problems? Yes _________No _________ Is there an IEP/504 Plan? Yes __________ No _________

What do they suggest is needed to help the patient? ____

____

Do you agree with teacher, or what are your ideas about what is needed? ______________________________

____

Is the patient on any medications at the present time? Yes _________ No _________

For what is it prescribed? ___________________________ How long has he/she been on it? _______________

What is the medicine and who prescribed it? ____

Does this affect his/her behavior? Yes ___________ No ____________ How? ____________________________

____

IV. FAMILY ASSESSMENT:

	Education/Degree	Place of Employment/Job Position	Hours Worked
Father	________________	____	______________________
Mother	________________	____	______________________

Describe overtime work or second job, if any: ____

____

____

Home schedule of parents:

Father ____

____

Mother ____

____

Do you think the family is under financial strain? Yes _________ No _________

Are you receiving any type of financial assistance? Yes _________ No _________

Describe a typical day experienced by your family: ____

____

Has either parent or other family members ever received medication, counseling, or therapy?

Yes ________ No ________

If yes, describe the problem: ____

____

____

Prescriber/Therapist ____ Date _______________

How would you describe your marriage/relationship during the past six months? (circle one)

Very Good Good Fair Bad Very Bad

How would you describe your marriage during the last month? (circle one)

Very Good Good Fair Bad Very Bad

Does either parent have a physical health problem that interferes with normal functioning?

Yes _____________ No ______________ If yes, please describe: ______________________________________

____

V. CHILD MANAGEMENT:

Who ordinarily disciplines the patient? ____

How is the patient disciplined? Spank _________ Yell __________ Remove Privileges ___________

Send to Room ___________ Reasoning __________ Other ____________________________________

How often do you need to use discipline?

____

Have your methods of discipline been effective? ____

Do you and the patient's mother/father agree on discipline? _________________________________

What does your son/daughter like to do with you?

Mom: ____

____

Dad: ____

____

VI. SIBLING ASSESSMENT

Emotional status:

Has any sibling ever received counseling or psychotherapy? Yes _________ No _________

If yes, describe the problem: ____

____

____

Prescriber"Therapist ____ Date ____________________

Does any sibling have an emotional or behavioral problem that concerns you? Yes _________ No_________

If yes, describe the problem:____

____

____

VII. ADOLESCENT ASSESSMENT:

If applicable, please complete the following:

To your knowledge, has your **adolescent**:

Used alcohol or drugs? Yes _________ No _________

If yes, please elaborate ____

____

____

Had a positive drug screen Yes _________ No _________

Used tobacco Yes _________ No _________

Been sexually active Yes _________ No _________

Run away from home Yes _________ No _________

Had legal difficulties Yes _________ No _________

If yes, please explain (probation officer, court date, etc.) ____

____

____

Does your adolescent have difficulties with any of the following:

	Often	Occasionally	Seldom	Never
Missed curfews	_______	_______	_______	_______
Skipping school	_______	_______	_______	_______
Failing grades	_______	_______	_______	_______
Problems with peers	_______	_______	_______	_______
Suicide threats or attempts	_______	_______	_______	_______
Destruction of property	_______	_______	_______	_______
Aggression	_______	_______	_______	_______