Spence Counseling Center PC
12035 Q Street • Omaha, NE 68137
PH:402.991.0611 • Fax: 402.991.6228 • www.spencecounselingcenter.com

OFFICE USE ONLY
Therapist________________ Photo ID _____
Location: OM JC FR CB RO LW BC
Info Complete ____ Ins Card____ COF _____
Elig/Ben ______ B/F _______ M/S ______
Scanned ____________ Date _____________

CLIENT INFORMATION

Client Full Legal Name: ____

Address: ____ Client SS#: ______________________

City: ____________ State: ______ Zip: _____________ Client DOB: ___________ Gender: Male ____ Female ____

Single ____ Married ____ Co-habitating ____ Divorced ____ Widowed ____ Minor ____

Home Phone: ______________________ Cell Phone: ________________________ Work Phone: _________________________

Employer: ______________________________ E-mail: ____

Emergency Contact Name: ________________________________ Emergency Contact Phone: ______________________________

CONTACT INFORMATION

May we contact you by phone and/or leave a message? *(Please check the boxes)* May we **e-mail/text** you and leave a message?

Home: Yes ☐ No ☐ **Cell**: Yes ☐ No ☐ **Work**: Yes ☐ No ☐ **E-mail:** Yes ☐ No ☐ **Text:** Yes ☐ No ☐

Your therapist may use e-mail or text as a means to communicate with clients between sessions. This type of communication will be "business" topics that may include: insurance issues, appointment confirmation or changes, payment arrangements, etc. Therapy sessions will NOT be conducted over e-mail or texting and any communication should not be construed as such unless specific arrangements are made and agreed to in advance and in writing. I further understand and accept the risks associated with unsecured electronic communications.

Consent to Communicate with Primary Care Physician (PCP)

In order to coordinate care, we may need to contact your PCP. I give my consent to any communication with my PCP as needed.

☐ **I refuse to give consent to send information to my Primary Care Physician.**

Name of Doctor & Medical Facility____
Address ____ City, State, Zip _____________________________________
Phone ________________________ Fax ________________________________

IF CLIENT IS A MINOR

If this is a divorce situation, please fill out the information below.
Also, provide a copy of the divorce decree, temporary order, and parenting plan.

Child Lives With: Both Parents _____ Mother: _____ Father _____ Other (specify) ______________________

Primary Legal Custody: Both Parents _____ Mother: _____ Father _____ Other (specify) _________________

Primary Physical Custody: Both Parents _____ Mother: _____ Father _____ Other (specify) _______________

Legal Guardian Name: _________________________________ Cell/Home/Work Phone (*circle phone*): _________________________

Address *(if different than above)*: ___________________________________ City, State, Zip _______________________________

HOUSEHOLD INFORMATION

First & Last Name	Date of Birth	Gender	Relationship

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INSURANCE INFORMATION

We will need to make a copy of your Insurance Card and Photo ID.
***** Failure to provide this information could result in full cash rates for services rendered.*****

Primary Insurance

Insurance Company: ___________________________ Policy #: ________________________ Group #: ____________________

Policyholder Legal Name: ____ Policyholder SS# ____________________________

Policyholder DOB: __________________ Policyholder Gender: Male ___ Female ___ Relationship to client: _____________

Secondary Insurance

Insurance Company: ___________________________ Policy #: ________________________ Group #: ____________________

Policyholder Legal Name: ____ Policyholder SS# ____________________________

Policyholder DOB: __________________ Policyholder Gender: Male ___ Female ___ Relationship to client: _____________

_________________________________ _________________________

Client Name **Date of Birth**

_________________________________ _______________________________ ________________________

Client or Guardian Signature **Print Name** (*if different from client)* **Date Signed**

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Consent to Treatment, Use, and Disclose Your Health Information

This form is an agreement between you, ____________________(***client name***) and me/us Spence Counseling Center, P.C. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here ___________________ (***minor child***).

When we examine, diagnosis, treat, or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to let us use this information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent.

If you do not sign this Consent Form agreeing to it and what is in our Notice of Privacy Practices, we cannot treat you as permitted by Section 164.506 of the Code of Federal Regulations.

_____ Initials

Telehealth Session Consent

Spence Counseling Center will be using Microsoft Teams for video and web-based telecommunications with our clients. Microsoft Teams is a HIPAA compliant, encrypted platform that is secure and private for therapy sessions. This service is being offered as an alternative to an in-person session. The session will be conducted between yourself and any other party you choose to be present during the session in a virtual room. The session will be conducted on a phone, computer, or i-pad and both parties will need to have cellular or internet connectivity. Your therapist will send you a link by e-mail or text ahead of time to join the session meeting.

You will need to disclose to your therapist your current location and any other parties including their role that will be participating in the telehealth session. There are potential risks to this technology, including interruptions, unauthorized access, or technical difficulties. I also understand that my therapist or I can discontinue the telehealth session if it is felt the video conferencing connections are not adequate. I also understand that I can discontinue the telehealth session at any time. Therefore, I give consent to conduct telehealth sessions with my therapist.

_____ Initials

Shortened Notice of Privacy Practices

Our practice is dedicated to maintaining the privacy of your personal health information. We are required by law to do this. These laws are complicated, but we must provide you with important information. This Notice is a shortened version of the full legally required Notice of Privacy Practices (NPP) which is available in the office, so refer to the Complete Notice for more information. Even in the Complete Notice, we can't cover all possible situations, so please talk to your provider or our Privacy Officer, Rhonda Spence, about any questions or problems.

We reserve the right to change our Consent Form and Notice of Privacy Practices in accordance with Section 164.520 of the Code of Federal Regulations and clients will be notified if we change them. You are always welcome to have a copy of our Consent or Notice of Privacy Practices in paper or electronic form. If you are concerned about some of your information, you have the right to ask us. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your written request. After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

_____ Initials

______________________________	_________________________	__________________________
Client/Guardian Signature	**Print Name**	**Date Signed**

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Financial & Billing Agreement

Insurance

1) I hereby give consent to Spence Counseling Center for myself and/or my dependents in the evaluation and treatment regarding my therapy that may be advisable or necessary in their opinion.
2) Spence Counseling Center will as a courtesy call the insurance company for medical benefits on your policy. While we attempt to obtain the most accurate and up-to-date information, benefits cannot be guaranteed until the insurance has processed the claim. Your therapist will provide a benefit sheet at your first session.
3) Our office will file all insurance claims, however, not all providers are participating with all insurance plans. It is ultimately the client's responsibility to ensure coverage at the time of service.
4) I authorize any holder of medical information on myself and/or my dependents to release said information needed to determine benefits payable for medical services. I further authorize payments for services furnished to myself and/or my dependents be made payable to Spence Counseling Center.
5) I agree to notify Spence Counseling Center as soon as possible if my name, address, phone, or insurance information changes. If insurance coverage changes, I will bring in the card(s) as soon as possible.
6) Clients who begin treatment as a cash client and then change their mind to use insurance, will only be allowed to use the insurance card from the point it is presented to Spence Counseling Center. We will NOT go back, and process claims on previous dates of service.

_______ **Initials**

Payment

1) I understand and agree that **I must notify Spence Counseling Center within 24 hours to cancel or change an appointment** for myself and/or dependents. **If not, I will be billed and agree to pay the fee of $75.00.**
2) Having insurance coverage does not guarantee payable benefits. I understand that I am responsible and agree to pay for any deductibles, co-pays, co-insurances, or any amounts not covered by my insurance which are due AT THE TIME of SERVICE unless other payment arrangements have been made with the office.
3) **I understand that if I am late to my appointment by 15 minutes, I may be charged a late fee notice of $40.00. This is a cash fee that is not payable by my insurance company that I will owe.**
4) I also understand that if my account is not paid within 90 days of receiving my first bill, my account may be turned over to a collection's agency. Clients with accounts turned over to a collection's agency will be responsible to pay a $50 administrative fee to Spence Counseling Center prior to seeing a therapist again. They may also be required to pay cash at the time of each session for future appointments.
5) If you choose to put a credit card on file with Spence Counseling Center and the credit card declines more than two times for services, your account will be charged a $25.00 service fee for each occurrence. You can NOT use an FSA/HSA for decline or cancellation fees.

_______ **Initials**

Collections Notification

I agree and understand that any cellular or landline, phone numbers and email addresses provided by myself to this office into any of our service providers, including, but not limited to, third-party, debt, collectors, now, and in the future may be used as a means to contact me for any reason, Including but not limited to, billing, and collecting payment, and this office, and our service providers may leave messages for me manually and by using automatic systems such as by artificial or pre-recorded voice or text messages. In the future, should I acquire a new or different cellular, landline or email address, I agree that this consent would stay effective.

_______ **Initials**

Legal or Court Requirements *(If applicable)*

If your therapist is requested to present their mental health evaluation or counseling session information in any type of court proceeding, deposition, appearance, or any other type of legal action that requires records or an appearance for deposition or other legal proceeding, **I understand and acknowledge this service will be charged at their legal rate, which is twice the fee per hour of individual therapy** and it will be prorated in quarter-hour increments. I understand that I will also be charged for travel time to and from legal proceedings, review and preparation of reports or records, actual time spent in court, and any other time devoted to the legal proceedings. In cases settled out of court or rescheduled, the fees above will still be charged. **All fees MUST be paid prior to the release of records or reports and/or prior to scheduling any legal appearances.** According to Nebraska Statute 71-8404 Access Charges, a provider may charge no more than a $20.00 handling fee and $0.50 per page copying fee.

_______ **Initials**

This consent shall hold valid for this and all future visits unless revoked in writing.
My signature demonstrates that I have read, understand, and agree with the above.

______________________	______________________	______________________
Client or Guardian Signature	**Print Name**	**Date Signed**

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OFFICE USE ONLY
Therapist____________ Client______________
Therapist____________ Client ______________
Admin Int: _________ Date: ______________

Credit Card on File Agreement

Cardholder Name: ____

Credit card billing address: ______________________________ **Required - Zip Code:** ______________

List of family members being seen:

________________ ________________ ________________ ________________

Primary Card Number: ______________________________ Card Expiration: _________ (MM/YY) **Debit Credit FSA/HSA**

Secondary Card Number: ______________________________ Card Expiration: _________ (MM/YY) **Debit Credit FSA/HSA**

REQUIRED - E-mail address for receipts & decline notifications: ______________________________

______________________________ ______________________________
Authorized Signature **Date**

I have read and agree with the Billing Rights information below.

_____ **(Initial)** I authorize Spence Counseling Center to charge my credit card on a weekly, monthly, or as-needed basis for the amounts due for services received and which match client responsibility amounts as determined by my insurance company's explanation of benefits (EOBs) or your client benefit sheet. My credit card statements will serve as receipts for payments processed. *<u>This designates my Signature on File and therefore it is not required that I sign paper receipts each time</u>.* This authorization is to remain in effect until Spence Counseling Center receives notification from me of its termination. If my credit card information changes for any reason, I will notify Spence Counseling Center as soon as possible. If I am a returning client and my account has been in collections, a $50.00 administrative fee will be charged before I see a therapist at Spence Counseling Center again.

In the event of repeated declined charges (at least two), your account will be charged a <u>$25.00</u> service fee for each occurrence.
You can <u>NOT</u> use an FSA/HSA for decline or cancellation fees.

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