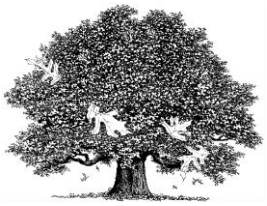
Welcome to Arbor Family Counseling



Please take a few minutes to review the following office policies and procedures.

Appointments

Clients meet with our therapists by appointment only. Office hours are Monday through Thursday from 9:00 AM to 9:00 PM, and Friday from 9:00 AM to 5:00 PM. For your convenience, our phones are answered 24 hours. If you need to cancel an appointment, please give us 24-hour notice. If we receive no notice, we will assess a "no-show" charge of $30.00.

Professional Referrals

Our therapists can make referrals to psychiatrists and/or psychologists as appropriate.

Payments

Our therapists appreciate your need for, and will establish with you, a definite understanding regarding financial arrangements. If you are coming to Arbor through an Employee Assistance Program (EAP) or Student Assistant Program (SAP), you may receive some initial sessions at no charge to you. Generally, however, the payment policy is as follows:

- Your first appointment in the office must be paid in full at that time.
- At your request, we will file an insurance claim for you if you provide all the applicable information requested in the client registration process.

Financial Responsibility

Ultimate financial responsibility for our service rests with you and your family, regardless of insurance coverage. We file insurance claims as a courtesy to you, and do not become involved in disputes between you and your insurance company regarding covered charges, deductibles, etc. We will, of course, provide factual information as necessary to assist you.

Receipt of Notice of Privacy Practice

I acknowledge that, upon request, I may receive information about my protected health information, client rights and responsibilities via the Notice of Privacy Practice. I understand the Notice may be revised at any time, and that any revisions will be posted in the waiting room. A new copy of the Notice will be available if requested.

_____ _____

Signature of Client or parent/guardian Date

ARBOR FAMILY COUNSELING
11605 Arbor Street, Suite 106
Omaha. NE. 68144
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Consent for Treatment

Authorization for Treatment: I hereby authorize Arbor Family Counseling, their assistants and/or designees in charge of my care to administer any treatment as may be necessary or advisable in my diagnosis and treatment. I am aware that the practice of behavioral healthcare is not an exact science and I acknowledge that no guarantees have been made to me as to results of treatment and therapy received at this agency. I will follow the instructions of my service provider(s) in the provisions of said care.

Authorized Representative: I hereby authorize Arbor Family Counseling, its service provider(s) and representatives to act on my behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for services provided to me by Arbor Family Counseling.

The undersigned certifies that he or she has read the foregoing, is the client, client's guardian, power of attorney, or parent, or is duly authorized by or on behalf of the parent to execute the above and accept these terms.

_____ _____
Signature of Client or Personal Representative Date

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

By signing this consent, you are giving us permission to use or disclose your protected health information to provide treatment to you, to obtain payment for the services we provide, and for other professional activities known as "health care operations" (for example: quality improvement activities).

These uses and disclosures are described more fully in our Notice of Privacy Practices. You have the right to review that Notice before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the waiting room. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation. This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

_____ _____
Signature of Client or Personal Representative Date

_____ _____
Signature of Witness Date

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Client Information

DEMOGRAPHICS				COMMUNICATIONS	
First Name		MI:		Home Phone	
Last Name				Work Phone	
Address/PO Box				Cell Phone	
City/State/Zip				E-mail Address:	
Birth Date					
Gender	○ Male ○ Female			OK to leave messages at:	
Social Security Number				○ Home ○ Work ○ Cell	
Marital Status	○ Single ○ Married ○ Other_____			○ **DO NOT** leave messages	
Last Year (grade) of School Completed				Emergency contact:	
Academic Degrees Earned (if any)				Name	
				Phone Number	

EMPLOYER, FAMILY, AND REFERRAL RELATIONSHIPS					
Employer				Occupation/Position	
Spouse's or Parent's Name (indicate which)					
		Age		Occupation	
Children, sibling's, or other relatives names					
		Age		School/Occupation	
		Age		School/Occupation	
		Age		School/Occupation	

Referred by	○ Employee Assistance ○ Arbor Client ○ Another Therapist ○ Doctor ○ Minister ○ School ○ Insurance Company ○ Court/Legal ○ Yellow Pages/Internet ○ Other_____		
May we thank the referral source?	YES ○ NO ○	Name/Phone	
		Address	
		City/State/Zip	

BACKGROUND INFORMATION

Please check all areas of concern: ○ Suicidal Feelings ○ Anxiety ○ Children ○ Marriage ○ School ○ Drugs/Alcohol ○ Financial ○ Depression ○ Physical or Sexual Abuse ○ Stress ○ Parents ○ Family ○ Work ○ Medical ○ Sexual

What is the reason for seeking counseling at this time?

Has the client been to counseling before? If so, when, where, and why?

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Billing Information

RESPONSIBLE PARTY (IF OTHER THAN CLIENT)

First Name		MI:		Home Phone	
Last Name				Work Phone	
Address/PO Box				Cell Phone	
City/State/Zip				E-mail Address:	
Birth Date					
Gender	○ Male ○Female				
Relationship to the Client	○ Parent ○ Spouse ○ Other _____				
Employer - Company Name					

INSURANCE COMPANY INFORMATION (IF APPLICABLE)

Who is the policy holder?	○ Client ○ Responsible Party (named above)	
Under employer's health plan?	○ Yes ○ No	
Plan Type/Name/Number		

PLEASE PRESENT THE POLICY HOLDER'S INSURANCE CARD TO THE STAFF FOR COPYING.

POLICY HOLDER'S AUTHORIZATIONS

I hereby authorize release of information by Arbor Family Counseling to my insurance company.

_____ _____
Signature Date

I hereby authorize my insurance benefits to be paid directly to Arbor Family Counseling Associates for services rendered by therapists involved in my treatment, and I agree that I am financially responsible for all charges not covered by insurance.

_____ _____
Signature Date

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Medical History

Client's Name _____ Birth Date _____

Physician's Name _____ Office Phone _____

Physician's Address _____

Street & Number/PO Box *City* *State* *Zip*

Drug Allergies (list) _____

Has the client ever had any indication of the following disorders? Please

- Check **"C"** and underline the condition if the client is **currently** experiencing it**,**
- Check **"P"** and underline the condition if the client has experienced it in the **past** but not currently, or
- Check **"N"** if the client has **never** experienced the problem.

C	P	N	
☐	☐	☐	Eyes, ears, nose or throat (e.g., vision or hearing difficulty, frequent nosebleeds, sore throat)
☐	☐	☐	Upper respiratory (e.g., colds, bronchitis, asthma, allergies, emphysema, tuberculosis, hoarseness, persistent cough, shortness of breath
☐	☐	☐	Heart (e.g., chest pain, palpitations, high blood pressure, heart attack)
☐	☐	☐	Gastrointestinal tract (e.g., ulcers, hernia, nausea, vomiting, diarrhea, constipation, intestinal or rectal bleeding, hemorrhoids)
☐	☐	☐	Liver (e.g., hepatitis, cirrhosis)
☐	☐	☐	Kidneys, bladder, prostate, urinary tract (e.g., infections, swelling, blood in urine)
☐	☐	☐	Endocrine system (e.g., diabetes, thyroid)
☐	☐	☐	Muscular/nervous system (e.g., arthritis, gout, muscle aches, weakness, numbness)
☐	☐	☐	Blood disorder (e.g., anemia, immune deficiency)
☐	☐	☐	Excessive use of tobacco, alcohol, or drugs
☐	☐	☐	Significant weight change in the past year (if YES, indicate number of pounds _____) Gain ____; Loss ____
☐	☐	☐	Mental health (e.g., depression, schizophrenia, bipolar disorder)

--OVER--

If the client is currently dealing with a mental health problem, what (if any) medication(s) is the client currently taking for this problem?

_____

_____

What other medications (prescription or over the counter) is the client currently taking?

_____

_____

Does the client smoke?

☐ Yes (indicate how much per day _____ or per week _____) ☐ No

Is the client currently pregnant or nursing? ☐ Yes ☐ No

Date of client's last visit to a doctor _____

Reason for visit _____

Client's immediate family members not living: Cause of death:

_____ _____

_____ _____

_____

Has the client or any family member ever experienced any of the following (check all that apply)?

☐ drug or alcohol abuse ☐ physical abuse ☐ sexual abuse ☐ suicide

If you answered YES, Currently or Past, to any of the questions on this form, please explain briefly:

_____

_____

_____

....

Signature Date

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Alcohol Use Questionnaire

As part of our service, it is important to examine lifestyle issues likely to affect the health of our clients. This information will assist us in giving you the best treatment and highest possible standard of care. These next questions are about your use of alcoholic beverages in the past year. 'Alcoholic beverages' refers to beer, wine, brandy, and liquor, like whiskey, gin, or scotch, including mixed drinks like gin and tonic. This information pertains to our adult clients and is completely voluntary.

Please circle the answer on each line that best describes your answer to each question.

	0	1	2	3	4	
1. How often do you have a drink containing alcohol? **(IF NEVER, GO TO QUESTION 9)**	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the past year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the past year have you needed a drink first thing in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the past year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the past year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking and suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	