Brittany Mrsny, LIMHP
11725 Arbor St Ste 210
Omaha, NE 68144
Phone: 402.522.6361

COLLABORATIVE
counseling center

New Patient Information

Patient Name: _____ Date:_____

Address: _____

Phone: _____ Secondary phone: _____

DOB: _____ Gender: _____

Email address: _____

Emergency contact (relationship to client): _____

Marital Status: (circle) Single Married Widow Divorce

Social Security Number: _____-_____-_____

If under 19 years old, Social Security Number of parent/guardian: _____-_____-_____

**If the client is a minor whose parents are not married, which parent has legal custody? _____

Race/Ethnicity: ___Native American or Alaska Native ___ Asian ___ African American ___ Native Hawaiian or Other Pacific Islander ___ White ___ Hispanic ___ Other ___ Refuse

Preferred Language: _____

Primary Care Provider (PCP): _____ PCP Phone Number: _____

PCP Address: _____

Primary Insurance: _____

Primary Insurance Holder's Name: _____ Date of Birth: ____/____/_____

Relationship to Patient: _____

ID #: _____ Group #: _____ Employer: _____

Secondary Insurance: _____

Secondary Insurance Holder's Name: _____ Date of Birth: ____/____/_____

Relationship to Patient: _____

ID #: _____ Group #: _____ Employer: _____

I have or will contact my Insurance Company to verify my Mental Health Benefits. I understand this is my responsibility. I hereby give my permission to Brittany Mrsny LIMHP to administer treatment as may be deemed necessary in the diagnosis and/or treatment of my condition. I hereby authorize my insurance benefits to be paid directly to Brittany Mrsny LLC, and the release of any information required by third party payers in claim processing and understand that I am financially responsible for any remaining balance.

Client Signature*:*_____

Signature of guardian if minor: _____

Therapist signature:_____

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Office Financial Policy and Billing Agreement

Name (*print*) _____ Social Security # _____

Insurance Coverage:

- I agree to contact my **Insurance Company to verify the Mental Health benefits.** (You pay for your insurance. It is your responsibility to know the benefits of your policy). _____*initial*
- **It is generally the clients' responsibility to clarify and resolve a dispute with the insurance company.** _____*initial*
- If insurance is being filed, **any deductible not yet met is due at the time of service.**_____*initial*
- I understand any **co-pay is due at the time of service.** If a minor, the person that accompanies the child will pay the co-pay. _____*inital*

Payment:

- If insurance is *not* being filed, **payment is due at the time of service.** _____*initial*
- **I agree to provide a 24-hour notice to cancel an appointment. A late charge of $30.00 may be assessed if notice is not provided.** _____*initial*
- If a client does **not show for a scheduled appointment,** there may be a **no-show charge of $30.00.**_____*initial*
- Statements will **not** be sent to a third party, without their **written agreement to pay,** on file. _____*initial*
- Accounts are **NOT** carried **beyond 60 days,** without payment. I understand my account may be sent to a collection agency if it becomes delinquent. _____*initial*
- Fees are subject to change at the discretion of the clinician. A fee schedule is available upon request._____*initial*
- There is a $30 administration charge for checks that do not clear the bank. _____*initial*

I certify that I have read, understand and agree to the above writings. The undersigned is the client or is duly authorized by or on behalf of the client to execute the above and accept its terms.

_____ _____

Signature of Client or Responsible Party **Date**

_____ _____

Signature of Witness **Date**

Clients Bill of Rights

Revised: May 1, 2018

As a client of Collaborative Counseling Center, you have the following rights in addition to your rights as required by law and codes of ethics. These rights belong to every client; Collaborative Counseling Center shall not hold any client to be an exception to the rights outlined in this bill of rights.

1. Every client has the right to receive accurate, easily understood information about the counselor in the form of a professional disclosure statement. Every client has the right to request further information needed to make informed decisions about their counseling experience, including the counselor's qualifications, the counselor's counseling methods, possible benefits and risks of counseling, alternative counseling methods, alternatives to counseling, and applicable laws, regulations, and codes of ethics. The counselor shall provide the client with any assistance needed to understand all such information and to make informed decisions about their counseling experience, including alternative forms of information.

2. Every client has the right to choose their counselor and to have access to services they need, including services that ensure continuity of care. Every client has the right to refuse counseling. The counselor shall provide the client with appropriate referrals if the counselor cannot meet the client's need.

3. Every client has the right to emergency services. The counselor shall provide information on other available emergency services in cases where counselor cannot provide emergency services.

4. Every client has the right and responsibility to participate in all decisions regarding their counseling experience. Clients who are not able to fully participate in such decisions have the right to be represented by another person who is.

5. Every client has the right to considerate, respectful care from the counselor at all times and under all circumstances. In delivering counseling services and in making marketing, outreach, and enrollment decisions, the counselor shall not discriminate against any client on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, gender identity, genetic information, or source of payment.

6. Every client has the right to communicate with the counselor in confidence, and to have the confidentiality of their individually identifiable information protected. Every client has the right to be informed of legal, ethical, and practical limitations to their right to confidentiality. Every client has the right to review and copy their own counseling records and to request amendments to their records.

7. Every client has the right to a fair and efficient process for resolving differences with the counselor. The counselor shall provide the client with information on how to access this process and shall not retaliate against the client for accessing this process.

8. Given these clients' rights, the counselor shall expect and encourage every client to assume reasonable responsibilities that will increase the likelihood of achieving best outcomes with available resources.

I hereby attest that I have read and understand the client bill of rights.

Client signature: _____ Date: _____

Therapist signature: _____ Date: _____

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Treatment Agreement

I understand and agree that **Brittany Mrsny, LIMHP** is providing therapeutic mental health services to myself/ my child, _____. The reason I (we) have requested outpatient mental health services is: _____
_____

Confidentiality Policy:

- All client information and therapeutic information is kept confidential unless client is reporting suicidal ideation or homicidal ideation. The therapist then has the duty to warn or release information to police/law enforcement or hospital for purposes of client/community safety. _____*initial*
- Client information may be released to other providers for coordination of care if client signs a release of information. _____*initial*

If client is a minor I also understand that my child's trust in his/her provider is essential to the therapeutic process. Therefore, I further agree that:

- Discussions between the above named provider and my child may be held confidential from me unless my child is at risk of harming him/herself or others. _____*initial*
- My child's other parent, unless his/her parental rights have been terminated, or otherwise limited by law, may be given the same information and recommendations regarding my child, that I am given. _____*initial*
- My child's other parent, unless his/her parental rights have been terminated or limited by law, may make an appointment to review my child's treatment records at a time when the provider is available to address any questions or concerns that may arise. _____*initial*
- I will **NOT** request that any treatment records be released to my attorney. _____*initial*
- My attorney will **NOT** request the provider's testimony or deposition in the event of a legal dispute. _____*initial*
- **I have been informed that, should custody or placement of my child ever be an issue, it is recommended that I seek an independent custody evaluation from a Psychologist who specializes in forensic evaluation.** _____*initial*

Discharge policy:
Clients will be discharged for 3 no show appointments. Collaborative Counseling Center holds the right to discharge clients if a discharge is warranted. Examples of situations that may warrant a discharge include:

- Failure to comply with client responsibilities/financial policy
- Any behavior considered disruptive to the clinic, staff, or other clients
- If the therapist is unable to meet the level of care or scope of care the client requires

  _____ *initial*

I certify that I have read, understand, and agree to the aforementioned. The undersigned is the client or is duly authorized by or on behalf of the client to execute the above and accept its terms.

_____ _____

Signature of Client or Responsible Party **Date**

_____ _____

Signature of Clinician **Date**

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can have access to this information. Please review it carefully.

By law, collaborative counseling center is required to protect the privacy of your personal health information. We are also required to give you this notice to tell you how we may use and/or disclose your personal health information (PHI).

Personal health information (PHI)includes any record of services you receive including, but not limited to:

- dates, times, and length of your counseling session
- Information you share during a counseling session or at other times
- your counselors observations of you
- your counselors assessment of your mental health concerns
- results of psychological tests
- treatment plans an homework suggestions
- medication records
- billing and insurance information

Most of your PHI is in written form. Information about you that is not written down is also considered part of your PHI and is protected by law the same way written information is protected.
Information that cannot be traced back to you is not considered part of your personal health information. Examples include;

- information about an experience you had that many People also had, and
- information that is changed or made vague so that you could not be associated with it

Collaborative counseling center must use and/or disclose your PHI to provide information:

- to you, or someone who has the legal right to act for you
- to the secretary of the Department of Health and Human services, when the degree to which your privacy is protected is being examined, and
- where required by law

Collaborative counseling center has the right to use and/or disclose your PHI to be paid for services provided to you. For example:

- Your insurance company may ask for your PHI as a condition for paying for services you receive
- if your account is referred to a collection agency, the collection agency may ask for the dates of sessions and the related charges and payment history
- to make sure you received quality care, to provide customer services to you, to resolve any complaints you have, or to contact you about research studies

Collaborative counseling Center may use or disclose your PHI for the following purposes under limited circumstances:

- to stay in federal agencies that have the legal right to obtain such information (such as a licensing board investigating an ethics complaint)
- for public health activities (such as reporting disease outbreaks)
- for government healthcare oversight activities (such as insurance fraud investigations)
- for judicial and administrative proceedings (such as in response to a court order)
- for law enforcement purposes (such as providing limited information to locate a missing person)
- for research studies that meet all privacy law requirements (such as research on effectiveness of a counseling technique)
- to avoid a serious and imminent threat to health or safety
- for the purpose of supervision, consultation and training
- to create a collection of information that can no longer be traced back to you

By law, collaborative counseling center must have your written permission (authorization) to disclose or use your PHI for any purpose that isn't set out in this notice. You may take back (revoke) you are written permission at any time, except when collaborative counseling center has already acted, based on your written permission.
by law, you have the right to:

- view and receive a copy of your PHI held by collaborative counseling center
- have your PHI amended if you believe it is wrong or if information is missing in the counselor agrees. if the cancer disagrees, you may have a statement of your disagreement added to your PHI
- receive A listing of those getting your PHI. this listing will not include disclosures to which you have already consented, i.e. those for treatment, payment, or health care operations, sent directly to you or to your family; nor disclosures made to law enforcement or for national security purposes
- ask that we communicate with you in a different manner (for example, by sending materials to APO box instead of your home address)
- receive a separate paper copy of this notice

If you believe collaborative counseling center has violated these privacy practices, you may contact Michelle Book, LIMHP 402-522-6405. If you wish to file a complaint, you may contact the Department of Health and Human Services at HHSS.HIPAAOffice@dhhs.ne.gov

Filing a complaint will not affect the services you receive.

By law, Collaborative Counseling Center is required to follow the terms in this privacy notice. If any changes are made to the way your PHI is used while you are a client, you will receive a new notice within 60 days of the change.

This notice went into effect August 1, 2019.

I hereby attest that I have read and received the **HIPAA Notice of Privacy Practices**.

Signature of client: _____

Date:_____

Signature of therapist: _____

Date: _____

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Fee Schedule- effective August 1 2019

CPT Codes for LIMHP- filed to insurance company

90791- Psychiatric Diagnostic Evaluation	$170.00
90832- Psychotherapy w/ patient or family member present; 30 min	$70.00
90834- Psychotherapy w/ patient or family member present; 45 min	$115.00
90837- Psychotherapy w/ patient or family member present; 60 min	$160.00
90846- Family therapy (w/out client present)	$110.00
90847- Family therapy (with client present)	$115.00

Crisis Session-

90839- Psychotherapy for patient in crisis; 60 min	$160.00
+90840- crisis add-on code for each additional 30 minutes	$80.00

Self Pay Charges-

Consultation (hourly rate)-	$160.00
Phone calls/phone consultation-	(charged for time spent @ pro-rated hourly rate)
Letters	(charged for time spent @ pro-rated hourly rate)
Reports	(charged for time spent @ pro-rated hourly rate)
School Conference	(charged for time spent @ pro-rated hourly rate)
Travel	(charged for time spent @ pro-rated hourly rate)
No show and late cancellation charge	$30.00

Thank you for your business!

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Authorization for Release of Information

Client Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

I, hereby, as the parent or guardian of a child under 18 years of age, or I, as an eligible adult (18 years of age or older) do request and authorize **Brittany Mrsny, LIMHP** to receive and provide the information below:

☐ All information necessary for coordination of care

☐ Initial Diagnostic Intake/ Discharge Summary

☐ Psychological Testing Reports

☐ Psychiatric Assessment

☐ Other _____

The purpose of releasing this information is due to the following:

☐ Coordination of Care

☐ Per request

☐ Other

Name of person or organization that will be receiving and/or releasing information is:

Name of person/organization:_____

Address:_____

Phone Number:_____ Email/Fax Number:_____

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows Collaborative Counseling Center to release and/or exchange your protected health information. You can revoke this authorization at any time by submitting a request in writing. Revoking this authorization will not affect any action taken prior to receipt of your written request. *I understand this authorization will expire 360 days from the signed date. Psychotherapy notes may not be included in this authorization along with any other protected health information.*

_____

Printed name of Client or Responsible Party

_____ _____

Signature of Client or Responsible Party Date

_____ _____

Signature of Witness Date