Today's Date: _____

LIFE RESOURCES, LLC

New Client Information

Legal First Name: _____ **MI**: _____ **Last Name**: _____

Preferred Name: _____ **Email**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Home Phone: (____) _____-_____ **Work Phone**: (____) _____-_____ **Cell Phone**: (____) _____-_____

SSN: _____/_____/_____ DOB: _____/____/_____ **Gender**: _____ **Sex**: _____

Marital Status: Married /Single/ Widowed/ Divorced/ Separated. **Pronouns**: _____

Spouse's Name: _____ **Contact Preference?** _____

Only If Client is a Minor Complete Below:

Parent/Guardian Name: _____ Phone Number: (_____) _____-_____

As the parent or legal guardian of _____, I authorize his/her treatment. As parent or legal guardian, I have the right to request information concerning the above minor's evaluation and treatment.

X_____ **X** _____

Parent/ Guardian Signature Date: _____/_____/_____ **Witness Signature** Date: _____/_____/_____

➢ **Person Financially Responsible**: Initial if same as client listed above _____

Name: _____ Relationship to Client: _____

Date of Birth: _____/_____/_____ SSN: _____-_____-_____ Employer: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone :(_____) _____-_____ Work Phone :(_____) _____-_____

Emergency Contact: Name: _____ Relationship: _____

Phone :(_____) _____-_____ Cell Phone :(_____) _____-_____ Work Phone :(_____) _____-_____

Veteran Status:

Are you a Veteran? _____ Is this visit due to an accident of any kind? _____

EAP **Employee**: _____ **Employer:** _____ **EAP Company**: _____

Phone Number: _____ **Authorization #:** _____ **# Sessions authorized**: _____

Insurance Information: (please provide the front desk with a copy of the insurance card(s)

Primary Insurance: _____ Phone Number: _____

Policy Holder's Name: _____ DOB: ____/____/_____Relationship to Client: _____

Policy Number: _____ Group Number: _____ Co-payment: _____

Policy Holder's Employer: _____

Secondary Insurance: _____ Phone Number: _____

Policy Holder's Name: _____ DOB: ____/____/_____Relationship to Client: _____

Policy Number: _____ Group Number: _____ Co-payment: _____

Policy Holder's Employer: _____

Provider: _____

*DX_____

LIFE RESOURCES, LLC
New Client Information

Acknowledgement of Insurance Processing

In order to process claims and receive payment from insurance carriers, it is helpful for each client to be aware of the certain processes mental health services require. Most insurance plans require prior authorization for a service such as therapy. Please contact your carrier by calling the customer help line located on the back of your card to ensure that your plan does not require prior authorization or a referral from your primary care physician. If you have any questions, please feel free to contact our billing department.

Life Resources, LLC will complete and mail an insurance claim of your behalf. However, you are responsible for all pre-authorization requirements, insurance claim follow up, and all charges not covered by your insurance. Life Resources, LLC reserves the right to charge the patient the full amount of the visit if there is no response from the insurance company within 45 days.

Please be aware that all clients that have co-pays or co-insurances must pay them at the time of service. If you are unable to make the payment at that time, a statement will be mailed to you and payable within 10 days of receipt. If necessary, a payment plan can be made with our billing department. In the event that we have not received payment within 90 days of service, a collection process will commence. Please keep our office up-to-date with any change of address to avoid any complications with statements.

I understand and agree to abide by the above financial policy.

X_____ **Date**: _____/_____/_____

Signature of Client/Guarantor

No-Show Agreement

Please inform the office with 24 hour notice if you are unable to make your appointment. Upon the event that a client has no-showed for their appointment, Life Resources, LLC reserves the right to charge for the allotted time. This fee is not covered by any insurance plan.

INSURANCE RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS:

I authorize **Life Resources, LLC** to release to my Medicare carrier or the Insurance carrier listed above any medical information needed for authorization or payment of this or a related claim. I also authorize payments directly to this office for the mental health benefits. I understand that I am responsible for all pre-authorization required by my insurance. Furthermore, I understand that I am financially responsible for all charges whether or not paid by my insurance company.

X_____ **Date**: _____/_____/_____

Signature of Client/Guarantor

Provider: _____
Dx: _____

LIFE RESOURCES, LLC
New Client Information

Brief Medical History

Are you currently taking any medication, prescription or over the counter? (YES or NO)
If so, please list:

_____

_____

Do you have any medical conditions? (YES or NO)
If so, please list:

_____

_____

Have you been hospitalized for mental illness? (YES or NO)
If so, please describe:

_____

_____

Have you ever been seen by a mental health provider? (YES or NO)
If so, please list the provider's name: _____

Please sign below if you wish to grant Life Resources, LLC permission to receive information from your previous mental health provider.

X_____ **Date**: _____/_____/_____
Signature of Client/Guarantor

Please feel free to use the space below to describe the primary reason for your visit.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Provider: _____
Dx: _____

INFORMED CONSENT FOR MENTAL HEALTH TREATMENT

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy, whose goal is your well-being. There are also certain limitations to those rights that you should be aware of. As therapists, we have corresponding responsibilities to you.

My Responsibilities to You as Your Therapist

I. Confidentiality

With only a few specific exceptions outlined below, you have the absolute right to the confidentiality of your therapy. We cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, we may legally speak to another health care provider or a member of your family about you without your prior consent, but we will not do so unless the situation is an emergency. We will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you.
If you elect to communicate with me electronically at some point in our work together, please be aware that these services are not completely confidential. All electronic records are retained in the logs of your or my internet service or cellular provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service or cellular provider. Correspondence we receive from you, and any responses that I send to you, may be printed out and kept in your treatment record.

The following are legal exceptions to your right to confidentiality. We will attempt to inform you of any time when we think we will have to put these into effect.

1. If supervision occurs, your confidential information may be shared.
2. If we have concerns about child and/or elder abuse or neglect.
3. If we are concerned you may harm yourself or someone else.
4. Under court order.

Provider: _____
Dx: _____

II. Other Rights

We are always willing to discuss how and why we've decided to do what we do, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

III. Your Responsibilities as a Therapy Client

You are responsible for coming to your session on time and at the time we have scheduled. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than twenty-four hours notice, you must pay for that session at our next regularly scheduled meeting. The answering machine has a time and date stamp which will keep track of the time that you called me to cancel. We cannot bill these sessions to your insurance. The only exception to this rule about cancellation is if you would endanger yourself by attempting to come (for instance, driving on icy roads), or if you or someone whose caregiver you are has fallen ill suddenly. If you no-show for two sessions in a row and do not respond to my attempts to reschedule, I will assume that you have dropped out of therapy and will make the space available to another individual.

• Psychiatric Diagnostic Evaluation $200	• Individual Psychotherapy 45 min $150
• Individual Psychotherapy 60 min $200	• Family Psychotherapy $200

You are responsible for paying for your session weekly unless we have made other firm arrangements in advance. Co-pays are due at the time of the appointment.

IV. Consent to Treat

I have reviewed carefully, asked any questions that I needed to, and understand this consent to receive mental health services. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process. I agree to pay the session fee. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with Life Resources, LLC. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions.

Signed: _____ Date: _____

Witness: _____ Date: _____

Provider: _____
Dx: _____

LIFE RESOURCES, LLC
New Client Information

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

This notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and it's implementing regulations (HIPAA). It is designed to tell you how we may, under federal law, use or disclose your Health Information.

1. We may use or disclose your health information for purposes of treatment, payment or healthcare operations without obtaining your prior authorization and here is an example.
    a. Our billing department may access your information and send relevant parts to other insurance companies to allow us to be paid for the services we render to you.
2. We may also use or disclose your Health Information under the following circumstances without obtaining your prior authorization:
    a. To notify and/or communicate with your family. Unless you tell us you object, we may use or disclose your Health Information in order to notify your family or assist in notifying your family, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in any communications with your family and others.
    b. For Health Oversight Activities. We may use or disclose your Health Information to health agencies during the course of audits, investigations, certification and other proceedings.
    c. In response to Subpoenas or for Judicial and Administrative Proceedings. We may use or disclose your Health Information in the course of any administrative or judicial proceeding. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person.
    d. For Concerns of Abuse or Neglect. We may disclose your Health Information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your Health Information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Provider: _____
Dx: _____

e. To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to identify or locate a suspect, fugitive, material witness or missing person, comply with a court order or subpoena and other law enforcement purposes.

f. To Coroners and Funeral Directors. We may use or disclose your Health Information for purposes of communicating with coroners, medical examiners and funeral directors.

g. To Aid Specialized Government Functions. If necessary, we may use or disclose your Health Information for military or national security purposes.

h. For Worker's Compensation. We may use or disclose your Health Information to company with worker's compensation laws.

i. To Correctional Institutions or Law Enforcement Officials, if you are an inmate.

3. For all other circumstances, we may only use or disclose your Health Information after you have signed an authorization.
    a. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.
4. You should be advised that we may also use or disclose your Health Information for the following purposes:
    a. Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about treatments or health-related benefits and services that may be of interest to you.
    b. Change of Ownership. In the event that our entity is sold or merged with another organization, your Health Information/record will become the property of the new owner.
    c. Providing Information to our plan sponsor (if a health plan). We may disclose your Health Information to our plan sponsor.
5. Your Rights
    a. You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with your request.
    b. You have the right to receive your Health Information through confidential means through a reasonable alternative means or at an alternative location.
    c. You have the right to inspect and copy your Health Information made by use, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, healthcare operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with family; and/or for certain government functions, to name a few.

Provider: _____
Dx: _____

d. You have a right to a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one of more of these rights, contact Susan Meyerle, 402-477-0651.

6. Our Duties
   a. We are required by law to maintain the privacy of your Health Information (and to provide you with a copy of this Notice).
   b. We are also required to abide by the terms of this Notice.
   c. We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health Information even if it was created prior to the change in the Notice. If such amendment is made, we will immediately display the revised Notice at our office and provide you with a copy of the amended Notice. We will also provide you with a copy, at any time, upon request.
7. Complaints to the Government

   You may make complaints to the Secretary of the Department of Health and Human Services if you believe your rights have been violated. We promise not to retaliate against you for any complaint you make to the government about our privacy practices.
8. Contact Information

You may contact us about our privacy practices by calling the Privacy Officer, Susan Meyerle at:

Life Resources, LLC
P.O. Box 57235, Lincoln, NE 68505-7235
Telephone: 402-477-0651

OR You may contact the DHHS at:

US Department of Health and Human Services
200 Independence Avenue, SW, Washington DC, 20201
Telephone: 202-619-0257, Toll Free: 1-877-696-6775

Receipt of Notice of Privacy Practices (HIPAA)

Under the Health Insurance Portability and Accessibility Act of 1996, I have a right to review the privacy practices of Life Resources, LLC. I have received, read, and understand the Notice of Privacy Practice.

Signature: _____ Date: _____

Provider: _____
Dx: _____