AMBER JURGENSMEIER LIMHP, LCSW, LADC
11580 West Dodge RD
Omaha, NE 68154
PH: (402)238-1431 FAX: (402)281-1862
amber@compassionatemindstherapy.com

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CLIENT INTAKE FORM

Legal Last Name_____First Name_____Middle Initial_____

Preferred Name_____Preferred Pronouns:She __ He__ Other:__ Gender_____

Client's Social Security Number:_____ Date of Birth____/____/_____Age_____

Street Address_____City_____State_____Zip Code_____

Primary Phone _____Secondary Phone _____Email_____

May we contact you? (circle one) YES/NO Preferred contact: (circle one): Phone/ Text/ Email

Emergency Contact: Name_____Phone Number_____

Relationship Status: Married __Partnered__Single_____Other_____

Name of Spouse/Partner:_____ Spouse/Partner's Date of Birth_____/____/_____

Primary Insurance Information/Employee Assistance Program Information

Primary Insurance Name_____Insured Date of Birth /_____/_____

Insurance Company/EAP_____Insurance (800) Number_____

Insurance Member #_____Plan #_____

Insured's Employer_____Address_____

Employer/Student Information (Please choose one)

Employed with _____ __Unemployed __Disabled __Retired

Student at_____

Referred By/How Did You Hear About Us?

__Former/Returning Client __Relative __Friend __Court/Legal

__ Employee Assistance Program __Insurance Company __School __Minister/Priest/Rabbi

__Physician/Doctor __Another Therapist __Internet __Other

We offer courtesy appointment reminders. Please choose one of the following options:

__Phone #Reminder_____ __Text # Reminder_____

__Email Reminder_____ __No Reminder Requested

Authorized Person/Patient's Name (Print)_____

Authorized Person/Patient's/Guardian's Signature:_____

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HIPPA NOTICE of PRIVACY PRACTICES

This notice describes how medical information about you may be used, disclosed and how you can obtain access to this information. PLEASE REVIEW IT CAREFULLY.

This NOTICE of PRIVACY PRACTICES describes how we may use and disclose your (PHI) Protected Health Information to carry out treatment, payment or health care operations and for the purposes that are permitted and/or required by law. Protected Health Information (PHI) is information about you, including demographic information, that may identify you that relates to your past, present and/or future physical or mental health/ condition/related health care services. This notice also describes your rights to access and control your PHI.

Uses and Disclosures of Protected Health Information:

Your PHI may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example: We can disclose your PHI (as necessary) to a psychiatrist in order to coordinate care.

Payment: Your PHI will be used (as needed) to obtain payment for your health care services. Example: Information needed to verify insurance coverage and/or benefits, process claims, or any other information needed for billing and/or collection purposes. In addition, we may bill the person in your family who is financially responsible for your account.

Healthcare Operations: We may use or disclose (as needed) your PHI in order to support the business activities of our organization. For example: We may call you by name in the waiting room when your provider is ready to see you. We may use/disclose your PHI, as necessary, to contact you to remind you of your appointment.

Other Uses or Disclosures of Your Information (NO CONSENT REQUIRED)

There are some instances where we may be required to use and disclose information without your consent. Under Nebraska State Law, we are obligated to report any information that you and/or your child/children report about physical or sexual abuse to Child Protective Services. If you provide information that informs us that you are in danger of haring your self or other. Information shared with law enforcement if a crime is committed on or premises or against our staff or as required by law such as a subpoena or court order. Clinical records, psychotherapy notes and other disclosures require a separate signed release of information.
You have the right to or will receive notification of a breach of any unsecured personal health information. You have a right to restrict any disclosure of personal health information where you have paid for services out-of-pocket and in full.

Uses and Disclosures of PHI (Written Authorization is REQUIRED)

Other uses and disclosures of your PHI will be made only with your WRITTEN authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time in writing, except to the extent that your provider has already taken an action in reliance on the use or disclosure indicated in the authorization.

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CLIENT RIGHTS

Right to request how we contact you: It is our normal practice to communicate with you using the address, phone number and email that you provided to use when you scheduled your initial appointment. As an example, we may communicate with you regarding billing matters or to prove appointment reminders, etc. Sometimes, we may leave a voicemail message. You have the right to request that our office communicate with you in a different way.

Right to release your medical records: You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing at any time. A revocation however is not valid to the extent that we acted in reliance on such authorization.

Right to inspect and copy your medical and billing records: You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, please contact our office manager. Under limited circumstances we may deny your request to inspect and copy your records. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records: If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information or amend the record. We will make a decision on your request within 60 days, or in some cases within 90 days. Under certain circumstances, we may deny your request to add or amend information. If we deny your request, you have a right to file an appeal stating that you disagree. Both your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures: You may request an accounting of any disclosures we have made related to your medical information. Exceptions include information that was used for treatment, payment, or health care operational purposes or any information that you granted consent to release. This also excludes any information we were required to release. Please submit your request in writing to the office manager to receive information regarding disclosure made for a specific time period no longer than six years. We will notify you of the cost involved in preparing this.

Right to request restrictions on uses and disclosures of your health information: You have the right to ask for restrictions on certain uses and disclosures of your health information. This request will need to be made in writing and submitted to our office manager. We however are not required to agree to such a request.

Right to complain: If you believe your privacy rights have been violated, please contact us personally to address your concerns. If you are not satisfied with the outcome, you may file a written complaint with the Department of Health and Human Services. Please note that an individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy: You have the right to receive any future policy changes secondary to state and federal law changes. The officer manager will be able to provide this for you.

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INFORMED CONSENT

Thank you for choosing Amber Jurgensmeier, LIMHP, LCSW, LADC. Today's appointment will take approximately 60 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Amber Jurgensmeier is a Licensed Independent Mental Health Practitioner, Licensed Clinical Social Worker, Licensed Alcohol and Drug Counselor. Amber has over 10 years of mental health and substance abuse experience working with children, adolescents, young adults and families within the Omaha Metropolitan area. Treatment philosophy and practices will be discussed with you today.

CONFIDENTIALITY and EMERGENCY SITUATIONS: Verbal communication and clinical records are strictly confidential with the exception of the following situations: (1). Information (diagnosis and dates of service) shared with your insurance provider to process your billing claims; (2). information you and/or your child/children report about physical, sexual, or elder abuse, in which by Nebraska State Law, this information must be reported to the Department of Children and Family Services; (3). if you provide information that you are in danger of harming yourself or others; (4). when a signed release of information that you have signed to have specific information shared; or (5). when required by law. If an emergency situation for which you feel is necessary requires immediate attention, please contact our office to have your provider paged. If you are not contacted within 15 minutes by either your provider or another treatment provider, you as the client or guardian understand that you are to contact the emergency services in our community (911) for mental health emergencies. Amber Jurgensmeier LIMHP, LCSW, LADC will follow emergency services with standard counseling and support as needed.

OFFICE HOURS: Our office is open to receive telephone calls from 8a.m.- 8p.m Monday and Wednesday. Tuesday and Thursdays from 8a.m.-2p.m. and Fridays from 8am-12p.m. These hours may vary in which you will be notified of office hour changes. Furthermore, your provider may offer different and/or additional appointment times. Voicemail is available for you to leave a message when our office is closed, as well during office hours when all lines are busy. Messages received overnight or on the weekend will be attended to the following business day. In case of an emergency, please contact 911 or go directly to the nearest hospital emergency room.

COORDINATION OF TREATMENT: As part of your treatment care, it is important that all health care providers providing care to you work together. We would like your permission to communicate with your primary care physician or any other health care provider either you or your provider deems necessary. Your consent is valid for six months. ***Please understand that you have the right to revoke this authorization, in writing, at any time by providing us notice.*** If you prefer to no information to be shared, please decline consent.

_____**I grant consent to inform my identified primary care physician/other health care provider**

NOTE* A Release of Information will be provided

_____**I decline consent to inform my identified primary care physician/other health care provider**

NOTICE of PRIVACY PRACTICES and CLIENT RIGHTS: I/We have read and received a copy of the Notice of Privacy Practices and the Client Rights Documents _____**Clients Initials** ___/___/____**Date**

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FINANCIAL and INSURANCE: As a courtesy, our office per your request/authorization will bill your insurance company, HMO, responsible party or third-party payer for you. We ask you pay your co-payment or coinsurance amount at each session. In the event you have not met your deductible, the full fee is due at the time of service unit your deductible has been met. If your insurance company denies payment or does not cover standard counseling sessions, we request that you pay the balance due at that time. **Client balances that exceed $200 will be asked to be paid in full prior to being seen.** In the event that your account is overdue and turned over to our collection agency, you or the responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask every client to authorize payment of medical benefits directly to Amber Jurgensmeier, LIMHP, LCSW, LADC. You may keep a credit card on file to pay for co-payments or coinsurance amounts.

Please notify us immediately following this session of any changes in your health insurance, place of employment, home address or any other pertinent medical health information. Failure to do so, may result in our inability to be able to process insurance claims on your behalf and therefore you will be held responsible for full payment of each session not covered by your insurance. Please note that the financial responsibility for your treatment is ultimately yours.

POLICY OF NON-COVERED SERVICES: To provide consistent quality care to you, and to coordinate your care with other providers or organizations, we may request an additional charge for services that are not typically covered or reimbursed by your issuance provider. Such non-covered services will therefore be billed to you directly as a standard hourly rate for your treatment provider. If you have any questions regarding this, please ask to speak with our office manager or your treatment provider. The following are a list of some of non-covered services, in which are billed at the standard hourly rate: *Legal/court related services; Preparation of reports/letters for other providers or organizations; Completion of documentations (disability claims, insurance reviews, workers' compensations, etc; Consultations by telephone/email; Duplication of your medical records; Evaluation, testing or treatment services or etc.*
We appreciate your cooperation and at any time you may have questions regarding insurance, fees, balances or payments, please feel free to speak to our Office Manager and Billing Specialist, Kelly Duden.

MISSED APPOINTMENTS/CANCELLATION POLICY: We are privileged to be a part of your mental health treatment team. We do understand that there may be extenuating circumstances, in these instances, we request that any appointment cancellation or rescheduling to be made at least **24 HOURS IN ADVANCE.** We value your time and hope that you value ours. Missed appointments or cancelled appointment less than 24 hours in advance affect us and prevent us from being able to provide services to others in need. We have a cancellation and/or missed appointment policy noted below:

Courtesy reminder calls/texts/emails are provided before your appointment, yet ultimately you are responsible for remembering your scheduled appointment. If appointments are missed or not cancelled within **24 HOURS IN ADVANCE**, you will be charged a $100 fee. Furthermore, we have a **2 late/cancel no show policy**, if you have late cancelled or no showed for 2 appointments, you will not be rescheduled. We realize that there may be emergency situations where a 24 hour cancellation notice is not possible and those situations will be handled individually. We appreciate your consideration of our time and will express the same consideration for your. If any questions or concerns regarding this matter, please speak with your treatment provider.

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I (patient's name)_____agree and consent to participate in the mental health care offered and provided by Amber Jurgensmeier, LIMHP, LCSW, LADC a licensed professional as defined by Nebraska Law. I also understand I am consenting and agreeing only to those mental health services that Amber Jurgensmeier LIMHP, LCSW, LADC is qualified to provide within the scope of her professional licenses, certifications and training.

Authorized Person/Patient's Name (Print)_____

Authorized Person/Patient's/Guardian's Signature:_____

Witness Signature:_____

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PARENTAL CONSENT FOR MENTAL HEALTH TREATMENT OF A MINOR

Child's Name:_____ Date of Birth_____/___/_____

As the parent or legal guardian with the authority to consent on behalf of the minor child named above, I herby give my consent for the minor to seek counseling services by:

AMBER JURGENSMEIER, LIMHP,LCSW, LADC

This consent will be valid until the minor reaches the age of 19, but can be revoked at any time by written notification. Any questions relating to this form or the proposed treatment can be directed to:

AMBER JURGENSMEIER, LIMHP,LCSW, LADC
402-238-1431 ext 1005

Print Name of Parent/Guardian _____

Signature of Parent/Guardian _____ Date ___/___/____

Therapist Signature_____ Date ___/___/____