



CLIENT INTAKE FORM

Legal Last Name _____ First Name _____ Middle _____

Preferred Name _____ Preferred Pronouns: She ___ He ___ Other: _____

Client's Social Security Number _____ Age _____ Date of Birth _____

Gender _____ Relationship Status: Married ___ Partnered ___ Divorced ___ Single ___ Widowed ___

Home Telephone _____ Cell Phone _____ Email Address _____

Street Address _____ City _____ State _____ Zip Code _____

May we contact you at Home **Yes No?** Work **Yes No?** Cell Phone **Yes No?** Email **Yes No?**

Name of Spouse [if applicable] _____ Spouse's Date of Birth _____

Name(s) of Children and Date of Birth(s) [if applicable] _____

Emergency Contact Name and Telephone Number: _____

Employer Information

Are you (please choose one) [] Employed [] Unemployed [] Student [] Disabled [] Retired

Client's Employer Name: _____ Telephone Number _____

Street Address: _____ City: _____ State: _____ Zip Code _____

Primary Insurance Information/Employee Assistance Program Information

Primary Insured Name _____ Address _____ Home Telephone _____

Name of Insurance Company/EAP _____ Insurance/EAP (800) Phone _____

Insurance Member # _____ Plan # _____ Date of Birth of Insured _____

Insured's Employer _____ Address _____ Phone _____

Referred By/How Did You Hear About Us?

- I am a former client returning
- Employee Assistance Program
- Physician, Dr. _____
- Yellow Pages
- Relative
- Minister/Priest/Rabbi
- Another Therapist
- Other _____
- Friend/Family
- Insurance Company
- Website
- Court/Legal
- School
- Internet

As a courtesy, we offer appointment reminders. Please choose one of the following options:

- Please call me for my appointment reminder at _____
- Please email my appointment reminder to _____
- Please do not give me any appointment reminders

Print Authorized Person or Patient's Name: _____

Authorized Person or Patient's Signature: _____

Name: _____
ID: _____
DOB: _____

_____ Intake Date
_____ Therapist Initials

COMPASSIONATE MINDS THERAPY, LLC
HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date: MARCH 18, 2019

Compassionate Minds Therapy, LLC has been and always will be committed to maintaining our clients' confidentiality. We will only release your health care information in accordance with federal and state laws and the code of ethics for the counseling profession.

This notice describes our policies related to the use and disclosure of your health care information.

Uses and disclosures of your health information for the purposes of: Providing treatment services, collecting payment and conducting healthcare operations. These are necessary activities for provided our client's quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT: We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. This may include include consultants and potential referral sources.

PAYMENT: Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims, as well as information needed for billing and collection purposes. We may also bill the person in your family who is identified as the primary insurance holder or responsibility party.

HEALTHCARE OPERATIONS: We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

Other uses or disclosures of your information, which does not require your consent: There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse. In this circumstance, in accordance with Nebraska State Law, we are obligated to report this to Child Protective Services. If you provide information that informs us that you are in danger of harming yourself or others. Information shared with law enforcement if a crime is committed on our premises or against one of our staff. Any other instances as required by law such as a subpoena or court order. Information to remind you of /or to reschedule appointments or other treatment alternatives.

Clinical records, psychotherapy notes, and other disclosures require a separate signed release of information. You have a 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.

Name: _____
ID: _____
DOB: _____

_____ Intake Date
_____ Therapist Initials

COMPASSIONATE MINDS THERAPY, LLC

CLIENT RIGHTS

Right to request how we contact you.

It is our normal practice to communicate with you at your home address and via the daytime phone number you provided us when you scheduled your appointment, about health matters, billing information, and appointment reminders (if requested). If permitted by you, we may sometimes leave messages on your voicemail. You also reserve 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 that you identify. You have the right to revoke this authorization, in writing, at any time. However, please note that a revocation 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 the office manager. Under limited circumstance we may deny your request to inspect and copy. 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 to 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 a statement that you disagree. 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, if any, we have made related to your medical information, except for information we used for treatment, payment, health care operational purposes, information that was shared with you or your family, or information that you gave us specific consent to release. This also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than seven years, please submit your request in writing to Compassionate Minds Therapy, LLC Privacy Officer. We will notify you of the cost involved in preparing this list.

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 must be in writing and submitted to our office manager. However, please note that we 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, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. 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 changes in state and federal laws.

COMPASSIONATE MINDS THERAPY, LLC
BETSY S. MAYFIELD LIMHP, LMHP, LADC, NCC, SAP
INFORMED CONSENT

Thank you for choosing Betsy S. Mayfield, LIMHP, LMHP, LADC, NCC, SAP. 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. Betsy Mayfield is a Licensed Independent Mental Health Practitioner, Licensed Alcohol and Drug Counselor, a National Certified Counselor. Betsy has over 10 years of mental health and substance abuse experience working with adults, couples and families within the Omaha Metropolitan area. As a Registered Provider of the Nebraska Supreme Court Probation Administration, Betsy offers substance abuse evaluations, recommendations and treatment for individuals facing consequences associated with their substance use. Treatment philosophy and practices will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for the following situations: a) information (diagnosis and dates of service) shared with your insurance company to process your claims; b) information you and/or your child or children report about physical, sexual, or elder abuse; then, by Nebraska State Law, this information must be reported to the Department of Children and Family Services; c) where you sign a release of information to have specific information shared; d) if you provide information that you are in danger of harming yourself or others; or e) when required by law. If an emergency situation for which you feel immediate attention is necessary, please call the office to have a counselor paged. If no call is received within 15 minutes, you as the client or guardian understand that you are to contact the emergency services in the community (911) for those services. Betsy S. Mayfield LIMHP, LMHP, LADC, NCC, SAP will follow those emergency services with standard counseling and support as needed.

HOURS: Our front desk is open to take telephone calls Monday through Thursday from 8:30 am until 8:00 pm, Fridays 8:30 am until 2:00 pm. These hours may vary. Furthermore, your therapist may offer different and/or additional appointment times. Voicemail is available to leave a message when the office is closed, as well as, when all lines are busy during the day. Messages left overnight or on the weekend will be attended to the next business day. In the case of an emergency, please contact 900 or go directly to the nearest hospital emergency room.

COORDINATION OF TREATMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for six months. Please understand that you have the right to revoke this authorization, in writing at any time by sending notice. If you prefer to decline consent no information will be shared.

If consent is granted, you will be provided a release of information form to be completed for each treatment provider.

You may inform my physician(s)

I decline to inform my physician

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' document.

Initials _____

Date _____

Name: _____
ID: _____
DOB: _____

_____ Intake Date
_____ Therapist Initials

FINANCIAL INFORMATION

FINANCIAL/INSURANCE ISSUES: As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-payment or coinsurance amount. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. **If your balance exceeds \$200.00 we will need to ask that you pay for services when rendered.** In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Betsy S. Mayfield, LIMHP, LIMHP, LADC, NCC, SAP. You may put a credit card on file to pay for charges not covered by your insurance.

Following this meeting we ask you to notify us immediately as to any change in your health insurance, place of employment, home address or other information pertinent to our records. (Failure to do this may result in our no longer being able to process insurance claims for you and you would be held responsible for full payment of each session not covered by your insurance). The financial responsibility for your treatment is ultimately yours.

Policy on Non-Covered Services: In order to offer you consistent quality care and to coordinate this care with other providers or organizations, we may need to charge for services that are not typically covered or reimbursed by your insurance company. A list of these services is provided below. When we provide these services, we will bill you directly. These services are billed at the standard hourly rate for your therapist or doctor. If you have any questions regarding this policy, please ask our staff. The following are a list of some of the services not covered by insurance companies. These services are billed at the standard hourly rate:

- Court ordered and legal related services
- Preparing reports or letters for other providers or organizations
- Completing documents (for disability claims, insurance reviews, workers' compensation, etc.)
- Consultations by telephone or e-mail
- Duplication of your medical records
- Evaluating, testing or treatment services not covered by your insurance

We sincerely appreciate your cooperation and at any time you have questions regarding insurance, fees, balances or payments please feel free to ask one of our billing staff.

Missed Appointment Cancellation Policy: We consider it an honor and privilege to be of service & hope for a long and mutually satisfying relationship. We do understand that there may be extenuating circumstances; however, we request that any cancellation or rescheduling of your appointment be made at least **24 hours in advance**. We value your time and hope that you value ours. Missed appointments or appointments cancelled less than 24 hours in advance affect us all and prevent us from being able to serve others in need. Because of this, we have created a cancellation and missed appointment policy outlined here.

Name: _____

_____ Intake Date

ID: _____

_____ Therapist Initials

DOB: _____

You will be charged a **\$100.00** fee for missed appointments or appointments not cancelled at least 24 hours in advance of the scheduled visit. If you are new to our practice and cancel or are a no-show within 24 hours of your first visit and wish to reschedule, a cancellation fee of **\$35.00** will be applied to your bill at the time of your rescheduled appointment.

We provide reminder calls before your appointment as a courtesy. You are still responsible for remembering your scheduled appointments. Stating that you did not receive a reminder call or that the call was made after the 24-hour deadline, does not make your missed or cancelled appointment an exception. Furthermore, we have a **3 late cancel/no show policy**. If you late cancel or no show for 3 appointments, you will not be rescheduled. We appreciate your consideration of our time and will express the same consideration for yours.

We realize that there may be emergency situations where a 24-hour cancellation notice is not possible, and those situations will be dealt with individually. Questions? Please ask your therapist.

I, the undersigned, agree and consent to participate in the mental health care offered and provided by Betsy S. Mayfield, a mental health and substance abuse professional as defined by Nebraska Law

I understand that I am consenting and agreeing only to those mental health services that the above-named professional is qualified to provide within the scope of the professional's license, certifications, and training.

Please Print Patient's Name: _____

Patient Signature: _____

Date: _____

Witness Signature: _____

Date: _____



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 hereby give my consent for the minor to seek counseling services by

Betsy S. Mayfield LIMHP, LMHP, LADC, NCC, SAP

This consent will be valid until the minor reaches the age of 19, but can be revoked at any time by written notification.

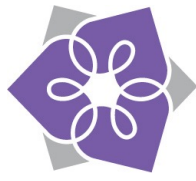
Any questions relating to this form or the proposed treatment can be directed to Betsy S. Mayfield LIMHP, LMHP, LADC, NCC, SAP at 402-238-1431 ext. 1003.

(Print Name of Parent/Guardian)

(Signature of Parent/Guardian)

(Date)

(Therapist Signature)



compassionate minds THERAPY

Mental and Physical Health Questionnaire

Current Symptoms (Check Symptoms You Have Recently Experienced)

- | | | |
|--|---|---|
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Loss of Interest | <input type="checkbox"/> Sleep Disturbances |
| <input type="checkbox"/> Appetite Changes | <input type="checkbox"/> Avoidance | <input type="checkbox"/> Crying Spells |
| <input type="checkbox"/> Feelings of Guilt | <input type="checkbox"/> Unable to Enjoy Activities | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Feelings of Helplessness | <input type="checkbox"/> Feelings of Worthlessness | <input type="checkbox"/> Low Self-Esteem |
| <input type="checkbox"/> Feelings of Hopelessness | <input type="checkbox"/> Thoughts of Death | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Racing Thoughts | <input type="checkbox"/> Excessive Worry | <input type="checkbox"/> Self-Harm Behaviors |
| <input type="checkbox"/> Concentration Problems | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Homicidal Thoughts |
| <input type="checkbox"/> Feelings of Panic | <input type="checkbox"/> Frequent Mood Swings | <input type="checkbox"/> Increased Risky Behavior |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Excessive Energy | <input type="checkbox"/> Increased Irritability |
| <input type="checkbox"/> Feeling Keyed Up or On Edge | <input type="checkbox"/> Gastrointestinal Upset | <input type="checkbox"/> Headaches |

Have you ever participated in outpatient therapy? Yes No If Yes please provide names & approximate treatment dates for each provider seen in the space provided below.

Provider: _____ Dates: _____

Provider: _____ Dates: _____

Provider: _____ Dates: _____

Have you ever had inpatient treatment for psychiatric purposes? Yes No If Yes please provide the name(s) of the treatment facilities & the approximate dates for each stay.

Facility: _____ Dates: _____

Facility: _____ Dates: _____

Facility: _____ Dates: _____

Have you ever been diagnosed with any mental health conditions? Yes No If Yes please list all diagnoses below:

Please list all psychotropic medications (with dosages) that you are currently being prescribed.

Allergies: Please list any food, medication, or other allergies you have.

Are you currently being treated by a psychiatrist? Yes No If Yes who are you currently seeing?

Provider: _____ Dates: _____

Have you ever attempted suicide? Yes No - If Yes when? _____

Physical Health Information

Please list any past health conditions including major illnesses, broken bones, and surgeries which required medical treatment. Please also list any hospitalizations for medical conditions.

Please list all medications (with dosages) for physical health reasons that you are currently being prescribed.

Is there any additional family medical history? Yes No If Yes, please explain _____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

Yes No If Yes, please explain: _____

Have you participated in regular exercise/sports/recreation (about 3 times a week) to keep fit Yes No

Have you been dieting to lose weight? Yes No

Use of Caffeine: Indicate how often in a day you drink beverages containing caffeine including pop, coffee, tea, or energy drinks. _____ Daily _____ Weekly _____ Monthly

Substance Use History

Have you smoked cigarettes on a daily basis? ____ Yes ____ No If yes, # per day: _____

How often in the past month did you drink alcohol? (please circle your answer)

A. I do not drink at all B. About once a month C. 2 to 3 times a month D. 2 to 3 times a week E. Once a day or more

On days that you drink, how many servings of beer/wine/spirits/ do you consume? _____

How often in the past month have you used illicit drugs? (please circle your answer)

A. I do not use drugs at all B. About once a month C. 2 to 3 times a month D. 2 to 3 times a week E. Once a day or more

Please list the names of any illicit drugs and the quantity consumed.

Have you ever been hospitalized for chemical dependency treatment? ____ Yes ____ No If Yes please provide the name(s) of the treatment facilities & the approximate dates for each stay.

Facility: _____ Dates: _____

Facility: _____ Dates: _____

Facility: _____ Dates: _____

Family Background

Where were you born? _____ Where did you grow up? _____

Were you adopted? ____ Yes ____ No

Father's Name: _____ Age: _____ Occupation: _____

Mother's Name: _____ Age: _____ Occupation: _____

List your sibling's names and ages: _____

Did your parents divorce? ____ Yes ____ No If Yes, how old were you when they divorced? _____

If your parents divorced, whom did you live with? _____

Are you currently: Married Partnered Divorced Divorced Single Widowed

How long? _____

If not married, are you currently in a relationship? Yes No If Yes, How long? _____

How would you identify your sexual orientation? _____

What is our spouse or significant other's occupation? _____

Describe the relationship with your spouse or significant other: _____

Do you have any children? Yes No If Yes, list names and ages: _____

Describe the relationship with your children: _____

Educational/Occupational/Legal Background

Education – Years completed or highest degree earned _____

Military Service: Yes No If Yes, Present Past How long? _____ Rank _____

Employer Name: _____ Length of employment: _____

Recent/Current Legal Issues: Yes No If Yes please provide a description of current legal issues.

Financial Problems: Yes No

Are there any other concerns that you wish to share with your therapist? _____