2608 Old Fair Road
Grand Island, NE 68803
Phone: 308.382.5297
Fax: 308.382-5315

525 South 9th Avenue
Broken Bow, NE 68822
Phone: 308.872.5040
Fax: 308.872.5060

3500 Central Ave, Ste C
Kearney, NE 68845
Phone: 308.455.1560
Fax: 308.455.1450

CLIENT INFORMATION

Name_____ Soc. Sec. #_____

Date of birth_____ Guardian Name_____ Guardian's SS#:_____

Address_____ City_____ State/Zip_____

Home phone_____ Alternate phone_____ Cell phone_____

Permission to leave a message at any of the above numbers? (Circle) Y / N

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Employer_____ Occupation _____

School _____ Teacher/Grade_____

Main Contact person(s) and relationship(s)

_____

I would like a 24-hour reminder for my appointments: ☐ Yes ☐ No thanks

If yes, please use this phone#/email:_____ ☐ Call ☐ Text ☐ Email* (*Initial Below)

Mobile Carrier (to receive text mgs): ☐Staighttalk ☐Verizon ☐US Cellular ☐Viaero ☐ Other:_____

Email Address:_____

I would like to receive your free bi-monthly newsletter:

☐ Yes-at the above email ☐ Yes-via postal mail to the above address ☐ No thanks

Emergency Contact_____ Emergency Number_____

Physician Name and Phone Number_____

Medication_____

PRIMARY INSURANCE

Name of Insured _____

Relationship to patient_____

Insured Birth Date_____

Insured Soc. Sec. #_____

Insured Employer_____

Insurance Co._____

Insurance Co. Phone #_____

Group #_____

Policy #_____

ADDITIONAL INSURANCE

Name of Insured _____

Relationship to patient _____

Insured Birth Date_____

Insured Soc. Sec. #_____

Insured Employer_____

Insurance Co._____

Insurance Co. Phone #_____

Group #_____

Policy #_____

Client Name:_____ SS#_____

INFORMED CONSENT FOR COUNSELING

CONFIDENTIALITY: Wholeness Healing Center maintains a strict policy of confidentiality. All services are guided by the Ethical Principles and Standards for the American Counseling Association, the National Association of Social Workers and the licensing laws of the State of Nebraska. I understand that all information I disclose within sessions is confidential and not to be revealed to anyone outside Wholeness Healing Center except under these conditions:

1.) When communication of my diagnosis and other clinical information to my insurance company is necessary for payment;
2.) When I have given permission for information to be shared with another person;
3.) When disclosure is required by law (e.g., when there is reasonable suspicion of abuse of children or adults; when there is a court order);
4.) If I am under 19 years of age, my counselor may advise my parent(s) or legal guardian about developments that could significantly affect my health or well-being. In such situation(s), the specific contents between my counselor and me will not be discussed, but my overall progress may be discussed in general terms; or
5.) When I present an immediate risk of causing serious harm to myself or another person.

SUPERVISION AND CONSULTATION:
Supervision is sometimes necessary for the purpose of providing the best service possible. Supervision may be required by your insurance company (Medicaid), our office policy (for quality assurance) and/or licensing requirements (provisionally licensed therapists). All staff at Wholeness Healing Center are under the supervision of Dr David Duke, Ph.D. At times, the supervisor will be consulted about different cases. If your case is discussed with our supervisor(s), it will be done without revealing any identifying information. The additional names of these supervisors vary by therapist and can be requested through contacting our supervising coordinator, 308-382-5297 ext. 113. All supervisors are bound by the same confidentiality standards as your therapist. No consultation will result in any compromise of your confidentiality.

ACTIVE PARTICIPATION:
Counseling is a mutual, collaborative process. You and your therapist will work together to develop goals for your therapy. You are responsible for making the effort to work on the problems or issues that concern you. Your therapist is committed to help you in this process.

RISKS/BENEFITS:
No one can guarantee that counseling or counseling services (EMDR, neurofeedback and/or hypnosis) will produce certain results. There can be many benefits to participating in counseling. The benefits vary and can be maximized by active participation, honesty and consistent attendance. There are also some risks associated with counseling services. The risks vary but can best be managed and minimized through open communication and reporting any changes that occur after or during treatment. There is also the potential for dual relationships, which can be very common in rural settings. A dual relationship is any routine contact with the therapist outside of therapy, such as attending the same church. If a dual relationship occurs, it is best to discuss this issue when it occurs to minimize the risk and assess its impact on the therapeutic relationship. Your direct honest feedback can help minimize risks. We can assure you that our counselors will use their professional skills, to the best of their ability, to address any concerns and help manage possible risks.

APPOINTMENTS:
Services are by appointment only and generally last 45 minutes. The frequency of appointments will be determined by you and your therapist.

CANCELLATIONS AND NO SHOWS:
There is a 24-hour cancellation policy and all appointments not canceled with 24 hours notice are subject to a late cancellation fee. There is also a no show policy and all appointments that you do not attend without calling to cancel are subject to a no show fee. I agree to pay these fees, if incurred, they will not be billed to my insurance company. I understand that I cannot be seen again by my therapist until these fees are paid or payment arrangements have been made.

Client Name:_____ SS#_____

FEES AND FINANCIAL ARRANGEMENTS:
Wholeness Healing Center counseling fees are: $150.00 for the initial appointment; family/couple sessions are $110.00 (45 minutes) and individual sessions are $100.00 (45 minutes). Additional fees for services, if unknown, should be inquired prior to the appointment. Often we will call on your behalf to inquire your insurance benefits. Any information we receive from your insurance is not a guarantee of their payment or a guarantee of your financial liability. We ask for payment at the time of service. If this does not work for you, please speak with the receptionist about setting up a payment plan. All services: sessions, groups, hypnosis sessions/groups, and group materials fees are non-refundable, even if you are unable or choose not to complete the program. Any returned check will be charged a 25.00 fee. **(Initial below)**

x I am aware of Wholeness Healing Center's fees for treatment and I agree to pay the remainder of what my insurance does not cover. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that if payment for services is not made, the therapist may stop my treatment. I understand all services/materials are non-refundable.

ELECTRONIC COMMUNICATION (EMAIL/TEXTING):
Electronic communication is not a confidential means of communication. You may choose to still communicate electronically with Wholeness Healing Center (as indicated above on preferred contact method) but you must acknowledge the risks. **(Initial below)**

x I authorize Wholeness Healing Center to contact me electronically regarding appointments, as indicated above. I understand that electronic communication (email/text) is not a confidential means of communication.
x I acknowledge that counseling will not be done electronically (email/text). If I send any information electronically that is not in regards to scheduling, I understand that my therapist may not reply but will instead bring the information to the next session to address.
x I understand that any electronic correspondence may become part of my client record.
x I understand that Wholeness Healing Center cannot ensure that electronic messages will be received or be promptly responded to. Therefore, in case of an emergency, I am encouraged to call the front desk, emergency after hour's phone number or 911.

TERMINATION:
Also, please be aware of the following conditions in regard to discontinuing therapy.
You may be discharged as a client:

1.) If your therapist believes that they he/she is unable to help you, because of the kind of problem you have or because his/her training and skills are not appropriate, you will be informed of this fact and referred to another therapist who may meet your needs.
2.) If you have two consecutive "no shows" or same-day cancellations for appointments.
3.) If you have not had and kept an appointment in our office in 6 consecutive weeks and this is not part of your treatment plan.
4.) If you commit an act of violence toward, threaten, or harass any staff member or client of Wholeness Healing Center, you may be immediately terminated from treatment.
5.) If you are terminated from therapy for something other than completing the agreed-upon treatment plan, you will be given contact information for other sources of therapy. However, this is not a guarantee of further treatment services.

My signature below acknowledges that I have read, understand and agree to the above statements. I have received Wholeness Healing Center's privacy policies, understand my rights as a client and how my information may be used and disclosed. I understand and authorize supervision of my case, if necessary. I agree to actively participate in my counseling. I understand the risks and benefits associated with counseling and/or other services offered at Wholeness Healing Center. I understand that if I have any questions regarding the above statements, associated risks or my privacy rights, I can talk to my therapist about my questions or contact the assistant director at (308) 382-5297 ext. 113.

X_____ _____
Signature of patient or parent if minor Date

X_____
Witness

Wholeness Healing Center
HIPAA PRIVACY POLICY
Notice of Privacy Practices
(Effective April 14, 2003)

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY WHOLENESS HEALING CENTER, P.C. AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR PROTECTED HEALTH INFORMATION (PHI):

Understanding what is in your health record and how your health information is used will help you to ensure its accuracy, allow you to better understand who, what, when, where and why others may access your health information, and assist you in making more informed decisions when authorizing disclosure to others. The information that identifies you and that relates to your past, present and future physical or mental health condition and related health care services is referred to as Protected Health Information ("PHI").

When you visit us, we keep a record of your symptoms, progress, diagnoses, treatment plan, and other medical information. We also may obtain health records from other providers. In using and disclosing this protected health information (PHI), it is our objective to follow the Privacy Standards of the federal Health Insurance Portability and Accountability Act, 45 CFR Part 464. The law allows us to use and disclose PHI without your specific authorization for treatment, payment, operations and other specific purposes explained on the next page. This includes disclosing PHI to those who are involved in your care for the purpose of providing, coordination, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. This also includes contacting you for appointment reminders and follow-up care. All other uses and disclosures require your specific authorization.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of you PHI. For training or teaching purpose, PHI will be disclosed only with your authorization. Your PHI will be provided to make 24-hour confirmation calls to remind you of your appointments. If this is a problem, please let our privacy officer know or indicate so on your initial paperwork.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigation or determining our compliance with the requirement of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

- Abuse and Neglect
- Deceased Persons
- Family Involvement in Care
- National Security
- Judicial and Administrative Proceedings
- Emergencies
- Law Enforcement
- Public Safety (Duty to Warn)

The following language addresses these categories to the extent consistent with the *NASW Code of Ethics.*

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are as follows:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigation (such as the social work licensing board or the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Your Rights Regarding your PHI.

You have the following rights regarding PHI we maintain about you. To exercise any of these rights please submit your request in writing to our Privacy Officer at
2608 Old Fair Road, Grand Island, Nebraska 68803

- Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies. You have a right to an electronic copy of your records, where one exists.
- Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request. If you pay cash for mental health services, you have the right to restrict our office from submitting services and diagnosis to your insurance company.
- Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- Right to a Copy of this Notice. You have the right to a copy of this notice.
- Right to Notification in the event of a security breach.
- Right to Opt Out of of receiving solicitations for fundraising and/or marketing.

Complaints

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at 2608 Old Fair Road, Grand Island, Nebraska 68803 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257.

We will not retaliate against you for filing a complaint.

(Revised April 1st, 2013)

Wholeness Healing Center

"Heart Centered Wellness For Life"

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Fax: 308.455.1450

AUTHORIZATION TO DISCLOSE/OBTAIN INFORMATION

Communication between your therapist and your primary care physician (PCP) is important to make sure all care is complete, comprehensive and well coordinated; this form allows your therapist to share information with your PCP. No information will be released without your signed authorization.
If you wish not to sign this release, please sign at the bottom of the page refusing this request.

Patient's Name_____ Date of Birth_____

I authorize Wholeness Healing Center

To: ☐ Disclose to
☐ Obtain from
Organization or individual:_____
Street Address:_____
Phone Number:_____ Fax Number:_____

Information to be Disclosed:

All applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis and medication(s) if necessary.

_____
_____

Purpose of the Disclosure:

The purpose of this disclosure is to release behavioral health evaluation and/or treatment information to the PCP to ensure quality and coordination of care.

I understand that I have a right to revoke this authorization at any time. I understand that a revocation will be made in writing and will not apply to information that has already been released in response to this authorization. I understand that a revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless previously revoked this authorization will automatically expire six (6) months from date of discharge. I consider a photocopy of this authorization to be as valid as the original.

I understand that authorizing the disclosure of protected health information is voluntary and that I can refuse to sign this authorization. I understand that I do not have to sign this form in order to obtain enrollment, payment or treatment for services. I understand that I may inspect or have copied the information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by federal privacy rules.

_____ _____
Signature of Patient of Legal Representation Date

_____ _____
If signed by legal representative, relationship to patient Signature of Witness

I refuse to sign this authorization to release/obtain information with my primary care physician.

_____ _____
Signature of Patient of Legal Representation Date

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Clinician Communication Form

Client Name:_____ Date of Birth:_____

Dear Colleague:

I saw the above patient, who gave me an authorization to release the following information for continuity of care.

Brief Summary of therapeutic services/presenting concerns:

_____

_____

_____

_____

_____

_____

Plan of treatment/Other Treatment Requests:

_____

_____

_____

_____

_____

If you have any questions or would like additional information, please contact me.
Thank You.

Clinician Name:_____ Date Sent/Faxed:_____

Clinical Signature:_____