Prairie Winds Healing, LLC
908 N Howard Ave Suite 102
Grand Island NE 68803-3529
308-398-6050

1. Intake Questionnaire - ADULT 1

Demographic Information

Name:

Date:

DOB:

Birthplace:

Given Name at birth:

Gender Identity:

Preferred Pronouns:

Sexuality:

Race:

Ethnicity:

Address:

City:

State:

Zip:

County:

Phone Number(s):

Can I leave a voicemail?:

Email:

Would you like to receive email communication?:

Can I send something in the mail?:

How were you introduced to us?:

How Have We Come to Meet?

What are the 3 most significant concerns you have right now? How long have each been going on? Put them in order of importance:

What do you think those who care about you would say their concern(s) is/are regarding you?:

What solutions (helpful or unhelpful) have you tried to resolve your concerns?:

Have you had therapy in the past? If so, with whom and when? What reasons did you attend therapy for? Please share with us about your experience. What was helpful or unhelpful?:

Change is Coming…

What are your expectations from therapy? What are your expectations of the therapist?:

Looking into the future, how will you know our work and time together have been worth it? List concrete changes you will see:

What other things would you like to see change in your life (family, career, health, relationships, etc.)?:

Do you foresee any obstacles to achieving your goals or the desired changes?:

How long do you think therapy will need to last to achieve your goals? Write down a target date:

List 5 strengths about yourself or that others say about you, and give examples of each:

Is there anyone you would like to be a part of your sessions or think may be helpful to be part of sessions now or in the future?:

Medical & Wellness Information

What do you do for wellness (i.e., healthy food choices, exercise, limits on TV/electronics/work, managing stress, family time, leisure, etc.)? Give examples:

How do you achieve balance in your life?:

Have you ever received psychiatric services before?:

If yes, how long ago, with whom, for what, medications prescribed and results::

Do you have any allergies (food, environmental, medicinal, animal, etc.):

Do you have any current or past medical issues, hospitalizations, accidents, injuries, or surgeries? If yes, what?:

Is there a family history of the above medical issues/concerns?:

Are you presently under a physician's/psychiatrist's care? If so, for what reason?:

Is there anyone in your life currently dealing with a medical issue you are concerned about? If so, whom, for what?:

In the past year, have there been any changes in your life? (i.e., moves, appetite, sleep, health, family, overall functioning)?:

List any medications (over-the-counter & prescribed), nutritional or herbal supplements, or alternative treatments (acupuncture, chiropractic, etc.) you are taking/doing and the reasons:

Important Questions We Must Ask

Have you ever had thoughts of killing yourself?:

If yes, please explain:

Have you ever planned on killing yourself?:

If yes, please explain:

Have you ever attempted to kill yourself?:

If yes, please explain:

Has anyone in your family or close to you died by suicide?:

If yes, please explain:

Have you ever felt you wanted to harm or kill someone else seriously?:

If yes, please explain:

Do you have weapons in your home or access to weapons?:

If yes, who has access to them, and what are the safety protocols around them?:

Is there any history or presence of abuse or violence?:

If so, please explain:

Are you currently using any illegal drugs or prescription medications in a way other than what was prescribed, or is the reason you are seeking therapy services substance-related?:

Have you ever witnessed or experienced a trauma? Do you have recurring nightmares and flashbacks, or avoid anything uncomfortable or painful? If so, please explain:

Do you currently have legal issues, or is the reason you are seeking therapy related to a court order? If so, please explain:

Career/Job, Recreation and Leisure

What is your current occupation? How would you describe your fulfillment of your job/career?:

What is your highest level of education completed and field of study?:

What do you enjoy doing during your free/leisure time?:

Intimate Relationships

If you are currently in a relationship, describe your relationship:

How would you describe your communication?:

How would you describe intimacy and sex in your relationship?:

* If you are in a relationship, answer the following regarding your relationship

1. Like:

2. Dislike:

3. Not enough of:

4. Too much of:

5. Ideal relationship:

Understanding Your Family & Influences

* Space left for therapist to draw family tree (genogram):

Parent’s marital status:

Please describe your relationship with your parents:

How would you describe your upbringing?:

Who lives with you currently?:

Do you have any pets? If yes, names, types, and relationship to each pet:

Describe your relationship with the following

Mother:

Father:

Mother’s Significant Other:

Father’s Significant Other:

Siblings: Age, Name and Sex

1. Sibling 1:

2. Sibling 2:

3. Sibling 3:

Children

1. Child 1:

2. Child 2:

3. Child 3:

Significant Other/Spouse:

Relationships

Describe your relationship with your friends:

Who would you say your support system is (people, organizations, or affiliations)?:

Do you belong to any religious or spiritual groups?:

If yes, what is your level of involvement?:

How do your religious or spiritual beliefs/practices influence your life?:

Please list anything else that is important for us to know about you that would assist us in working with you to achieve your desired results:

Prairie Winds Healing, LLC. 308-398-6050 908 N. Howard Ave Suite 102 Grand Island, Nebraska 68803

2. ASSIGNMENT OF BENEFITS AND BILLING AUTHORIZATION FORM 1

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. You agree to fill out and execute any additional necessary forms that may be required for your particular insurance carrier. In some cases, the insurance benefits can only be determined once the insurance company receives the claim and the claim is adjudicated.

Client Full Name:

Client Date Of Birth:

Insurance Policy Holder Name:

Insurance Policy Holder's Date Of Birth:

Relation to client:

Primary Insurance:

Secondary Insurance:

Secondary Insurance Policy Holder Name and Date of Birth:

Address:

City:

State:

Zip Code:

Telephone:

Primary Insurance Policy #:

Group #:

Secondary Insurance Policy #:

Group #:

Assignment of Benefits

I hereby assign all medical and mental health benefits, including major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other mental health/medical plan, to issue payment check(s) directly to Prairie Winds Healing, LLC for therapy services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand I am responsible for any amount not covered by insurance, EAP services, or vouchers.

Client's Initials:

Authorization to Release Information

I hereby authorize Prairie Winds Healing, LLC and its therapists to:

1. Release any information necessary to insurance carriers regarding my therapy and sessions. I understand that my therapist may be required to release certain information to the insurance company at their request to procure necessary authorizations and process payment claims. This information may include but is not limited to, types of service, dates of service, times of service, diagnosis, treatment plans, the progress of therapy, and, at times, treatment notes and/or summaries. I authorize the release of such information if necessary, understanding the limits of confidentiality regarding using my insurance benefits. I also acknowledge receipt of Prairie Winds Healing, LLC's Notice of Privacy Practices.

2. Request payment of insurance benefits be made directly to Prairie Winds Healing, LLC for services performed.

3. If necessary, file a formal written complaint, if permitted by law, on my behalf to the state Insurance Commissioner or other appropriate state agency if payment for services is not timely received.

I have requested therapy services from Prairie Winds Healing, LLC, for myself and/or my dependents. I understand that by making this request, I become fully financially responsible for all charges incurred during the treatment authorized. I further understand that fees are due and payable on the date that services are rendered. I agree to pay all such charges immediately upon presenting the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Client Name:

Legal Guardian:

Printed Name:

Therapist:

Date:

Prairie Winds Healing, LLC. 308-398-6050 908 N Howard Ave Suite 102 Grand Island, Nebraska 68803

3. Release of Information: HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION 1

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date:

I. The Patient

This form is for use when such authorization is required and complies with the Health Insurance Portability Act of 1996 (HIPPA) Privacy Standards.

Client Full Name:

Client Date Of Birth:

Client ID Number:

SSN:

II. Authorization

I authorize [Agency/Provider Name] to use or disclose the following: (check one)

☐ All of my medical-related information

☐ My medical information ONLY related to a specific diagnosis. (complete sentence below)

My medical information only related to:

☐ My medical-related information in a specified date range. (enter date range below)

Enter date range:

☐ Other (please explain below)

Please explain other:

III. Disclosure

The Authorized Party has my authorization to disclose Medical Records to: (check one)

☐ Any party that is approved by the Authorized Party.

☐ Only the following party (enter details below)

Name:

Address:

Phone Number:

Fax Number:

Email Address:

IV. Purpose

The reason for this authorization is: (check one)

- [ ] General Purpose at my request (general)
- [ ] To receive payment. To allow the authorized party to communicate with me for marketing purposes when they receive payment from a third party.
- [ ] To sell my medical records. To allow the Authorized Party to sell my medical records. I understand that the Authorized Party will receive compensation for the disclosure of my medical records and will stop any future sales if I revoke this authorization.
- [ ] Other (please explain below)

Explain other:

V. Termination

The authorization will terminate: (check one)

- [ ] Upon sending a written revocation to the Authorized Party
- [ ] On the following date: (enter below)

Date:

- [ ] Other (please explain below)

Explain Other:

VI. Additional Consent for Certain Conditions

Sensitive information. This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

Check One

- [ ] I consent to have the above information released.
- [ ] I do not consent to have the above information released.

VII. Acknowledgement of Rights

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient (if filling out electronically, type your name, you will have the opportunity to sign at the end):

Client Full Name:

If the patient is unable to sign use the signature area below

The patient is unable to sign due to (check one)

☐ Being a Minor (complete the statement below)

The Patient is _____ years old and considered a minor under state law:

☐ Being Incapacitated (please explain below)

Patient is incapacitated due to:

☐ Other (please explain below)

Signature of Representative (if filling out electronically, type your name, there will be an option to sign at the end):

Date:

Printed Name of Representative:

Relationship to Patient (check one)

☐ Parent

☐ Guardian

- [ ] Spouse
- [ ] Other (please explain below)

Explain other:

4. THERAPY CONSENT, POLICIES, & AGREEMENT 1

PART I: THERAPEUTIC PROCESS

BENEFITS/OUTCOMES

The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). Participating in therapy may include benefits such as resolving presenting problems and improved intrapersonal and interpersonal relationships. The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope with work, family, personal, relational issues, etc. Participating in therapy can lead to a greater understanding of individual and relational goals and values. This can increase relational harmony and lead to greater happiness. Progress will be assessed regularly, and client feedback will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the outcome of therapy.

EXPECTATIONS

To reach their therapeutic goals, clients must complete tasks assigned between sessions. Therapy is a challenging fix. It takes time and effort and may move slower than expected. We identify goals, review progress, and modify the treatment plan during therapy.

RISKS

In achieving therapeutic benefits, clients must act to achieve desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and changing relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort and relational changes that may not be intended initially. We will work collaboratively toward a desirable outcome; however, therapy goals may still need to be reached.

STRUCTURE OF THERAPY

● Intake Phase – The therapeutic process, structure, policies, and procedures will be discussed during the first session. We will also explore your experiences surrounding the presenting problem(s).

● Assessment Phase – The initial evaluation may last 2-4 sessions. During this assessment phase, your therapist will be getting to know you. Your therapist will ask questions to gain an understanding of your worldview, strengths, concerns, needs, relationship dynamics, etc. During this relationship-building process, your therapist will gather much information to aid in the therapeutic approach best suited for your needs and goals. If it is determined that your therapist is not the best fit for your therapeutic needs, they will provide referrals for more appropriate treatment.

● Goal Development/Treatment Planning – After gathering background information, you and your therapist will collaborate to identify your therapeutic goals. If therapy is court-ordered, plans will encompass your goals and court-ordered treatment goals based on documentation from the court (please provide any court documents).

● Intervention Phase – This phase occurs from session two until graduation/discharge/termination. Each client must actively participate in therapy sessions, utilize solutions discussed, and complete assignments between sessions. Progress will be reviewed, and goals adjusted as needed.

● Graduation/Discharge/Termination – As you progress and get closer to completing goals, we will collaboratively discuss a transition plan for graduation/discharge/termination.

LENGTH OF THERAPY

Therapy sessions are typically weekly or biweekly for 45-60 minutes,
depending upon the nature of the presenting challenges and insurance authorizations. It is difficult to predict how many sessions will be needed initially. You and your provider will collaboratively discuss from session to session the following steps and how often therapy sessions will occur.

APPOINTMENTS AND CANCELLATIONS

You are responsible for attending each appointment and agree to adhere to the following policy: If you cannot keep the appointment, you MUST notify our of ice to cancel or reschedule the appointment within 48 hours of the scheduled appointment time. If you cancel or reschedule more than three times, we may re-evaluate your needs, desires, and motivations for treatment. Each insurance panel has a different policy on whether providers can charge for missed appointments.

Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. Your therapist may periodically take time off for vacation or seminars or become ill. Attempts will be made to give adequate notice of these events. If your provider cannot contact you directly, a colleague may contact you to cancel or reschedule an appointment.

FEES

The fee for each 60-minute therapy session is $180.00, family therapy sessions are $190.00, and 45-minute therapy sessions are $155.00. Your copayment is due at the time of service. It is encouraged for you to be familiar with your insurance plan, deductible, and required copayments. It is your responsibility to notify our office of any changes in insurance. Failure to do with rejected or denied claims will become your financial responsibility. Acceptable forms of payment are exact-amount cash, check
(insufficient-funds checks will be returned upon the total cost of the original amount plus $ 45.00 for any returned check), or credit/debit card. If a scheduled appointment time is missed or canceled less than 48 hours in advance, please refer to the “Appointments and Cancellations” policy above.

The provider reserves the right to terminate the counseling relationship if more than three sessions are missed without proper notification.

The provider charges their hourly rate in quarter hours for phone calls over 10 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. All costs for services outside of the session will be billed to you directly, as these are not covered by insurance.

TRIAL, COURT-ORDERED APPEARANCES, LITIGATION

Rarely, but on occasion, a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. To protect your confidentiality, it is strongly suggested that you not be involved in court. If your provider gets called into court or has to prepare for a potential court appearance by you or your attorney, you will be charged a fee of $225.00 per hour, including travel time, court time, preparing documents, etc.

COPIES OF MEDICAL RECORDS

Should you request a copy of your medical records, the cost is
$1.50 per page. Payment for your medical records will be due before or upon receipt and can be picked up at the office. Please allow at least two weeks to prepare medical records.

PHONE CONTACTS AND EMERGENCIES

Office hours vary by therapist and are by appointment. If you need to contact your provider for any reason, please call 308-398-6050 or leave a voicemail, and a return call will be made within 24 business hours or as soon as possible. In case of an emergency, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 988. Or call or text the Suicide Crisis Line at 988. If you or someone else is in danger of harm, dial 911.

PART II: CONFIDENTIALITY

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, except for the following limitations

● Child Abuse: Child abuse or neglect, including but not limited to domestic violence in the presence of a child, child-on-child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or neglect, your therapist must report this to the appropriate authority.

● Vulnerable Adult Abuse: Vulnerable adult abuse or neglect. If information about a vulnerable adult or elder abuse is revealed, your therapist must report this to the appropriate authority.

● Self-Harm: Threats, plans, or attempts to harm oneself. Your provider is permitted to take steps to protect the client's safety, which may include disclosure of confidential information.

● Harm to Others: Threats regarding harm to another person. If you threaten bodily harm or death to another person, your provider must report this to the appropriate authority.

● Court Orders & Legal Issued Subpoenas: If your provider receives a subpoena for your records, they will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. Your provider will contact you twice by phone; if they cannot contact you by phone, they will send you written correspondence. If a court of law issues a legitimate court order, your provider must provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, your provider is required to comply with a court order.

● Law Enforcement and Public health: A public health authority that is authorized by law to collect or receive such information to prevent or control disease, injury, or disability; to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative,
or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or action; limited information (such as name, address DOB, dates of treatment, etc.) to a law enforcement official to identify or locate a suspect, fugitive, material witness, or missing person; and information that your provider believes in good faith establishes that a crime has been committed on the premises.

● Governmental Oversight Activities: To appropriate agency information directly relating to the receipt of health care, claim for public benefits associated with mental health, or qualification for, or receipt of, public benefits or services when your mental health is integral to the claim for
benefits or services, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

● Upon Your Death: To a law enforcement official for the purpose of alerting of your death if there is a suspicion that such death may have resulted from criminal conduct; to a coroner or medical examiner to identify a deceased person, determining a cause of death, or other duties as authorized by law.

● Victim of a Crime: Limited information, in response to a law enforcement official's request for information about you if you are suspected to be a victim of a crime; however, except in limited circumstances, your provider will attempt to get your permission to release information first.

● Court-Ordered Therapy: If therapy is court-ordered, the court may request records or documentation of participation in services. You and your provider will discuss the information and/or documentation with you in session prior to sending it to the court.

● Written Request: Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given instead of actual “psychotherapy/progress notes,” except if the third party is part of the medical team. If therapy sessions involve more than
one person, each person over 18 MUST sign the release of information before the information is released.

● Fee Disputes: In the case of a credit card dispute, your provider reserves the right to provide the necessary documentation (i.e., your signature on the “Therapy Consent & Agreement” that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If
there is a financial balance on the account, a bill will be sent to the home address on the intake form unless otherwise noted.

● Couples Counseling & “No Secret” Policy: When working with couples, all confidentiality laws exist. It is requested that neither partner attempt to triangulate your therapist into keeping a “secret” that is detrimental to the couple's therapy goal. Suppose one partner asks that your provider keep a “secret” in confidence. In that case, they may choose to end the therapeutic
relationship and give referrals for other therapists as our work and your goals then become counter-productive. However, if one party requests a copy of couples or family therapy records in which they participated, authorization from each participant (or their representatives and/or guardians) in the sessions before the records can be released.

● Dual Relationships & Public: Our relationship is strictly professional. To preserve this relationship, it is imperative that there is no relationship outside of the counseling relationship (i.e., social, business, or friendship). If you and your provider run into one another in a public setting, they will not acknowledge you not to jeopardize confidentiality. If you acknowledge your
provider in a public environment, they will acknowledge you. Please remember that doing so may risk your confidentiality.

● Social Media: No friend requests on our personal social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) will be accepted by current or former clients. If you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. Your provider cannot be liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform. They are neither confidential nor monitored and may become part of medical records.

● Electronic Communication: If you need to contact your provider outside of your sessions, please do so via phone.

○ Clients often use text or email as a convenient way to communicate in their personal lives. However, texting introduces unique challenges to the therapist–client relationship. Texting is not a substitute for sessions. Texting and sharing outside a secure portal is not confidential. Phones can be lost or stolen, and emails can be intercepted. DO NOT communicate sensitive information over text. The identity of the person texting is unknown, as someone else may possess the client’s phone.

○ Do not use email for emergencies. In the case of an emergency, call 911 your local emergency hotline, or go to the nearest emergency room. Additionally, e-mail is not a substitute for sessions. If you need to be seen, please call to book an appointment.

○ E-mail is not confidential. Do not communicate sensitive medical or mental health information via email. Furthermore, if you send an email from a work computer, your employer has the legal right to read it. E-mail is a part of your medical record.

● Sessions Outside the Office: Occasionally, clients like to meet in an alternate location (i.e., their home, in public, or somewhere more conducive for them). Your provider may be able to accommodate this request; however, this can put your confidentiality at risk.

PART III: HEALTH INSURANCE

YOUR INSURANCE COMPANY

Using insurance, your therapist must give a mental health disorder
diagnosis that goes into your medical record. The clinical diagnosis is based on your current symptoms, even though you may have been previously diagnosed. You and your therapist will discuss your diagnosis during the session. Your insurance company will know the times and dates of services provided. They may request further information to authorize additional services regarding treatment.

IMPORTANT

Some psychiatric diagnoses are not eligible for reimbursement (i.e., marriage/couples therapy). In the event of non-coverage or denial of payment, you will be responsible for paying for the services provided. Prairie Winds Healing, LLC and your therapist reserves the right to seek payment of unpaid balances by a collection agency or legal recourse after reasonable notice to the client.

PRE-AUTHORIZATION & REDUCED CONFIDENTIALITY

When visits are authorized, usually only a few sessions are granted at a time. When these sessions are complete, we may need to justify the need for continued service, potentially causing a delay in treatment. Confidentiality cannot be guaranteed if insurance requests information for continued services. Sometimes, additional sessions are not authorized, leading to an end of the therapeutic relationship even if therapeutic goals are not met.

POTENTIAL NEGATIVE IMPACTS OF A DIAGNOSIS

Insurance companies require providers to give a mental health diagnosis (i.e., “major depression” or “obsessive-compulsive disorder”) for reimbursement. Psychiatric diagnoses may negatively impact you in the following ways

1. Denial of insurance when applying for disability or life insurance;
2. Company (mis)control of information when claims are processed;
3. Loss of confidentiality due to the increased number of persons handling claims;
4. Loss of employment and/or repercussions of a diagnosis in situations where you may be required to reveal a mental health disorder diagnosis on your record. This includes but is not limited to applying for a job, financial aid, and/or concealed weapons permits.
5. A psychiatric diagnosis can be brought into a court case (i.e., divorce court, family law,
criminal, etc.).

It is important that you are an informed consumer. This allows you to take charge of your health and medical record. At times, having a diagnosis can be helpful (i.e., a child needing extra services in the school system or a person being able to receive a disability).

EMERGENCY CONTACT

Prairie Winds Healing, LLC must have someone to contact on your behalf. In case of an emergency, who should we contact?

Full Name:

Relationship:

Phone Number(s):

Please check here that you agree and sign below. Thank you.

- [ ] I agree to allow Prairie Winds Healing, LLC to contact my emergency contact on my behalf in the case of an emergency

Client Name:

Date:

PART IV: CONSENT

1. I understand the Therapy Agreement, Policies, and Consent information. I have discussed any questions regarding this information with Prairie Winds Healing, LLC. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize Prairie Winds Healing, LLC, and its therapists to provide counseling services that are considered necessary and advisable.

2. I authorize the release of treatment and diagnosis information (as described in Part III above) necessary to process bills for services to my insurance company and request payment of benefits to your therapists. I acknowledge that I am financially responsible for payment whether or not covered by insurance. If insurance does not cover fees, Prairie Winds Healing, LLC and its therapists may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

3. Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to

(therapist name):

to provide treatment to my minor child(ren). If I have a unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to your therapist before or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment before the initial session.

Your signature signifies that you have been offered/ received a copy of the “Therapy Agreement, Policies, and Consent” for your records.

Printed Name of Minor Child:

DOB:

Date:

Therapist:

PART IV: CONSENT (CLIENT'S COPY)

1. I understand the Therapy Agreement, Policies, and Consent information. I have discussed any questions regarding this information with my provider. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize my provider to provide counseling services considered necessary and advisable.

2. I authorize the release of treatment and diagnosis information (as described in Part III above) necessary to process bills for services to my insurance company and request payment of benefits to my provider, Prairie Winds Healing, LLC. I acknowledge that I am financially responsible for payment whether or not covered by insurance. If fees are not covered by insurance, my provider, Prairie Winds Healing, LLC, may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

3. Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for the minor(s) in my custody and give permission to my provider to provide treatment to my minor child(ren). If I have a unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to my provider before or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment before the initial session.

Your signature signifies that you have received a copy of the "Therapy Agreement, Policies, and Consent" for your records.

Printed Name of Minor Child:

DOB:

Therapist:

Date:

Prairie Winds Healing, LLC 308-398-6050 908 N Howard Ave, Suite 102 Grand Island, Nebraska 68803

0. ASSIGNMENT OF BENEFITS AND BILLING AUTHORIZATION FORM 2

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. You agree to fill out and execute any additional necessary forms that may be required for your particular insurance carrier. In some cases, the insurance benefits can only be determined once the insurance company receives the claim and the claim is adjudicated.

Client Full Name:

Client Date Of Birth:

Insurance Policy Holder Name:

Insurance Policy Holder’s Date Of Birth:

Relation to client:

Primary Insurance:

Secondary Insurance:

Secondary Insurance Policy Holder Name and Date of Birth:

Address:

City:

State:

Zip Code:

Telephone:

Primary Insurance Policy #:

Group #:

Secondary Insurance Policy #:

Group #:

Assignment of Benefits

I hereby assign all medical and mental health benefits, including major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other mental health/medical plan, to issue payment check(s) directly to Prairie Winds Healing, LLC for therapy services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand I am responsible for any amount not covered by insurance, EAP services, or vouchers.

Client's Initials:

Authorization to Release Information

I hereby authorize Prairie Winds Healing, LLC and its therapists to:

1. Release any information necessary to insurance carriers regarding my therapy and sessions. I understand that my therapist may be required to release certain information to the insurance company at their request to procure necessary authorizations and process payment claims. This information may include but is not limited to, types of service, dates of service, times of service, diagnosis, treatment plans, the progress of therapy, and, at times, treatment notes and/or summaries. I authorize the release of such information if necessary, understanding the limits of confidentiality regarding using my insurance benefits. I also acknowledge receipt of Prairie Winds Healing, LLC's Notice of Privacy Practices.

2. Request payment of insurance benefits be made directly to Prairie Winds Healing, LLC for services performed.

3. If necessary, file a formal written complaint, if permitted by law, on my behalf to the state Insurance Commissioner or other appropriate state agency if payment for services is not timely received.

I have requested therapy services from Prairie Winds Healing, LLC, for myself and/or my dependents. I understand that by making this request, I become fully financially responsible for all charges incurred during the treatment authorized. I further understand that fees are due and payable on the date that services are rendered. I agree to pay all such charges immediately upon presenting the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Client Name:

Legal Guardian:

Printed Name:

Therapist:

Date:

Prairie Winds Healing, LLC. 308-398-6050 908 N Howard Ave Suite 102 Grand Island, Nebraska 68803

0. Credit / Debit Card Payment Consent

Client name:

(Card holder) Name on card if different than client:

Card Type:

Last 4 digits of card number:

Expiration Date :

I authorize {{{{ replace with your company }}}} to charge my credit/debit/health account card for professional services 24 hours before our scheduled appointment. If I do not cancel before 24 hours, I recognize that {{{{ counselor's name }}}} will charge my card as a late cancel or no show if I do not show up for the appointment. I will be billed for the full session charge {{{{ breakdown charges per service }}}}.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Client Initials:

Card holder Initials (If different than client):

Date:

Signature:

0. GAD-7 Scale

Generalized Anxiety Disorder 7-item Scale (GAD-7)

Patient Name:

Date of Visit:

Client Questions

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Feeling nervous, anxious, or on edge:

2. Not being able to stop or control worrying:

3. Worrying too much about different things:

4. Trouble relaxing:

5. Being so restless that it's hard to sit still:

6. Becoming easily annoyed or irritable:

7. Feeling afraid as if something awful might happen:

Questionnaire Score

Add up all the numbers for answers 1-7 above.

Total Score:

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?:

0. GAD-7 Scale 1

Generalized Anxiety Disorder 7-item Scale (GAD-7)

Patient Name:

Date of Visit:

Client Questions

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Feeling nervous, anxious, or on edge:

2. Not being able to stop or control worrying:

3. Worrying too much about different things:

4. Trouble relaxing:

5. Being so restless that it's hard to sit still:

6. Becoming easily annoyed or irritable:

7. Feeling afraid as if something awful might happen:

Questionnaire Score

Add up all the numbers for answers 1-7 above.

Total Score:

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?:

0. Informed Consent for Psychotherapy

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:
1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

0. Notice of Privacy Practices

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

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

• Make sure that protected health information (“PHI”) that identifies you is kept private.
• Give you this notice of my legal duties and privacy practices with respect to health information.
• Follow the terms of the notice that is currently in effect.
• I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules and regulations allow health care providers who have direct treatment relationship with the client to use or disclose the client’s personal health information without the client’s written authorization, to carry out the health care provider’s own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word “treatment” includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep “psychotherapy notes” as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
a. For my use in treating you.

b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
c. For my use in defending myself in legal proceedings instituted by you.
d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
e. Required by law and the use or disclosure is limited to the requirements of such law.
f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
g. Required by a coroner who is performing duties authorized by law.
h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a

copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

0. PHQ-2 Questionnaire

Patient Health Questionnaire 2 (PHQ-2)

Patient Name:

Date of Visit:

Client Questions

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things:

2. Not being able to stop or control worrying:

Questionnaire Score

Add up all the numbers for answers 1-2 above.

Total Score:

0. PHQ-9 Questionnaire

The Patient Health Questionnaire 9 (PHQ-9)

Patient Name:

Date of Visit:

Client Questions

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things:

2. Feeling down, depressed or hopeless:

3. Trouble falling asleep, staying asleep, or sleeping too much:

4. Feeling tired or having little energy:

5. Poor appetite or overeating:

6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down:

7. Trouble concentrating on things, such as reading the newspaper or watching television:

8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual:

9. Thoughts that you would be better off dead or of hurting yourself in some way:

Questionnaire Score

Add up all the numbers for answers 1-9 above.

Total Score:

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?:

0. Standard Intake Questionnaire

Complaint

What is your major complaint?:

Have you previously suffered from this complaint?:

If Yes, enter previous therapist(s) seen for complaint, describe treatment:

Aggravating Factors:

Relieving Factors:

Current Symptoms

(check all that apply)

- [ ] Anxiety
- [ ] Appetite Issues
- [ ] Avoidance
- [ ] Crying Spells
- [ ] Depression
- [ ] Excessive Energy
- [ ] Fatigue
- [ ] Guilt
- [ ] Hallucinations
- [ ] Impulsivity
- [ ] Irritability
- [ ] Libido Changes
- [ ] Loss of Interest
- [ ] Panic Attacks
- [ ] Racing Thoughts
- [ ] Risky Activity
- [ ] Sleep Changes
- [ ] Suspiciousness

Medical History

Exercise Frequency:

Exercise Type:

Allergies:

What medications are you currently using?:

Previous diagnoses/mental health treatment:

Previously treated by:

Previous medications:

Dates treated:

Previous medical conditions:

Previous surgeries:

Family History

Were you adopted? If yes, at what age?:

How is your relationship with your mother?:

How is your relationship with your father?:

Siblings and their ages:

Are your parents married?:

Did your parents divorce? If yes, how old were you?:

Did your parents remarry? If yes, how old were you?:

Who raised you? Where did you grow up?:

Family member medical conditions:

Family member mental conditions:

Treated with medication?:

Medications:

Present Situation

Work:

Are you married? If yes, specify date of marriage:

Are you divorced? If yes, specify date of divorce:

Prior marriages? If yes, how many?:

What is your sexual orientation?:

Are you sexually active?:

How is your relationship with your partner?:

Do you have child(ren)? If yes, how is your relationship with your child(ren)?:

Are you a member of a religion/spiritual group?:

Have you ever been arrested? If yes, when and why?:

Have you ever tried the following?

(check all that apply)

- [ ] Alcohol
- [ ] Tobacco
- [ ] Marijuana
- [ ] Hallucinogens (LSD)
- [ ] Heroin
- [ ] Methamphetamines
- [ ] Cocaine
- [ ] Stimulants (Pills)

- [ ] Ecstasy
- [ ] Methadone
- [ ] Tranquilizers
- [ ] Pain Killers

If yes to any, list frequency/dates of use:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

Do you smoke cigarettes? If yes, how many per day?:

Do you drink caffeinated beverages? If yes, how many per day?:

Have you ever abused prescription drugs? If yes, which ones?:

Additional

Anything else you want the doctor to know?:

0. Telehealth Treatment Consent

Information and Informed Consent for Telemental Health Treatment

Telemental health is live two - way audio and video electronic communications that allows therapists and clients to meet outside of a physical office setting.

Client Understanding

I understand that telemental health services are completely voluntary and that I can withdraw this consent at any time.

I understand that none of the telemental health sessions will be recorded or photographed.

I agree not to make or allow audio or video recordings of any portion of the sessions.

I understand that the laws that protect privacy and the confidentiality of client information also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.

I understand that telemental health is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet based communication is not 100 % guaranteed to be secure.

I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

I understand that I or my therapist may discontinue the telemental sessions at any time if it is felt that the video technology is not adequate for the situation.

I understand that if there is an emergency during a telemental health session, then my therapist may call emergency services and/ or my emergency contact.

I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to telemental health services.

I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re - contact.

I understand a “no show” or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment. I understand credit card or other form of payment will be established before the first session.

I understand my therapist will advise me about what telemental health platform to use and she will establish a video conference session.

Client Consent

Client Name:

☐ I hereby give my informed consent for the use of telemental health in my care.

Client Initials:

Date of Birth:

Email:

Phone Number:

Client Signature:

0. Telehealth Treatment Consent 1

Information and Informed Consent for Telemental Health Treatment

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Client Consent

Client Name:

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Client Initials:

Date of Birth:

Email:

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