neubauer
mental health services

5426 vegas drive las vegas, nv 89108 phone: 702-806-5268 fax: 702-485-1107

New Client Registration Information

Identifying Information

1. Client Name:
2. Guardian/Relationship:
3. Date of Birth:
4. Gender:
5. Relationship Status: Single
6. Ethnicity (optional):
7. Residence (home, foster, group):
8. Address
9. E-mail Address, of caretaker/provider:
10. Phone Number:
11. Social Security Number:
12. Client occupation/grade in school:
13. Employer/School:
14. Work/School Phone:

Insurance Information

15. Primary Insurance Company Name:

16. Primary Claim Address:

17. Primary Insurer's Phone Number:

18. Primary Policy Holder Name/Responsible Party:

19. Policy Holder Date of Birth:

20. Policy Holder Social Security Number:

21. Primary Relationship to Client:

22. Primary Policy Number:

23. Primary Group Number:

24. Secondary Insurance Company Name:

25. Secondary Claim Address:

26. Secondary Insurer's Phone Number:

27. Secondary Policy Holder Name/Responsible Party:

28. Secondary Policy Holder Date of Birth:

29. Secondary Policy Holder Social Security Number:

30. Secondary Relationship to Client:

31. Secondary Policy Number:

32. Secondary Group Number:

33. Household Members

Name	Age	Relationship

34. Other significant relationships (marital, romantic, relatives):

1 hereby guarantee payment for the entire balance of the above named client. I authorize treatment of the above named client. I assign and authorize payment of medical benefits directly to NHMS and/or its representatives. I authorize release of any information, including confidential medical records, requested by insurance companies, payors or government agencies in connection with this assignment. To cancel an appointment, the above named client must notify NMHS at least 24 hours prior to the scheduled appointment time, or else I will be responsible for a $50 dollar cancellation fee. If the above named client fails to attend an appointment, I will be responsible for paying a $50 missed appointment fee. I have read, understand, agree to the described disclosure, financial policy, and various releases and guarantee.

Signature of Responsible Party Date NMHS Representative Date

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What Brings You In?

Nature of Presenting Concern(s)

1. Is there any current risk of self or others?
2. Areas of concern?
3. How often do the problems arise?
4. Why are you seeking help now?
5. Prior efforts to solve the problem?
6. What kind of plans are in place currently?
7. What are your treatment goals?
8. Are you willing to work cooperatively with NMHS Clinician to develop and attain treatment goals?

9. Behavioral Checklist:

If yes to any of the below, describe in space provided (e.g. symptoms, emotions, behaviors, etc.):

Verbal aggression:

Physical aggression:

Poor communication:

Property destruction:

Elopement:

Poor boundaries:

Sexual acting out:

Self-harm:

Anxiety/Obsessive traits:

Compulsive traits:

Depression/Mood Symptoms:

Alcohol/Drug abuse:

Relational:

Psychotic symptoms:

Poor social competency:

Opposition/defiance:.

Other:

Client Background

1. Abuse history:

    a. Physical:

    b. Sexual:

    c. Emotional:

    d. Mental:

2. Medical history:

3. Current Medications:

Medication	Dosage	Frequency	Purpose	Physician

4. Substance Problems

5. Previous mental health treatment (include estimated dates and providers, psychologists, psychiatrists, therapists, hospitalizations, etc.) Please continue back of page if necessary:
Suicidal Ideation and/or attempts:

6. Suicidal Ideation and/or Attempts:

7. Legal History:

8. Military History:

9. Satisfaction with work/school:

10. Relational Satisfaction (are you happy with friends?)

11. Sexual Satisfaction:

12. Appetite:

13. Other:

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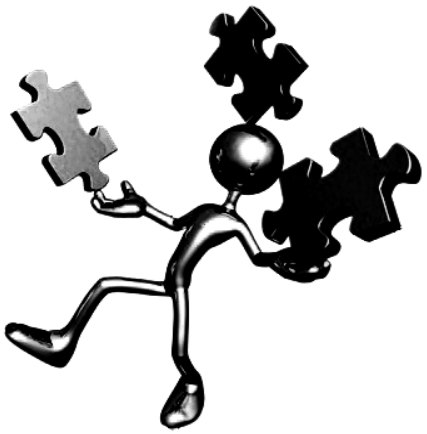
Acknowledgment of Participation in Treatment Plan Development

I, _____, acknowledge that I participated in the development of the treatment plan for (name of individual for whom services are being provided). I was given an opportunity to discuss treatment goals and to ask questions about the services that will be provided by Neubauer Mental Health Services.

Signature of Responsible Party Date NMHS Representative Date



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1. Mental Health Services

There are many different methods we may use to deal with the problems that you hope to address. Behavior therapy is not like a medical doctor visit. Instead, it calls for an active effort on your part. In order for therapy to be most successful, the things we talk about must be worked on during both our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationship solutions to specific problems and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

2. Sessions

We normally conduct an evaluation that will last from 2 to 4 sessions. By the end of the evaluation, the therapist will be able to offer you some first impressions of what our work will include and a treatment plan to follow. You should evaluate this information along with your own opinions of whether you feel comfortable working with your therapist. If you decide to continue, the therapist will usually schedule one or more 45-minute sessions (time may vary) per week at an agreed upon time. Once an appointment time is scheduled, that time is reserved exclusively for you. You will be expected to pay for the appointments you schedule unless you provide 24 hours advance notice of cancellation. Insurance companies will not pay for canceled or no-show appointments. Voicemail is available 24 hour a day seven days a week should you need to cancel an appointment and are unable to reach us directly.

Therapy involves a large commitment of time, money and energy so you should be very careful about the therapist you select. If you have questions about procedures, you and your therapist should discuss them whenever they arise. If your doubts persist, the therapist will be happy to help you set up a meeting with another mental health professional for a second opinion.

Client Initials _____ Date _____

3. Professional Fees

The usual fee for the first session is $150 and $100 for additional sessions. For other services you may need, the therapist's time is charged at $100 per hour, although the cost will be broken down if the therapist works for periods of less than one hour. Other billable services include letters to other professionals, telephone conversations lasting longer than five minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, completion of disability forms and the time spent performing any other service you may request of me outside of a normal therapy session. If you are requesting a sliding scale fee, it is your responsibility to communicate to the therapist you are seeking this option. If you become involved in legal proceedings that require the therapist's participation, you will be charged for the therapist's professional time even if the therapist is called to testify by another party. Because of the difficulty of legal involvement, the charge of $125 per hour for preparation, travel, and attendance at any legal proceeding will apply. If depositions, court hearings, or other legal meetings are canceled by the court, attorney or other related party with less than 48-hour notice, there will be a cancellation fee of $225 regardless of the reason for cancellation. There is a cancellation fee of $50 for sessions not canceled within 24 hours of their scheduled date and time.

4. Billing and Payments

It is our business policy to require full payment for therapy services at the time services are rendered unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Insurance co-pays are due at the time service is rendered as mandated by contract with your insurance company. You are welcome to pay with cash or check; however, at this time, we are unable to accept credit card payments. If your account has not been paid for more than 60 days and arrangements for payments have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, the costs will be included in the claim. In most collection situations, the only information released regarding a patient's treatment is his/her name, the nature of services provided and the amount due.

5. Insurance Reimbursement

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. You should carefully read the section in your insurance coverage booklet that describes mental health services. NMHS will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled. If it is necessary to clear confusion, we are willing to call the company on your behalf. However, you (not your insurance company) are ultimately responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers prior to your first appointment. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often short-term treatment approaches designed to work out specific problems that interfere with the person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

Client Initials _____ Date _____

You should be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans or summaries or even copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, NMHS has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information data bank. We will provide you with a copy of any report we submit, if you request it. Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your treatment. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above.

6. Contacting US

While we are usually in our offices during regular business hours, we will be unavailable to talk to you on the telephone while meeting with a client. When your therapist is unavailable, you may leave a message on your therapist's voicemail. Your therapist will make every effort to return your call within 24 to 48 hours with the exception of weekends and holidays. When leaving a message, please inform your therapist of when you are available along with a contact number. In emergency situations contact the nearest emergency room or call 911.

7. Professional Records

The laws and standards of our professions require that we keep treatment records. You are entitled to receive a copy of the records unless your therapist believes that seeing them would be emotionally damaging, in which case your therapist will be happy to send them to a mental health professional of your choice. We recommend that you review them with your therapist present so that we can discuss the contents. Clients will be charged an appropriate fee for any time spent in preparing information requests.

8. Minors

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to request an agreement from parents that they give up access to your records. If they agree, we will provide them only with general information about our work together, unless your therapist feels there is a high risk that you will seriously harm yourself or someone else. In this case, your therapist will notify them of the concern. We will also provide them with a written or oral summary of your treatment when it is complete. Before giving your parents any information, your therapist will discuss the matter with you, if possible, and will do their best to handle any objections you may have.

9. Confidentiality

In general, law protects the privacy of all communications between a client and therapist, and your therapist can only release information about your treatment to others with your written permission. But there are a few exceptions.

- In most legal proceedings, you have the right to prevent your therapist from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order your therapist's testimony if he/she determines that the situation demands it.

- There are some situations in which we are legally obligated to take action even if we have to reveal some information about the patient's treatment. If we believe that a client is threatening serious bodily harm to another, we are required to take protective actions. These actions may include notifying the potential victim, contacting the police, filing a report with the appropriate state agency or seeking hospitalization for the client. If the client threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a situation occurs such as this, we will make every effort to fully discuss it with you before taking any action.

- We may occasionally find it helpful to consult other professionals about a case. During a consultation, we make every effort to avoid revealing the identity of the client. The consultant is also legally bound to keep the information confidential. If you don't object, your therapist will not tell you about these consultations unless he/she feels it is important to our work together.

- While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. Your therapist will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not attorneys. Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Any questions or concerns regarding the above policies?

Signature of Client: Date

Signature of Guardian: Date

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NNIHS Intern Consent Form

This form is to notify you that Neubauer Mental Health Services is a Clinical Social Work-Internship site. NMHS is an association of Master's Degree level clinicians that includes Licensed Clinical Social Worker's, Licensed Marriage and Family Therapist's, Licensed Clinical Professional Counselors as well as respective Board interns from the above named Boards. NMHS clinical services are under the direct supervision of NMHS Clinical Director, Nicholas L. Neubauer, L.C.S.W., and NMHS Medical Director, Dr. Charles Mahakian, M.D.

Prior to obtaining full independent licensure in the State of Nevada, individuals must complete a Board approved internship in approved clinical settings.

Neubauer Mental Health Services is an approved clinical setting that utilizes interns to diagnose, asses, and treat, clients. Please discuss with you clinician their level of licensure and any concerns that you may have. For further follow up, please feel free to contact Nicholas L. Neubauer L.C.S.W.

Board approved on-site supervisors ultimately oversee the clinical practice of all interns and can make themselves available for consultation at all times. NMHS Interns are required to maintain client confidentiality, as required by both Federal and State laws.

Consent:

I have read the above information and consent to myself (or person under my guardianship) being treated by a NMHS Intern.

Client/Guardian Signature: Date:

HIPAA PRIVACY STATEMENT

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present and future physical or mental health or related condition is referred to as Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by sending you a copy in the mail upon request at your next appointment.

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, 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 eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services to determine medical necessity or utilization review. If it becomes necessary to use a collection process due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for collection purposes.

For Health Care Operations: We may disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessments activities, employee review, licensing and conducting other business activities. For example: billing or typing services. For training or teaching purposes PHI will be disclosed only with your authorization.

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 Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Client Initials _____

The following is a list of categories of uses and disclosures permitted by HIPAA without authorization:

- **Child Abuse/Neglect – Elder Abuse/Neglect – Emergencies**
- **National Securities – Law Enforcement – Public Safety (Duty to Warn)**

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 as follows:

1. Required by law, such as the mandatory reporting of child abuse or neglect to mandatory government agency audits or investigations.
2. Required by Court Order.
3. Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or to the public. This includes the notification to the target of the threat.

Verbal Permission: We may 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 at any time.

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 to Sage Health Services.

Right to Access to Inspect and Copy: You have the right, which may be restricted only in exceptional circumstance, 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. 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.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical/mental health matters in a certain way or at a certain location. Right to Copy of this Notice: You have a right to a copy of this notice.

Complaints: If you believe we have violated your privacy rights, you have the right to file a complaint in writing to Sage or with the Secretary of Health and Human Services at:200 Independence Ave., S.W., Washington, DC 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.
The effective date of this Notice is April 14, 2014.

Client Initials _____

CONSENT TO USE UNECRYPTED E-MAIL OR TEXT

It is very important that you are aware that computer e-mail, texts, and e-fax communication, can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. While data on NMHS laptop is encrypted, e-mails and e-faxes are not. It is always a possibility that e-faxes, texts, and e-mail can be sent erroneously to the wrong address and computers. Unencrypted e-mail or texts provide as much privacy as a postcard. You should not communicate any information to your health care provider that you would not want to be included on a postcard that is sent through the Post Office.

E-mail messages on your computer, your laptop, iPad, phone or other devices have inherent privacy risks - especially when your e-mail access is provided through your employer or when access to your e-mail messages is not password protected. NMHS laptop is equipped with a firewall, a virus protection and a password, and all confidential information from the computer is backed up on a regular basis onto an encrypted hard drive. Please, note that e-mails, faxes, and texts are all part of your clinical records. Also, be aware that phone messages are transcribed and sent to NMHS via unencrypted e-mails. Please notify NMHS limit, in any way, the use of e-mail, texts, cell phone calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, it will be assumed that you have evaluated the risks and made an informed decision, NMHS will view it as your agreement to truce the risk that such communication may be intercepted, and your desire to communicate on such matters will be honored. Please do not use texts, e-mail, voice mail, or faxes for emergencies.

PLEASE NOTE*

AT NO TIME ARE NMHS CLINICIANS TO HAVE INTERACTIONS WITH ANY NMHS CLIENT VIA SOCIAL MEDIA

Patient's Name:

Cell Phone Number:

E-mail Address:

Patient's Signature:

Date:

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NMHS FINANCIAL RESPONSIBILITY STATEMENT

All patients pay portions or estimates based on the information provided to NMHS by the client and/or his or her insurance carrier. The client/guarantor must understand that having an insurance benefit does not guarantee payment. The insurance carrier makes the final decision as to whether payment will be made after it receives and reviews the claim.

When a client is treated at NMHS, as a courtesy, our administrator contacts that patients third party payer to check insurance eligibility and pre-certification for insurance payment.

Also, as a courtesy, NMHS will bill the patient's insurance carrier for all services. The client/guarantor is responsible for ALL OUTSTANDING BALANCES should the insurance company fail to or deny payment for PART OR ALL of the charges. Any non-payment as a result of the client/guarantor's failure to provide insurance information prior to the first visit is also the client/guarantor's financial responsibility.

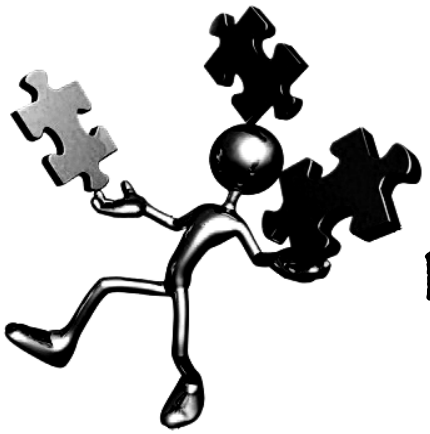
It is the client/guarantor's responsibility to ensure all insurance premiums, dues, and COBRA payments are current throughout the patient's treatment at NMHS. Any payment denied by the insurance carrier for services provided is the financial responsibility of the client/guarantor.

The patient's insurance coverage is a contact between the client and the insurance carrier; NOT BETWEEN NMHS AND THE INSURANCE CARRIER. As such, that client should be aware that policy information/coverage can often change. Therefore, it is the patient's sole responsibility to know his or her coverage. Any costs incurred by the client/guarantor due to a change in the patient's insurance policy is the sole responsibility of the client/guarantor.

By signing below, the client/guarantor acknowledges that they have read, understand, and agree to all the terms of this financial responsibility statement.

Printed Client Name:

Client/Guarantor Signature: Date:



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Authorization for Health Records Request/Release

Name:

Birth Date:

Address:

Phone:

I authorize Neubauer Mental Health Services to:

Method of Release:

☐ Obtain my health/mental health/other information from: ☐ Mail ☐ Fax

☐ Release my health/mental health/other information to: ☐ Phone ☐ Picked Up

Name:

Address:

Phone: Fax:

The information you authorize for release may include, but is not limited to, information regarding mental health, drug or alcohol use/abuse, communicable diseases, pregnancy, and HIV/ AIDS. Redisclosure: This information is being disclosed to you from records whose confidentiality is protected by federal law, federal regulations (42 CRF part 2) prohibit you from making any further disclosure of this information except with specific written consent of the person to who it pertains.

Records Requested:

☐ Copy of all health records (including mental health)

☐ Other: _____

This release will expire on/at _____ or with written notification from the client.

Client/Guardian Signature: _____ Date: _____

NMHS representative signature: _____ Date: _____