Catalyst
BEHAVIORAL HEALTH
5539 S. 27th St., Suite 104
Lincoln, NE 68512

Client Information

Name (Last, First, MI): _____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: (_____) _____ - _____ Type (Home, Cell, Work, etc.): _____
Permission to Leave Voicemails: ☐Yes ☐No Permission to Send Text Messages: ☐Yes ☐No ☐N/A

Secondary Phone (*if applicable*): (_____) _____ - _____ Type (Home, Cell, Work, etc.): _____
Permission to Leave Voicemails: ☐Yes ☐No Permission to Send Text Messages: ☐Yes ☐No ☐N/A

E-Mail Address: _____

Gender: _____ Ethnic/Racial Identity or Heritage: _____

Social Security Number (SSN): _____-_____ - _____

Emergency Contact: _____ Phone: (_____) _____ - _____ Relationship: _____

Relationship Status (check all that apply):
☐ Single ☐ In a Relationship ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)
☐ Other: _____

Employment Status (check all that apply):
☐ Employed (Full/Part-Time) ☐ Unemployed ☐ Disabled ☐ Student
☐ Other: _____

Highest Educational Grade Completed:
☐ Elementary School ☐ High School ☐ College ☐ Graduate/Professional School

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Do You Have Medical Insurance Coverage? ☐ Yes ☐ No

Primary Insurance Company: _____

Policy #: _____ Group#: _____

Policy Holder's Employer's Name_____ Employer's Phone #: (_____) _____ - _____

Employer's Address_____

If Other than Self:
Policy Holder's Name: _____DOB: _____ Relationship: _____

Policy Holder's Social Security #: _____-_____ - _____ Policy Holder's Date of Birth: _____/_____/_____

Secondary Insurance Company: _____

Policy #: _____ Group#: _____

Policy Holder's Employer's Name_____ Employer's Phone #: (____) _____ - _____

Employer's Address_____

If Other than Self:
Policy Holder's Name: _____ Relationship: _____

Policy Holder's Social Security #: _____-_____ - _____ Policy Holder's Date of Birth: _____ /_____ /_____

Responsible Party or Guarantor (*If Other than Client*): _____

Address: _____ Phone #: (____) _____ - _____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature of this document authorizes Kendra J. Hubbard, MS, LIMHP to submit claims for benefits for services rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize and assign payment of all/any insurance benefits to Kendra J. Hubbard, MS, LIMHP that is otherwise payable to me for her services as described on the assigned payment forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Kendra J. Hubbard, MS, LIMHP will be credited to my account in accordance with the above assignment.

_____

Patient Name (Print)

_____

Signature of Patient/Guardian (*Note: If the patient is under the age of 19, the parent/guardian must sign*)

_____

Date Document Signed

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Billing Policy

The fees for services provided by Kendra J. Hubbard, MS, LIMHP will be in accordance with the reasonable value set forth by established community guidelines and standards. At the present time, the fee for a diagnostic interview/initial session (CPT Code: 90791) is $225 after which the billing rate for a licensed independent mental health provider is $195 per 60-minute individual therapy (CPT Code: 90837) and 45- minute individual therapy (CPT Code: 90834), and $195 per 60-minute family therapy (CPT Codes: 90846, 90847).

Clients are required to provide a valid credit card at the time of their first initial session for the office to keep in their file. Co-pays are the client's responsibility and are required to be paid at the time of service. Clients are also responsible for any deductible, co-insurance and/or out-of-pocket balances remaining after insurance benefits have been applied. Electronic payment is offered as an option and includes a $5.00 convenience fee. To avoid paying this additional fee, please use cash or check made payable to Kendra Hubbard, MS, LIMHP. A 5% finance charge will accrue on any unpaid balances that are 90 days or more past due. A $25 return check fee will also be charged for any checks that are returned for insufficient funds. That fee in addition to the amount of the check will automatically be charged to the client's credit card on file. Client statements are available for viewing on the Patient Portal. If no payment is received within 30 days of the statement date, a payment will be automatically charged to the client's credit card on file. The client will be notified in advanced of the transaction, and offered the option to provide an alternative method of payment. Kendra J. Hubbard, MS, LIMHP does offer payment plans to those who need assistance with their balances. Uninsured clients or self-pay clients are required to pay for services in full at the time of their appointment before they can be seen. Uninsured or self-pay clients are responsible for the first initial session fee of $225, followed by adjusted rates on follow-up sessions. Kendra J. Hubbard, MS, LIMHP reserves the right to delay, defer, or discontinue services for any reason, including if the balance owed is not paid at the time it is due.

Sessions that are cancelled without at least 24 hours notice before the session will be considered late cancellations. Two late cancellations will be allowed before a warning letter will be sent out. One No Show appointment will be allowed before a warning letter will be sent out. After this, any appointment that is not cancelled with 24-hour notice, or any No Show appointment will be charged a $50 fee. The client is required to pay this fee in full prior to scheduling the next appointment. This charge is also not billed through insurance. Should a client discontinue their services with Kendra J. Hubbard, MS, LIMHP, they are responsible for the payment of any remaining balance for services rendered. Kendra J. Hubbard, MS, LIMHP reserves the right to forward any unpaid accounts to a collection agency to be recovered.

I, _____, understand that I am ultimately liable for the balance on my account for any services provided by Kendra J. Hubbard, MS, LIMHP regardless of the status of my insurance situation. With my signature, I agree to adhere to the agency's billing policies and procedures, and to pay any fees that I owe the agency based upon such policies. I hereby authorize direct payment and all benefits due under my insurance policy to Kendra J. Hubbard, MS, LIMHP. I authorize the release of medical or other protected health information necessary to process insurance claims.

_____

Signature of Patient/Guardian

_____

Date Document Signed

Credit Card Information:

Card Holder Name: _____ Account Number: _____

Exp. Date: _____ Security Code: _____ Billing Zip Code: _____

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Acknowledgement of Receipt

Patient's Name: _____ **Patient's DOB:** _____

Authorization for Treatment

I acknowledge that I have been given the opportunity to review the Consent to Treatment and Confidentiality Statement. I may obtain a current copy upon request. I understand that Catalyst Behavioral Health has the right to change the Authorization for Treatment at any time.

Acknowledgement of Receipt of Privacy Notice

I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices for Protected Health Information. I may obtain a current copy upon request. I understand that Catalyst Behavioral Health has the right to change the Notice of Privacy Practices at any time.

Billing Policy/Co-Payments

I acknowledge that I have been given the opportunity to review Kendra J. Hubbard, MS, LIMHP's billing policy. I understand that co-pays, if appropriate, must be paid at the time of visit. I understand that I am responsible for all fees not paid by my health insurance. Payment is due 30 days after receipt of statement. I understand that if no payment is received within 30 days, a payment will be automatically charged to my credit card on file. Electronic payment is offered as an option and includes a convenience fee: 0-$100, $3.00; $100-$200, $4.00, and $200+, $5.00. To avoid paying this additional fee, please use cash or check made payable Kendra J. Hubbard, MS, LIMHP. I understand Kendra J. Hubbard, MS, LIMHP does offer financial assistance in the form of payment plans. Uninsured and/or self-pay clients are required to pay for services in full at the time of their appointment. Kendra J. Hubbard, MS, LIMHP reserves the right to submit any unpaid balances to a collection agency for recovery. Questions about insurance, billing, and payment plans can be directed to Gina Pashby, our office manager at (402) 261-8313.

Appointment No-Show Fee

I have been advised that this office requires a 24-hour prior notice on all appointment cancellations. I have been advised that there will be a $50.00 no show fee for appointments that are canceled with less than 24-hour notice. This fee is not covered by any insurance plan and must be paid prior to my next visit. I understand that three no-show/late cancellations in one year may be cause for automatic discharge from Catalyst Behavioral Health.

Office Hours and Phone Calls

Catalyst Behavioral Health is open Monday through Friday, 9am-4pm, with limited appointments on Fridays. We will make every effort to return a phone call as soon as possible, but if your call is urgent, please note that with our office staff.

Patient/Guardian Signature: _____

Printed Name: _____

Date: _____

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Consent for Treatment

Patient's Name: _____ **Patient's DOB:** _____

I, _____, hereby give my consent to Kendra J. Hubbard, MS, LIMHP to provide mental health services to me;

and/or I, _____ (Parent/Guardian) to the above named patient, hereby give my consent for treatment.

_____ I understand that:

- Kendra J. Hubbard, MS, LIMHP may send my medical record information to my insurance company.
- I must pay my share of the costs (e.g., co-pays, amounts until a met deductible, etc.)
- If I do not have insurance, or if my insurance does not cover mental health services, I must pay for these services in full.

_____ I understand that:

- I have the right to refuse any treatment.
- I have the right to discuss all treatments with my provider.
- There may be a charge for late cancellations or no-show appointments.

_____ While I anticipate benefits through treatment, I am aware of unforeseen factors that may hinder my counseling and mental health treatment; I realize particular results cannot be guaranteed.

_____ Counseling and/or mental health treatment may escalate my emotional, mental, or physical conditions; I may experience new stressors during treatment and while attempting to make life changes.

_____ If I experience a life-threatening mental health emergency, I am to contact 911 or go to my nearest emergency room. In the event of other emergencies outside of business hours, I am aware that I can contact

_____ Issues discussed with my clinician will remain confidential, *with a few exceptions.* There are some special circumstances that limit confidentiality including: a) a statement of intent to harm myself or others; b) statements indicating harm or abuse of children or vulnerable adults; c) issuance of a subpoena from a court of law; d) when your insurance company is involved; e) when you have signed a Release of Information allowing for your information to be discussed with an identified party.

I know of no reason why I should not or cannot undertake this mental health treatment and agree to participate fully and voluntarily.

Patient's Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Clinician Signature: _____ **Date:** _____