Catalyst
BEHAVIORAL HEALTH

Name (Last) _____ (First) _____ (Middle) _____

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

City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Soc. Sec#_____-_____-_____ Male: [] Female: []

Single: [] Married: [] Separated: [] Divorced: [] Widowed:[]

Race: _____ Ethnicity:_____ Preferred Language:_____

Email Address: _____

Parent/Spouse's Name: _____ Soc. Sec#_____-_____-_____

Purpose of Visit: _____

Emergency Contact: _____ Phone: ( ) _____-_____

Primary Care Physician: _____ Phone: ( ) _____-_____

Do You Have Medical Insurance? Yes [] No [] (If Yes Please Answer **ALL** Questions Below)

Primary Insurance Company_____

Policy #_____ Group#_____

Does your insurance require authorization prior to the first session? Yes [ ] No [ ] If yes have you contacted the company? Yes [ ] No [ ]

Policy Holder's Name & Relationship_____

Policy Holder's Soc. Sec#_____-_____-_____ Policy Holder's Date of Birth_____/_____/_____

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

Employer's Address_____

Secondary Insurance Co._____

Policy #_____ Group #_____

Policy Holder's Name & Relationship_____

Policy Holder's Soc. Sec #_____-_____-_____ Policy Holder's Date of Birth_____/_____/_____

Policy Holder Employers Name: _____ Employer's Phone ( ) _____-_____

Employer's Address_____

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 my physician to submit claims for benefits for services rendered for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that 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 Krysta Hunt, LIMHP, PLADC 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 Krysta Hunt, LIMHP, PLADC will be credited to my account in accordance with the above assignment.

_____ _____ _____

(Print Name of Patient) (Authorized Signature of Patient/Parent/Guardian) (Date)

Note: If the patient is under the age of 19, the parent or guardian must sign all legal documents.

Krysta Hunt, LIMHP, PLADC.
5539 S. 27th St., Suite 104 Lincoln, NE 68512
Phone (402) 261-8313 Fax (402) 939-0437
khunt@catalystbehavioralhealth.com

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BEHAVIORAL HEALTH

Informed Consent

I, _____, (Client/Parent/Guardian) hereby give my consent to Krysta Hunt, MA, LIMHP to provide _____ (Client) with mental health services.

_____ I understand that:

- Krysta Hunt, MA, 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.) for mental health services.
- If insurance does not cover mental health services or I am uninsured, 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.
- I may be charged 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 Name: _____ **DOB:** _____

Client/Guardian Signature: _____ **Date Signed:** _____
Note: If the patient is under the age of 19, the parent or guardian must sign all legal documents.

Clinician Signature: _____ **Date Signed:** _____

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Consent to Treat

Authorization for Treatment
I acknowledge that I have been given the opportunity to review the Informed Consent and Patient Rights & Responsibilities. I may obtain a current copy upon request. I understand that Catalyst Behavioral Health (CBH) 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 CBH has the right to change the Notice of Privacy Practices at any time.

Office hours and Phone calls
Office staff is available 9am-4pm Monday through Thursday, and Friday, 9am-12pm to address any questions or concerns. Every effort will be made to return my phone call as soon as possible. If my call is urgent, I will note this with our office staff or when I leave a message on Catalyst's confidential voice mail.

Appointment No-Show Fee
I have been advised that this office requires a 24-hour prior notice on all appointment cancellations and I have reviewed the CBH Extended Billing Policy. I have been advised that there will be a $50 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 the clinic.

Billing Policy/Copayments
I acknowledge that I have been given the opportunity to review Krysta Hunt, MA, LIMHP's Extended 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 Krysta Hunt, MA, LIMHP does offer financial assistance in the form of payment plans. 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. Krysta Hunt, MA, LIMHP does reserve the right to submit any unpaid balances to a collection agency for recovery. **Clients are now required to provide a valid credit card at the time of their first initial session for the office to keep in their electronic file.** Once uploaded into our secure system, this information is immediately shredded. This information will be updated yearly or when a card has expired. I understand that if no payment is received within 30 days, a payment will be automatically charged to my credit card on file. Cards will not be charged without prior notification and opportunity to provide alternate payment will be offered at that time. Please direct any questions about insurance, billing, and payment plans to Gina Pashby, our office manager.

Print Patient Name: _____ **DOB:** _____

Client/Guardian Signature: _____ **Date Signed:** _____
Note: If the patient is under the age of 19, the parent or guardian must sign all legal documents.

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Extended Billing Policy

The fees for services provided by Krysta Hunt, MA, LIMHP will be in accordance with the reasonable value set forth by established community guidelines and standards. At the present time, the fee for the diagnostic interview/ initial 45-minute session (CPT Code 90791) is $225 after which the billing rate for a licensed independent mental health practitioner is $150 per 60-minute individual therapy (CPT Code 90837), $95 per 45-minute individual therapy (CPT Code 90834), $85 per 30-minute individual session (CPT Code 90832), and $175 per 45-minute family therapy session with or without client present (CPT Code 90847 and 90846). Copays 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 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 to Krysta Hunt, MA, LIMHP.

Client statements are mailed out on the first of each month. 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. If payment is not received for two consecutive sessions, the client may not schedule an appointment until the fees owed are paid in full. Balances that are 90 days past due will begin accruing 5% finance charges every 30 days. Krysta Hunt, MA, 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 $150, followed by adjusted rates on follow up sessions. Krysta Hunt, MA, 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. Krysta Hunt, MA, LIMHP does reserve the right to forward any unpaid accounts to a collection agency to be recovered.

Sessions that are cancelled without at least 24-hour notice before the session will be considered a late cancellation. 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 Krysta Hunt, MA, LIMHP they are responsible for the payment of any remaining balance for services rendered. Krysta Hunt, MA, LIMHP does reserve the right to forward any unpaid accounts to a collection agency to be recovered.

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. Once uploaded into our secure system, this information is immediately shredded. This information will be updated yearly or when a card has expired.

Credit Card Information

Card Holder Name: _____ **Account Number:** _____

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

I, _____, understand that I am liable ultimately for the balance on my account for any services provided by Krysta Hunt, MA, 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 Krysta Hunt, MA, LIMHP for services provided. I authorize the release of medical or other protected health information necessary to process insurance claims.

Print Patient Name: _____ **DOB:** _____

Client/Guardian Signature: _____ **Date Signed:** _____

Note: If the patient is under the age of 19, the parent or guardian must sign all legal documents.

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Authorization for Use and Disclosure of Protected Health Information

I, _____, hereby request and authorize Krysta Hunt, MA, LIMHP to release and/or receive
(client/parent/guardian)
Protected Health Information (PHI), as specified below, to/from _____
(name of person/provider/agency)
at _____.
(address/phone/fax/secure email)

Information authorized to release or receive (please check all that apply):

☐ Medical History and Physical	☐ Family & Social History	☐ Medication Information	☐ Psychological Testing
☐ Psychological Evaluation	☐ Treatment Plan	☐ Academic Records	☐ Lab Reports
☐ Psychiatric Evaluation	☐ Discharge Summary	☐ Hospital Records	☐ Entire Record
☐ Chemical Dependency Eval.	☐ Substance Use History	☐ Attendance/Participation	☐ Other:

Information may be used for evaluation, treatment, educational planning, follow-up, continuity of care or for further medical treatment. This authorization is good for one year from the date signed or for _____ days.

I have reviewed this authorization form and confirm that it reflects my wishes to release/receive protected healthcare information. I understand that any disclosure of information carries with the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. By signing this document, I release Krysta Hunt, MA, LIMHP from any liability resulting from this disclosure. I also have the right to revoke this authorization at any time and must do so in writing to the office manager at Catalyst Behavioral Health. I further understand that actions already taken based on this authorization, prior to revocation, will not be affected. A photocopy or fax of this document shall have the same effect as the original.

Patient Name: _____ **DOB:** _____

Client/Guardian Signature: _____ **Date Signed:** _____
Note: If the patient is under the age of 19, the parent or guardian must sign all legal documents.

Witness/Clinician Signature: _____ **Date Signed:** _____

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DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ☐ **Male** ☐ **Female** **Date:** _____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed (e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed))?	0	1	2	3	4	

WHODAS 2.0

WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

12
Interview

Section 4 Core questions

Show flashcard #2

In the past 30 days, how much difficulty did you have in:		None	Mild	Moderate	Severe	Extreme or cannot do
S1	Standing for long periods such as 30 minutes?	1	2	3	4	5
S2	Taking care of your household responsibilities?	1	2	3	4	5
S3	Learning a new task, for example, learning how to get to a new place?	1	2	3	4	5
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	1	2	3	4	5
S5	How much have you been emotionally affected by your health problems?	1	2	3	4	5

In the past 30 days, how much difficulty did you have in:		None	Mild	Moderate	Severe	Extreme or cannot do
S6	Concentrating on doing something for ten minutes?	1	2	3	4	5
S7	Walking a long distance such as a kilometre (or equivalent)?	1	2	3	4	5
S8	Washing your whole body?	1	2	3	4	5
S9	Getting dressed?	1	2	3	4	5
S10	Dealing with people you do not know?	1	2	3	4	5
S11	Maintaining a friendship?	1	2	3	4	5
S12	Your day-to-day work/school?	1	2	3	4	5

H1	Overall, in the past 30 days, how many days were these difficulties present?	***Record number of days*** ____
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	***Record number of days*** ____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	***Record number of days*** ____

This concludes our interview. Thank you for participating.

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Patient Rights & Responsibilities

As a person receiving mental health services here at Catalyst Behavioral Health, you have the right to:

- Be treated with dignity and respect.
- Ask questions and get answers about services offered here to determine the most appropriate treatment program. You can get information about treatment procedures, costs, and risks. You can request a change in your treatment or service as well.
- Participate fully in decisions regarding your health care service. This includes having your family involved in your treatment with your consent.
- Not be subject to verbal, physical, sexual, emotional or financial abuse; harsh or unfair treatment.
- Make complaints, have them heard, get a prompt response, and not receive any threats or mistreatments as a result. You can file a grievance if you are not satisfied with the response to a complaint.
- Be assisted by an advocate of your choice; for example, family, friend, case manager, member of a consumer advocacy committee or organization, etc.
- Not be discriminated against on the basis of race, age, gender, religion, national origin, sexual orientation, disability, or marital status.

All patients, to the extent capable, have the responsibility to:

- Pursue health lifestyles. Patients should pursue lifestyles known to promote positive health results, such as proper diet and nutrition, adequate rest, and regular exercise. Simultaneously, they should avoid behaviors known to be detrimental to one's health, such as smoking, excessive alcohol consumption, and drug abuse.
- Actively participate in decisions about their health care and cooperate on mutually accepted courses of treatment. Patients should comply with treatment regimens and regularly report on treatment progress. If serious side effects, complications, or worsening of the condition occur, they should notify their providers promptly. They should also inform providers of other medications and treatments they pursue simultaneously.

Patient Name: _____ **DOB:** _____

Client/Guardian Signature: _____ **Date Signed:** _____

Note: If the patient is under the age of 19, the parent or guardian must sign all legal documents.

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Notice of Privacy Practices

This notice, effective July 1st, 2014, 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 medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called 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 posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

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

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. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

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