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

Catalyst
BEHAVIORAL HEALTH

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

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: _____ 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 o 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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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:** _____

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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 mental health provider is $195 per 60-minute individual therapy (CPT Code: 90837).

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. 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. 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 $195, 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, LMHP 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, LMHP 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

_____
Printed Name

_____
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, LMHP'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, LMHP. I understand Kendra J. Hubbard, MS, LMHP 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, LMHP 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 th at 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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Notice of Privacy Practices

Effective Date: July 1, 2014

This notice describes how your medical information may be used and disclosed, as well as 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. This information 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 (e.g., insurance companies). 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 about questions you have asked, test results, etc. ***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 include:

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

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

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which you may revoke at any time. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication, and for the sale of such information.

Your rights regarding your PHI:

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **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 the 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 services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy:

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third-party without your expressed permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third-party to provide services such as newsletters, surveys to improve our services, or company updates. In such cases, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third-party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and downloaded information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but is not linked to any personal information that can identify you or any visitor to our site.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites, and we encourage you to check the privacy practices of all Internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any losses, claims, or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:

You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Catalyst Behavioral Health. If you have questions and/or would like additional information, you may contact us at (402) 261-8313.

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Patient Rights & Responsibilities

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

- Be treated with dignity and respect.
- Ask questions and get answers about services offered at Catalyst Behavioral Health to determine the most appropriate treatment for you. Information about treatment procedures, costs, and risks can be provided for you. You can also request a change in your treatment or service, if desired.
- Participate fully in decisions regarding your health care service, including having your family or significant others involved in your treatment.
- 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 also have the right to file a grievance if you are not satisfied with the response provided to a complaint.
- Be assisted by an advocate of your choice (e.g., 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 healthy 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 are pursuing simultaneously.