Vivian R. Herndon Counseling, P.C.
8424 West Center Road, Ste 203
Omaha, Nebraska 68124
402-659-4742

CONSENT TO TREATMENT

The undersigned requests and consents to behavioral health care for the patient including all examinations, tests, and other procedures which the clinician may deem necessary as appropriate. I acknowledge that no guarantees have been made as to the results of such care. By signing this form, I also agree to all the terms and conditions described below.

CONTINUING OUTPATIENT CARE. In some cases, proper treatment of a mental health condition requires continuing treatment of diagnosis over a course of repeated outpatient visits. In such cases, the request, consent and agreements herein shall apply to all repeat visits and all continuing treatments and diagnosis of the same condition.

I HEREBY CERTIFY THAT I HAVE READ, I UNDERSTAND, AND I AGREE TO THE INFORMATION SET FORTH ABOVE AND THAT, IF I AM NOT THE PATIENT, I AM DULY AUTHORIZED TO SIGN FOR THE PATIENT.

_____ _____

Signature of patient or representative of patient Date

_____

Relationship to patient if other than self

ASSIGNMENT OF BENEFITS

I hereby authorize Vivian R. Herndon Counseling, P.C., Omaha, Nebraska to furnish to the insurance company all information which said insurance company may request concerning my present illness or injury. Information may also be disclosed to the referring physician or to other health care providers, facilities or agencies. I hereby assign to Vivian R. Herndon Counseling, P.C., Omaha, Nebraska, the amount of money to which I am entitled for mental health expenses for each claim submitted.

Date _____ Signed _____

Vivian R. Herndon Counseling, P.C.
8424 West Center Road, Suite 203
Omaha Nebraska, 68124
402-659-4742

Office Financial Policy and Billing Agreement

Name: _____

Insurance Coverage

- Client agrees to contact Insurance Company to verify Mental Health benefits. You pay for your insurance. It is your responsibility to know the benefits of your policy. _____ (Initial)
- Co-pays will be collected at each visit. Your insurance coverage will be checked before your first visit, but you should call your insurance carrier to verify your specific benefits. _____ (Initial)
- Should a dispute arise on a claim, it is generally the client's responsibility to clarify and resolve the dispute with the insurance company. _____ (Initial)
- If insurance is being filed, any deductible not yet met is due at the time of service as well as any co-pay. _____ (Initial)

Payment

- If insurance is not being filed, payment is expected at the time of service. _____ (Initial)
- I agree to provide a 24-hour notice to cancel an appointment. Otherwise no-show charges will be assessed. _____ (Initial)
- There will be a charge if you fail to keep your scheduled appointment. The fees will begin with a charge to you of $50 for the first missed appointment, $75 for second missed appointment and $100 for third missed appointment. If an appointment is not kept or 24 hour notice of cancellation is not given, the cancellation fee will be your responsibility and will be billed directly to you. _____ (Initial)
- A service requested by the client, but not covered by the client's Insurance Plan may be arranged under a separate written agreement with the provider. _____ (Initial)
- Phone calls are not billable to your insurance. Phone calls over 10 minutes are billed for the amount of time spent on the phone, at the pro-rated hourly rate. _____ (Initial)
- Our fees are subject to change at the discretion of the practice. A fee schedule is available upon request. _____ (Initial)
- There is a $30 administration charge for checks that do not clear the bank. _____ (Initial)
- Questions regarding your account should be directed to Midwest Medical at 402-504-4680. _____ (Initial)
- If there are any changes in your personal information (i.e. address, phone number and insurance coverage) please inform us as soon as possible. _____ (Initial)
- You will be responsible for remembering your appointments. _____ (Initial)

Patient _____

Date _____

Vivian R. Herndon Counseling, P.C.
8424 West Center Road, Ste 203
Omaha, Nebraska 68124

Client Information

Date: _____

Last Name: _____ First Name: _____MI: ____
Address: _____
City/State/Zip: _____

Birth Date: _____ Male _____ Female _____
Marital Status: _____ Spouse Name: _____
Children's Name & Ages: _____
Employer/Company Name: _____

Home Phone: _____Ok to leave messages at: _____ Home____ Work _____ Cell
Work Phone: _____ Or….Do not leave messages _____
Cell Phone: _____
Fax: _____
E-Mail (Optional) _____

Emergency Contact:
Name: _____ Phone: _____ Relationship to client: _____

Insurance Company Information

PLEASE PRESENT THE POLICY HOLDER'S INSURANCE CARD

Plan type or Name: _____ Responsible Party (if not Client):
Insurance Company: _____ Name: _____
Claims Address: _____ Address:_____
Customer Service Phone #: _____ City/State/Zip: _____
Who is the policy holder? _____ Birth Date: _____
Member's ID No: _____ Home Phone: _____
Policy No: _____ Relationship to Client: _____
Group No Employer/Co: _____
Authorization No: _____

Primary Care Physician: _____ Referring Physician: _____

NAME:_____ DATE OF BIRTH:_____

PLEASE FILL OUT THIS FORM TO THE BEST OF YOUR KNOWLEDGE. IT IS TO ASSIST US IN WORKING WITH YOU AND WILL BE HELD IN COMPLETE CONFIDENCE.

Please list any medical conditions or operations:_____

_____

_____

Please list any medication allergies: NONE

_____

Please list all current medications including non-prescription drugs and supplements: NONE

MEDICATION	DOSAGE	REASON PRESCRIBED	DATE BEGUN

Have you ever been on an anti-depressant such as (please circle all that apply): NONE

Tofranil (Imipramine) Pamelor (Nortriptyline) Trazodone

Remeron (Mirtazepine) Serzone (Nefazadone) Prozac (Fluoxetine)

Elavil (Amitriptyline) Anafranil Paxil (Paroxetine) Luvox

Wellbutrin (Buproprion) Cymbalta Effexor (Venlafaxine) Celexa (Citalopram)

Zoloft (Sertraline) Lexapro Emsam (or MAO Inhibitor) Viibryd

Have you ever taken an anti-psychotic such as (please circle all that apply): NONE

Thorazine Mellaril Stelzaine Haldol Prolixin Abilify Geodon

Risperdal Navane Zyprexa Seroquel Invega Saphris

Have you ever taken a tranquilizer or sedative such as (please circle all that apply): NONE

Valium Librium Tranxene Ativan (Lorazepam) Xanax (Alprazolam)

Restoril (Temazepam) Klonopin (Clonazepam) Sonata Buspar (Buspirone)

Lunesta Rozerem Ambien

Have you ever taken an ADD drug such as (please circle all that apply): NONE

Dexedrine (Dextroamphetamine) Ritalin Cylert Adderall Provigil

Strattera Concerta Focalin Vyvanse

Have you ever taken a mood stabilizer such as (please circle all that apply): NONE

Lithium Depakote Lamictal (Lamotrigine) Tegretol Trileptal Neurontin Gabitril

Zonegram Topamax Geodon Risperdal Abilify Zyprexa Seroquel Equetro

PATIENT NAME:_____ DATE OF BIRTH:_____

Have you ever abused prescription drugs? ☐ YES ☐ NO

If so, what: _____

Are you currently using "street" drugs such as (please circle all that apply): NONE

LSD or Acid Barbiturates (or "downers") Amphetamines (or "uppers")

Crank Cocaine Marijuana Bath Salts Glue Sniffing PCP Solvents

Other:_____

Do you drink alcohol? ☐ YES ☐ NO

If YES, how many times a week?_____ How many drinks each time?_____

Do you use tobacco? ☐ YES ☐ NO

If YES, how many packs per day? Less than one:_____ One pack:_____ Two packs:_____

Do you drink caffeine? ☐ YES ☐ NO

If YES, how much? _____

Do you gamble? ☐ YES ☐ NO

If YES, how much money do you lose in a week _____ in a month _____

Do you have a shopping problem? ☐ YES ☐ NO

Are you or have you experienced domestic abuse? ☐ YES ☐ NO

Do you spend a lot of time on the internet? YES NO

If YES, how much time in a day _____ How many days in the week _____
Do you look at pornography? YES NO

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

PATIENT RIGHTS & RESPONSIBILITIES

Vivian R. Herndon Counseling, P.C. respects the basic rights of patients to personal dignity and independence of expression, decision-making and action. Vivian R. Herndon Counseling, P.C. also expects behavior on the part of the patient, as well as their relatives, to be reasonable and responsible.

PATIENT RIGHTS:

- To access services or accommodations that are available or medically indicated regardless of race, creed, sex, age, national origin, religion, disability or source of payment for care.
- To receive considerate, respectful care at all times, in all circumstances with recognition of personal dignity.
- To have personal and informational privacy, within the guidelines of applicable federal, state and local laws.
- To expect reasonable safety in the clinic practices.
- To know the identity and professional status of those providing care.
- To participate in decisions involving health care. Appropriate consent must be obtained for treatment including an explanation of risk and benefits. Patients may refuse, consent to, or limit treatment to the extent permitted by law. When refusal of treatment prevents the provision of appropriate care in accordance with ethical and professional standards, the relationship with the patient may be terminated upon reasonable notice.
- To consult with a specialist at their request and own expense.
- To have the right to qualified adult interpreters and/or communication equipment as necessary for effective communication. These services will be provided at no charge to the patient.
- To have the right to obtain complete and current information concerning diagnosis and treatment and to participate in care decisions. When it is not advisable or possible to give such information to a patient, the information may be made available to the patient's legal representative.
- To be billed only for services provided. Patients have the right to request and receive an itemized explanation of the entire bill, regardless of the source of payment.

PATIENT RESPONSIBILITIES

- To provide, to the best of their knowledge, accurate and complete information about their present complaints, hospitalizations, medications, changes in condition and other matters relating to their health.
- To comply with the treatment plan recommended by their approved and licensed practitioner.
- To keep appointments and to follow the cancellation policy.
- Patients are responsible for their own actions if they refuse treatment or refuse to follow the practitioner's instructions.
- To assure that the financial obligations of their health care are fulfilled as promptly as possible.
- To be considerate of the rights of other patients and clinic personnel. Patients are also expected to respect the property of others and the clinic.

Patient Signature: _____

Date: _____

Vivian R. Herndon Counseling, P.C.
8424 West Center Road, Suite 203
Omaha Nebraska, 68124
402-659-4742

Credit Card Payment Policy

In an attempt to keep our client's accounts up to date, we have implemented a very successful system of payment. By having your credit card information on file, we can efficiently update your account after each session.

In addition, the cancellation policy requires that 24-hour notice be given if it is necessary to cancel or change an appointment. At the discretion of the doctor or therapist, the following charges may be applied:

First late cancellation or failure to show for an appointment - $50
Second late cancellation or failure to show - $75
Third or more cancellations or failure to show - $100

I have been made aware of this policy and understand that my credit card may be charged for these fees. I also understand that my insurance will not cover cancellation charges.

I authorize Vivian R. Herndon Counseling, P.C. to charge this account for co-pays and cancellation fees as explained above.

Credit Card Information

Card Number _____

Visa/MC Expiration Date (Mo/Yr) _____ 3-digit CID _____

Name of Card Holder _____

Address of Card Holder _____

_____ _____
Signature of Cardholder Date

If you have any question about this policy, please discuss it with your therapist.

Vivian R. Herndon Counseling, P.C.
8424 West Center Road Ste 203
Omaha, NE 68124
Phone: 402-659-4742

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 INFORMATION 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, or future physical or mental health or condition and related health care services are 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 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 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, or 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: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care 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. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed 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 the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

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 those that are:

- Required by Law, such as mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as mental health licensing board or 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.

Verbal permission: We may use or 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.

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 Vivian R. Herndon, LIMHP:

*** Right of access to inspect and copy:** You have the right, which may be restricted only in exceptional circumstances, 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. Your therapist may ask that you access this information in a scheduled session.

*** 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 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 twelve month period.

*** Right to request restrictions:** You have the right to request a restriction or limitation on the use or disclosure of your PHI treatment, payment, or health care 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 medical matters in a certain way or at a certain location.

*** Right to a copy of this notice:** You have the 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 with Vivian R. Herndon Counseling, P.C., or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is July 9, 2012

Vivian R. Herndon Counseling, PC
8424 West Center Road, Ste. 203
Omaha, NE 68124
Phone: 402-659-4742 Fax: 402-934-7680

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name: _____
DOB: _____
SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Vivian R. Herndon Counseling, P.C.'s Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Vivian R. Herndon, LIMHP.

Signature of Patient/Client Date

Signature of Parent/Guardian/or Personal Representative* Date

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, etc.)

___ Patient/Client Refuses to Acknowledge Receipt:

Signature of Staff Member Date