Vision Focused Counseling, LLC

Today's date: _____

Full Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Phone ( )_____ Email: _____

(Calls will be discreet, but please indicate any restrictions for contacting you, including days or times.)

_____

Who suggested you contact me? _____

May I have your permission to thank this person for the referral? Yes No

Employer: _____

Your medical doctor or clinic: _____
Phone: _____
Insurance Company_____ ID Number _____
Group Number _____ Phone number listed on back of card _____
Deductible _____ CoPay_____

Please list any significant health problems from your past or for which you currently receive treatment. _____
Are you currently taking any medications? Yes No
If yes, please list the appropriate dosages, how often you take them, and who prescribes them to you:
_____
_____

Have you had prior counseling, treatment, or assessment elsewhere? Yes No If yes, please describe:
_____

Have you ever been hospitalized for mental health reasons? Yes No

If yes, when? _____

Briefly describe the difficulties which brought you in today.
_____

Describe the ways that your concerns currently interfere with your personal and/or professional life.
_____

Please add any additional information that you feel may be useful:
_____

Vision Focused Counseling, LLC

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction. but if we do. we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

5221 S 48th St #7A Lincoln NE 68516 402-217-0600 FAX 833-815-2407
www.visionfocusedcounseling.com Email: visionfocusedcounseling@gmail.com

In the Interest of Transparency

Welcome! I appreciate you. I hope this form gives you comfort and confidence about coming into my practice.

Confidentiality

It is your legal right that I keep our sessions and my records completely confidential. I will tell no one what you tell me. I will not even reveal that you are receiving services from me. If I see you in a store, I will not acknowledge you. (No offense.) 😊
Your confidentiality is protected by state law and by the rules of my profession. However, there are some situations that arise:
1. If you make a serious threat to harm yourself or another person, I have to report this to the appropriate authorities.
2. When there is information that leads to a reasonable suspicion of child abuse or abuse of a vulnerable adult, I have to report it.
3. When a court orders me to disclose, or when required in conformity to state or federal laws, information may be released.
4. If you sign a release of information, such as your insurance company/doctor inherent in your contract with them.
5, If there is a medical emergency during our session, information may be disclosed to medical personnel to help you.

About Our Appointments

An appointment is a commitment to your healing. I would appreciate it very much if you can let me know when you must reschedule or cancel an appointment *at least* 24 hours in advance. Scheduled appointments that are missed without any notice (except for situations that both of us can agree are unpredictable emergencies) will be billed the no-show fee ($30.00).

Fees, Payments, and Billing

Payment for services is important in any professional relationship. I wish to keep our relationship free from any collection agencies. As a result, I think it is important to take care of all co-payments at the beginning of our time. My current regular fees are as follows:

Therapy Services: For an appointment of 60 minutes, the fee is $150.00. For family counseling, the fee is $200.00 per session. I conduct drug and alcohol evaluations and the fee is $300.00. Occasionally, I have enough clients to form a therapeutic group or educational class and the fee is $100.00 for 6 weekly group sessions. Any alternative payment plan arrangements are encouraged because I want to work with your budget. Mental healthcare should be financially unattainable.

Health Insurance Coverage and Payments

Because I am a licensed professional, many health insurance plans will help you pay for therapy, assessments, and other services I offer. I am glad to help with your insurance claim submissions when necessary. At the same time, your insurance contract is between you and your company. I encourage you to speak with your insurance company to verify your coverage and to discuss any pre-authorizations, deductibles, and fee arrangements. All co-payments, co-insurance are due at the time that services are provided.

Generally, your health insurance company will receive only my statement. This gives the dates of our appointments, my charges, and an agreed upon diagnosis. It will become part of your permanent medical record. As part of cost control efforts, an insurance company will sometimes ask for more information on symptoms, diagnoses, and my treatment methods. I will let you know if this should occur and what the company has asked for. If you are concerned about the confidentiality of your insurance records (or Life Insurance concerns) or if any other issues regarding confidentiality are a concern to you, please bring these up and we can discuss them to your satisfaction.

If You Have a State or Federally Funded Healthcare Contract

If you are a member of Medicaid and/or Medicare programs, some decisions about what kind of care you need and how much of it you can receive will be reviewed by the administrators. The plan has rules, limits, and procedures that we should discuss. Please bring your health insurance plan's description of services to one of our early meetings, so that we can talk about it and decide what to do.

In order to help you with any health insurance benefits, I will have to send information about you to your managed care company (if you have one) or to an agent of your insurance company. These companies are increasingly asking for more information about clients and will want to know about your problems, symptoms, family and work life, and so forth. This information will be reviewed by the staff of the insurance and managed care companies. If you are concerned about loss of confidentiality, lack of control over your treatment, or the possible negative impact of a required psychiatric diagnosis, please bring these issues to my attention and we can discuss treatment and payment options.

Emergencies

When you call my work number, 402-217-0600, you will either speak with me directly, or you will get my confidential voice mailbox. If you get my voicemail, feel free to leave a detailed message. Also, be sure to provide a phone number where I can reach you later when I am available.

If you have a behavioral or emotional crisis and cannot reach me immediately by telephone, I recommend that you and/or your family members call the Crisis Line, 988. In Lincoln the number is 402-475-6695. The Crisis Line is staffed by caring individuals who are available 24 hours a day to talk with you and provide assistance during an emergency. The Crisis Line is equipped to make referrals to appropriate emergency care centers throughout Lancaster County. If needed, please consider Bryan West Emergency room if you do not feel safe. They are there to care and help and conduct a professional evaluation, to make suggestions.

My Emergency Contact: _____ Relationship: _____

Our Agreement

I, the client, have read the material presented above. I agree to enter into a therapeutic relationship and/or engage in an assessment according to the points covered in this handout. I understand that any of the issues mentioned can be discussed and may be open to change. If at any time during our time together I have questions about any of the subjects discussed in this handout, I can raise these concerns and have them discussed until I am satisfied. I understand that after therapy or assessment begins, I have the right to withdraw my consent to therapy at any time, for any reason. I affirm, however, that I will make every effort to discuss concerns about my progress with therapist before ending therapy. By signing below, I indicate my commitment to my Self and giving my best efforts to my Self.

_____ _____

Signature of client Date

_____

Printed Name

I, the therapist, believe that this client understands the issues and is fully competent to give informed consent to be cared for and treated. I agree to enter into therapy/conduct assessment with the client, as shown by my signature here.

_____ _____

Signature of Therapist Date

I truly appreciate the chance you have given me to be of professional service to you, and look forward to a healing experience and relationship with you. If you are satisfied with my services, please suggest to others that they are also worth it!

Vision Focused Counseling LLC 5221 S 48th St. #7A Lincoln, NE 68516 402-718-8467

Authorization for Release of Information

Client's Name: _____ Date of Birth: _____

Address: _____

City: _____ _____ State: _____ Zip: _____

I authorize the following person or organization to:

☐ Receive Information from VFC ☐ Provide Information to VFC ☐ Both Receive and Provide Information

Name: _____

Address: _____

City: _____ _____ State: _____ Zip: _____

Phone: _____ Fax: _____

The type and amount of information to be used or disclosed is as follows (include dates where appropriate):

- ☐ Complete records
- ☐ Immunization record
- ☐ IEP/IFSP/IPPreports
- ☐ Consultation reports
- ☐ PT/OT/Speech therapy summaries
- ☐ Behavioral assessments and/or progress notes
- ☐ Lab results/x-ray reports
- ☐ Admission or discharge summaries
- ☐ History/Physical exam (H&P report)
- ☐ Psychological or psychiatric evaluation(s)
- ☐ Communication related to care and treatment
- ☐ Other: _____

_____

I understand that the information in my child's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

For the purpose of:

☐ Ongoing communication for specialized care provided by Vision Focused Counseling LLC services

☐ Other _____

I understand that I have a right to revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of VFC. If I do this, it will prevent any releases after the date it is received but can not change the fact that some information was sent or shared before that date. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand and agree that this Authorization will be valid and in effect until _____ (one year) unless I choose to revoke it. I understand that after that date, no more information can be used or released to VFC unless I sign a new Authorization like this one.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an authorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____

Signature of client Date

_____ _____

Signature of parent/guardian Signature of Counselor

Client Rights and Responsibilities

A client has a right to the following:	
1.	To respectful, compassionate care
2.	To refuse treatment
3.	To be informed of your progress
4.	To have knowledge of the names and professional status of all staff and counselors
5.	To the consideration of your privacy and individuality with respect to treatment plans
6.	To be fully informed of the charges for available services at the time of admission
7.	To participate in planning your treatment program
A client has a responsibility for the following:	
1.	To be honest about current (and historically significant) events, thoughts, feelings, and behaviors that relate to you as a client
2.	To attempt to understand the problem and follow the direction offered by staff
3.	To be considerate, respectful of the rights of others, their property, and objects in VFC
4.	To honor the confidentiality of other clients (Examples: in group and waiting area)
5.	To keep appointments and arrive on time for appointment and if cancellation is necessary, to call at least 24 hrs. in advance or a fee of $30.00 will apply
6.	To comply with the policies and expectations of VFC
7.	To voice complaints and recommend changes in policies and services at VFC using the grievance procedure
As a State certified counselor/agency, our goal is to provide the highest quality of services possible. We can only be as good as our communication with you, the client. Please let us know of any concern or informational feedback you have for our office. We appreciate your honesty and look forward to working with you to achieve your goals. Signing below indicates that you have read and understand this information.	

Grievance Procedure: Grievances should be addressed by the client with their therapist. If the concerns are not addressed and the problem continues, the client will be asked to put their complaints in writing to be delivered to the Owner/Director of VFC or the appointee if such grievance is against the Director. The grievance will be investigated immediately. A written answer will be given to the client within five days. If the client is not satisfied with the answer, they may present the complaint to the Administrator of VFC. At any time, the Nebraska Licensing Department can be notified of the complaint.

- I have reviewed the client rights and responsibilities and understand the grievance procedure should I have a complaint.

Client Signature:	
Date:	
Counselor Signature:	
Date:	

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	