CLEARWATER COUNSELING, PC

MENTAL HEALTH SERVICES

Client Demographic Information

Name: Last _____ First _____ M.I. _____

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

Home Phone: _____Work Phone: _____ Cell: _____

Email Address: _____Please note if it is not okay to contact you via any of these methods.

Birth Date: _____ Sex: M _____ F _____ Transgender_____ Non-binary _____

Marital Status: Married _____ Single _____ Divorced _____ Live-in _____

Payment for Services Information

Check here for **private payment** without health insurance: ____ at a rate of ____ per session Insured's

Employer's Name: _____

Insured's Employer's Address: _____

Primary Insurance: _____

Policy #/Member ID #: _____ Group #: _____

Name of **Insured & Relationship** to Client: _____

Address of Insurance Company: _____ Phone #: _____

_____ _____

Signature of Client Date

_____ _____

Signature of Insured and/or legal guardian Date

312 N. Elm St., Suite 112, Grand Island, NE
12127 Pacific St. Omaha, NE
t: 308-210-8487
f: 844-270-3685
info@clearwatercounselingne.org
www.clearwatercounselingpc.org

CLEARWATER COUNSELING, PC

MENTAL HEALTH SERVICES

Consent to Treatment

Welcome to our practice
We offer services to people of all ages, including individual, group, family and marital/couples therapy. We provide referrals for issues beyond our expertise, as well. Except in an emergency, services are by appointment only.

We expect and encourage you to obtain knowledge of the procedures, goal and possible side effects of psychotherapy and counseling. We will keep you informed about treatment alternatives available to you. You have the right to refuse or question therapeutic procedures and your therapist may terminate treatment at any time. However, we encourage our clients to schedule a closing session.

There are some risks related to treatment. They may include: intense and unwanted feelings, recollections or unpleasant life events, having unpleasant thoughts, questioning values and personal beliefs and changes in relationships. It is important to remember that these feelings and experiences may be natural and normal. Therapy and counseling may result in other major life decisions related to family living arrangements, employment and lifestyles. These changes may result from closer examination of one's beliefs and values. They are legitimate and outcomes of the therapy and counseling experience.

I acknowledge that I have been given the opportunity to review my rights in the therapeutic and professional relationship as described in the document "Patient Information and Financial Policies" and have been given the opportunity to ask questions. I consent to take part in the treatment by the licensed independent contractors at Clearwater Counseling, PC. I understand that the practices are not an exact science and I acknowledge that no promises have been made to me as to the results of treatment provided by Clearwater Counseling, PC or its independent contractors. I am aware that I may stop my treatment at Clearwater Counseling, PC at any time. Fees are subject to change at the discretion of Clearwater Counseling, PC. A fee schedule is available upon request.

I voluntarily consent to mental health treatment from the providers and staff at Clearwater Counseling, PC. No guarantees have been made to me regarding the results of treatments. I consent to the use and disclosure of protected health information about me for treatment and payment. I have read this form, and I have had the opportunity to ask questions and receive answers to those questions.

_____ (initial)

I understand that I am financially responsible for my treatment as the client, guardian, conservator or insured for all charges not covered by the above assignments. I understand that it is my responsibility to know my health insurance benefit information. Clearwater Counseling, PC is not responsible for knowing your particular health insurance benefit information.

_____ (initial)

CLEARWATER COUNSELING, PC

MENTAL HEALTH SERVICES

Patient Information and Financial Policies

About Clearwater Counseling, PC
Clearwater Counseling, PC is a mental health services provider serving the Omaha, Lincoln and Grand Island area. The private practice was founded on the idea that all individuals deserve access to quality mental health services in order to live happier and healthier lives. Our experienced team of professionals offer services to children, adolescents and adults who have been diagnosed with mental health disorders. Through personalized and compassionate care, our therapists aim to treat mental health diagnoses while promoting growth, development and well-being.

As with any treatment, services at Clearwater Counseling, PC come with risks and benefits. You should always consider the risks and benefits when making decisions regarding your health. Please discuss these with your provider. We are available to help you through difficult times, make recommendations and support you in finding the best treatment approach for you. Please initial next to each section below, indicating that you understand these policies.

_____ Confidentiality

Clearwater Counseling, PC will treat with great care all of the information you share. In order to provide the highest quality of care, treatment at Clearwater Counseling, PC may involve communication and/or collaboration with any of the providers at Clearwater Counseling, PC. It is your legal right that your sessions and record be kept private. We ask that you sign an Authorization to Release and Receive Information form before communicating with or sending any records to anyone outside of Clearwater Counseling, PC. There are some situations in which your confidentiality is not protected. The following are the most common:

- If you are sent by court for evaluation or treatment. The court will often expect a report.
- If you are being sued or suing someone else, the court or an attorney may ask for your records from Clearwater Counseling, PC.
- If you make a threat to harm yourself or others or there is any concern about someone's safety the law and our ethics require that we try to protect anyone from harm. This may involve reporting the threat.

_____ Appointments and Scheduling

- The length of treatment and frequency of sessions varies for each individual and your unique set of circumstances.
- Please arrive on time. If you are late, your provider may not be able to meet with you and you will be asked to reschedule. You may be charged a late cancellation fee.

_____ Medical Records, Forms and Letters

- There is a minimum $20 fee for medical records or for the company to write letters on your behalf.
- The first year after discharge, medical records are free of charge, and letters written on your behalf will have a minimum $20 fee.
- A signed letter of release or request form may be required to process the form or letter.
- Please allow 7-10 business days to complete forms or letters.

_____ Communication and Social Media

- We want to make communication with you as convenient as possible and know that technology can be a wonderful resource. Unless otherwise indicated, we will communicate with you about scheduling via phone, email and texting.
- We encourage you to like/follow us on Facebook for news and information, however you are not required to do so. For your privacy, our practitioners do not accept invitations on their private accounts but we are happy to connect with you via Facebook message on the Clearwater Counseling, PC page.

_____ After Hours Telephone Services

- We ask that you schedule a face-to-face appointment, as this is always best.
- If you feel that you are experiencing a life threatening emergency, go to your nearest emergency department or dial 911.

_____ Discharge from the Practice

If you are "discharged" or "dismissed" from the practice, it means you can no longer schedule appointments or consider us to be your provider. You will have to find another practice for your services. Common reasons for dismissal include the following:

- Failure to keep appointments or frequent cancellations (3 cancellations in a row)
- Noncompliance or failure to follow provider instructions about an important health issue
- Abusive to staff
- Failure to pay your bill

Financial Policies
Understanding your financial responsibilities is important to your financial health and an essential element to your treatment at Clearwater Counseling, PC.

_____ Co-payments, Deductibles, and Fees

- All co-payments, insurance deductibles, and fees for service not covered by insurance are due at the time of service.
- We accept cash, personal checks, and credit cards. Payments are also accepted by phone and online via the patient portal. Note: Please ask your provider to set up patient portal for you.

_____ Minors and Patients with Divorced Parents

- Whoever (parent, grandparent, babysitter, etc.) accompanies a minor to his/her appointment is expected to bring payment at the time of service.
- For separated or divorced parents, payment is expected from the parent bringing the child in for treatment. We will not bill another parent for payments due at time of service; regardless of which parent is responsible for insurance.

_____ Insurance

- Your insurance policy is a contract between you and your insurance company. It is your responsibility to know and understand the provisions, limits, and requirements of your individual benefit plan(s).
- We will file your insurance claim for you; however, we cannot guarantee benefits or payments. You remain financially responsible for all services provided by this office.
- If your insurance carrier denies payment for services, you remain financially responsible for payment regardless of any insurance company determination, quote, or misquote, except where prohibited by law or prior contractual agreement.
- Please bring your current insurance card to each visit and notify our staff of any changes in your coverage, address, telephone or family status.

_____ Private Pay/Cash Discounts

- Because there are fees associated with billing insurance companies and third party payers, we offer a discounted rate for insurance eligible services when you choose to pay privately.
- When using this option, it is expected that you pay at the time of service, which further reduces the cost of sending statements.

_____ Credit Card Agreements

We are able to securely store your credit card information and automatically deduct any charges. Please ask your provider to set this up for you if you are interested.

_____ Billing Statements

- The balance on your statement is due and payable upon receipt. In order to avoid any financial stress, we ask that you pay your balance within 30 days. After this period, it is considered past due.
- If the balance is not paid in full or other arrangements made with our office, the receptionist will not be able to schedule an appointment with you. You will have to talk with your provider about scheduling.
- Payments can be made in person, by mail, by phone or online via the patient portal.

_____Past Due Accounts

- If your account balance is overdue by sixty (60 days) or more or you make no attempt to set up a payment plan, future appointments will be cancelled until account balance is paid.
- If your account must be sent to a collection agency, you will be responsible for account balance, plus any fees charged by collection agency.
- Financial noncompliance may result in termination from the practice.

_____ Returned Checks

- There is a $25 charge for checks returned for insufficient funds.

_____ Cancelled, Late, and Missed Appointments

- There is a $75 fee for cancellations made less than 24 hours in advance of the scheduled appointment. This fee is not covered by insurance and must be paid prior to your next appointment.
- There is a $75 fee for missed appointments. This is not covered by insurance and must be paid prior to your next appointment.
- Patients who arrive more than 15 minutes past their scheduled appointment time may need to be rescheduled and will incur a missed appointment fee.
- It is important that we provide time for all patients receiving treatment at Clearwater Counseling, PC. If there are numerous no-shows or you are habitually cancelling/rescheduling your appointments, we may not be able to continue scheduling you.

_____ Questions

It is important that you understand the expectations of your treatment and work at Clearwater Counseling, PC. Please let us know if there is anything in this document that you do not understand or if you have any questions. We will provide assistance.

Acknowledgement

I have read and understand the policies of Clearwater Counseling, PC and its independent contractors. I agree to be bound by its terms.

I agree to assign insurance payments to be made directly to Clearwater Counseling, PC for services rendered.

_____ _____

Client/Guardian Signature Date

_____

Client/Guardian Name (Printed)

_____ _____

Provider Signature Date

CLEARWATER COUNSELING, PC

MENTAL HEALTH SERVICES

Fee Schedule for Therapy and Services

Service	Fee
Initial interview and assessment	$265
Substance Abuse Evaluation	$265
Co-Occurring Evaluation	$426
Individual psychotherapy and/or counseling	$220 (47-53 minutes)
	$170 (39-46 minutes)
	$120 (30-38 minutes)
Family psychotherapy and/or counseling	$190 (45-50 minutes)

Other Services	Fee
Telephone conferences with you or your attorney	$50 per 1/4 hour
Letters written on your behalf	$50 per 1/4 hour
Court appearances and depositions	$300 per hour
Client requested travel for court cases	$80 per hour
Production of records	$35 minimum
No show or late cancellation fee*	$75

**Please note that your insurance company or employee assistance program will not pay for no shows or late cancellations. Payment will be your responsibility. Appointments must be cancelled within 24 hours of scheduled appointments to avoid a late cancellation fee.*

I acknowledge that I have read the above fee schedule and agree to the terms.

_____ _____

Client Signature Date

CLEARWATER COUNSELING, PC

MENTAL HEALTH SERVICES

Notice of Privacy Practices

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 notice carefully.

Your health record contains personal information about you and your health. This information about you that may identify you, which relates to your past, present or future physical or meial health or condition and related health care services, is 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, including the Health Insurance Portability and Accountability Act (HIPAA), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the NASW Code of Ethics. 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 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

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 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 (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 only with your authorization.

Required by Law. Under the law, we must disclose 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. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. It is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with HIPAA.

- **Child Abuse or Neglect.** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

- **Judicial and Administrative Proceedings.** We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

- **Deceased Clients.** We may disclose PHI regarding deceased clients as mandated by state law, or to a family member or friend that was involved in your treatment or payment for treatment prior to death, based on your prior consent. A release of information regarding deceased clients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons who have been deceased for more than fifty (50) years is not protected under HIPAA.

- **Medical Emergencies.** We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

- **Family Involvement in Care.** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

- **Health Oversight.** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

- **Law Enforcement.** We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

- **Specialized Government Functions.** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

- **Public Health.** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

- **Public Safety.** We may disclose your PHI if 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.

- **Research.** PHI may only be disclosed after a special approval process or with your authorization.

- **Fundraising.** We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

- **Verbal Permission.** We may also use or disclose your information to family members who 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 at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

_____ _____

Client Signature Date

_____ _____

Provider Signature Date

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 12127 Pacific St. Omaha, NE 68154.

- **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 is maintained in a "designated record set." A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your treatment. 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 or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- **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. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact us if you have any questions.

- **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 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 treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

- **Right to a Copy of this Notice.** You have the right to a copy of this notice. If you believe we have violated your privacy rights, you have the right to file a complaint in writing to our office at 12127 Pacific St. Omaha, NE 68154, 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 March 2020.

_____ _____

Client Signature Date

CLEARWATER COUNSELING, PC

MENTAL HEALTH SERVICES

Notice of Consent to Treatment
Receipt and Acknowledgement of Notice

Client Name: _____

Date of Birth: _____

I hereby acknowledge that I have received and read my copy of the Notice of Privacy Practices. I understand that if I have any questions regarding the Notice, or my privacy rights, I can contact my provider.

_____ _____

Signature of 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, healthcare surrogate, etc.)

_____ Client refuses to acknowledge receipt:

_____ _____

Signature of Staff Member Date

CLEARWATER COUNSELING, PC

MENTAL HEALTH SERVICES

Your Rights as a Client

- Select a professional counselor who meets your needs.
- Receive specific information about your counselor's qualifications, including education, experience, national counseling certifications, and state licensure.
- Obtain a copy of the code(s) of ethics your counselor must follow.
- Receive a written explanation of services offered, time commitments, fee scales, and billing policies prior to receipt of services.
- Understand your counselor's areas of expertise and scope of practice (e.g., career development, adolescents, couples, etc.).
- Ask questions about confidentiality and its limits as specified in state laws and professional ethical codes.
- Receive information about emergency procedures (e.g., how to contact your counselor in the event of a crisis).
- Ask questions about counseling techniques and strategies, including potential risks and benefits.
- Establish goals and evaluate progress with your counselor.
- Request additional opinions from other mental health assessment professionals.
- Understand the implications of diagnosis and the intended use of psychological reports.
- Obtain copies of records and reports.
- Terminate the counseling relationship at any time.
- Share any concerns or complaints you may have regarding a professional counselor's conduct with the appropriate professional counseling organization or licensure board.

Your Responsibilities as a Client

- Adhere to established schedules. If you must miss an appointment, contact your counselor as soon as possible.
- Pay your bill in accordance with the billing agreements.
- Follow agreed-upon goals and strategies established in sessions.
- Inform your professional counselor of your progress and challenges in meeting your goals.
- Participate fully in each session to help maximize a positive outcome.
- Inform your counselor if you are receiving mental health services from another professional.
- Consider appropriate referrals from your counselor.
- Avoid placing your counselor in ethical dilemmas, such as requesting to become involved in social interactions or to barter for services.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

_____ _____

Client Signature Date

My signature below shows that I have explained this statement to the client, and that a copy of this form has been offered to the client.

_____ _____

Provider Signature Date

CLEARWATER COUNSELING, PC

MENTAL HEALTH SERVICES

Court Testimony

Court testimony and the production of records: in the event that your therapist is required to testify at your request, or after receipt of a subpoena, you will be responsible for payment of the therapist's time and travel, at rates described in our fee schedule. If you request, or we are subpoenaed to produce your records, you will be charged at rates described in our fee schedule.

By signing this document, you consent to treatment by Clearwater Counseling, PC and agree that you are individually responsible for the payment of our fees unless we have approved other arrangements in advance. Married couples who both sign this form are each responsible for the payment of fees for services provided to either of them, except for services provided by us after either spouse notifies us in writing that he or she will no longer pay for services provided to the other.

Name of Client(s): _____

_____ _____

Client Signature Date

_____ _____

Client Signature Date

Counselor reviewed and discussed with client: Yes _____ No _____

_____ _____

Therapist Signature Date

CLEARWATER COUNSELING, PC

MENTAL HEALTH SERVICES

Emergency Contact Release Form

Client Name: _____ Date of Birth: _____

Provider/Requester: I hereby authorize **Clearwater Counseling, PC** to release information to the following' person in the event of a medical or mental health emergency:

Emergency Contact Name: _____

Relationship to Client: _____

Address: _____

Phone number: _____

For the purpose of: CARE DURING A MEDCIAL/MENTAL HEALTH (SUICIDAL/HOMICIDAL) EMERGENCY

The information authorized to be released (please initial below):
Any information related to a medical concern or emergency _____
Any information needed to secure safety when suicidal or homicidal _____

I have been told that, in order to protect the limited confidentiality of records, my agreement to obtain or release' information is necessary and that this permission is limited for the purposes and to the person listed above, and' will be effective for one year after the date of my signature. A photocopy or facsimile of this form may be' accepted in lieu of the original signed form. I also understand that this consent is revocable except to the extent' that action has been taken on it already.

I further understand that **Clearwater Counseling, PC** will not condition my treatment on whether I give authorization for the requested disclosure.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature (if child is under age 14) Date

_____ _____
Witness Signature Date

Release valid from _____ to _____

CLEARWATER COUNSELING, PC

MENTAL HEALTH SERVICES

Authorization for the Release of Protected Health Information

Patient Name: _____ Date of Birth: _____

Address (including City/State/Zip)_____

_____

Phone Number: _____ Email _____@_____

Release Information From:	**Release Information To:**
Provider/Facility Name: _____	_____
_____	_____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone: _____ Fax _____	Phone: _____ Fax _____
	Email: _____

Information to be Released: **Service Dates:** From: _____ To: _____

	Clinic				Hospital		Ancillary		Other
☐	Allergy	☐	Neurology	☐	Anesthesia Records	☐	CT/MRI	☐	Immunization Record
☐	Audiology/Cochlear	☐	Ophthalmology	☐	Behavioral Health/IRTC	☐	EEG	☐	Itemized Billing Records
☐	Craniofacial	☐	Orthopedic	☐	Consultation Reports	☐	EKG	☐	Nutrition
☐	Ear, Nose, Throat	☐	Pediatric	☐	Discharge Summary	☐	Lab	☐	School/Work Release
☐	GI	☐	Psychiatry	☐	History & Physical	☐	Sleep Study	☐	Verbal Communication
☐	Internal Medicine	☐	Speech & Language	☐	Operative Report	☐	X-ray		
Other:									

Purpose for which information is to be used:

☐ Treatment/Referral ☐ Insurance ☐ Evaluation

☐ Changing Doctors ☐ Personal/At Request of Patient ☐ Other (Please specify)

State and federal law protect the following information. Please check the box if you want to include this information with your records.

☐ Alcohol, Drug, or Substance Abuse Records ☐ HIV Testing & Results

Release Format: ☐ Paper ☐ CD/DVD **Release Method:** ☐ Mail ☐ Pick up ☐ Fax ☐ Email ☐ Portal

By signing this authorization form, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to Clearwater Counseling, PC at 12127 Pacific St. Omaha, NE 68154. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire in one year from the date signed or on the following date/event/condition of outpatient mental health services, whichever occurs sooner.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.
- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

CLEARWATER COUNSELING, PC

MENTAL HEALTH SERVICES

Patient History

Current Symptom Checklist (Rate intensity of symptoms you or your child are experiencing)

None=This symptom is not present. *Mild*=Impacts quality of life, but no significant impairment of day to day functioning. *Moderate*=Significant impact on quality of life and/or day to day functioning. *Severe*=Profound impact of quality of life and/or day to day functioning.

	None	*Mild*	*Moderate*	*Severe*
Depressed mood	☐	☐	☐	☐
Appetite Disturbance	☐	☐	☐	☐
Sleep Disturbance	☐	☐	☐	☐
Elimination Disturbance	☐	☐	☐	☐
Fatigue/low energy	☐	☐	☐	☐
Psychomotor development delays	☐	☐	☐	☐
Poor concentration	☐	☐	☐	☐
Poor grooming	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐
Agitation	☐	☐	☐	☐
Emotionality	☐	☐	☐	☐
Irritability	☐	☐	☐	☐
Generalized Anxiety	☐	☐	☐	☐
Panic Attacks	☐	☐	☐	☐
Obsessions/compulsions	☐	☐	☐	☐
Bingeing/purging	☐	☐	☐	☐
Laxative/diuretic abuse	☐	☐	☐	☐
Anorexia	☐	☐	☐	☐
Paranoid ideation	☐	☐	☐	☐
Circumstantial Situations (Communication Disorder)	☐	☐	☐	☐
Loose associations	☐	☐	☐	☐
Delusions	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐
Aggressive behaviors	☐	☐	☐	☐
Conduct problems	☐	☐	☐	☐
Oppositional behavior	☐	☐	☐	☐
Sexual dysfunction	☐	☐	☐	☐
Grief	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐
Social isolation	☐	☐	☐	☐
Worthlessness	☐	☐	☐	☐
Guilt	☐	☐	☐	☐
Elevated mood	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐
Dissociative states	☐	☐	☐	☐
Self-mutilation	☐	☐	☐	☐
Significant weight gain/loss	☐	☐	☐	☐
Emotional trauma victim	☐	☐	☐	☐
Physical trauma victim	☐	☐	☐	☐
Sexual trauma victim	☐	☐	☐	☐
Substance abuse	☐	☐	☐	☐
Other (specify)	☐	☐	☐	☐