W E L C O M E

TO THE OFFICES OF

WOODHAVEN COUNSELING ASSOCIATES, INC.

LeaAnn Lape-Brinkman, Ph.D.
Nicholas Battafarano, M.D.
Sheryl Overby, MS, NCC, LMHP
Katherine Merkley, Ph.D.
Joyce Sasse, DNP, APRN, NP, CNS
Stacie Spies-Matz, Psy.D.
Sally Gilbreath, LIMHP, LPC
Shari Conner, Ph.D.
LuAnne Even, Psy.D.
Amber Lawrence, LIMHP, LMFT
Paul Wilken, APRN
Craig Caspari, LIMHP, CMFT, MBA
Mel Brestel, LIMHP, LCSW
Samantha Acosta, LIMHP, LMFT

12001 Q Street Omaha, Nebraska 68137 Phone (402) 592-0328
FAX (402) 592-4170 www.woodhavencounseling.com

GENERAL INFORMATION

Thank you for choosing Woodhaven Counseling Associates, Inc. The following information is provided to acquaint you with our agency policies and procedures. Please note that all of our providers are considered independent contractors working under contract with our agency. As such, your specific provider may have individual policies that differ with those described below. Your provider will discuss this with you and provide you with his or her own written policies.

We encourage you to keep this information for your records; current clients will be informed of any relevant changes.

Business Office Hours

Monday and Friday	9:00 AM to 5:00 PM
Tuesday, Wednesday, Thursday	9:00 AM to 8:00 PM
Saturday (varies)	9:00 AM to 2:00PM

Communication

Phone
In the event that we cannot take your call during business hours, please leave your name, phone number and a brief message. We will return your call as soon as possible. If it is after-hours and your call is an *emergency*, follow the prompts to be connected to the answering service, who will page the on-call provider.

Email
Email communication will be decided upon by you and your therapist.

Texting
Because text messaging is an unsecure and impersonal mode of communication, we do not send or respond to texts.

Social Media
We do not communicate with or contact any clients through personal social media platforms like Twitter, Instagram, or Facebook. Any “friend” requests cannot be honored. This is to protect your privacy and ours, and to keep our relationship strictly professional.

Prescription Refills
If you are calling for a refill on your medication, please contact your pharmacy first. They will contact your provider if needed. This will ensure that refills are handled efficiently.

Appointments

You can expect your appointment to begin promptly. Please check with the front desk if your therapist is more than 10 minutes late. Standard therapy appointments are **45 minutes** in length. If it becomes necessary to cancel your appointment, please notify us as soon as possible. A late cancellation fee of $90 is charged if less than 24 hours notice is given or if you simply do not show for an appointment. We cannot bill insurance for missed or late cancel appointments, and it will be your responsibility to pay the cancellation fee.

Confidentiality

In order to protect your privacy, all information discussed in the context of our work with you stays within Woodhaven Counseling Associates, Inc. and your provider, unless we have your written consent to release information. There are exceptions to this rule, however, which include the following:

> If we believe that a person who is under the age of 19, over the age of 60, or considered disabled is being harmed, we are legally required to report this to the appropriate state agency.
>
> If we believe that you are threatening serious bodily harm to someone else, we are legally required to take steps to protect you and the person at risk.
>
> If we believe that you are at risk of harming yourself we may be obligated to seek additional care, which may mean releasing information without your permission.
>
> In most legal proceedings, you have the right to withhold permission for us to provide any information about your treatment. In some proceedings, a judge may order our testimony via a subpoena.

Minor children (under the age of 19):

Your therapist will provide parents/guardians with general information about treatment status. However, in order to effectively provide care, children and adolescents need to feel that their privacy is being respected. Therefore, although parents/guardians have a legal right to information, it is our policy to maintain your child's privacy. You will, however, be informed if there is any reason to believe that your child is at serious risk of harming him/herself or others.

These issues are taken very seriously and with the intent to maintain everyone's safety. We will make every effort to fully discuss these issues with you before taking any action, to the extent that we're able to do so.

Your Children

For safety reasons, children must be supervised during appointments. If your child or children are not involved in counseling, please make other arrangements for them. We cannot be responsible for supervising unattended children.

Consent to Treat

All adults deemed able to make independent decisions for their care provide their own consent by signing the bottom of this form. In the event that a guardian or caretaker has been legally determined as responsible for providing legal consent, his/her signature will also be obtained.

Treatment for minors (defined as under the age of 19 by Nebraska state law) requires the legal consent of a parent/guardian, unless s/he is legally married or emancipated. In the event that the minor is under the legal custody of two parents, written consent must be obtained from both under most circumstances. Furthermore, **a copy of the divorce decree and/or legal custody arrangement must be provided at the first session.** If you believe that your circumstances warrant an exception to this, please discuss it with your therapist.

Termination

Ending therapy is typically a mutual decision, based on the degree to which your goals have been met. Although you have the right to terminate care at any time, we ask that you let us know this so that we can a) problem-solve, and b) understand that you will no longer be in care and provide alternatives if appropriate.

There are times when your therapist may make a unilateral decision to terminate your care:

(a) When it becomes reasonably clear that a client no longer needs the service, is not likely to benefit, or is being harmed by continued service

(b) When threatened or otherwise endangered by the client or another person with whom the client has a relationship

To the extent that it is appropriate, your therapist will provide pre-termination care and suggest alternative service providers.

Financial Policies

- Payment at the time of each appointment is expected. If special arrangements are necessary, please discuss this with your therapist during the first appointment.
- There will be a service charge of $30 for NSF (bounced) checks.
- We reserve the right to charge for emergency, after-hours telephone calls, and office consultations, should the need for such become time-consuming. Your provider will provide you with information about fees for specific needs, but will generally be $30 per 15-minute increments of work.
- Fees are charged for written letters pertaining to your treatment; specifics also to be determined.
- Copies of your records will be provided to you upon request for a nominal fee.

- As stated above, fees are charged when appointments are cancelled with less than twenty-four (24) hours notice or when a client does not arrive for a scheduled appointment. We cannot legally bill insurance for this, so you will be personally responsible for these fees.

- Failure to pay for services may result in termination of treatment, with a referral for alternative providers. We reserve the right to use legal means to secure payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim.

- When a divorced, non-custodial parent is expected to pay for services to a minor, it is the custodial parent's responsibility to assure that payment arrangements are made. If there is a dispute or problem regarding payment, the parent who requested the services will be held responsible for those fees.

- In the event that your provider or our agency must retain legal consult in order to provide the best possible care for you or to protect our ability to do so, you will be charged for this service.

Insurance/Managed Care

We work with several insurance and managed care companies. Many have their own unique requirements for authorizing treatment sessions. We make every reasonable effort to understand your coverage and help you get the benefits your coverage offers. However, it is the client's responsibility to know and understand the benefits and limitations of your policy. You should know your co-pay amount; your annual deductible amount; your lifetime benefit; whether pre-certification for services is required; and if your coverage limits the maximum number of therapy sessions you can have each year.

Please be aware that most managed care companies take the following position: *The authorization of services is not a guarantee of payment.* **Consequently, you are fully responsible for the portion of the bill not paid by your health care benefits plan.**

Your signature below indicates that you have read the information in this document and agree to abide by its terms.

_____ _____

Signature of Client, Parent Or Guardian

Date

Name of Client (printed) _____

Witness _____

Woodhaven Counseling Associates, Inc.
NEW CLIENT INFORMATION

Date _____ Client No. _____

Client Information

Full Name: _____ Birth Date: _____ Age: _____ Sex: θ- M θ- F

Address: _____ City: _____ State: _____ ZIP: _____

Employer/School:_____ Work/School Phone: _____ Okay to call? θ Yes θNo

Home Phone: _____ Okay to call? θ Yes θNo Cell Phone: _____ Okay to call? θ Yes θNo

Marital Status_____ Social Security Number _____

Religious preference: _____ Highest Grade Completed _____

Has the client had previous counseling/therapy? θ - None θ - Office (outpatient services) θ - Hospital

Is the client taking prescribed medication? θ - No θ - Yes (specify all & Dr.): _____

_____

In Case of Emergency, Contact: Name: _____

Relationship to client _____ Day Phone: _____ Evening Phone: _____

Who may we thank for referring you to us? _____

If the client is a minor child, a biological parent or legal guardian must complete this section

If the child's parents are divorced, to which parent has the court given custody?

θ - Mother θ - Father θ - Joint θ - Other _____

Your Name: _____ Birth Date: _____ Age: _____ Sex: θ- M θ- F

Address: _____ City: _____ State: _____ ZIP: _____

Employer : _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____

Marital Status: _____ Social Sec. Number: _____ Your Relationship to client:_____

If applicable, please list name and contact information for the non-custodial parent:_____

_____

If applicable, please list name and contact information for child's caseworker:_____

Family Information

Please list everyone living in the client's home:

Name	Age	Sex	Relationship	Name	Age	Sex	Relationship
_____				_____			
_____				_____			
_____				_____			

Does the client have children who are not living in the home? θ - No θ - Yes

Insured Person's Information

Full Name: _____ Birth Date: _____ Age: _____ Sex: θ- M θ F

Address: _____ City: _____ State: _____ ZIP:_____

Employer: _____ Work Phone: _____ Home Phone: _____

Marital Status: _____ Social Sec. Number: _____ Relationship to client:_____

Insurance ID or Group No.: _____ Insurance Co.: _____

Please Continue on Other Side of Form

Consent for Treatment

I _____ (name of patient), agree and consent to participate in behavioral health care services offered and provided at/by Woodhaven Counseling Associates, Inc., a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of nineteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

_____ _____

Signature of Client, Parent/Guardian Date

Relationship to Patient (if applicable):_____

Consent for Use and Disclosure of Health Information

I give my consent for the use or disclosure of mine or my child's protected health information (PHI) by the staff of Woodhaven Counseling Associates, Inc. for the purpose of treatment, payment, and healthcare operations. By signing this form, I am agreeing to let WCA, Inc. use my information and send it to others. The Notice of Privacy Practices explains this in more detail. **I have received the Notice of Privacy Practices and understand I should read it before signing this consent.**

- ✧ I understand that if I do not sign this consent form agreeing to what is in the Notice of Privacy Practices, WCA, Inc. cannot treat me and/or my child (ren).
- ✧ WCA, INC. reserves the right to change its privacy practices. In this case, all current or revised Notices of Privacy Practices may be obtained from WCA, Inc.'s Privacy Officer.
- ✧ I have a right to request (in writing) a restriction of how my PHI is used or disclosed to carry out treatment, payment, or healthcare operations. WCA, Inc. is not required to agree to the restrictions that I may request. However, if WCA, Inc. agrees to a restriction that I request, the restriction is binding on WCA, Inc. Additionally, I understand that I have the right to revoke this consent, in writing, at any time.
- ✧ My PHI means health information, including demographic information, collected from me and created or received by my physician or health plan. This PHI relates to my past, present or future physical or mental health or condition and identifies me or my child.

_____ _____

Signature of client,
parent or legal guardian Date

_____ _____

Witness Client's Name

❑ Copy given to Client or Parent/Legal Guardian

Woodhaven Counseling Associates, Inc.

CURRENT PROBLEM CHECKLIST -- CHILDREN/YOUTH

NAME: _____ AGE: _____ DATE: _____

Completed by : _____ Relationship to Child: _____

By completing this checklist, you will help us understand your concerns more quickly. For each problem listed: Circle the "Y" if the child has had the problem within the last month. Circle the "N" if the child has not had the problem during the last month. If there is a check box, please check where appropriate.

Y N Doesn't pay attention; is easily distracted
Y N Is forgetful; loses things more than agemates
Y N Can't sit still for long; restless; bouncy; squiggly; fidgets; out of seat at school
Y N Acts too quickly; doesn't think things through

Y N Talks excessively; frequently interrupts others
Y N Loss of interest; does not care about things like he/she used to
Y N Lacks energy, is easily tired or fatigued
Y N Suicidal thoughts; he/she talks about dying; would rather be dead than alive

Y N Depressed; feels blue, low, or down much of the time
Y N Feelings easily hurt; sensitive; feels others don't understand him/her
Y N Shows no guilt; seems not to feel badly after misbehaving
Y N Tense; anxious, very worried or keyed up about various things

Y N Feels like no one cares about him/her; feels unloved
Y N Irritable; moody; easily upset or angered; touchy
Y N Easily angered; temper problems; tantrums
Y N Difficulty getting along- with adults; often argues or verbally fights with them

Y N Difficulty getting along with agemates; often argues or fights with them.
Y N Withdrawn; stays to him/herself;seems to avoid social contact
Y N Difficulty making or keeping friends; no one to play with; picked on
Y N Very shy; avoids people; Uncomfortable with agemates

Y N Sleep problems, such as difficulty going to sleep or staying asleep; nightmares
Y N Reports or appears to see, hear, feel things are not really present
Y N Abuse of: ☐ - alcohol ☐ - drugs/marijuana ☐ - tobacco products
Y N Is attention seeking; demands a lot of parent's or teacher's time

Please continue on the back page

Y N Has poor coordination; is accident prone; hurts self repeatedly.
Y N Does not do as asked; he/she is disobedient; at ☐ home and/or at ☐ school
Y N Academic or learning problems in school; grades below expectations
Y N Misses more school than is really necessary; is often tardy

Y N Steals at ☐ - home, at ☐ - school, or in the ☐ - community
Y N Has run away ☐ - once; ☐ - two or three times; ☐ - more than three times
Y N Has been ☐ - Physically, ☐ - emotionally, or ☐ - sexually abused or victimized
Y N Gets into physical fights with ☐ - agemates, ☐ - parents, or ☐ - other adults

Y N Wets the bed or his/her pants; messes self
Y N Often complains of headaches, nausea or stomach problems; or other ailments
Y N Complains of dizziness, fainting, things spinning; a fear of falling over

Child/youth's overall health is: ☐ - Excellent ☐ - Good ☐ – Fair ☐ - Poor

List major health problems: _____

_____

Woodhaven Counseling Associates, Inc.
12001 Q Street • Omaha NE 68137
Voice: 402 592-0328 • Fax: 402 592-4170 • Email: wca@woodhavencounseling.com

Authorization for Release of Information

My Name (Client): _____ My Date of Birth: _____

Address: _____

City: _____State: _____Zip:_____

I authorize _____ **to communicate with the following person/organization:**

Name: _____

Address: _____

City: _____State: _____Zip:_____

Phone: _____ Fax: _____

I Authorize the Information Release in order to:
☐Receive Information from WCA, Inc. ☐Provide Information to WCA, Inc. ☐Both Receive and Provide Information

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

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

I understand that the information in my or 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.

This Release is for the purpose of:

☐ Ongoing communication for treatment provided by Woodhaven Counseling Associates, Inc.

☐ 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 WCA, Inc.. 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_____ (or up to one year from date below if not specified) unless I choose to revoke it. I understand that after that date, no more information can be used or released to or from WCA, Inc. 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 re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Client Signature of Parent/Guardian/Authorized Legal Representative

_____
Date