

W E L C O M E

TO THE OFFICES OF

WOODHAVEN COUNSELING ASSOCIATES, INC.

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GENERAL INFORMATION

Thank you for choosing Woodhaven Counseling Associates, Inc.. The following information is provided to acquaint you with our policies and procedures.

Business Office Hours

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

Telephone Answering

There are times when we cannot personally answer the telephone. If your call is answered by our recording machine, 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. A therapist will return your call as soon as possible.

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 cancellation is necessary, please notify us as early as possible. A late cancellation fee (50% of the hourly fee) is charged if less than 24 hours notice is given or if a client simply does 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

Information or opinions can be given to others only with your written consent. There is an exception to this rule, however. When there is reason to believe a child or elder has been abused, or if a client threatens self-harm or harm to another person, the law requires that a report be made.

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Your Children

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

Financial Policies

Our priority is to provide you with the best possible service. This service is based on a friendly, business-like understanding between therapist and client. It is felt that misunderstandings can be minimized if financial policies are agreed upon from the very beginning.

- 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.
- Fees are charged for emergency, after-hours telephone calls and office consultations.
- Fees are charged for written letters pertaining to your treatment.
- 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.
- 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 fee payment, the parent who requested the services will be held responsible for those fees.

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.

At the same time, you are responsible 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 precertification of sessions is required; and, you should know 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.**

I have read and agree to the policies outlined in this welcome letter.

Signature of Client, Parent
Or Guardian

Date

Name of Client (printed) _____

Woodhaven Counseling Associates, Inc.
NEW CLIENT INFORMATION

Date _____

Client No. _____

Client Information

Full Name: _____ Birth Date: _____ Age: _____ Sex: - M - F
Address: _____ City: _____ State: _____ ZIP: _____
Employer/School: _____ Work/School Phone: _____ Okay to call? Yes No
Home Phone: _____ Okay to call? Yes No Cell Phone: _____ Okay to call? Yes No
Marital Status _____ Social Security Number _____
Religious preference: _____ Highest Grade Completed _____
Has the client had previous counseling/therapy? - None - Office (outpatient services) - Hospital
Is the client taking prescribed medication? - No - 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?

- Mother - Father - Joint - Other _____

Your Name: _____ Birth Date: _____ Age: _____ Sex: - M - 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? - No - Yes

Insured Person's Information

Full Name: _____ Birth Date: _____ Age: _____ Sex: - M - 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):

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

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