Catalyst
BEHAVIORAL HEALTH

Name (Last) _____ (First) _____ (Middle) _____
Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ Date of Birth: _____ Soc. Sec# _____
Gender/Pronouns: _____ Race: _____
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino Preferred Language: _____
Single: ☐ Married: ☐ Separated: ☐ Divorced: ☐ Widowed: ☐ In a Relationship: ☐

Email Address: _____
Parent/Spouse/Guardian's Name: _____
Emergency Contact: _____ Phone:
Primary Care Physician: _____ Phone:

Do You Have Medical Insurance? Yes ☐ No ☐ **(If Yes Please Answer ALL Questions Below)**
Primary Insurance Company _____
Member ID # _____ Group# _____
Does your insurance require authorization prior to the first session? Yes ☐ No ☐ Not Sure ☐
If yes, have you contacted the company? Yes ☐ No ☐
Policy Holder's Name & Relationship _____
Policy Holder's Soc. Sec#: Policy Holder's Date of Birth:
Policy Holder's Employer's Name _____ Employer's Phone #
Employer's Address _____
Secondary Insurance Co. _____
Policy # _____ Group # _____
Policy Holder's Name & Relationship _____
Policy Holder's Soc. Sec #: Policy Holder's Date of Birth:
Policy Holder Employers Name: _____ Employer's Phone
Employer's Address _____
Responsible Party or Guarantor (if other than patient): _____
Address: _____ Phone:

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature of this document authorizes my physician to submit claims for benefits for services rendered for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize and assign payment of all/any insurance benefits to Apryl Benedict, LICSW that is otherwise payable to me for her services as described on the assigned payment forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Apryl Benedict, LICSW will be credited to my account in accordance with the above assignment.

_____ _____ _____
(Print Name of Client) (Authorized Signature of Client/Parent/Guardian) (Date)

*Note: If the client is under the age of 19, the parent or guardian must sign all legal documents.

Apryl Benedict, LICSW
Paradigm Shift Counseling Services, LLC
2001 Pine Lake Road, STE 200 Lincoln, NE 68512
Phone: 402-261-8313 Fax: 866-259-2325
Creating Positive Change

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BEHAVIORAL HEALTH

Informed Consent

I, _____ (Client/Guardian) hereby give my consent to Apryl Benedict, LICSW, to provide _____ (Client) with mental health services.

_____ I understand that:

- Apryl Benedict, LICSW, will send my medical record information to my insurance company.
- I must pay my share of the costs (e.g., co-pays, amounts until a met deductible, etc.) for mental health services.
- If insurance does not cover mental health services or I am uninsured, I must pay for these services in full.

_____ I understand that:

- I have the right to refuse any treatment.
- I have the right to discuss all treatments with my provider.
- I may be charged for late cancellations or no-show appointments.

_____While I anticipate benefits through treatment, I am aware of unforeseen factors that may hinder my counseling and mental health treatment: I realize that particular results cannot be guaranteed.

_____Counseling and/or mental health treatment may escalate my emotional, mental, or physical conditions and I may experience new stressors during treatment and while attempting to make life changes.

_____If I experience a life-threatening mental health emergency, I am to contact 911 or go to my nearest emergency room. In the event of other emergencies outside of business hours, I am aware that I can contact the crisis line at 800-247-4941.

_____Issues discussed with my clinician will remain confidential, with a few exceptions. There are some special circumstances that limit confidentiality including a) a statement of intent to harm yourself or others; b) statements indicating harm or abuse of children or vulnerable adults; c) issuance of a subpoena from a court of law; d) when your insurance company is involved; e) when you have signed a Release of Information allowing for your information to be discussed with an identified party.

I know of no reason why I should not or cannot undertake this mental health treatment and agree to participate fully and voluntarily.

Print Client Name: _____ **DOB:** _____

Client/Guardian Signature: _____ **Date Signed:** _____

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Billing Policy

Authorization for Treatment
I acknowledge that I have been given the opportunity to review the Consent to Treatment and Confidentiality Statement. I may obtain a current copy upon request. I am aware this authorization to treat does not include court testimony by my provider. I understand that Catalyst Behavioral Health (CBH) has the right to change the Authorization for Treatment at any time.

Acknowledgment of Receipt of Privacy Notice
I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices for Protected Health Information. I may obtain a current copy upon request. I understand that CBH has the right to change the Notice of Privacy Practices at any time.

Office Hours and Phone calls
The office staff is available 9 am-4 pm Monday through Thursday, and 9 am-12 pm on Friday to address any questions or concerns you have. Phone calls received after 3 pm may not be returned until the next business day. We will make every effort to return a phone call as soon as possible, but if your call is urgent, please note that with our office staff or when you leave a message on our confidential voicemail.

Billing Policy/Copayments
I acknowledge that I have been given the opportunity to review my provider's billing policy. I understand that co-pays, if appropriate, must be paid at the time of visit. I understand that I am responsible for all fees not paid by my health insurance. Payment is due 30 days after receipt of the statement. A return check fee will be applied to my account in the case of a returned check. Electronic payment is offered as an option and includes a $5 convenience fee. To avoid paying this additional fee, please use cash or a check made payable to your provider. A 1.33% finance charge will accrue on any unpaid balances that are 90 days or more past due. I understand my provider does offer financial assistance in the form of payment plans. I understand that uninsured/self-pay clients are required to pay for services in full at the time of their appointment before they can be seen. Or if a provider is out of network with my insurance, additional payment arrangements can be made. We reserve the right to submit any unpaid balances to a collection agency for recovery. **Clients are now required to provide a valid credit card at the time of their first initial session for the office to keep in their electronic file.** Once uploaded into our secure system, this information is immediately shredded. This information will be updated yearly or when a card has expired. I understand that if no payment is received within 30 days, payment will be automatically charged to my credit card on file. Cards will not be charged without prior notification, and the opportunity to provide alternate payment will be offered at that time. Billing policies may be updated or modified throughout the calendar year. Please direct any questions about insurance, billing, and payment plans to Gina Pashby, our office manager. (Continued on back)

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Billing Policy (Cont'd)

Provider Rates
At this present time, the fee for the first initial diagnostic interview (CPT Code 90791) is $275 after which the billing rate is $240 per 60-minute session (CPT Code 90837), $225 per 45-minute therapy session (CPT Code 90834), $170 per 30-minute therapy session and $225 per 45-minute family therapy session with or without the patient present (CPT Code: 90847/90846). Apryl Benedict, LIMHP, CMSW reserves the right to raise her rates at any time.

Appointment No-Show Fee
I have been advised that this office requires 24-hour prior notice on all appointment cancellations, and I have reviewed the CBH billing policy. I have been advised that there will be a $75.00 Late Cancel/No Show fee for appointments that are missed or canceled with less than 24-hour notice as required. This fee is not covered by any insurance plan and must be paid prior to my next visit. I understand that three no-show/late cancellations in one year may be the cause for an automatic discharge from the clinic. Exceptions to this policy are solely based on my provider's discretion.

Credit/Debit/HSA Number: _____

Expiration Date: _____

Security Code: _____

Patient/Guardian Signature: _____

Printed Name: _____

Date: _____

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Extended Billing Policy

The fees for services provided by Apryl Benedict, LICSW will be in accordance with the reasonable value set forth by established community guidelines and standards. At the present time, the fee for the first initial 60-minute session, code 90791, is $275, after which the billing rate for a Licensed Independent Mental Health Practitioner provider is $240 per 60-minute individual therapy, code 90837, $225 per 45-minute individual therapy, code 90834, $170 per 30-minute individual session, code 90832, and $225 per 45-minute family therapy session with or without client present, code 90847 and 90846. Apryl Benedict, LICSW reserves the right to raise her rates at any time. Copays are the client's responsibility and are required to be paid at the time of service. Clients are also responsible for any deductible, co-insurance and or out of pocket balances remaining after insurance benefits have been applied. Client statements are mailed out on the first of the month. Electronic payment is offered as an option and includes a $5.00 convenience fee. To avoid paying this additional fee, please use cash or a check made payable to Apryl Benedict, LICSW.

If no payment is received within 30 days of the statement date, a payment will be automatically charged to the client's credit card on file. The client will be notified in advance of the transaction. If payment is not received for two consecutive sessions, the client may not schedule an appointment until the fees owed are paid in full. Balances that are 90 days past due will begin accruing 1.33% finance charges every 30 days. Apryl Benedict, LICSW does offer payment plans to those who need assistance with their balances. Uninsured clients, or self-pay clients are required to pay for services in full at the time of their appointment before they can be seen. Uninsured or self-pay clients are responsible for the first initial session fee of $225, followed by adjusted rates on follow up sessions. Apryl Benedict, LICSW reserves the right to delay, defer, or discontinue services for any reason, including if the balance owed is not paid at the time it is due. Apryl Benedict, LICSW does reserve the right to forward any unpaid accounts to a collection agency to be recovered.

Clients are required to provide a valid credit card at the time of their first initial session for the office to keep in their file. Once uploaded into our secure system, this information is immediately shredded. This information will be updated yearly or when a card has expired.

I understand that I am liable ultimately for the balance on my account for any services provided by Apryl Benedict, LICSW regardless of the status of my insurance situation. With my signature, I agree to adhere to the agency's billing policies and procedures, and to pay any fees that I owe the agency based upon such policies. I hereby authorize direct payment and all benefits due under my insurance policy to Apryl Benedict, LICSW for services provided. I authorize the release of medical or other protected health information necessary to process insurance claims.

Card Information Must Be Provided to the Front Office Previous to the Initial Session

Print Client Name: _____ **DOB:** _____

Client/Guardian Signature: _____ **Date Signed:** _____

*Note: If the client is under the age of 19, the parent or guardian must sign all legal documents.

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Consent to Treat

Authorization for Treatment
I acknowledge that I have been given the opportunity to review the Informed Consent and Patient Rights & Responsibilities. I may obtain a current copy upon request. I understand that Catalyst Behavioral Health has the right to change the Authorization for Treatment at any time.

Acknowledgement of Receipt of Privacy Notice
I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices for Protected Health Information. I may obtain a current copy upon request. I understand that Catalyst Behavioral Health has the right to change the Notice of Privacy Practices at any time.

Office hours and Phone calls
Office staff is available Monday through Thursday, 9am-4pm, and Friday, 9am-12pm to address any questions or concerns. Every effort will be made to return a phone call as soon as possible. If my call is urgent, I will note this with the office staff or when I leave a message on Catalyst Behavioral Health's confidential voicemail.

Appointment No-Show Fee
I have been advised that this office requires a 24-hour prior notice on all appointment cancellations, and I have reviewed the Catalyst Behavioral Health Extended Billing Policy. I have been advised that there will be a $75.00 no show fee for appointments that are canceled with less than 24-hour notice. This fee is not covered by any insurance plan and must be paid prior to my next visit. I understand that three no-show/late cancellations in one year may be cause for automatic discharge from the clinic.

Billing Policy/Copayments
I acknowledge that I have been given the opportunity to review the Extended Billing Policy for Apryl Benedict, LICSW. I understand that co-pays, if appropriate, must be paid at the time of visit. I understand that I am responsible for all fees not paid by my health insurance. Payment is due 30 days after receipt of statement. I understand Apryl Benedict, LICSW does offer financial assistance in the form of payment plans. Uninsured clients or self-pay clients are required to pay for services in full at the time of their appointment before they can be seen. Apryl Benedict, LICSW does reserve the right to submit any unpaid balances to a collection agency for recovery. **Clients are now required to provide a valid credit/debit card at the time of their first initial session for the office to keep in their electronic file.** Once uploaded into our secure system, the information is immediately shredded. This information will be updated yearly or when a card has expired. Cards will not be charged without prior notification and the opportunity to provide an alternate payment will be offered at that time. Please direct any questions about insurance, billing, and payment plans to Gina Pashby, our office manager.

Print Client Name: _____ **DOB:** _____

Client/Guardian Signature: _____ **Date Signed:** _____

*Note: If the client is under the age of 19, the parent or guardian must sign all legal documents.

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Patient Rights & Responsibilities

As a person receiving mental health services here at Catalyst Behavioral Health, you have the right to:

- Be treated with dignity and respect.
- Ask questions and get answers about services offered here to determine the most appropriate treatment program. You can get information about treatment procedures, costs, and risks. You can request a change in your treatment or services as well.
- Participate fully in decisions regarding your health care services. This includes having your family involved in your treatment with your consent.
- Not to be subject to verbal, physical, sexual, emotional, or financial abuse, harsh, or unfair treatment.
- Make complaints, have them heard, get a prompt response, and not receive any threats or mistreatments as a result. You can file a grievance if you are not satisfied with the response to a complaint.
- Be assisted by an advocate of your choice, for example, family, friend, case manager, member of a consumer advocacy committee, or organization, etc.
- Not to be discriminated against on the basis of race, age, gender, religion, national origin, sexual orientation, disability, or marital status.

All clients, to the extent capable, have the responsibility to:

- Pursue healthy lifestyles. Clients should pursue lifestyles known to promote positive health results, such as proper diet and nutrition, adequate rest, and regular exercise. Simultaneously, they should avoid behaviors known to be detrimental to one's health, such as smoking, excessive alcohol consumption, and drug abuse.
- Actively participate in decisions about their health care and cooperate on mutually accepted courses of treatment. Clients should comply with treatment regimens and regularly report on treatment progress. If serious side effects, complications, or worsening of the condition occur, they should notify their providers promptly. They should also inform providers of other medications and treatments that they pursue simultaneously.

Print Client Name: _____ **DOB:** _____

Client/Guardian Signature: _____ **Date Signed:** _____

*Note: If the client is under the age of 19, the parent or guardian must sign all legal documents.

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Telehealth Consent

I, _____ (Client/Guardian), hereby give my consent to my provider to provide _____ (Client) with medically necessary live, interactive video telehealth services located at the following distant site location: 2001 Pine Lake Road, STE 200, Lincoln NE 68512.

I understand that:

a. There are potential benefits and risks of telehealth video services (e.g. limits to patient confidentiality) that differ from in-person services.
b. I retain the right to refuse telehealth video services at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
c. All existing confidentiality protections shall apply to my telehealth video services and I agree to receive an email with a link attached to join telehealth video sessions as appropriate.
d. I shall have access to all medical information resulting from the telehealth communication, as provided by law.
e. Information from the telehealth video services (images that can be identified as mine or other medical information from the telehealth video service) cannot be released to researchers or anyone else without my written consent.
f. If I decline telehealth video services for any reason (e.g. technological difficulties, etc.), I will work with my provider to find alternative treatment options, including telephone sessions or in-person services on a case-by-case basis.
g. I will be informed if this telehealth video service will be recorded.
h. I will be informed if any additional people beyond my provider will be present at all sites during my telehealth video service.
i. I retain the right to exclude anyone from either the originating or distant site.
j. A safety plan is needed that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis situation.
k. My provider may determine that due to certain circumstances, telehealth video services are no longer appropriate and that we should resume our services in person or through other alternative options.
l. This consent is valid for six months for follow-up telehealth video services with this health care provider.

I have read this document carefully and my questions have been answered to my satisfaction.

_____ **DOB:** _____
Print Client Name

_____ **Date Signed:** _____
Client/Guardian Signature *

_____
Emergency Contact **Relationship to Client** **Phone Number**

_____
Email Address (where link to sessions can be sent) **Phone Number (if problems occur)**

*Note: If the client is under the age of 19, the parent or guardian must sign all legal documents. Additionally, if you choose to sign this document electronically, you agree your electronic signature is the legal equivalent of your manual signature on this document.

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Telehealth Patient Rights & Responsibilities for Participation in Telehealth Services

Prior to starting video-conferencing services, we discussed and agreed to the following:

- Confidentiality still applies for telehealth services, and nobody will record the session without permission from the client.
- We agree to use the video-conferencing platform selected for our virtual sessions and the provider will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a private, quiet space that is free of distractions (including cell phones or other devices) during the session.
- It is important to use a secure internet connection rather than public /free Wi-Fi.
- It is important to be on time. If you need to cancel or change your telehealth appointment, you must notify the provider in advance by phone or email.
- We need a backup plan (e.g., a phone number where you can be reached) to restart the session or reschedule it, in the event of technical problems.
- You should confirm with your insurance company that the video session will be reimbursed or covered. If they are not covered, you are responsible for full payment.

What you can expect:

- Therapists are utilizing the platform MYIO which is HIPAA compliant.
- Clients will need to register for an online portal account with MYIO to access their telehealth session.
- Once the provider has initiated/started the session, the client will see a yellow banner on their portal account page which when clicked, will launch the session. If the client logs into their account prior to the clincician starting the session, they will have the option to do a self-check -in.
- If the client attempts to log in more that 15 minutes prior to their appointment, the self-check-in button will not be available.

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NEW CLIENT INTAKE FORM

Name: _____ **Age:** _____ **Marital Status:** _____

Describe the reason for your appointment today?

Have you seen a counselor previously? If yes, please list dates of treatment:	Yes	No
Have you ever had suicidal ideation or attempts? If yes, list approximate dates and if hospitalization was required	Yes	No
Please list any past or current mental health diagnosis.		
Please list any medications you currently are prescribed.		
Who is your primary care physician?		

CURRENT SYMPTOMS CHECKLIST: (check for any symptoms present)

( ) Depressed mood
( ) Unable to enjoy activities
( ) Issues with sleep
( ) Nightmares
( ) Concentration issues
( ) Change in appetite
( ) Excessive guilt
( ) Increased substance use
( ) Anxiousness
( ) Impulsivity
( ) Increased risky behavior
( ) Increased/Decreased sex drive
( ) Angry outbursts
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Excessive Worry
( ) Panic attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) Loss of Interest
( ) Fatigue
( ) Intrusive thoughts

What hobbies or leisure activities do you enjoy?

Please describe your support system. (Family, friends, church, etc.)

What do you hope to gain through your counseling experience?

Do you drink alcohol? Yes No
If yes, how often? Rare Social Occasions Daily Weekly

Do you have any substance abuse history or concerns? Yes No

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Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, or hopeless.	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep, or sleeping too much.	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy.	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating.	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control worrying.	☐ 0	☐ 1	☐ 2	☐ 3
3. Worrying too much about different things.	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing.	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it's hard to sit still.	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable.	☐ 0	☐ 1	☐ 2	☐ 3
7. Feeling afraid as if something awful might happen.	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020