Client Information

Name (Last) _____ (First) _____(Middle Initial) _____

Address: _____ Cell # ( ) _____ - _____

City: _____ State: _____ Zip: _____ Soc. Sec # _____-_____-_____

Date of Birth: _____/_____/_____ Gender/Pronouns: _____ Ethnicity:_____

Single: ☐ Married: ☐ Separated: ☐ Divorced: ☐ Widowed: ☐ In a Relationship: ☐

Email Address: _____

Parent/Spouse/Guardian's Name: _____
Emergency Contact: _____ Phone: (_____) _____- _____
Primary Care Physician: _____ Phone: (_____) _____- _____

Were you referred to our office? Yes: ☐ No: ☐ Referred by: _____

Do you have Medical Insurance? Yes: ☐ No: ☐ (**If Yes Please Answer ALL Questions Below)**

Primary Insurance Company: _____
Member ID #: _____ Group #: _____
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 Company: _____
Member ID #: _____ Group #: _____
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: _____

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 provider to submit claims for benefits for services rendered without obtaining my signature on 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 claim. I authorize and assign payment of all/any insurance benefits to KLR Counseling, LLC that is otherwise payable to me for his 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 KLR Counseling, LLC will be credited to my account in accordance with the above assignment.

* If the client is under the age of 19, the parent/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.

_____ _____ _____

(Printed Name of Client) (Signature of Client/Patient/Guardian) (Date)

KLR Counseling, LLC
Kipp Ransom, LIMHP, LPC
2001 Pine Lake RD STE 200 Lincoln NE 68512
Pho: (402) 261-8313 Fax: (866) 321-6448

Informed Consent

Patient's Name: _____ Patient's DOB: _____

I, _____, hereby give my consent to KLR Counseling, LLC to provide mental health services to me.

And/or I, _____ (Parent/Guardian) to the above-named patient, hereby give my consent for treatment.

I understand that:

- KLR Counseling, LLC, may 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.)
- If I do not have insurance, or if my insurance does not cover mental health services, 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.
- There may be a charge for late cancellations or no-show appointments.
- I am aware this consent does not include court testimony by my provider.

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

Counseling and/or mental health treatment may escalate my emotional, mental, or physical condition; 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 these after-hours crisis line at 1-800-247-4941.

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 me or others; b) statements indicating harm or abuse of children/vulnerable adults; c) issuance of a subpoena from a court of law; d) when your insurance company is involved; e) when you have a signed 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.

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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Billing Policy

Provider Rates

The fees for services offered by KLR Counseling, LLC., 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 diagnostic interview CPT Code 90791 is $290 after which the billing rate for a psychologist is $275 for individual therapy CPT Code 90837, $250 for individual therapy CPT Code 90834, $225 for an individual session CPT code 90832, $275 for a family session with or without patient present CPT Codes 90846 and 90847. KLR Counseling, LLC reserves the right to raise its rates at any time.

PAYMENT:

Clients are required to provide a valid credit card at the time of their initial session for the office to keep on file. Once uploaded into our secure system, this information is immediately shredded. This information will be updated yearly or when a card has expired. Client statements are available for viewing on the Client Portal. If no payment is received within 30 days of the statement date, payment will be automatically charged to the credit card on file. Credit cards will not be charged without prior notification, and the opportunity to provide alternate payment will be offered at that time. Balances that are 90 days past due will begin accruing 1.33% finance charges every 30 days. KLR Counseling LLC does offer financial assistance in the form of payment plans. KLR Counseling, LLC 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. KLR Counseling LLC reserves the right to submit any unpaid balances to a collection agency for recovery. Billing policies may be updated or modified throughout the calendar year. Please direct any questions regarding billing and payment to Gina Pashby, our office manager

Billing Policy/Copayments

I acknowledge that I have been given the opportunity to review my KLR Counseling LLC billing policy. I understand that co-pays, if appropriate, must be paid at the time of our 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 KLR Counseling, LLC, 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. If KLR Counseling, LLC, 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. Once uploaded into our secure system, this information is immediately shredded. This information will be updated yearly or when a card has expired

LATE CANCELLATION/NO-SHOW FEE: KLR Counseling, LLC requires 24-hour notice prior to all appointment cancellations. There will be a $75.00 fee for appointments that are cancelled with less than 24-hour notice or if the client fails to show up to their appointment. This fee is not covered by any insurance plan and must be paid prior to the next visit. Three (3) no-show/late cancellations in one year may be cause for an automatic discharge from the clinic. Exceptions to this policy are solely based on provider's discretion.

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Billing Policy (Cont'd)

ADDITIONAL FEES: If additional reports or meetings not covered by the insurance company are needed, the client agrees to pay for the time it takes to write these reports and/or attend these meetings. Reports that would incur a fee include, but are not limited to disability claims, Workman's Compensation, or review of treatment for an attorney. Meetings that would incur a fee include but are not limited to speaking with an attorney or testifying in court. If I am needed for court, fees may include time lost for cancelled sessions, time for preparation, travel, or waiting.

Appointment No-Show Fee

I have been advised that this office requires 24-hour prior notice on all appointment cancellations, and I have reviewed KLR Counseling, LLC billing policy. I have been advised that there will be a $75 Late Cancel/No Show fee for appointments that are missed/cancelled 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 3 no-show/late cancellations in one year may result in 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 KLR Counseling, LLC, 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 session, CPT code 90791, is $290 after which the billing rate for a Ph.D. provider is $275 for an individual therapy CPT code 90837, $250 for an individual therapy CPT code 90834, $225 for individual therapy CPT code 90832, $275 for family therapy CPT code 90847 and $275 for family therapy CPT code 90846. KLR Counseling LLC reserves the right to raise its rates at any time.

Clients are required to provide a valid credit card at the time of their initial session for the office to keep in their electronic file. 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, or out-of-pocket balances remaining after insurance benefits have been applied. I understand that extended sessions that are over 60 minutes long may not be covered by my insurance, and I am responsible for any amounts not covered by my insurance. Client statements are mailed out on the first of the month. If no payment is received within 30 days of the statement date, a payment will automatically be charged to the client's credit card on file. The client will be notified in advance of the transaction. Electronic payment is offered as an option and includes a $5 convenience fee in addition to your payment for KLR Counseling, LLC processing fees. To avoid paying this additional fee, please use cash or a check made payable to KLR Counseling, LLC. For any returned checks for non-sufficient funds, a return check fee will be applied to your account. 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 KLR Counseling, LLC, 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. KLR Counseling, LLC, does reserve the right to forward any unpaid accounts to a collection agency to be recovered.

Sessions that are cancelled without 24-hour notice will be considered late cancellation. Two late cancellations/no show appointments will be allowed before a warning letter is sent out. After this, an appointment that is not cancelled with 24-hour notice, or any no show appointment will be charged a $75 fee. The client is required to pay this fee in full prior to scheduling the next appointment. This charge is also not billed through insurance. Exceptions to this policy are solely based on Kipp Ransom's discretion. Should a client continue their services with KLR Counseling, LLC., that are responsible for the payment of any remaining balance for services rendered. KLR Counseling, LLC., does reserve the right to forward any unpaid accounts to a collection agency to be recovered.

I understand that I am liable for the balance on my account for any services provided by KLR Counseling, LLC., 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 on such policies. I hereby authorize direct payment and all benefits due under my insurance policy to KLR Counseling, LLC., for services provided. I authorize the release of medical or other protected health information necessary to process insurance claims.

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Acknowledgement of Receipt

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 am aware this authorization to treat does not include court testimony by my provider. I understand that KLR Counseling LLC 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 KLR Counseling, LLC has the right to change the Notice of Privacy Practices at any time.

Office Hours and Phone Calls

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

Professionals or Agencies to be Contacted During a Crisis:

Center Point Crisis Response Phone: (402) 475-6695
Suicide Prevention Lifeline Phone: 1(800) 273-8255
Bryan West Mental Health Emergency Center: (402) 481-1111 Address: 2300 S 16th St, Lincoln, NE 68502

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 KLR Counseling, LLC Extended Billing Policy. I have been advised that there will be a $75 no-show fee for appointments that are cancelled 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 3 no-show/late cancellations in one year may result in an automatic discharge from the clinic.

Billing Policy/Copayments

I acknowledge that I have been given the opportunity to review KLR Counseling, LLC Extended Billing Policy. I understand that co-pays, if appropriate, must be paid at the time of our 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. I understand KLR Counseling, LLC., 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. KLR Counseling, LLC `does reserve the right to submit any unpaid balances to a collection agency for recovery. **Clients are required to provide a valid credit/debit card at the time of their first initial sessions 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.

Print Patient Name: _____ DOB: _____

Client/Guardian Signature: _____ Date: _____

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Patient Rights and Responsibilities

As a person receiving mental health services here at KLR Counseling, LLC, 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 service as well.
- Participate fully in decisions regarding your health care service, including having your family involved in your treatment.
- Not be subject to verbal, physical, sexual, emotional, or financial abuse; harsh or unfair treatment.
- Make complaints, have them heard, get a prompt response, and do not receive any threats or mistreatments as a result, or 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 patients, to the extent capable, have the responsibility to:

- Pursue healthy lifestyles. Patients should pursue lifestyles known to promote positive health results, such as proper diet, 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. Patients 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 they are pursuing simultaneously.

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Telehealth Consent

I, _____ (Client/Guardian), hereby give my consent to

KLR Counseling, LLC to provide _____ (Client) with medically necessary live, interactive video telehealth services located at the following distant site location: **2001 Pine Lake Rd, Suite 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 protection shall apply to my telehealth video services and I agree to receive an email with a link attached to join telehealth sessions as appropriate.
d. I shall have access to all medical information resulting from telehealth communication, as provided by law.
e. Information from the telehealth services (images that can be identified as mine or other medical information from the telehealth 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 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.
k. My provider may determine that due to certain circumstances, telehealth 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 services with Dr. Tracy List, Ph.D., LLC.

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

Print Name: _____ DOB: _____

Client/Guardian Signature: _____ Date: _____

Email Address: _____Phone Number: _____

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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 quiet, private 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 through Valant.
- 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 clinician starting the session, they will have the option to do a self-check-in.
- If the client attempts to log in more than 15 minutes prior to their appointment, the self-check-in button will not be available.

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DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	