Insight
Counseling and Recovery, LLC

2908 W 39th Street, Suite B - Kearney, NE 68847 – Phone:(308) 237-0391 – Fax: (308) 708-7452

NEW CLIENT REGISTRATION

DEMOGRAPHIC INFORMATION	Today's Date:
Client's Name:	Marital Status: _____ Married ______ Separated _____ Divorced _____ Single _____ Widowed
Race:	Sex: __________ Male __________ Female
Address / City / State:	
Date of Birth:	Age:

Guardian (if applicable):		
Contact Information:	Home:	Cell:
Emergency Contact:	Name:	Phone:
Current Employment Status:	_____ Unemployed _____ Full-time _____ Part-time _____ Retired _____ Other	
	Employer:	Position:

Insurance Information:	Coverage: ________ Private Insurance __________ Medicaid __________ Medicare
Policy Holder Name / Date of Birth:	
Insurance Company:	
Insurance Identification Number:	Group Number:
Secondary Insurance:	
Insurance Identification Number:	Group Number:
Voucher Eligible / Probation Officer:	

Authorization to Release Information:

I hereby authorize Insight Counseling and Recovery, LLC to release necessary and appropriate medical information to my insurance company(s) as listed above and third party payers(s) in order to process insurance claims for the services rendered. I authorize payment of medical benefits to the provider of services rendered.

Client / Guardian Signature: X ____ Date: ____________________

Financial Policy Information

- Payment is expected for services (minus any reimbursement from insurance) at the time of each appointment, or on a monthly basis after a statement has been issued to you. The amount due is often referred to as your co-pay or co-insurance for services rendered. Interest at the rate of 1.33% per month or the maximum allowable legal rate may be added to unpaid balances that are ***60 days past due***.
- Account balances are not to exceed $300.00. If a balance were to exceed $300.00, a payment plan must be set up and arranged with our office manager before additional appointments can be made.
- I agree to assume the financial responsibility for up to a regular fee charged for a missed appointment or an appointment canceled within less that 24 hours notice.
- In the event that an account surpasses ***120 days past due*** and inquires regarding payment planning have been declined or the arranged payment plan is not followed, credit management services will be utilize for the purpose of collections at that time. Please contact our billing administrator with questions regarding accounts and payment options.

I have read the information listed above regarding the financial policy and I am aware of the expectations regarding payments. I accept responsibility to verify benefits of my insurance policy and coverage for the services rendered.

Client / Guardian Signature: X ______________________________ Date: ____________________

Appointment Reminder Notification:

By signing the line below, I give consent for Insight Counseling and Recovery, LLC to confirm scheduled appointments for the client listed above through an automated reminder, which is provided by TherapyNotes. I understand this system may call or text the number or email address I list below, and leave an automated message reminding me of my appointment.

Preferred Phone: ____________________________ Preferred Email: ______________________________

Client / Guardian Signature: X ______________________________ Date: ____________________

Consent to Treatment: **I consent to participate in treatment and the behavioral health care services offered by Insight Counseling and Recovery, LLC.**

Client / Guardian Signature: X ______________________________ Date: ____________________

***Privacy Policy Notification*: I have received a copy and understand the notice of privacy practices.**

Client / Guardian Signature: X ______________________________ Date: ____________________

Advanced HealthCare Directive Information / Disclosure

As our client: (1) You have the right to give instructions and directions about your own health care, (2) you also have the right to name someone else to make health care decisions for you in the event that you are unable to do so and (3) the Advance Health Care Directive form lets you do one or both these things. It also enables you to write down your wishes about organ donation and primary physician selection.

Would you like additional information regarding the Advance Health Care Directive at this time? ____________ Yes _____________ No	If yes, client and witness initial that this information has been given to client: __________ __________

Coordination of Care Information

As part of your care, our facility and clinicians believe it's beneficial to coordinate and collaborate with others when it is indicated and authorized. As you receive behavioral health services in our facility, it is beneficial to coordinate and communicate with your primary care provider (PCP) in addition to other providers that you're working with to ensure that you are receiving quality care. The protected health information (PHI) disclosed may include but is not limited to diagnosis, treatment planning, and medical information as deemed appropriate. As our client, please select one of the following options listed:

_____ Yes. I would like you to notify my primary care physician (PCP) that I am receiving behavioral health services at Insight Counseling and Recovery, LLC; I am aware that I will sign a release of information.

_____ No. I waive my right at this time to notify my primary care provider (PCP) that I am receiving behavioral health services at Insight Counseling and Recovery, LLC.

_____ At this time, I do not have a primary care provider (PCP) and do not wish to be referred to see one at this time.

Client / Guardian Signature: X ______________________________________ Date: ___________________

Informed Consent Regarding Telehealth Services

If you chose to utilize telehealth service options, you acknowledge there is an increased risk for exposure of your private health information. We will utilize secure telehealth platforms to reduce the risk regarding exposure due to technology use and will only conduct telehealth sessions where confidentiality can be reasonably assured. We do ask you consider the location you choose to receive services to minimize any risk of exposure of your confidential information and that you have access to adequate support if a safety issue were to arise.

By signing below, I acknowledge I understand the risk of telehealth services, have had the opportunity to ask questions of my provider regarding telehealth services and agree to receive telehealth services if this is mutually agreed upon by myself and provider. As our client, please select one of the following options regarding telehealth:

_____ Yes. I consent to utilizing telehealth services and acknowledge this is based upon provider preference.

_____ No. I waive my option to utilize telehealth services.

Client / Guardian Signature: X ___________________________________ Date: _____________________

DISCLOSURE OF CLIENTS RIGHTS AND RESPONSIBILITIES

Clients have the right to:

- Be treated with dignity and respect by all clinical and administrative staff of Insight Counseling and Recovery, LLC.
- Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have your treatment and records kept confidential.
- Inquire about and ask your provider about their work history, training, education background, and qualifications.
- Freely file a complaint or appeal in the event that concerns arise.
- Have knowledge regarding your rights and responsibilities throughout the treatment process.
- Request certain preferences in a provider.
- Have access to treatment and care in a timely manner.
- Know about your treatment options regardless of cost or coverage.
- Share in developing your plan of care by collectively discussing and exploring treatment goals.
- Receive information in a language you can understand.
- Receive a clear explanation of your condition, symptoms, and treatment options available.
- Inquire and receive information about Insight Counseling and Recovery, LLC in addition to providers, programs, services, and your role in the treatment process.
- Ensure decisions about your care are made on the basis of treatment needs throughout the treatment process.
- Decline participation or withdraw from services at any time and receive referral information if requested.

Clients have the responsibility to:

- Treat those providing care in addition to staff of Insight Counseling and Recovery, LLC with dignity and respect.
- Provide clinicians with adequate information to help them provide appropriate and adequate behavioral health services.
- Provide the necessary information for insurance processing, inquire and ask questions concerning your outstanding bill, and make payment arrangements with staff as needed.
- Let your counselor know about any issues or concerns with paying fees for the services rendered
- Inform those within your treatment team such as your provider and primary care physician about any medication changes, including medications given to them by others.
- Keep appointments as scheduled and notify the office in a timely manner in the event that you need to cancel or change an appointment.
- Report abuse and any concerns of fraud.
- Inform your therapist if and when the formulated treatment plan is not working for them or addressing their presenting concerns.
- Inquire by asking questions about the care you're receiving and actively participate throughout the treatment process.
- Follow the treatment plan as created by the provider and the client.
- Follow the agreed upon medication plan if applicable.
- Inform your therapist in the event that you decide to withdraw or discontinue therapy services.

My signature below indicts that I have been informed of my rights and responsibilities as listed above, and that I understand this information.

Client / Guardian Signature: X ______________________________________ Date: ____________________

CLIENT BACKGROUND INFORMATION

Describe concern(s) you would like to address in therapy and potential goals you hope to achieve:

____

____

____

When did this concern(s) begin?

____

____

____

How have you and your support system coped and/or responded to this concern or concerns?

____

____

____

How will you and your support system know when things are better or have changed in a positive way?

____

____

____

Referred to counseling at this time by: ____

DEVELOPMENT HISTORY
Any exposure to drugs and/or alcohol prior to your birth? _____ Yes ______ No ______ Unsure
Any complications with your birth? _____ Yes ______ No _____ Unsure
To your knowledge, any concerns or delays in regards to developments such as speech, hearing, language, walking, or other abilities? ______ Yes _____ No If yes, please explain: ____
Have you experienced any serious injuries as a result of an accident and/or involving a head injury? _____ Yes _____ No If yes, please explain: ____________________________________

MEDICAL HISTORY	Please identify the following providers overseeing your care at this time: Name:	Location:
General Practitioner /		

Primary care provider (PCP)		
Psychiatrist / APRN:		
Other Medical Provider:		
Please list any chronic medical conditions present:		
Allergies:		

Please identify and explain any issues associated with the following:

Sleep: ____	Vision: ____
Hearing: ______________________________________	Speech: ____
Changes in eating: _______________________________	Weight loss/gain: _________________________________

Any history of significant injuries such as a head injury, in addition to any illnesses, or debilitating conditions:

Medical history pertaining to children; please indicated the number of children:

_____ Fathered _____ Pregnancies _____ Births _____ Miscarriages _____ Abortions

CURRENT MEDICATIONS	
(1) Medication:	Dosage:
Date Prescribed:	Prescribing Physician:
Reason for medication:	Date medication discontinued:

(2) Medication:	Dosage:
Date Prescribed:	Prescribing Physician:
Reason for medication:	Date medication discontinued:

(3) Medication:	Dosage:
Date Prescribed:	Prescribing Physician:
Reason for medication:	Date medication discontinued:

EDUCATION BACKGROUND	
Did you graduate from high school? ____ Y ____ N	Please circle one of the following: GED / Diploma

Do you have any concerns with learning in regards to disabilities or attention difficulties? If Yes, please explain:

____

Have you completed or pursued any education program past high school? If yes, please list your degree, and area in which you studied: ____

MILITARY HISTORY	Have you ever served in the armed forces? ______ Yes ______ No
If you have served in the military, please answer the following:	Branch in which you serve/served: ________________________ Duties / positions held: ________________________ ________________________

EMPLOYMENT HISTORY	Please list information on the last three (3) jobs in which you have held.	
Current status:	______ Unemployed ______ Part-time ______ Full-time ______ Retired/Other	
Employer	Job Description / Duties	Dates of Hire
1.		
2.		
3.		

FAMILY INFORMATION / BACKGROUND		
Please list those that currently live with you: (Name, age, and relationship)		
1.		
2.		
3.		
4.		
Please identify individuals within your family who have struggled with any of the following (this includes parents, siblings, family on paternal father's and paternal mother's side of the family).		
Alcohol Use/Abuse:		
Drug Use/Abuse:		
Family history of mental illness:		
Other relevant information:		

LEGAL HISTORY	Please provide information regarding any legal charges, the date charged, and outcome:
Current:	
Past:	
Past:	
Other relevant information:	

COUNSELING & TREATMENT HISTORY	Have you previously had counseling? ____ Y ____ N If yes, please answer the following:

Please identify the dates, location, and treatment goals:	1. ____________ 2. ____________ 3. ____________	
Have you received inpatient psychiatric care for behavioral health concerns?	____ Yes _____ No If yes, please identify when, where, and concerns present at that time: 1. ____________ 2. ____________	
Have you participated in a treatment program for substance abuse?	_____ Yes _____ No (examples include residential treatment, IOP, outpatient counseling) 1. ____________ 2. ____________ 3. ____________	
Any history of the following? If yes, please explain:	Emotional Abuse	
	Physical Abuse	
	Sexual Abuse	
	Suicidal Thought/Attempts	
	Substance Abuse	
Other relevant information:		

ALCOHOL / DRUG HISTORY			
Please check next to each substance "yes" or "no" if you have ever used any of the following:			
Substance	**Yes**	**No**	**Date first use / last use**
Alcohol			
Uppers such as meth, crack, cocaine			
Downers such as Valium, or barbiturates			
Marijuana / K2			
Hallucinogens			

Inhalants			
Others (please specify)			

ADDITIONAL INFORMATION / OTHER RELEVANT INFORMATION	
Please feel free to provide any additional information:	