



# PSYCHOLOGICAL & COUNSELING SERVICES, PC

Offering a Full Range of Psychological & Counseling Services

## PERSONAL DATA SHEET

TODAY'S DATE: \_\_\_\_\_

CLIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

HOME ADDRESS (INCLUDE ZIP): \_\_\_\_\_

PREFERRED CONTACT NUMBER: \_\_\_\_\_ LEAVE MESSAGES AT THIS NUMBER?  Y  N

ALTERNATE CONTACT NUMBER: \_\_\_\_\_ LEAVE MESSAGES AT THIS NUMBER?  Y  N

PLACE OF EMPLOYMENT: \_\_\_\_\_

TYPE OF INSURANCE: \_\_\_\_\_ MEMBER NUMBER: \_\_\_\_\_

INSURANCE COMPANY CONTACT PHONE: \_\_\_\_\_

PRIMARY INSURED'S NAME, SSN, DOB (IF NOT CLIENT): \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE:** I hereby authorize Psychological & Counseling Services to release to my insurance company all information necessary to obtain authorizations or support any insurance claims on this account and secure timely payments due to the assignee or myself.

**SIGNATURE** (Patient or Parent/ Guardian) \_\_\_\_\_ Date \_\_\_\_\_

**STATEMENT OF FINANCIAL RESPONSIBILITY:** I agree to be financially responsible for the charges that occur today and any subsequent charges that may occur. I understand that I am responsible for any claims not paid by my insurance coverage.

I also understand that I am responsible for half the session fee if I fail to cancel within 24 hours or fail to appear for an appointment.

**SIGNATURE** of Person Responsible for Account \_\_\_\_\_ Date \_\_\_\_\_

**HIPAA PRIVACY NOTICE:** I acknowledge receipt of the HIPAA Privacy Notice.

**SIGNATURE** (Patient): \_\_\_\_\_ Date \_\_\_\_\_

**SIGNATURE** (Parent/ Guardian): \_\_\_\_\_ Date \_\_\_\_\_



## PSYCHOLOGICAL & COUNSELING SERVICES, PC

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### INFORMED CONSENT FOR TREATMENT

TODAY'S DATE: \_\_\_\_\_

CLIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

(Note: If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent.)

I give consent for evaluation and treatment to be provided for myself/my child by  
(name of therapist) \_\_\_\_\_.

- I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.
- The risks, benefits, side effects and alternatives of treatment as well as the consequences of noncompliance with treatment have been discussed with me and I have had the opportunity to ask questions.
- I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree to play an active role in my treatment process.
- I understand that I may terminate treatment at any time.
- I understand that what is discussed in therapy is confidential unless and until I (the client or parent) give consent to its release, with two exceptions. The therapist will need, and is compelled by law, to report to an appropriate other person(s) if:
  1. The therapist believes that I am in danger of hurting myself or someone else, and
  2. If there is reasonable suspicion that a child has been abused or neglected.

My signature below shows that I understand and agree with all of the above statements. I will have ongoing opportunity to ask questions about the treatment process.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient (if applicable)

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

# CONSENT FOR COMMUNICATION WITH PHYSICIAN

## HIPAA AUTHORIZATION

BY SIGNING THIS FORM, YOU PERMIT THE HEALTH CARE PROVIDERS IDENTIFIED BELOW  
TO DISCLOSE YOUR CONFIDENTIAL PERSONAL HEALTH INFORMATION

**PATIENT.** The patient whose information may be released is:

NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
PHONE \_\_\_\_\_

DOB \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_

Communication between behavioral health providers and your primary care physicians or other behavioral health providers is important to help ensure that you receive comprehensive and quality health care. Your personal health information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary.

I authorize Psychological & Counseling Services and the physician/ clinician named below to release information related to my evaluation and treatment. This consent will last for six months from the date signed. I understand that I may revoke my consent at any time.

**PHYSICIAN.** The following provider(s) may disclose my personal health information to the subsequent mental health clinician:

Provider: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, ZIP \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**MENTAL HEALTH CLINICIAN.** The following provider(s) may disclose my personal health information to the above physician:

Name: \_\_\_\_\_ of Psychological & Counseling Services, PC  
12728 Augusta Ave, Ste. 150; Omaha, NE 68144 (402)330-1537 Fax: (402)330-9331

**PURPOSE OF DISCLOSURE.** The reason I am authorizing release is:

My request  Other (describe) \_\_\_\_\_

**EXPLANATION OF RIGHTS:** I understand that I can revoke this Authorization at any time by giving my written revocation to the Disclosing Provider. My revocation is not effective as to disclosures already made and actions already taken in reliance upon this Authorization. The authorization expires 180 days after it is signed.

I understand the disclosing provider may not condition treatment on my willingness to sign this authorization.

I am authorizing disclosure of information protected under federal law. This information, once disclosed, may be subject to re-disclosure by the recipient and no longer be protected by state or federal law.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Representative's Relationship to Patient

\_\_\_\_\_  
Representative's Printed Name