New Life Psychotherapy

Vanessa Neuhaus, M.S., LMFT, LIMHP
Lincoln, Nebraska
(402) 937-8410

Today's Date: _____

Client Name: _____

Client Rights Policy

As a professional psychotherapist, providing you with the assistance you need is important. I am committed to following the highest ethical standards of my profession and encourage you to ask any questions you have related to therapy or the policies of practice. In seeking services from New Life Psychotherapy (hereinafter NLP), I want you to know you have the right:

1. To ask questions at any time.
2. To be fully informed of the therapist's qualifications to practice, including training and credentials, years of experience, etc.
3. To be fully informed regarding the therapist's therapeutic orientation, areas of specialization, and limitations.
4. To ask questions relevant to your therapy, such as therapist's values, background and attitudes, and to be provided thoughtful, respectful answers.
5. To be fully informed of the extent of written or taped records of therapy and their accessibility.
6. To be fully informed of your diagnosis upon request (if the therapist uses one).
7. To specify or negotiate therapeutic goals and to renegotiate these goals when necessary.
8. To be fully informed regarding the therapist's estimation of length of treatment to meet your agreed-upon goals.
9. To be fully informed regarding specific treatment strategies employed by the therapist.
10. To refuse any intervention or treatment strategy.
11. To request that the therapist evaluate the progress of therapy.
12. To discuss any aspect of your treatment with others, including consulting another mental health professional.
13. To be provided with written summaries of written records at your request.
14. To require the therapist to send a written report regarding services rendered to a qualified mental health practitioner or mental health organization at your request.
15. To refuse to answer any question/s.
16. To know the ethics code to which the therapist adheres.
17. To solicit help from the ethics committee of the appropriate professional organization in the event of doubt or grievance regarding the therapist's conduct.
18. To terminate therapy at any time.

Confidentiality

Records of the identity, prognosis, or treatment of any client are confidential and will be disclosed only with the written consent of the client, the client's legal guardian, by order of the court of competent jurisdiction, or as otherwise required by law. It should be noted that I am required by law to report any information which I receive pertaining to child abuse or neglect. In addition, if I become aware that a client is acutely suicidal or is intending to harm another individual, I am required by law to take the steps necessary to prevent this action, including notification of the police or the threatened party.

Office and Financial Procedures

The initial intake session typically takes 60-75 minutes. Subsequent psychotherapy sessions are usually 50-60 minutes in length, unless otherwise arranged or circumstances warrant (EMDR and couple's sessions can take up to 90 minutes). Following the first session, an attempt is made to establish a regularly scheduled appointment time consistent with the frequency of appointments needed. If you cancel a session within 24 hours prior to the session, you will remain responsible for the session and will be charged a fee of $25.00. Cancelations must be made with a 24-hour notice to avoid a charge to your account.

There is generally no charge for brief (5-10 minute) telephone consultations between sessions with your therapist, unless the contact is occurring on a regular basis (typically more than once a week). For extended or frequent emergency contacts between sessions, additional charges will be assessed to the client at the rate normally charged. Additional charges are also made for the administration and scoring of tests, writing reports, scheduled consultations with a psychiatrist, other professional or family member, or involvement of a co-therapist.

The client/guardian is responsible for payment of the fee for each session at the time of the session, unless other arrangements are made in advance. Responsibility for payment of the bill remains with the client/guardian and not an insurance company. You will receive a statement as long as a balance exists regardless of your insurance company status. If services are not paid within 30 days, you will be charged 1.25% interest per month. If services are not paid within 90 days, this information will be sent to a Collection Agency. The interest at 1.25% on unpaid amounts will revert back to the date of first billing.

There is a $25.00 charge for returned checks.

_____ _____

(Client Signature) Date (Client Signature) Date

_____ _____

(Signature of parent/guardian) Date (Relationship to client)

_____

Vanessa Neuhaus, MS, LMFT, LIMHP Date

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Consent to Psychotherapy Treatment

I authorize the provision of psychotherapy treatment for myself, _____

or for _____ my _____
(specify relationship). This treatment may include such services as a diagnostic interview, pre-treatment assessment, the use of specific testing instruments, treatment planning, and individual, couple and/or family psychotherapy. I understand that my active participation in psychotherapeutic treatment and recommendations are an important component of successful treatment outcomes.

I understand that receiving therapy entails risks and benefits. Being aware that there may be potential for emotional strains, stresses, and life changes as a result of therapy, I agree to enter into the therapy process. The benefits from therapy may be that I will cope better with relationships and gain a better understanding of myself, my values, and my goals. This may lead to greater personal growth and improved relationships. I understand that NLP does not guarantee any particular results or outcome from the therapy process.

I am aware that NLP does not provide emergency services. In the event of a mental health emergency, I have been informed of phone numbers to call and local emergency resources.

I understand that the NLP uses electronic data storage and fax machines. All electronic records are subject to the same confidential restrictions and protected health information (PHI) may not be revealed or faxed to anyone outside the agency without my written permission. I understand that email will not be used for confidential communication, and may be used for scheduling purposes only.

I understand that it is reasonable and customary to arrive to appointments on time and to provide a 24-hour notice if I need to cancel a scheduled appointment. I understand that should a pattern of canceling appointments or not showing for appointments develop, NLP reserves the right to discontinue treatment and refer me (or my child) to another practitioner.

I understand that all information and records generated and obtained in the course of treatment will remain confidential within NLP and will not be released without written consent. This confidentiality will be followed according to the Health Information Portability and Accountability Act (HIPAA) and a separate HIPAA Notice will be reviewed and signed by me and placed in the file. I understand that the confidential information can be released under the following specific circumstances:

1) If an individual states that s/he intends to harm him/herself or others, it is the practitioner's duty to warn authorities and that person or persons at risk of harm or who have been threatened harm.
2) If an individual states that s/he intends to harm him/herself, it is the practitioner's duty to take whatever action is necessary and possible to protect that individual. Such action may include notifying family or the authorities.

3) If a client becomes involved in certain legal processes, medical, and behavioral health records may be subpoenaed. The practitioner's ability to protect a patient's confidentiality will be dependent on the legal situation. Records are usually subject to release in these circumstances.
4) If a client, during the course of treatment, informs the practitioner that a child or elderly individual is either currently being abused or has been abused in the past, it is the practitioner's legal and ethical responsibility to advise the authorities.

I understand that collaboration with any other individuals not affiliated with NLP regarding diagnosis, treatment protocol, or treatment progress will only be conducted following my written authorization. I understand audio-video taping of sessions may be recommended by NLP for treatment purposes. I have the right to decline any audio-video taping of my treatment sessions without consequence to services.

I understand that despite NLP's office location on University of Nebraska - Lincoln's East Campus, Vanessa Neuhaus as a private practitioner nor NLP are affiliated in any way with the University of Nebraska - Lincoln (UNL), The Couple and Family Clinic, The Family Resource Center, or the Marriage and Family Therapy graduate program at UNL.

The client/guardian is responsible for payment of the fee for each session at the time of the session, unless other arrangements are made in advance. Responsibility for payment of the bill remains with the client/ guardian and not an insurance company. You will receive a statement as long as a balance exists regardless of your insurance company status. If services are not paid within 30 days, you will be charged 1.25% interest per month. If services are not paid within 90 days, this information will be sent to a Collection Agency. The interest at 1.25% on unpaid amounts will revert back to the date of first billing.

I have read and understand the contents of this consent form and accept the conditions of this agreement.

_____ _____

(Client Signature) Date (Client Signature) Date

_____ _____

(Signature of parent/guardian) Date (Relationship to client)

_____

Vanessa Neuhaus, MS, LMFT, LIMHP Date

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Intake Questionnaire

Name of Client _____ Today's Date: _____

Client Date of Birth: _____

Gender Identity: ( ) Female ( ) Male ( ) Transgender ( ) Other/Prefer not to state

Sexual Identity: ( ) Asexual ( ) Bisexual ( ) Gay ( ) Heterosexual ( ) Lesbian ( ) Queer
( ) Questioning ( ) Do Not Know/Prefer Not to State

Relationship Status: ( ) Single ( ) Married ( ) Partnered/Committed Relationship ( ) Separated
( ) Divorced ( ) Widowed ( ) Other _____

Race: ( ) American Indian/Alaska Native ( ) Asian ( ) Black/African ( ) Native Hawaiian
( ) Other Pacific Islander ( ) Unreported/Prefer Not to Report ( ) White

Ethnicity: Do you consider yourself to be Hispanic or Latino? ( ) Y ( ) N ( ) Prefer Not to Report

Religious/Spiritual Orientation: _____

Address: _____
_____

City: _____ State: _____ Zip: _____

Preferred Phone Contact Number: _____ ( ) Cell ( ) Home ( ) Office

Email Address: _____

Would you like to receive appointment reminders via email? ( ) Y ( ) N

Primary Occupation: _____ Employer: _____

Last Completed Education Level: _____ Currently Attending School? : ( ) Y ( ) N

Referred By: ( ) Family Physician ( ) Self ( ) Therapist ( ) Friend ( ) Website
( ) Other _____

Name of Referral Person/Agency: _____ Phone# _____

Presenting Concerns and Personal Information

What's happening that made you decide to seek psychotherapeutic services? _____
_____
_____
_____

If therapy were to be successful, how would you know? How would things be different? _____
_____
_____
_____

Do you now or have you ever had thoughts of ending your life? _____
_____

What is your work history like? ( ) Good ( ) Poor ( ) Sporadic ( ) Other

How long do you normally keep a job? ( ) Weeks ( ) Months ( ) Years

Are you retired? ( ) Y ( ) N

If yes, what kind of work do you do/did you do in the past?_____

Have you ever served in the military? ( ) Y ( ) N

If yes, are you: ( ) Active ( ) Retired ( ) Other _____

Have you ever struggled with drug, alcohol, and/or behavioral addictions or abuse? ( ) Y ( ) N

If Yes, please describe: _____

_____

_____

Are you the survivor of a traumatic event? ( ) Y ( ) N

If yes, please describe: _____

_____

Have you you ever been arrested? ( ) Y ( ) N IF NO SKIP TO NEXT SECTION

In the past month? ( ) Y ( ) N If yes, how many times?_____

In the past year? ( ) Y ( ) N If yes, how many times?_____

If yes, what were you arrested for?_____

What was the name of your attorney?_____

Were you ever sentenced for a crime? ( ) Y ( ) N

If yes, number of prison sentences served?_____

What year(s) did this occur?_____
Are you currently or have you ever been on probation or parole? ( ) Y ( ) N

If yes, what is the name of your attorney or probation officer?

_____

Family Information and History

Client's Spouse/Partner (if applicable): _____

Age: _____ Occupation: _____ Employer: _____

Birthday: _____ Phone Number: _____

If Living W/ Parents:

Mother's Name: _____ Birthday: _____

Primary Occupation: _____ Employer: _____

Father's Name: _____ Birthday: _____

Primary Occupation: _____ Employer: _____

Name(s) of other Pertinent Family	Birthday	Gender	School/College/Employed
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Is there any history of mental illness on either side of your family? _____

_____

_____

_____

Has any one in your family ever struggled with alcohol and/or drug abuse/addiction or behavioral addictions (gambling, internet, pornography, etc.)?

_____

_____

_____

Has any significant person or family member entered or left your life in the last 90 days? ( ) Y ( ) N

How are the relationships in your family? ( ) Good ( ) Fair ( ) Poor ( ) Close ( ) Stressful ( ) Distant ( ) Other _____

How are the relationships in your support system (friends, extended family, etc.?) ( ) Good ( ) Fair

( ) Poor ( ) Close ( ) Stressful ( ) Distant ( ) Other _____

	Conflict	Abuse	Stress	Loss	Other
Are there any problems in your family now?	( )	( )	( )	( )	( )
Were there any problems with your family in the past?	( )	( )	( )	( )	( )
Are there any problems in your support system now?	( )	( )	( )	( )	( )
Were there any problems with your support system in the past?	( )	( )	( )	( )	( )

What are your strengths/favorite personal qualities? _____

_____

_____

Is there anything else you would like me to know about you? _____

_____

_____

Client Medical Information

Current Family Physician: _____ Phone# _____

Past and Current Medical/Surgical Problems: _____

_____

_____

Past and Current Medications and Dosages: _____

_____

_____

Have you seen a Mental Health Professional Before? ( ) Y ( ) N

If Yes, Name, When, & Reason for Changing:

_____

_____

_____

Current Psychiatrist, if applicable: _____

Are you currently pregnant? ( ) Y ( ) N

If yes, when are you due? (day/month/year) _____

Are you at risk for HIV/aids/sexually transmitted diseases (unsafe sex, using needles)? ( ) Y ( ) N

Please list allergies to medications or food:_____

_____

Has your physical health kept you from participating in activities? ( ) Y ( ) N

_____ _____

(Client Signature) Date (Client Signature) Date

_____ _____

(Signature of parent/guardian) Date (Relationship to client)

_____

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

NLP has adopted the following policies and procedures for protection of the privacy of the people served.

My Obligation to You

NLP respects your privacy. This is part of my code of ethics. I am required by law to maintain the privacy of "protected health information" about you, to notify you of my legal duties and your legal rights, and to follow the privacy policies described in this notice. "Protected health information" means any information I create or receive that identifies you and relates to your health or payment for services to you.

This Notice of Privacy Practices describes how I may use and disclose your protected health information (PHI) to carry out *treatment*, *payment,* or *healthcare operations* and for *other purposes that are permitted or required by law*. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. Your protected health information may be used and disclosed by the therapist for the purpose of providing psychotherapy services to you, for payment of bills, or other uses required by law.

Treatment: I will use and disclose your protected health information to provide, coordinate, or manage your treatment and any related services with written consent from you. At times, collaboration with other licensed mental health practitioners may be utilized so that I may provide you with systemic, ethical, and well-informed psychotherapeutic care. Only general information related to the dynamics of your presenting problems will be disclosed; your PHI is kept in strict confidentiality in these circumstances.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, sending information to collection agencies in the event of unpaid invoices.

Healthcare Operations: I may use or disclose, as-needed, your protected health information in order to support the activities of the practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training, licensing, and conducting or arranging for other business activities. For example, I may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. I may also call you by name in the waiting room when I am ready to see you. I may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. I may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by Law, Public Health issues as required by law, Communicable Diseases as required by law.

Other Purposes Permitted or Required by Law: Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke releases of information, at any time, in writing, except to the extent that I have already taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

- You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

- You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

  Your provider is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

- You have the right to request to receive confidential communications from us by alternative means or at an alternative location. For example, you may request that I use another phone number to contact you than that which has been provided previously.

- You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

- You may have the right to have your therapist amend your protected health information. If I deny your request for amendment, you have the right to file a statement of disagreement with me and I may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- You have the right to receive an accounting of certain disclosures I have made, if any, of your protected health information. I reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to me or to the State Department of Health and Human Services if you believe your privacy rights have been violated by NLP. You may file a complaint with me by notifying me of your complaint. **I will not retaliate against you for filing a complaint.**

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Receipt of HIPAA Privacy Practices

Name of Client: _____

By signing this form I verify that I (initial which applies)

_____: received a copy of the HIPAA notice of privacy practices for NLP and have reviewed and agree to the policies described therein.

_____: received a copy of the HIPAA notice of privacy practices for NLP and have reviewed them but do **NOT** agree to the policies described therein.

_____: was sent the HIPAA notice of privacy practices by mail from NLP and have reviewed them and agree to the policies described therein on.

I understand that by signing this document I am verifying that I am aware of the HIPAA rights and responsibilities.

_____ _____
(Client Signature) Date (Client Signature) Date

_____ _____
(Signature of parent/guardian) Date (Relationship to client)

_____
Vanessa Neuhaus, MS, LMFT, LIMHP Date

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Payment for Services Contract

Today's Date: _____

Name of Client: _____

I understand that my fee will be $75 for my Initial Intake Session.

$50 per Session thereafter (50 - 60 min)

I understand that I am assuming responsibility for payment of my bill at the time of the session, unless other arrangements are made and herein specified. I agree that NLP may release my name to any necessary party in the course of obtaining payment.

Payment of the bill to NLP is the client's responsibility. There is a $25.00 charge for returned checks.

Signature of this contract authorizes payment of medical benefits to NLP for services rendered.

_____ _____
(Client Signature) Date (Client Signature) Date

_____ _____
(Signature of parent/guardian) Date (Relationship to client)

_____
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Client No Show/Late Cancel Policy

Today's Date: _____

Name of Client: _____

It is important that clients provide a 24-hour notice of cancellation of a scheduled appointment. If a client does not provide this 24-hour notice of cancellation, the appointment will be considered the same as not showing for the appointment. When a client does not show for a scheduled appointment, or cancels with less than 24 hours notice, there will be a charge of $25.00 for this scheduled time.

Please initial the following:

_____ I understand that this charge will be the responsibility of the client

_____ I understand the Client No Show Policy and agree to abide by it.

_____ _____
(Client Signature) Date (Client Signature) Date

_____ _____
(Signature of parent/guardian) Date (Relationship to client)

_____
Vanessa Neuhaus, MS, LMFT, LIMHP Date