1620 Wilshire Drive | Suite 220 | Bellevue, NE 68005
Phone 402.502.1931 Fax 402.999.4812

Patient Name: _____ SS# _____

Street Address: _____ DOB: _____ Age: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Okay to leave a voice or text reminder on Primary Phone: Y N Secondary Phone: Y N

Employer/School: _____ Occupation: _____

Email for confidential information: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Do you authorize this person to discuss your care in the event of an Emergency or if your Provider feels you are at risk? Yes or No (please circle and sign below)

Signature of Understanding: _____

Primary Insurance: _____ Policy Holder Name: _____

Policy Holder DOB: _____ Relationship to Patient (self, spouse, dependent): _____

Policy Holder Address (if different): _____

Policy or Member ID #: _____ Group #: _____

Secondary Insurance: _____ Policy Holder Name: _____

Policy Holder DOB: _____ Relationship: _____

Policy Holder Address (if different): _____

Policy or Member ID #: _____ Group #: _____

Patient Name (printed): _____

Patient/Guardian Signature: _____ Date: _____

Patient First & Last Name: _____

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OFFICE POLICIES

Informed Consent: Thank you for choosing our office for your mental health needs. We realize that starting mental health treatment is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will do our best to give you all the information you need. Your provider has earned at a minimum a Master of Science Degree in Psychiatric/Mental Health Nursing and is licensed by the State of Nebraska as a Nurse Practitioner. Treatment philosophy and practices will be discussed with you today.

Confidentiality & Emergency Situations: Your verbal communication and clinical records are strictly confidential with exception to the following situations: a) information (diagnosis and dates of service) shared with your insurance company to process your billing claims; b) information you and/or your child or children report about physical, sexual or elder abuse; then by Nebraska State Law, this information must be reported to the Department of Children and Family Services; c) where you sign a release of information to have specific information shared; d) if you provide information that you are in danger of harming yourself or others; or e) when required by law. If an emergency arises, you as the patient or guardian understand that you are to contact emergency services in the community (911) or go to your nearest emergency room and your provider will follow up with standard counseling and support as needed.

Office Hours: Thrive is regularly open Tuesday through Thursday 10:00 to 6:00 and Fridays 9:00 to noon. You have selected to receive care at a private practice facility. We pride ourselves on offering more personalized care. That said, we do not have a large staff to answer phones 24/7. During office hours your provider is seeing patients and will not be available to come to the phone. Please give your provider 72 hours to return your message. We do not offer after-hours or on-call crisis services. Voicemail is available 24/7 when no one is available, or the office is closed. If you are experiencing an emergency, please contact either 988 or 911 or go directly to the nearest hospital emergency room.

The Thrive office is closed in recognition of all National Holidays.

Inclement Weather: Our office follows the local Public Schools (Bellevue, Omaha, Millard) weather/snow cancellation policy. Your in-person appointment will be changed to a telehealth appointment for these closures.

Coordination of Treatment: It is important that all healthcare providers work together. As such, we request your permission to communicate with your primary care physician or any other health care provider you or your provider deems necessary. Your consent is considered valid for one year.

Please understand that **you have the right to revoke this consent at any time by sending written notice**. If you prefer to decline consent, no information will be shared. If consent is granted and coordination necessary, you will be provided with a release of information form to be completed for each treatment provider.

___ You may inform my provider(s) ___I decline to inform my provider(s)

Patient First & Last Name: _____

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Financial Policies

Policy on Non-Covered Services: To offer you consistent quality care and to coordinate this care with other providers or organizations, we may need to charge for services that are not performed during a scheduled appointment or are not typically covered or reimbursed by your insurance company. We request that you schedule an appointment to address your needs; however, when we provide these services outside of an appointment, you will be billed directly. These services are billed at the standard hourly rate for your provider.

The following is a list of some of the services not covered by insurance companies and would be billed at an hourly rate:

* Court ordered and legal-related services
* Preparing reports **or letters** for other providers or organizations (e.g. schools)
* Documentation completion (i.e., disability, insurance reviews, workers' compensation, etc.)
* Consultations by telephone or email
* Duplication of your medical records

_____ ***Initial here that you understand this policy on non-covered services.***

Financial/Insurance Issues: As a courtesy we will bill your insurance company, responsible party, or third-party payer for you. All co-payments or coinsurance amounts are due at the time of service. In the event you have not met your deductible, the full fee is due at time of service until the deductible is satisfied. If your insurance company denies payment, we will request payment of the balance due at that time. We ask that patients authorize payment of medical benefits directly to their provider. We require you keep an active debit or credit card securely on file to pay co-pays and charges not covered by your insurance. Co-pays are to be paid PRIOR to your appointment; co-insurance is paid AFTER your insurance processes – generally within 30 days of your last appointment.

_____ ***Initial here that you understand our co-pay/co-insurance policy***

It is important that you notify us immediately of any changes in your health insurance, place of employment, home address, telephone number or other information pertinent to our records. Failure to do this may result in our no longer being able to process insurance claims on your behalf and you will be held responsible for full payment of each session not covered by your insurance. Please note that the financial responsibility for your treatment is yours.

Missed Appointment/Cancellation Policy: We consider it an honor and a privilege to be of service and hope for a mutually beneficial relationship. We understand that there may be extenuating circumstances; however, we request that any cancellation or rescheduling of your appointment be made at least **24 hours in advance**. Missed appointments or appointments canceled less than 24 hours in advance affect us all and prevent us from being able to serve others in need. Because of this, we have created a cancellation policy and missed appointment outlined here:

You will be charged a $100.00 fee after the first missed appointment or appointment not canceled at least 24 hours in advance of the scheduled visit.

We provide reminder calls/texts before your appointment as a courtesy. You are still responsible for remembering your scheduled appointments. Stating that you did not receive a reminder or that the call was made within the 24-hour deadline does not make your missed or canceled appointment an exception. Furthermore, we have a **TWO late cancel/no-show policy.** If you late cancel or no-show for two appointments, you will not be rescheduled. We realize that there may be emergency situations where notice is not possible and those will be dealt with individually.

Patient First & Last Name: _____

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Past Due Accounts: Your account is past due after 30 days. If your account is more than 60 days overdue, or your balance exceeds $100.00, without honoring a payment plan, you will not be seen until your account is paid in full – this may impact your prescriptions as they will not be filled. If your account is overdue and turned over to our collection agency, you or the responsible party will be responsible for all fees incurred to collect the debt owed - in addition to the balance. _____ ***Initial here that the past due policy is understood***

Prescriptions and Refills: It is crucial to take the correct medications in the correct doses. Many prescriptions require periodic blood work, or a follow-up visit prior to receiving a refill. Therefore, it is important that you keep your scheduled appointments. Please call your pharmacy or use your pharmacy app to request refills. Our goal is to give you a prescription during your appointment with enough refills to sustain you until your next appointment. If you miss your next appointment or run low on medications, please contact your pharmacy to ask for a refill and **allow a 72-hour notice on all refill requests**. ALL MEDICATIONS, even refills, must be reviewed and approved by a licensed prescriber prior to approval. Requests received over the weekend will not be reviewed until the next business day.

It is standard practice to require regular follow-up appointments when certain controlled substances are prescribed. These include stimulants, anti-anxiety medications, and sleep aids. Please be aware of this standard and understand that your prescriptions may not be refilled if you do not schedule and attend regular appointments.

- The general standards for follow-up are as follows:
- Psychostimulants every 3 months PER FEDERAL LAW
- Benzodiazepines every 3-4 months.
- Sleep medications every 6 months

NDMP - The Federal National Drug Monitoring Program: was established in Nebraska in January 2017. Thrive Mental Health complies with all aspects of this program. We are required by law to submit information about the medications prescribed to our patients to the DEA. We also receive information from NDMP about medications prescribed to our patients from other providers.

Notice of Privacy Practices & Patient Rights: I have read and received a copy of the 'Notice of Privacy Practices' and 'Patient Rights' documents.

Initials: _____ **Date:** _____

I, the undersigned, agree and consent to participate in the mental health care offered by my provider**, Janette Stallings**, a licensed nurse practitioner as defined by Nebraska Law. I have read the policies detailed herein in regard to this care and my obligations/ responsibilities. *I understand that I am consenting and agreeing only to those mental health services that the above-named professional is qualified to provide within the scope of the professional's license, certifications, and training.*

Patient's Printed Name: _____

Patient or Guardian Signature: _____ **Date:** _____