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** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy or Member ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of Present Condition**

**Social and Developmental History**

Birthplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where did you grow up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your parents get divorced when you were a child? Yes or No If yes, how old were you? \_\_\_\_\_\_\_

Father’s occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother’s occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you close to your mother, father, or both parents growing up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you close now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many siblings do you have? \_\_\_ Were you close growing up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have any early development problems as a child? (Premature, walking, talking, making friends)

Yes or No If yes, please identify.

Highest Level of Education attained:

Do you currently live alone or with others? (Please circle one)

Do you have any children? How many? \_\_\_\_\_ Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently in a romantic relationship? Yes or No If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_

How would you describe the relationship (e.g., supportive, nurturing, complicated)?

Spouse or partner’s current occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you/were you a victim of any form of physical/sexual/emotional abuse? \_\_\_\_\_ Yes \_\_\_\_\_\_ No

\*Optional\* brief description of abuse:

What activities do you enjoy doing in your leisure time?

Please circle any areas of stress in your life you would like to discuss: Family of origin, Romantic Relationship, Friendships, Educational, Occupational, Economic, Housing, Legal and Physical Health.

Primary reason for seeking care:

**General Medical History**

Primary Care Physician (PCP) & Contact Info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any history of medical problems you **currently** have:

Please list any medical procedures/surgeries you have had in the past:

Have you ever had a TBI or concussion? Yes or No If yes, when?

Are you on any medications for any general medical problems? Yes or No

If yes, what medications?

Do you have any known allergies to medications? Yes or No

If yes, what medications and what was/is your reaction?

**Preferred Pharmacy Name and Location**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Females:**

At what age did you begin menstruation? \_\_\_\_\_\_\_

Any premenstrual symptoms (PMS)? Please describe (mood swings, cramps, bloating, sleep issues)

Do you use a method of contraception? If so, what type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been pregnant? Yes or No If yes, how many times?

Have you had any miscarriages? Yes or No If yes, how many?

Have you had any abortions? Yes or No If yes, how many?

**Mental Health History**

Have you ever been hospitalized for psychiatric reasons? Yes or No

If yes, when, and where?

Have you ever had outpatient treatment by a psychiatrist or Psychiatric NP? Yes or No

If yes, when and by whom?

Have you ever received counseling or therapy in the past? Yes or No

If yes, when and by whom?

**Please list any psychiatric medication you are taking and/or have taken in the past:**

|  |  |  |
| --- | --- | --- |
| Name of Medication/Dose, if known | Dates taken | Response: Side Effects or Benefits of medication |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Please list any illness (physical, mental or substance use) among **blood relatives (child, sibling, aunt, uncle, grandparent, cousin)**: Examples Depression, Anxiety, PTSD, Bipolar, ADHD, Drug/Alcohol abuse, Psychiatric Hospitalization, Suicidal ideation, or Suicide Attempt

**Mother’s Side (who) Father’s Side (who)**

Any additional family medical history we should be aware of (e.g. cancer, diabetes, hypertension)?

**Alcohol, Drug, and Tobacco Use – (if not applicable write “N/A”)**

Describe your use of alcohol. Have you had any negative consequences such as black outs, assault, DUI, injuries?

Describe your use of recreational drugs:

Describe your use of tobacco or nicotine products (smoke, chew, vape): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been convicted of any crimes, served time, or been on probation?

Details (if applicable):

Please add any additional information you think would be helpful for treatment:

Client Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**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 try our best to give you all the information you need. All our providers have earned at a minimum a Master of Science Degree in Psychiatric/Mental Health Nursing and are 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 client or guardian understand that you are to contact emergency services in the community (911) or go to your nearest emergency room and our providers will follow up with standard counseling and support as needed.

**Office Hours:** You have selected to receive care at a private practice facility. We pride ourselves on offering you 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; however, voicemail is available 24/7 as is email and the patient portal for messages when no one is available, or the office is closed. If you are experiencing an emergency, please contact 988, 911 or go directly to the nearest hospital emergency room. Thrive is open Tuesday through Thursday 10:00 to 6:00 and Fridays 9:00 to noon. *We are closed in recognition of all National Holidays.*

**Inclement Weather:** Our office follows the local Public Schools (Bellevue, Omaha, Millard) weather/snow cancellation policy. All in-person appointments 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 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)**

**Financial Policies**

**Policy on Non-Covered Services:** Tooffer 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. When we provide these services, you will be billed directly. These services are billed at the standard hourly rate for your provider – which is $300/hr. If you have any questions regarding this policy, please ask our staff.

The following are 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 (schools, landlords, employers, etc)

\* Documentation completion (i.e., disability, insurance reviews, workers’ compensation, etc.)

\* Consultations by telephone ($75 per 15 minutes)

\* Duplication of your medical records

**Financial/Insurance Issues**: As a courtesy we will bill your insurance company, HMO, responsible party, or third-party payer if you wish. We ask that at each session you pay your copayment or coinsurance amount. 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. **If your balance exceeds $200.00, we will need you to pay your bill in full before being seen or any medication refills.** If an account is overdue and turned over to our collection agency, you or the responsible party will be held responsible for any collection fee charged to our office to collect the debt owed in addition to the balance. We ask that every patient authorize payment of medical benefits directly to their provider. You may keep a credit card securely on file to pay co-pays and charges not covered by your insurance.

Please 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 so may result in 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. Ultimately, 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 long and mutually satisfying relationship. We request that any rescheduling of your appointment be made at least **24 hours in advance**. Missed appointments and appointments canceled with less than 24 hours of notice affect us all and prevent us from being able to serve others in need. Because of this, we have created the cancellation/missed appointment outlined here:

**You will be charged a $100.00 fee AFTER the first missed appointment or appointment not canceled a minimum of 24 hours in advance of the scheduled visit.**

We provide reminder calls or texts 48 hours 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 appointment 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 extenuating circumstances and emergency situations where notice is not possible and those will be dealt with individually.

**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. Please allow a 72-hour/3-business day notice on all medication refills. ALL MEDICATIONS, even refills, must be reviewed and approved by a licensed prescriber prior to approval. Please note that requests received over the weekend will not be reviewed until the next regular 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 (at the discretion of your provider) 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; more frequently if history of problems.

**PDMP - 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 Drug Enforcement Agency (DEA). We also receive information from the Nebraska Prescription Drug Monitoring Program (PDMP) about medications prescribed to our patients from other providers.

**Notice of Privacy Practices & Client Rights:** I have read and received a copy of the ‘Notice of Privacy Practices’ and ‘Client 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 regarding 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:** \_\_\_\_\_\_\_