Mindful Moments

Talia Placzek Counseling, LLC 919 Galvin Rd. S, Suite A, Bellevue, Ne 68005 Fax: (402) 625-0664

CLIENT INFORMATION FORM

Referral Service: ____Outpatient Services ___Consult

Client First Name:_____ MI:_____Last Name:_____

Parent(s) Name(s):_____DOB:_____

Parent(s) Name(s):_____DOB:_____

Client Current Address: _____City:_____State:___Zip:_____

Phone: (_____) _____Date of Birth: _____SSN:_____

Email:_____

Gender(M/F):_____ Marital St: _____Legal Status:_____ State Ward(Y/N):_____

Pay Sources (list all in order):_____

Insurance (if applicable):_____

Eval Date: _____Performed by:_____

Current/ Recent Therapist: _____Psychiatrist: _____

Current School & Grade: _____

Primary Care Physician:_____

Probation/Parole/Diversion Officer (circle): _____

PO Phone: _____PO Fax:_____

Judge:_____ Upcoming Court Date:_____

Tracker/Company: _____

Tracker Phone: _____Tracker Fax:_____

Family Permanency Specialist/Other Supports: _____

FPS Phone: _____FPS Fax:_____

CFS Oversight Manager/OJS: _____

Identifying Information upon intake (use back of form if necessary:_____

_____

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CLIENT RIGHTS & RESPONSIBILITIES

CLIENT RIGHTS:

- You have the right to refuse services. However, participation in treatment is an expectation and it should be known that such refusal may be cause for Talia Placzek Counseling, LLC to discharge a client from outpatient services.
- You have the right to have treatment provided on a standard schedule. Treatment schedules are given at the time of intake. In emergency situations, the client is advised to dial 9-1-1 or proceed to the nearest emergency room.
- You have the right to be treated with dignity and respect.
- You have the right to a prompt response to reasonable requests for service.
- You have the right to a safe environment, free from sexual, physical and emotional abuse.
- You have the right to help in the development of your treatment plan and discharge plan.
- You have the right to be informed of the type of treatment you receive and to be told of alternative ways you can receive care and treatment.
- You have the right to be informed of your progress and to discuss any questions or problems.
- You have the right to a timely referral upon discharge or when further services are determined to be necessary.
- You will be informed of your therapist's credentials, licensure, experience, professional associations, specialization and limitations.
- You have the right to be treated fairly without discrimination as to race, color, religion, natural origin, economic status, disability, marital status, sexual orientation, gender, military status or age.
- You have the right to be treated equitably and without prejudice or favoritism.
- You have the right to be informed of confidentiality laws. The laws of the State of Nebraska require that most issues discussed during the course of therapy with a psychotherapist are confidential. These laws permit you to waive the privilege of confidentiality by signing a release of information form. However, the release of confidential materials is required in situations of suspected child abuse, of potential harm to oneself or others, and in instances where the court may subpoena records or testimony. If you desire that information be communicated about you to someone, please ask for a release of information form. Both you and your parent/legal guardian will sign releases upon admission giving consent for staff to communicate to individuals specifically involved in your treatment.
- You have the right to know the cost of your care.
- The purpose of your clinical record is to document and evaluate your progress and treatment. Clinical records are the property of Talia Placzek Counseling, LLC. You have the right to examine your records and refute any information by inserting a counter-statement of clarification. All information is confidential and will not be released without a proper authorization as detailed by Federal Confidentiality Regulations. You have the right to request the transfer of a copy of your files to another therapist or agency.
- You have the right to receive services when they are needed. In emergency situations, the client is advised to dial 9-1-1 or proceed to the nearest emergency room.
- You have the right to an Advance Directive. An Advance Directive is a written statement in which you state your choice for health care or name someone to make such choices for you, if you become unable to make your own decisions about medical care. The two most common forms are a Living Will and Power of Attorney.

- You have the right to terminate services against medical advice, to the extent permitted by law, with the understanding that you will be responsible for any harm to you or others a result.
- Upon your request, you have a right to receive a copy of any release that you sign authorizing the disclosure of confidential information.
- You have the right to offer feedback and suggestions regarding any client rights and responsibilities.

CLIENT RESPONSIBILITIES:

- Clients have the responsibility to participate actively and honestly in treatment. In many cases, particularly when the client is a child or adolescent, effective treatment requires active involvement and participation of parents or other family members.
- Clients have the responsibility to keep scheduled appointments or to give notice of cancellation if client will be unable to keep an appointment.
- Clients have the responsibility to treat their therapist with dignity and respect.
- Clients are responsible for asking questions about any policy, procedure, or treatment which they do not understand or with which they do not agree.
- Clients are responsible for carefully reading and understanding any papers they may be asked to sign in relation to treatment.
- Clients have the responsibility to honor their financial contract by paying for the services received at the agreed-upon times and/or terms. The client is also responsible for providing Talia Placzek Counseling, LLC with all information necessary for billing health insurance or other third party insurance.

I have read and accept the Client Rights and Responsibilities:

_____ _____

Client Signature Date

_____ _____

Talia Placzek, LMHP Date

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COUNSELING AGREEMENT

PLEASE READ AND SIGN THE FOLLOWING PRIOR TO SEEING TALIA PLACZEK, LMHP:

CONFIDENTIALITY

Confidentiality means that Talia Placzek, LMHP has a responsibility to safeguard information obtained during counseling. All identifying information about your assessment and treatment is kept confidential, except as mandated by law. You must sign a release of information before any information about you is given to anyone, except as mandated by law.

In certain situations, mental health professionals are required by law to reveal information obtained during therapy to other persons or agencies without your consent. In such situations, Talia Placzek, LMHP is not required to inform you of her actions. Please note the following exceptions to confidentiality:

- Confidentiality does not apply to cases of suspected abuse/neglect of children, vulnerable adults, or the elderly.
- Confidentiality does not apply to cases of potential harm to self or others.
- A mental health professional may disclose confidential information in proceedings brought by a client against a professional.
- Confidentiality does not apply to cases involving criminal proceedings, except communications by a person voluntarily involved in a substance abuse program.
- Confidentiality may not apply in cases involving legal proceedings affecting the parent-child relationship.
- Confidentiality may not apply to cases involving a minor child. In such cases, the mental health professional may advise a parent, managing conservator or guardian of a minor, with or without minor's consent, of the treatment needed by or given to the minor.
- Confidentiality may not apply in a medical emergency involving the client.

Insurance and managed care companies require personal identification information, diagnosis, symptoms, treatment goals, prognosis, evaluation of progress, and other information before reimbursement is considered. Such companies may also maintain the right to have a copy of your records. For purposes of supervision and collaboration, consultation with clinicians at Mental Health Specialists of Bellevue will be permitted.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)/42 CFR Part 2/45 CFR

Talia Placzek, LMHP is required by law to protect the privacy of your health information. Although your counseling record is the physical property of Talia Placzek, LMHP, the information contained in your health record belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information.
- Inspect and obtain a copy of your health records with at least forty-eight hours' advance written notice to Talia Placzek, LMHP. Talia Placzek, LMHP reserves the right to review records with the client before the records are released to the client.
- Amend your health record as provided by regulation.
- Obtain an accounting of disclosures of your health information as provided by law.
- Request communications of your health care information by alternative means or locations.

Federal Regulations 42 CFR, Part 2 prohibits making further disclosure of this information without specific written consent of the person to whom it pertains.

- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- See 42 CFR Part 2 and 45 CFR for substance abuse and psychotherapy record confidentiality.

THE BENEFITS OF COUNSELING

One major benefit that may be gained from participating in counseling is the resolution of the concerns brought to therapy. Other possible benefits may be a better ability to cope with personal, family and other interpersonal relationships, and/or a greater understanding of personal goals and values.

THE RISKS OF COUSNELING

There are certain risks involved in counseling. You may experience a variety of negative emotions during therapy as you remember and therapeutically resolve unpleasant events. Seeking to resolve concerns between family members and other persons can similarly lead to discomfort as well as relationship changes that may not be originally intended. The greatest risk of counseling is that it may not by itself resolve your concerns. Talia Placzek, LMHP will do her best to assess progress and provide referral to other sources if that is deemed necessary and appropriate. Psychotherapy is a collaborative process and the progress you make will depend in large measure upon your investment in the process.

COST OF SERVICE

Regular therapy services are billed at:

- Initial session/intake: $180
- Individual sessions: $140 - $160 per session
- Family sessions: $140 per session
- Co-occurring and Substance Abuse Evaluations: $200

PAYMENT OF FEES

All fees should be paid at the time the service is rendered. Cash, personal check, MasterCard, Visa, American Express, and Discover Cards are welcome.

Most insurance plans have an annual deductible, which must be met prior to reimbursement. If you have such a deductible, this is your responsibility to pay. Some insurance plans require the insured to call prior to the first visit and obtain authorization for a specified number of visits. If you fail to obtain this authorization prior to your initial psychotherapy session, you are responsible for payment.

INSURANCE CLAIMS

Please remember that you are responsible for payment of all deductibles/fees/copays whether or not your health insurance provides reimbursement.

CANCELLATIONS

Cancellations must be made twenty-four hours in advance to avoid charge. When scheduling your appointment with your therapist, please keep in mind that this is your agreement that your therapist will hold this time slot exclusively for your session. Because this time is reserved by you, you will be billed $50 for any missed appointments. Cancellations made with less than 24 hours' advance notice will be billed $30.

NSF CHECKS AND REJECTED CREDIT CARD CHARGES

There will be a $25 charge for each insufficient funds check or credit card rejection.

LATE FEES

A late fee of $10 will be added to overdue accounts each month. Accounts over ninety days will be sent to a collection agency and will have additional fees.

WRITTEN ACKNOWLEDGEMENT AND CONSENT TO COUNSELING

I have read and accept this agreement and herewith consent to therapeutic services provided by Talia Placzek, LMHP.

_____ _____

Client Signature Date

_____ _____

Talia Placzek, LMHP Date

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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
CRIMINAL JUSTICE SYSTEM REFERRAL

I, _____ (DOB_____), hereby consent to communication between Talia Placzek Counseling, LLC and the following agencies/individuals:

Nebraska Probation Management Information System: Administrative Office of Courts & Probation

Sarpy County Drug Treatment Court Team Members/Officers

Juvenile or Adult Probation Office/Officer:

Adult Parole Office/Officer:

Juvenile or Adult Diversion Office/Officer:

Nebraska Department of Health and Human Services Caseworker:

The purpose of and need for the disclosure is to inform the criminal justice agency (ies) and drug court team members listed above of any and all information related to my treatment including, but not limited to the following: attendance and cooperation, progress in treatment, diagnosis and prognosis, evaluations, drug and alcohol information, family history and participation, social and case history, mental health issues, discharge summary, as well as treatment paperwork.

I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment.

I also understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records and that recipients of this information may re-disclose it only in connection with their official duties.

Signature of Defendant/Client Date

Talia Placzek, LMHP Date

Federal Regulations 42 CFR, Part 2 prohibits making further disclosure of this information without specific written consent of the person to whom it pertains.

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GENERAL PERMISSION TO RELEASE INFORMATION

I, _____ (DOB_____), hereby give permission for the agencies/individuals listed below to exchange specific information* with Talia Placzek Counseling, LLC, for the purpose of continued treatment and/or evaluation at Talia Placzek Counseling, LLC. *I understand that disclosure of information to said entities means that the information disclosed may be re-disclosed and will no longer be protected by the federal privacy law.*

NAME OF ORGANIZATION	RELATIONSHIP	TYPE OF INFORMATION
		Specifics
		Specifics
		Specifics
		Specifics

*Specific information means all available information in any one or each type selected from the following: Medical, Psychological, Psychiatric, School Information (including transcripts), Evaluations, Social and Case History, Treatment History, Legal, and Progress in Treatment.

I understand that my records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this consent, in writing, at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically 90 days after my termination from treatment.

_____

Signature of Client Date

_____

Talia Placzek, LMHP Date

Federal Regulations 42 CFR, Part 2 prohibits making further disclosure of this information without specific written consent of the person to whom it pertains.

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OUTPATIENT CONSENT TO TREATMENT

I, _____, hereby give my consent for and acknowledgement of the following items which are initialed:

_____I consent to receive treatment.

_____I authorize Talia Placzek Counseling, LLC, to release any information necessary for the completion of insurance forms for the determination of benefits payable to any insurance company, or any other institution/organization. A photocopy of this authorization shall be a valid as the original.

_____I have been informed of my therapist's credentials, licensure, experience, specializations, and limitations.

_____I understand the possible psychological risks involved in psychotherapy and understand psychotherapy is not an exact science and that the results cannot be guaranteed. Psychotherapy is often beneficial, but as with any treatment, there are inherent risks. During therapy, I may have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. Some of the possible benefits are improved interpersonal relationships, reduced feelings of emotional distress, resolution of problems resulting from past trauma, and increased problem solving skills.

_____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 therapist so that I will receive effective treatment. I also agree to play an active role in the therapeutic process.

_____I understand that alcohol, illegally obtained drugs, pornographic materials, paraphernalia, and weapons are prohibited on the premises.

_____I understand that my therapist may work with typists, internship students, supervisors, colleagues, legal entities, and case managers regarding my treatment and/or clinical files.

_____I authorize Talia Placzek Counseling, LLC, to relate my presence in this facility to specified callers and visitors, as documented on my releases in my clinical file.

_____I authorize Talia Placzek Counseling, LLC to contact myself on my resident phone and/or my personal cell phone. I also authorize Talia Placzek Counseling, LLC to leave messages at any of the above phones numbers.

I have read and accept the above checked items and have received an explanation of this consent form:

_____ _____
Client Signature Date

_____ _____
Talia Placzek, LMHP Date