Insurance Verification - Clinician Name _____

Name of Patient	Name:	DOB:	Gender:
Street Address	Street:		Apt:
	City	State	Zip
Phone		Ok to Text? Y/N	OK to Voice Mail Y/N
Email			OK appointment reminders Y/N
Emergency Contact		Relationship	Phone
Complete below if under 19 years old or under 26 using parents insurance			
Guardian/Parent	Name:		DOB:
	Street:		Apt:
	City	State	Zip
	Phone		

Insurance		
Subscriber Name		Male / Female
Subscriber DOB		Relationship: Self / Spouse / Child
ID Number	Group #	
Employer (or ACA)		
Benefit Phone #		
Second Insurance		
Subscriber Name		Male / Female
Subscriber DOB		Relationship: Self / Spouse / Child
ID Number	Group #	
Employer (or ACA)		
Benefit Phone #		

Please call your insurance ahead of time and get the following information.

What is my Copay/Coinsurance? _____

How much Deductible is left? _____

Are hour sessions (CTP 90837) covered? Y / N _____

Are Family sessions (CTP 90847) covered? Y / N _____

Is "Marriage Counseling" ALLOWED with 90847? Y / N _____

Office use only: [ ] Scan [ ] Uploaded [ ] Faxed Ins Ver [ ] Update Address [ ] Square

Waiver for Private Pay Clients
(Skip if using insurance)

At times patients with insurance coverage prefer to pay privately for confidentiality reasons. Using your insurance requires passing along information regarding diagnosis necessary for reimbursement (see Confidentiality Statement and HIPAA policies). This information is discoverable by underwriters of life, long-term care, and medical insurance policies and may impact future premiums or coverage.

Also It is common for insurance not to pay for marriage/couples/sex therapy. It is unethical and a breach of contract with your insurance company to bill "as family therapy" in order to get paid. If your insurance does not cover either the diagnosis (Z codes), or Marriage Counseling – a payment at time of service discount rate listed below is the alternative.

The usual rate is$225.00 for intakes, $130.00 individual and $150.00 for couples; however, payment at time of service permits a discounted rate of:

$95.00 for intake appointment (60 minutes).
$75.00 for 45 minute session (individual)
$85.00 for 60 minutes session (individual)
$95.00 for family/couples (60 minutes).

_____ (initial) I understand that I do not have mental health/marriage counseling benefits as part of my insurance policy or I do not meet the criteria for medical necessity and choose to continue through private pay OR…

_____ (initial) I am choosing to pay privately and will not submit to my insurance company for reimbursement. Should I desire to use my insurance in the future. I understand that I must revoke this waiver in writing AND only submit to insurance those sessions that have occurred AFTER the date of my written notification.

_____ _____

Client / Guardian Signature Date

CREDIT CARD ON FILE

At AdultSpan Counseling your credit/debit card information is kept confidential and secure using the Square credit card system. You may receive an email notifying you that your card has been linked to your AdultSpan PC account.

Our billing company sends bills towards the end of the month. You will only receive a bill only if we are sure it is your responsibility to pay. You will not receive a bill if you do not have a balance or until your insurance has paid (or applied it to your deductible or denied coverage of service or diagnosis). Your credit card on file will be used only as follows:

- At your request to pay by phone, or email.
- If you have a balance overdue by 90 days, I use the credit card on file to automatically charge the portion of the bill that is more than 90 days over due.

I authorize AdultSpan Counseling to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐Amex ☐Visa ☐Mastercard ☐Discover

Last 4 of CC Number _____ Exp Date ___ / ____ CVV# _____

Cardholder Name _____

Billing Address _____

City _____ State_____ Zip _____

Email for Invoices/Receipts: _____

Cardholder Signature _____ Date ____/____/____

I (we), the above signed, authorize and request J. Kipp Lanning at AdultSpan Counseling to charge my credit card, as indicated above. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to AdultSpan PC in writing: 1001 S 70th St. #225 Lincoln 68510

This portion will be removed and shredded after card number is stored in accordance with regulations by Square for security purposes:

Full Credit Card Number: _____-_____-_____-_____

Informed Consent for Therapy

Therapy will work on the goals that you bring. When working as a couple for relationship counseling, the goals that support the relationship for the couple will be the focus of counseling. Generally this works well, but sometimes it can be challenging emotionally and take some additional time throughout your week. Sometimes looking at problems to make changes is uncomfortable, please let me know if this is happening so I can help.

I won't do tests or assessments without your knowledge and agreement. Your records are kept secure according to state and federal regulations. We use an electronic health record though a business agreement that is HIPAA compliant. If you have questions on this please feel free to ask. Your specific therapist and their supervisor/ administrator are the only ones with access to your records. Regarding couples counseling: Intakes will be stored individually. Couples counseling will be billed as "family" sessions, the identified patient for insurance billing purposes will be discussed at your intake session along with confidentiality of the file.

Unless you are using Medicaid, your physician will not be notified of your treatment unless you specifically request this. If you are using Medicaid and do not want your physician contacted, let your therapist know.

I do not provide crisis counseling. As I am in session with other patients and have office hours, I will return calls during those office hours (described on my voicemail). If you have a medical emergency, please contact 911 emergency services. Otherwise – please use family and friends for support until an "urgent" appointment can be scheduled (within 24 hours). I do provide some limited phone contact through scheduled arrangements, this is not covered by insurance and will be billed according to my private pay rate.

I do not use social media to connect with, friend, message or otherwise communicate with patients. Posts / messages that this therapist believes may compromise your confidentiality will be deleted.

As the work we do requires clear thinking and can stir strong emotions, you cannot come under the influence of drugs or alcohol. Weapons are not allowed in the office. If your therapist suspects this, your appointment will be rescheduled.

Missed appointments with less than 24 hours notice are subject to a $50.00 late cancellation / no show fee.

Payments may be collected at the time of service. Any amounts not covered by insurance either due to deductibles; co-insurance; denied services, diagnoses, or dates of service will be the patient responsibility. Amounts over 90 days past due may be automatically collected by your therapist using the credit card on file.

_____

Name and date

Confidentiality of your Information

What is said in therapy needs to be confidential in order for therapy to work. Confidentiality means that your therapist will protect verbal, written/electronic information (i.e., your file) according to state and federal guidelines.

There are some limits to confidentiality. If you feel that you may harm yourself or others, your therapist will use the least information to the fewest people possible to reasonably ensure safety. Your therapist is required by law to report suspected abuse or neglect of a child or vulnerable adult to the authorities. At times your therapist will consult with other therapists about your treatment without identifying you.

Family or couples therapy is only as confidential as the other people in the room. Please respect each other's confidentiality. While your therapist would encourage you to use your support system (friends and family), please limit what you share about therapy. Sessions billed as a FAMILY session will require a release of information from all persons attending. There will be only one "family" file. Your therapist will discuss who is the identified patient for the file/billing. At times it may make sense to see members of the family individually and as a family. The pro/cons of this will be discussed as well as how the confidentiality for individual sessions will be handled.

Parents are asked to respect that confidentiality is important for children too. Your therapist will let you know if your minor child is in imminent harm. Just because your child may discuss risky behaviors does not mean they are in imminent harm. If you would like to clarify what you'd like to be told about, please talk to your therapist.

Your insurance requires date, diagnosis and the service in order to pay. They may rarely also request your file to ensure the services were "medically necessary." If you're concerned about this you may pay for your services yourself; however, you cannot submit it to insurance for reimbursement. Payment information may be sent via the credit card system to the email on file if you request a receipt.

If you contact your therapist through an insecure means (e.g., email or text) you agree that your therapist may respond with the requested information with the same communication channel. However, your therapist may require you to schedule a session or phone contact to discuss complex or sensitive information.

Court or legal requests for records will start with an attempt to get a release from all persons attending the sessions. If it is denied, this therapist will work to keep your information protected; however, ultimately may end up having to testify. This unlikely, and if you're concerned about this talk with your therapist about how this will be handled.

By signing below I agree I understand my rights and limits for confidentiality. I have been offered and received, if requested, a copy of the HIPAA policy for AdultSpan Counseling.

_____

Name and date

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

LEVEL 2—Depression—Adult*

*PROMIS Emotional Distress—Depression—Short Form

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If the measure is being completed by an informant, what is your relationship with the individual receiving care? _____

In a typical week, approximately how much time do you spend with the individual receiving care? _____ hours/week

Instructions: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (the individual receiving care) have been bothered by "no interest or pleasure in doing things" and/or "feeling down, depressed, or hopeless" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you (the individual receiving care) have been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) DAYS....							**Item Score**
		Never	**Rarely**	**Sometimes**	**Often**	**Always**	
1.	I felt worthless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2.	I felt that I had nothing to look forward to.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
3.	I felt helpless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
4.	I felt sad.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
5.	I felt like a failure.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
6.	I felt depressed.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
7.	I felt unhappy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
8.	I felt hopeless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	

LEVEL 2—Anxiety—Adult*

*PROMIS Emotional Distress—Anxiety—Short Form

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If the measure is being completed by an informant, what is your relationship with the individual? _____

In a typical week, approximately how much time do you spend with the individual? _____hours/week

Instructions to patient: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (individual receiving care) have been bothered by "feeling nervous, anxious, frightened, worried, or on edge", "feeling panic or being frightened", and/or "avoiding situations that make you anxious" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you (individual receiving care) have been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) DAYS....							**Item Score**
		Never	**Rarely**	**Sometimes**	**Often**	**Always**	
1.	I felt fearful.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2.	I felt anxious.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
3.	I felt worried.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
4.	I found it hard to focus on anything other than my anxiety.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
5.	I felt nervous.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
6.	I felt uneasy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
7.	I felt tense.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	

LEVEL 2—Substance Use—Adult*

*Adapted from the NIDA-Modified ASSIST

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If the measure is being completed by an informant, what is your relationship with the individual receiving care? _____

In a typical week, approximately how much time do you spend with the individual receiving care? _____ hours/week

Instructions: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (the individual receiving care) have been bothered by "using medicines on your own without a doctor's prescription, or in greater amounts or longer than prescribed, and/or using drugs like marijuana, cocaine or crack, and/or other drugs" at a slight or greater level of severity. The questions below ask how often you (the individual receiving care) have used these medicines and/or substances **during the past 2 weeks.** **Please respond to each item by marking (✓ or x) one box per row.**

During the past **TWO (2) WEEKS**, about how often did you use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed?							**Clinician Use**
		Not at all	**One or two days**	**Several days**	**More than half the days**	**Nearly every day**	**Item Score**
a.	Painkillers (like Vicodin)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
b.	Stimulants (like Ritalin, Adderall)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
c.	Sedatives or tranquilizers (like sleeping pills or Valium)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
Or drugs like:							
d.	Marijuana	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
e.	Cocaine or crack	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
f.	Club drugs (like ecstasy)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
g.	Hallucinogens (like LSD)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
h.	Heroin	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
i.	Inhalants or solvents (like glue)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
j.	Methamphetamine (like speed)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
						Total Score:	

INTAKE QUESTIONNAIRE

Description of Present Problem

_____

_____

_____

_____

_____

What made it important to get help with this problem now?

_____

_____

What have you already tried to do to take care of this problem?

_____

_____

_____

When did you first start to struggle with this problem?

_____

_____

_____

How often is this a problem?
[]Continuous []most days [ ] weekly [ ] monthly [ ] every couple of months

When this is a problem, how intense is it
[ ] overwhelming [ ] interferes with focus/tasks [ ] worrisome [ ] minor irritation

If this problem were to go away, what would you be doing differently or how would you be feeling differently than you do now?

_____

_____

Safety Issues:

Please note if you are having any thoughts about the following:
[ ] Suicidal [ ] Assault [ ] Drug Relapse [ ] Risky/illegal sexual behavior

Past Psychiatric History:

Current and / or most recent previous counselor(s):

Counselor Name: Started Stopped

Issues addressed at that time?

Should I contact them?

What was most helpful and least helpful about this counseling experience?

Previous mental health inpatient or partial care hospitalizations

Location: Date(s)

Location: Date(s)

Location: Date(s)

Should I contact them?

What was most helpful and least helpful about this experience?

Previous Substance Abuse Treatment

Location: Date(s)

Location: Date(s)

Location: Date(s)

Should I contact them?

What was most helpful and least helpful about this experience?

Past Trauma History: *For example*, Bullying, physical assaults, combat, discrimination, natural disaster, sexual assaults, sexual molestations, life threatening accidents, child verbal/emotional/physical abuse, child emotional/social neglect, intimate partner violence, intimate partner social/emotional/verbal abuse, others.

Type	Year(s)	Did you get help?	Is it a current issue?	OK to ask follow up questions?

Is there a family history of mental health or substance abuse?

Mother's Side

Father's Side

Medical/Physical Health History – Please Check all he/she has been treated for in the past.

❍ AIDS	❍ Dizziness	❍ Nose bleeds	❍ Alcoholism	❍ Drug abuse
❍ Pneumonia	❍ Abdominal pain	❍ Epilepsy	❍ Rheumatic Fever	❍ Abortion
❍ Ear infections	❍ STD	❍ Allergies	❍ Eating problems	❍ Anemia
❍ Diarrhea	❍ Fainting	❍ Sore throat	❍ Appendicitis	❍ Fatigue
❍ Scarlet Fever	❍Arthritis	❍ Frequent urination	❍ Sinusitis	❍ Asthma
❍ Headaches	❍ Smallpox	❍ Bronchitis	❍ Hearing problems	❍ Stroke
❍ Bed wetting	❍ Hepatitis	❍ Sexual problems	❍ Cancer	❍ Tonsillitis
❍ Nausea	❍ Chest pains	❍ Kidney problems	❍ Tuberculosis	❍ Chronic pain
❍ Measles	❍ Toothache	❍ Colds/Coughs	❍ Mononucleosis	❍ Constipation
❍ Mumps	❍ Vision problems	❍ Chicken Pox	❍ Vomiting	❍ Sleeping disorders
❍ Miscarriages	❍ Whooping cough	❍ Diabetes	❍ Seizures	❍ Dental problems
❍ Thyroid problems	❍ High blood pressure			

Current Physical or Mental Health Treatments

Condition	Treatment provider	Current?

How long ago was your last physical? _____From? _____

Describe your exercise habits

_____

_____

How much sleep do you usually get?_____ Is it restful? _____

Any sleep disturbance issues (apnea, insomnia, sleep walking/talking, restless leg).

_____

_____

Describe any history of head trauma (e.g., you lost consciousness)

_____

Please list ALL your current medications, not just those for mental health.

Med	Dose	How many times a day?	Prescriber	Reason

Please list medications that have NOT worked well or had ADVERSE reactions

Family History

Who were your biological parents? Cultural/Ethnicity? Adoptions?

Are they still married? If divorced (or deceased) how old were you at the time?

As a child, what was your relationship like with your mother and father? Has it changed as you became an adult?

Where there other adult figures that were important in your upbringing and what was their relationship to you (e.g., step parents, grandparents, uncle/aunts).

What siblings did you grow up with as a child – please list them (first name is fine) in order from oldest to youngest and **include yourself**. Any important half or step sibling relationships?

Social History

Please list previous marriage partner(s), years together and any children:

Describe your current relationship (e.g., married, dating, living together, open)

Who is your current partner?

What year did you meet? Move in together? Married?

Please list children and ages.

What, if any current life stressors (e.g., work, unemployment, health issues, parenting, caring for elder parents, etc.) are causing stress in your relationship?

If you are coming for Marriage / Couples Counseling, which of the following area(s), if addressed, would **most improve your marital satisfaction**.

- [ ] **Communication** – we argue or bicker a lot and can't seem to let it go.
- [ ] **Intimacy** – we work well as a team, but we don't feel connected anymore
- [ ] **Passion** – feeling passionate, desirous and sexually attractive is missing.
- [ ] **Problem solving** – issues like chores, parenting and financial problems
- [ ] **Affair Recovery** – need help rebuilding trust & connection following an affair.
- [ ] **Sexual issues** – libido, erectile dysfunction, premature/delayed orgasm, etc.
- [ ] **Compulsive/addictive behavior** – drug /alcohol, gambling, pornography
- [ ] **Unsure about relationship** – trying to decide whether or not to divorce.

1(least)-10(most) what is the **most** satisfied you have **ever been** in your relationship?

1 2 3 4 5 6 7 8 9 10

1(least)-10(most) how satisfied with your relationship are you now?

1 2 3 4 5 6 7 8 9 10

Educational / Occupational History:

Please list diploma's, certifications and degrees earned starting with high school.

High School / GED	Year
Associates/Trade:	Year
Bachelors	Year
Graduate Degrees	Year
Graduate Degrees	Year

Please list your employment history.

Employer	Job	Start/Stop	Reason for leaving?

Please describe any military experience.

Legal History

Please list any current legal charges.

Please list any past charges AND convictions (if any) and sentences.