Rick Huls LIMHP

1932 Aspen Circle Suite I
Grand Island NE 68803
Phone 308-380-3697

WELCOME! Thank you for choosing my office. In order to serve you properly, we need the following information completed. ALL information will be confidential.

1. Personal Information

Client Name_____ Male _____ Female _____
Soc. Sec. #____-____-_____ Birthdate ____-____-_____ Home Phone _____
Address _____Email_____
City _____State _____ Zip Code _____

Please mark: Minor___ Single___Married___ Divorced___ Separated___
Employment Status: Full-time___ Part-time___ Unemployed___
Homemaker___ Student ___ Other ___

Spouse or Parent's Name _____
Spouse or Parent's DOB _____ SS# _____
Client Employer _____ Work# _____
Parent Employer _____ Work# _____
Spouse Employer _____ Work# _____
Business Address _____
If client is student, name of school _____ State _____

Were you referred by someone? Name_____
Are you currently receiving counseling? Yes _____ No_____
Name of counselor_____ Address _____
Religious Preference (Optional) _____

Other members of Household:

Names	Ages	Relationship to You
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician_____ Phone #_____

Existing Medical Conditions and Medications_____
_____
_____
_____

Chief Concern: Please describe the main concern that has brought you here.

_____

_____

_____

2. Responsible Party

Name of person responsible for this account _____

Relationship to you _____

(If different than information in #1, please fill in information below)

Address_____ Home Phone_____

Employer_____ Work Phone_____

Emergency Information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name_____ Home Phone _____

Address _____

3. Insurance Information

If you have health insurance, it may pay for part of the cost of therapy. You are responsible for your deductible and co-payment the day of service, unless other arrangements have been made. If you have not met your deductible, you will need to pay until it is met.

Name of subscriber (If different than client) _____

Relationship to client _____ Birthdate _____ SS# _____

Name & Address of Employer_____

Insurance Company_____ ID#_____ Group #_____

How much is your deductible? _____ How much have you met? _____ Co-pay ____

The method of payment that you choose will need to be approved by Rick Huls LIMHP.

4. Outpatient Service Contract

*Attached is an "Outpatient Service Contract". This is YOUR copy. Please read through the contract and then sign below stating that you have been given a copy and have read it through.

Signature _____ Date _____

5. Authorization & Release

I authorize release of any information concerning my/my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the therapist providing said services.

Signature _____ Date _____

(Client or parent/guardian signature, indicating agreement to all above statements)

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between your behavioral health provider(s) and your primary care physician (PCP) is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows your behavioral health provider to share valuable information with your PCP. No information will be released without your signed authorization. Once completed and signed, please give this form to your behavioral health provider.

Section 1. The Patient

Last Name	First Name	Middle Initial

Subscriber Number From ID Card	Insurance Company Name	Date of Birth (MM/DD/YYYY)	Phone Number

I hereby authorize the disclosure of protected health information about the individual named above.
I am: ☐ the individual named above (complete Section 8 below to sign this form)
☐ a personal representative because the patient is a minor, incapacitated, or deceased (complete Section 9 below)

Section 2. Who Will Be Disclosing Information About the Individual?

The following behavioral health provider may disclose the information:

Name (a person, or an organization if you are naming a facility)	Phone Number (if known)
Rick Huls LIMHP	308-380-3697

Section 3. Who Will Be Receiving Information About the Individual?

The information may be disclosed to the following primary care physician:

Name (a person, or an organization if you are naming a practice)	Phone Number (if known)

Street Address (if known)	City, State and Zip Code (if known)

Section 4. What Information About the Individual Will Be Disclosed?

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis, and medication(s) if necessary.

Section 5. The Purpose of the Disclosure

To release behavioral health evaluation and/or treatment information to the PCP to ensure quality and coordination of care.

Section 6. The Expiration Date or Event

This authorization shall expire 1 year from the date of signature below unless revoked prior to that date. _____

Section 7. Important Rights and Other Required Statements You Should Know

- You can revoke this authorization at any time by writing to the behavioral health provider named above. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- The information disclosed based on this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services.
- This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting your behavioral health provider named above.

Section 8. Signature of the Individual

Signature_____ Date (required) _____

Section 9. Signature of Personal Representative (if applicable)

Signature_____ Date (required) _____

Relationship to the individual (required): _____

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Last Updated:

Rick L. Huls LIMHP

1932 Aspen Circle Suite I
Grand Island, NE 68803
Phone: 308-380-3697

NEBRASKA NOTICE FORM

Notice of Therapist Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent.* To help clarify these terms, here are some definitions:

- **"PHI"** refers to information in your health record that could identify you.
- ***"Treatment, Payment, and Health Care Operations"***
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse** - When I have reasonable cause to believe that a child has been subjected to abuse or neglect, or if I observe a child being subjected to conditions which would reasonably result in abuse or neglect, I must report this to the proper law enforcement agency or to the Nebraska Department of Health and Human Services.

Adult and Domestic Abuse - When I have reasonable cause to believe that a vulnerable adult has been subjected to abuse or if I observe such an adult being subjected to conditions which would reasonably result in abuse, I must report this to the appropriate law enforcement agency or the Nebraska Department of Health and Human Services.

"Vulnerable adult" shall mean any person eighteen years of age or older who has a substantial mental or functional impairment or for whom a guardian has been appointed under the Nebraska Probate Code

- **Health Oversight Activities** –For the purpose of any investigation, the Director of Health and Human Services or the Director of Regulation and Licensure (the board which licenses me to practice) may subpoena relevant records from me.

- **Judicial and Administrative Proceedings** - If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization from you or your personal or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.
- **Serious Threat to Health or Safety** - If you communicate to me a serious threat of physical violence against a reasonably identifiable victim or victims, I must communicate such threat to the victim or victims and to a law enforcement agency.
- **Worker's Compensation** - If you file a worker's compensation claim, I must, on demand, make available records relevant to that claim to your employer, the insurance carrier, the worker's compensation court, and to you.

IV. Client's Rights and Therapist's Duties

Client's Rights:

- *Right to Request Restrictions* -You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request I will send your bills to another address.)

- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* - You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will inform you in writing or with a revised notice.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, please talk to me.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to the above address.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on January 1, 2008.

I have read and understand my rights as outlined above, and I give consent for treatment.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHIs that I maintain. I will provide you with a revised notice in writing the week the new policy is enforced.

Do you understand the above information?_____(yes)_____(no)

Would you like a copy? _____(yes)_____(no)

Signature: _____Date: _____

Revelations
COUNSELING

Rick Huls LMHP
1932 Aspen Circle Suite I Grand Island NE 68803
(308) 380-3697 Fax: (888) 505-7909 rhuls@live.com

NO SHOW POLICY

A no-show policy will take effect for patients of Rick Huls due to increased demand for prime time appointments. A no show is determined by whether the patient has contacted Rick Huls to cancel an appointment at least 4 hours prior to the appointment or is able to provide evidence of an emergency. It is preferred that patients cancel 24 hours prior to a session. Patients may cancel by sending a voicemail or email or text. Patients will not be charged if proper notification is received. As of January 1, 2019, the following fees apply:

First no show: Forgiven
Second no show: $30 to be paid prior to next appointment
Third no show: $60 to be paid prior to next appointment
Beyond three no shows: $60 each time

PAYMENT POLICY

Patients are responsible for paying therapy fees at the time of their session until their deductible has been met. Patients are responsible for copay charges at each session. Patients should check with their insurance provider to determine deductible and copay amounts. Payments may be cash, check or money order. I do not have a card terminal.

SOCIAL MEDIA POLICY

It is not ethical or appropriate for Rick Huls to engage in any contact with patients through social media such as private messages, excessive texting, Facebook, Twitter, etc. Patients have the right to set boundaries regarding the amount of phone or internet contact with Rick Huls. Any inappropriate contact by Rick Huls with a patient should be reported to the Nebraska State Board of Licensing.

Rick Huls LIMHP Patient Signature _____

Rick L. Huls, LIMHP
1932 Aspen Circle Suite I
Grand Island, NE 68803
308-380-3697

CONSENT TO RELEASE OF CONFIDENTIAL INFORMATION

I, _____, born on _____, give authorization for

Rick Huls, LIMHP and _____ to share the following information

regarding _____.
(Client's name and birthdate)

FROM Rick Huls LIMHP
to other Service Provider:

___ Intake Interview Information
___ Counselor Discharge Summary
___ Counselor Session Notes
___ History and Medical Treatment
___ Chemical Dependency Assessment
___ Psycho/Social Evaluation
___ Psychological Report
___ Diagnostic Personality Test Reports
___ Intelligence and Achievement Reports
___ Verbal Information
___ Other Information

TO Rick Huls LIMHP
from other Service Provider:

___ Discharge Summary
___ Physician Discharge Summary
___ History, Physical Exam, Lab Reports
___ Psychological Report
___ Psycho/Social History
___ Chemical Dependency Assessment
___ Diagnostic Personality Test Report
___ Intelligence and Achievement Reports
___ Department of Social Service Report
___ Grade Reports and/or Teacher Reports
___ Medications (History and Current)
___ Legal Information: Reports on Arrests, Police and/or Court Actions
___ Verbal Information
___ Other Information _____

This information is to be used for the purpose of _____.
This consent will terminate twelve (12) months from the date executed, or upon (List specific date, event or condition) _____.

I understand that my records may include drug, alcohol, and/or AIDS information which is protected under the Federal Confidentiality regulations (42 CFR, part 2).

Executed this _____day of _____, 2019.

(Signature of Client)

_____

(Signature of Parent/Guardian)

_____

(Signature of Witness)

_____

(Relationship to Client)

_____