GREAT PLAINS
MENTAL HEALTH ASSOCIATES

PATIENT INFORMATION. PLEASE PRINT AND FILL COMPLETELY

PATIENT LEGAL NAME: Last_____First_____M.I._____

PREFERRED NAME:_____GENDER: Male Female Other_____

PRONOUNS: he/ him/his_____she/her/hers_____they/them/theirs_____Other_____

AGE:_____DOB:_____SSN:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

MOBILE PHONE:_____HOME PHONE: _____

OK TO LEAVE A MESSAGE ON: MOBILE PHONE: Y N HOME PHONE: Y N

OK TO SEND TEXT REMINDERS: Y N

Email to be used for the Patient Portal: _____

Private pay without insurance? YES NO (If yes, be sure to sign and agree to private pay policies)

PRIMARY INSURANCE PAYOR: _____

POLICY NUMBER:_____GROUP #:_____ACTIVE DATE:_____

NAME OF SUBSCRIBER:_____

DOB OF INSURED:_____RELATIONSHIP TO CLIENT:_____

INSURED ADDRESS:_____

SECONDARY INSURANCE PAYOR:_____COMPANY:_____

POLICY NUMBER:_____GROUP #:_____ACTIVE DATE:_____

NAME OF SUBSCRIBER: _____

DOB OF INSURED:_____RELATIONSHIP TO CLIENT:_____

INSURED ADDRESS:_____

PRIMARY CARE PROVIDER:_____PHONE #: _____

Referral Source / How you heard of GPMH: _____

EMERGENCY CONTACT:_____RELATIONSHIP:_____

MOBILE PHONE #:_____HOME PHONE#:_____

IN CASE OF EMERGENCY OR IF YOUR PROVIDER FEELS YOU ARE AT RISK THIS INDIVIDUAL MAY BE CONTACTED. ***IF LEFT BLANK POLICE AND FIRE WILL BE CONTACTED FOR SAFETY CHECK WHEN NEEDED***

GREAT PLAINS
MENTAL HEALTH ASSOCIATES

Welcome to Great Plains Mental Health

We are pleased that you have selected Great Plains Mental Health as your mental health provider. We look forward to getting to know you so we can provide you with the highest quality of care to meets your individual needs. The mission of Great Plains Mental Health is to approach mental health care from a holistic and integrative model that includes all aspects of the human experience to understand and enhance mental wellbeing. We understand that finding a place of peace takes more than medication, it takes time and work. Great Plains Mental Health endeavors to provide the support for you to do that work using a variety of methods that include, in addition to counseling and medication therapy, meditation, yoga and more.

In this information packet you will find many important details about our clinic and its procedures. Please review this information carefully and feel free to ask questions. We are here to help.

OFFICE HOURS/NO AFTER HOURS EMERGENCY SERVICES

- Great Plains Mental Health is open Monday – Thursday from 8:00 am to 6:00 pm and Friday from 9:00 am to 12:00 pm.
- **Great Plains Mental Health does not offer after hours services or on-call crisis response**.
- **In case of an emergency, please call 9-1-1 or go to the closest hospital emergency department room.**

ABOUT INTEGRATIVE HEALTH CARE

Integrative health care is an approach to care that puts the patient at the center--taking a holistic view of each person and his or her unique circumstances. It values the relationship between each individual and his or her provider; using a variety of modalities to promote wellness and healing.

As with any treatment, services at Great Plains Mental Health (GPMH) come with risks and benefits. You should always consider the risks and benefits when making decisions regarding your health. Please discuss these with your provider. We are available to help you through difficult times, make recommendations and support you in finding the best treatment approach for you.

APPOINTMENTS AND SCHEDULING

- The recommended length of treatment and frequency of sessions varies with each individual and unique set of circumstances.
- Please arrive on time. If you are late, your provider may not be able to meet with you, and you will be asked to re-schedule. You may be charged a late cancelation fee if you arrive more than 15 minutes past your scheduled appointment time.
- The front desk can schedule up to 4 recurring appointments for you within 60 days. If you no call no show your appointments, you will no longer be allowed to pre-schedule your appointments more than one appointment at a time.

GREAT PLAINS
MENTAL HEALTH ASSOCIATES

WEATHER POLICY

- We will follow the Omaha School District weather / snow day cancellation policy. Please check for OPS closing reports for information.

PRESCRIPTIONS AND REFILLS

- Please call your pharmacy or use your pharmacy app to request refills.
- Each provider's goal is to give you a prescription during your appointment with enough refills to sustain you until your next appointment. If for some reason you miss your next appointment or are running low on medications, please contact your pharmacy to ask for a refill.
- The purpose of this policy is to make sure you are taking the correct medications in the correct doses. In addition, many prescriptions will require periodic blood work or even a follow-up visit with your nurse practitioner prior to receiving a refill. Therefore, it is very important that you keep your scheduled appointments.
- To serve you best, please allow a 24-48-hour notice on all medication refills. ALL MEDICATIONS, even refills, must be reviewed and approved by your nurse practitioner prior to approval. Please note that requests received over the weekend will not be review until the next business day.
- **Controlled substances require 1 week notice of refill. Please take care to manage refills in a timely manner.**
- 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
- Be careful to take medications exactly as prescribed or you will run short. It is our office policy and standard of care to **NOT refill prescriptions early. We will NOT replace lost or stolen medications** so take care to manage your medications appropriately.
- **NDMP - The Federal National Drug Monitoring Program** was established in Nebraska in January 2017. GPMH 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.

GREAT PLAINS
MENTAL HEALTH ASSOCIATES

CONFIDENTIALITY

GPMH will follow state and federal law regarding the confidentiality of private and protected health information. To permit proper coordination of care we ask you to sign an Authorization to Release Information when the law requires a patient's authorization to disclose information to a third party. There are exceptions to the requirement of patient authorization. The following are examples of situations when disclosures are permitted without patient authorization:

- If you are sent by the court for evaluation or treatment; the court typically requires a report.
- If the records are subject to a subpoena or court order: We must send the records
- If you make a threat to harm yourself or others or there is any concern about someone's safety the law, and our ethics require that we make every effort to protect someone from harm. This may involve reporting the threat to the proper officials

MEDICAL RECORDS, FORMS & LETTERS

- There is a minimum $25.00 fee for medical records or the completion of forms or letters. Additional charges may be applied depending on the nature and complexity of the form and letter. The minimum fee will be collected prior to the provider initiating work on the requested forms.
- A signed Authorization to release or request information may be required to process your request.
- Please allow 7-10 business days to complete forms or letters.

COMMUNICATION AND SOCIAL MEDIA

- We want to make communication with you as convenient as possible. Unless you instruct us otherwise, we will communicate with you about scheduling via phone, email, and texting using the preferred contact information you provided. By signing this form, you understand the risks in receiving protected health information via unencrypted (unsecured) text message and that such text messages could be read by a third party. You can always update your preferences with the front desk staff.
- I understand that I, having warranted authority to do so, hereby grant to Great Plains Mental Health Associates and its agents and independent contractors consent to call for billing and debt collection purposes any wireless/cell phone numbers that I provide to GPMH, and if I discontinue use of any phone number provided, I shall promptly notify GPMH and hereby indemnify GPMH and its agents and independent contractors from any expenses or other loss arising from any failure to notify.
- When communicating with your provider, please use the patient portal for a timely response. Please note that our providers check the patient portal messages during normal business hours. Do not use the portal for emergencies of any kind.

- We encourage you to sign up for our E-newsletter, for news and information about upcoming events, but you are not required to do this.
- Social media should not be used to communicate with us about your care, schedule appointments, or refill medications. Please call our front office staff to schedule appointments or discuss your care.

DISCHARGE FROM THE PRACTICE

There are times when professional relationships do not work out. When certain situations arise, it may be necessary or GPMH or an individual provider to terminate the patient provider relationship. In this event, you will receive a written notice to allow you time to locate another provider. At the end of the notice period, you can no longer schedule appointments, obtain medication refills, or consider us to be your provider. You will have to find another practice for your services. Common Reasons for Dismissal:

- Failure to keep appointments, frequent no-shows
- Noncompliance or failure to follow provider instructions about an important health issues
- Abusive to staff
- Disrespectful / Destructive behavior of child or patient while visiting GPMH
- Failure to pay your bill

FINANCIAL POLICIES

Understanding your financial responsibilities is important to your financial health and an essential element to your care and treatment at Great Plains Mental Health. It is your responsibility to read our policy and understand your responsibility.

BENEFITS VERIFICATION

- We bill your insurance as a courtesy to you. If information given is in error or payor is not responding, we will ask for your assistance to process the payment. If insurance denies the claim the amount owed becomes patient responsibility.
- It is your responsibility to verify your insurance coverage including obtaining pre-authorizations as required.
- We ask that you complete the Benefits Verification Form before your first appointment. When this form is completed, we will use the information you provide to bill your insurance.
- If you do not complete the Benefits Verification form, we will collect $100 for the initial appointment, and a minimum of $40 copay for all follow ups. Any credit accrued will be applied to future sessions or can be refunded to you.

GREAT PLAINS
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MINORS & PATIENTS WITH DIVORCED PARENTS

- Parent or guardian must submit custody decree to be kept on file at GPMH. GPMH staff and providers will be expected to follow the court order. We will not follow verbal requests or declarations.
- Whoever (parent, grandparent, babysitter, etc.) accompanies a minor to his/her appointment is expected to bring payment at the time of service. It will not be billed.
- For separated or divorced parents, payment is expected from the parent bringing the child in for treatment. We will not bill another parent for payments due at time of service; regardless of which parent is responsible for the insurance. However, a credit card can be kept on file if authorized verbally by cardholder.
- For minors coming to GPMH without a parent at time of appointment, **a credit card must be kept on file.** We do not want to burden the child with copay questions or need to locate parent for payment.
- The facility at GPMH was designed to be a peaceful and relaxing atmosphere. Please respect other patients' and their needs by following "library" type rules when at our facility.
    - Keep voices down
    - Step outside to conduct phone calls or business whenever possible
    - If videos or cell phone games are played use headset or turn off volume
    - **Children are expected to behave respectfully** – Destructive or disrespectful behavior will not be tolerated. This includes but is not limited to standing on the furniture, jumping on furniture, carving or marking furniture, loud disruptive behavior. Your provider will be informed and will address the issue in session.
      If disruptive behavior continues you will be asked to find another provider.

PRIVATE PAY/CASH DISCOUNTS

- Because there are fees associated with billing insurance companies and third-party payers, we offer a discounted rate for insurance eligible services when you choose to pay privately.
- When using this option, it is expected that you pay at the time of service which further reduces the cost of sending statements. We do this by keeping a credit card on file.
- If you do not wish to keep a credit card on file, we ask for payment at time of scheduling.

INSURANCE

- Your insurance policy is a contract between you and your insurance company. It is your responsibility to know and understand the provisions, limits, and requirements of your benefit plan(s).
- We will file your insurance claim for you; however, we cannot guarantee benefits or payments. You remain financially responsible for all services provided by this office.
- If your insurance carrier denies payment for services, you remain financially responsible for the

payment regardless of any insurance company determination, quote, or misquote, except where prohibited by law or prior contractual agreement.

- Please bring your current insurance card to each visit and notify our staff of any changes in your coverage, address, telephone or family status.
- I consent to telemedicine, understanding it is patient responsibility to verify insurance coverage.

CO-PAYMENTS, DEDUCTIBLES, AND FEES

- All co-payments, insurance deductibles, and fees for services not covered by insurance are **DUE AT TIME OF SERVICE**
- If unable to pay copay at time of service, appointment will be rescheduled and marked as a less than 24-hour cancellation and therefore subject to potential fees.
- If your deductible has not been met, we will expect payment in full prior to each appointment. Following your deductible being met, we will expect that you pay your co-pay at the time of each visit.
- We accept cash and credit cards. Payments are accepted by phone.
- **We do not accept checks at time of visit.** We will only accept checks via mailed payment of your monthly statement.

BILLING STATEMENTS

- The balance on your statement is due and payable upon receipt. To avoid any financial stress, we ask that you pay your balance within 30 days. After this period, it is past due.
- If the balance is not paid in full or other arrangements made with our office, the front desk will not be able to schedule an appointment for you. You will have to talk with your provider about scheduling.
- Payments can be made in person, by mail, or by phone.
- If your account balance is overdue by sixty (60) days or more or you have a balance of $400 or more, with no attempt to set up a payment plan; future appointments will be cancelled, and you may not be given the opportunity to make a new non-emergency appointment until payment is made.
- If your account must be sent to a collection agency, you will be responsible for all fees incurred from the collection agency and/or attorney.
- Financial noncompliance may result in termination from the practice.

CANCELLED, LATE AND MISSED APPOINTMENTS

- Missed appointments without proper notice of at least 24 hours results in time being blocked from other patients that may need it. Please understand, this is a standard practice and is a policy to ensure we can provide efficient services to all our patients.

- Patients who arrive more than 10 minutes past their scheduled appointment time may need to be rescheduled, 15 min or more may result in a no-show charge.
- A MINIMUM OF 24 HOURS NOTICE OF CANCELLATION for appointments is required. THE ACCOUNT WILL BE CHARGED FOR THE SESSION FOR MISSED APPOINTMENTS without the minimum notification as outlined below. Insurance companies do not reimburse for missed appointments. Therefore, charges incurred for missed appointments are the responsibility of the patient or guardian.
    - First missed appointment: No charge
    - Second missed appointment: $100 charge
    - Third missed appointment and greater: $150 charge
    - Medicaid patients will not be charged. However, after 3 missed appointments you will be dismissed as a patient and will need to find other services.
    - Missed appointment fees must be paid before scheduling your next appointment.
    - If an intake appointment is cancelled without 24-hour notice, a $200 deposit is required to reschedule. This deposit will not be refunded if second intake appointment is missed for any reason.

HIPAA NOTICE OF PRIVACY PRACTICES

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

II. IT IS OUR LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

By law we are required to ensure that your PHI is kept private. The PHI constitutes information created or noted by our practitioners that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you or the payment for such health care. We are required to provide you with this notice about our privacy practices. This notice explains when, why, and how we may use and disclose your PHI. Use of PHI means when we share, apply, utilize, examine, or analyze information within our practice; PHI is disclosed when we release, transfer, give or otherwise reveal it to a third party outside of our practice. With some exceptions, we may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, we are legally required to follow the privacy practices described in this notice. Please note that we reserve the right to change the terms of this notice at any time. Any changes will apply to PHI already on file. When we make any important changes to this notice, we will post a revised copy of it in our office and on our website. You may request a copy of this notice from us, or you can view a copy of it in our office.

III. How will we use and disclose your PHI

We will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.

We may use and disclose your PHI without your consent for the following reasons:

1. **For treatment.** We will use and disclose your PHI for treatment. We may disclose your PHI to physicians, psychiatrists, psychologists, and other health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, we may disclose your PHI to them in order to coordinate your care.

2. **For health care operations.** We may disclose your PHI to facilitate the efficient and correct operation of our medical practice. Examples: Quality control-we might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. We may also provide your PHI to our attorneys, accountants, consultants, and others for compliance purposes.

3. **To payment purposes.** We will use and disclose your PHI to bill and collect payment for the treatment and services provided to you. Example: We will send your PHI to your insurance company or health plan in order to receive payment for the health care services that I have provided to you.

4. **Business Associates.** We will disclose your PHI to our business associates and allow them to create, use and disclose your medical information to perform their services for us. For example, we may disclose your PHI to an outside billing company that processes health care claims for our practice.

5. **Other disclosures.** Examples: Your consent isn't required if you need emergency treatment provided that we attempt to get your consent after treatment is rendered. In the event that we try to get your consent but you are unable to communicate with us (for example, if you are unconscious or in severe pain) but we think that you would consent to such treatment if you could, we may disclose your PHI.

B. **Certain Other Uses and Disclosures Do Not Require Your Consent.** We may use and/or disclose your PHI without your consent or authorization of the following reasons:

1. **When disclosure is required for federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement**. If you are involved in a lawsuit or dispute, we may disclose PHI about you in response to a court or administrative order. For example, we may make a disclosure to the appropriate officials when a law requires us to report information to government agencies, law enforcement personnel and/or in an administrative proceeding. We may also disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if reasonable efforts have been made to notify you of the request or to obtain an order from the court protecting the information requested.

2. **If disclosure is compelled by the patient or the patient's representative pursuant to Nebraska Health and Safety Codes or to**

Corresponding federal statues of regulations, such as the Privacy Rule that requires this notice.

3. **Threats to Health or Safety.** Under certain circumstances we may provide PHI to law enforcement

personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public if we, in good faith, believe the use or disclosure is necessary to prevent or lessen the threat.

4. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or others, and if we determine that disclosure is necessary to prevent the threated danger.

5. **If disclosure is mandated by the Nebraska Child Abuse and Neglect Reporting Law.** For example, if we have reasonable suspicion of child abuse or neglect.

6. **If disclosure is mandated by the Nebraska Elder/Dependent Adult Abuse Reporting law.** For example, if we have reasonable suspicion of elder/dependent adult abuse or neglect.

7. **For public health activities.** We may disclose PHI about you for public health activities. For example, we may disclose PHI to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury or disability; or to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

8. **For health oversight actives.** We may disclose PHI to a health oversight agency for activities authorized by law. For example, we may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.

9. **For Law Enforcement functions**. We may release certain medical information if asked to do so by a law enforcement official:

- As required by law, including reporting certain wounds and physical injuries;
- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness or missing person;
- If you are the victim of a crime if we obtain your agreement or, under certain limited circumstances, if we are unable to obtain your agreement;
- To alert authorities of a death we believe may have been the result of criminal conduct;
- Information we believe is evidence of criminal conduct occurring on our premises; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

10. **For specific government functions.** We may disclose PHI for national security and intelligence activities authorized by law or for protective services of the President. If you are a military member, we may disclose PHI to military authorities under certain circumstances. If you are an inmate of a correctional institution or under the custody of law enforcement, we may disclose to the institution, its agents or the law enforcement official your PHI necessary for your health and the health and safety of other individuals.

11. **For research purposes.** In certain circumstances, we may disclose PHI in order to conduct medical research.

12. **For workers' compensation purposes.** We may disclose PHI as authorized by law for Workers' Compensation or similar programs that provide benefits for work-related injuries or illness.

13. **Treatment Alternatives**. We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

14. **Deceased Individuals**. We are required to apply safeguards to protect your PHI for 50 years following your death. Following your death we may disclose PHI to a coroner, medical examiner or funeral director as necessary for them to carry out their duties and to a personal representative (for example, the executor of your estate). We may also release your PHI to a family member or other person who acted as a personal representative or was involved in your care or payment for care before your death, if relevant to such person's involvement, unless you have expressed a contrary preference.

15. **Organ, Eye or Tissue Donation**. We may disclose PHI to organ, eye, or tissue procurement, transplantation or banking organizations or entities as necessary to facilitate organ, eye or tissue donation and transplantation.

16. **Incidental Uses and Disclosures**. There are certain incidental uses or disclosures of your PHI that occur while we are providing services to you or conducting our business. For example, we may need to use your name to identify you in the waiting area. Other individuals in the waiting area may hear your name being called. We will make reasonable efforts to limit these incidental uses and disclosures.

17. **Appointment reminders.** We may contact you as a reminder that you have an appointment for treatment or medical services.

18. If disclosure is otherwise specifically required by law.

C. **Certain Uses and Disclosures Require You to Have the Opportunity to Object.**

1. Disclosures to family, friends, and others. We may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment of your health care unless you object in whole or in part.

D. **Other uses and Disclosures Require Your Prior Written Authorization.** In any other situation not described in Sections IIIA, IIIB, and IIIC above, we will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that we haven't taken any action subsequent to the original authorization) of your PHI.

1. **Psychotherapy Notes**. These are notes made by a mental health professional documenting conversations during private counseling sessions or in joint or group therapy. Many uses or disclosures of psychotherapy notes require your authorization.

2. **Marketing**. We will not use or disclose your PHI for marketing purposes without your authorization. Moreover, if we will receive any financial remuneration from a third party in connection with marketing, we will tell you in the authorization form.

3. **Sale of Medical Information.** We will not sell your PHI to third parties without your authorization. Any such authorization will state if we will receive remuneration in the transaction.

IV. What Rights You Have Regarding Your PHI. These are you rights with respect to your PHI:

A. **The Right to Request and Get Copies of your PHI.** In general, you have the right to see your PHI that is in our possession, or to get copies of it; however, you must request it in writing. If we do not have your PHI but know who does, we will advise you how you can get it. Under certain circumstances, we may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. We will also explain your right to have the denial reviewed. If we maintain the medical information electronically in one or more designated records sets and you ask for an electronic copy, we will provide the information to you in the form and format your request, if it is readily producible. If we cannot readily produce the record in the form and format you request, we will produce it in another readable electronic form we both agree to. If you ask for paper copies of your PHI, we may charge you not more than $0.25 per page. We may see fit to provide you with a summary of explanation of the PHI, but only if you agree to it, as well as the cost, in advance. If you direct us to transmit your PHI to another person, we will do so, provide your signed, written direction clearly designates the recipient and the location for delivery.

B. **The Right to Request Restrictions on Uses and Disclosures of your PHI.** You have the right to ask that we limit how we use and disclose your PHI. While we will consider your request, we are not required to agree. If we do agree to your request, we will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that we are legally required or permitted to make. We are required to agree to your request that we not disclose PHI to your health plan for payment or health care operations purposes, if you pay out-of-pocket in full for all expenses related to that service prior to your request, and the disclosure is not otherwise required by law. Such a restriction will only apply to records that relate solely to the service for which you have paid in full. If we later receive an authorization form from you dated after the date of your requested restriction which authorizes us to disclose all of your records to your health plan, we will assume you have withdrawn your request for restriction.

C. **The Right to Get a List of the Disclosures We Have Made.** You are entitled to a list of certain disclosures of your PHI that we have made for the six years prior to your request. The list will not include uses or disclosures for treatment, payment, or health care operations, and certain types of other disclosures, for example disclosures in accordance with your authorization.

D. **The Right to Amend Your PHI.** If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that we amend the existing information or add the missing information. We are not required to make all requested amendments. If we deny your request, we will provide you with a written explanation of the reasons and your rights.

E. **Confidential Communications**. You may request that we communicate with you about your PHI in a certain way or at a certain location. We must agree to your request if it is reasonable and specifies the alternate means or location.

F. **Notification in the Case of a Breach**. We are required by law to notify you of a breach of your unsecured PHI. We will provide such notification to you without unreasonable delay but in no case more than 60 days after we discover the breach.

G. **The right to Get This Notice by Email.** You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

H. **How to Exercise These Rights**. All requests to exercise these rights must be in writing. We will respond to your request on a timely basis in accordance with our written policies and as required by law. Contact **Paula Whittle at 402-614--0010** for more information or to obtain a request.

V. Complaints.

If, in your opinion, I may have violated your privacy rights, of if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed below. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C.20201. If you file a complaint, we will take no retaliatory action against you.

VI. Person to Contact for Information About This Notice or To Complain About My Privacy Practices.

If you have any questions about this notice or any complaints about my privacy practices or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact Paula Whittle APRN, at Great Plains Mental Health Assoc. LLC, at 4610 South 133rd Street, Suite 109 Omaha, NE 68137.

VII. About this Notice. We are required to follow the terms of this notice currently in effect. We reserve the right to change our practices and the terms of this notice and to make new practices and notice provisions effective for all PHI that we maintain. Before we make such changes effective, we will make available the revised notice by posting it in our office, where copies will also be available. The revised notice will also be posted on our website. You are entitled to receive this notice in written form. Please contact Paula Whittle (information listed above) to obtain a written copy.

VIII. Effective Date of This Notice
This notice is effective December 25, 2019.
I Acknowledge receipt of this Notice:

RELEASE OF INFORMATION: I hereby authorize the release of medical records both written and oral, to insurance companies, employers, physicians, HCFA and any other institution or organization that may request information necessary to determine eligibility for health care benefits. I hereby acknowledge that I was offered a copy of the Great Plains Mental Health Associates LLC, HIPAA Notice of Privacy Practices.

GREAT PLAINS
MENTAL HEALTH ASSOCIATES

QUESTIONS

It is important that you understand the expectations of your treatment at GPMH. Please let us know if there is anything in this document that you do not understand or if you have any questions. We will provide assistance , if assistance is needed, please call 402-614-0010.

I UNDERSTAND AND AGREE TO THE TERMS OF ALL THE ABOVE MENTIONED POLICIES INCLUDING BUT NOT LIMITED TO CANCELLATION CHARGES, PAYMENT DUE AT TIME OF SERVICE, DISCHARGE POLICIES and TELEMEDICINE POLICIES.

- I consent to telemedicine, understanding it is patient responsibility to verify insurance coverage.
- I consent to the use and disclosure of protected health information for treatment, payment and necessary healthcare operations and have been offered a copy of the Notice of Privacy Practices.
- I authorize Great Plains Mental Health Associates, LLC to bill services rendered. I authorize that payment of Medicare and insurance benefits be made directly to Great Plains Mental Health Associates, LLC.
- I have received and reviewed full policies pages 1-14 of Great Plains Mental Health Associates, LLC.

PATIENT/GUARDIAN SIGNATURE:_____DATE: _____

PATIENT/GUARDIAN NAME (PRINTED): _____

CONSENT TO TREATMENT

PATIENT NAME_____**DOB**_____

I,_____, consent to treatment for therapy, counseling, and/or psychiatric care by Great Plains Mental Health Associates. By signing below, I voluntarily request and consent to those procedures and treatment provided by Great Plains Mental Health Associates LLC, that is necessary for my condition which is generally used and is common practice for the type of care I am requesting.

REASON FOR SEEKING CARE: _____

PATIENT SIGNATURE:_____Date:_____

LEGALLY AUTHORIZED REPRESENTATIVE:_____Date: _____

RELATIONSHIP IF NOT PATIENT: _____

GREAT PLAINS
MENTAL HEALTH ASSOCIATES

DATE: _____

NAME: _____

DOB: _____

DIAGNOSED MEDICAL CONDITIONS

MEDICAL CONDITION	YEAR OF DIAGNOSIS

ALLERGIES

MEDICATION	DATE	REACTION

ENVIRONMENTAL / FOOD ALLERGIES

SUBSTANCE	REACTION

CURRENT MEDICATIONS

MEDICATION	DIRECTIONS	DATE STARTED

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PAST MEDICATION

MEDICATION	START / STOP DATES	PROBLEM?

SURGICAL HISTORY

PROCEDURE	DATE	REASON FOR PROCEDURE

ANY OTHER DETAILS YOU WOULD LIKE YOUR PROVIDER TO KNOW?

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REVIEW OF SYSTEMS

Please check all **current** symptoms

General	□ Weight Loss	□ Weight Gain	□ Weakness	□ Fever	□ None
Eyes	□ Visual Loss	□ Double Vision	□ Blurry Vision	□ Eye Pain	□ None
Ears	□ Hearing Loss	□ Ringing	□ Ear Drainage	□ Ear Pain	□ None
Nose	□ Nasal Congestion	□Nasal Drainage	□ Allergies		□ None
Throat	□Swallowing Problems	□ Hoarseness	□ Throat Pain		□ None
Cardiovascular	□ Chest Pain	□ Palpitations	□ High Blood Pressure		□ None
Respiratory	□ Asthma	□ Cough	□ Shortness of breath		□ None
Gastrointestinal	□ Constipation	□ Diarrhea	□Bowel Changes	□ Heart Burn	□ None
Musculoskeletal	□ Arthritis	□ Muscle Aches	□ Joint Pain	□ Recent Injury	□ None
Skin	□ Lesions	□ Dryness	□ Itching	□ Rash	□ None
Neurologic	□ Dizziness	□ Headaches	□ Numbness	□Cognitive Changes	□ None
Endocrine	□ Diabetes	□Thyroid Sensitivity	□ Hot or Cold Sensitivity	□ Flushing	□ None
Sexual Health	□ Frequent Urination	□Painful Urination	□Libido Change		□ None
Menstrual Health	□ Menstrual Issues	□Mood Changes during Menstruation	□Heavy or Irregular Menstruation	□Currently Pregnant	□ Taking Birth Control
Psychiatric	□ Depression	□ Anxiety	□ Psychosis	□ Other (please list):	

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PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

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Severity Measure for Generalized Anxiety Disorder—Child Age 11–17

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

Instructions: The following questions ask about thoughts, feelings, and behaviors, often tied to concerns about family, health, finances, school, and work. **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
	During **the PAST 7 DAYS**, I have...	**Never**	**Occasionally**	**Half of the time**	**Most of the time**	**All of the time**	**Item score**
1.	felt moments of sudden terror, fear, or fright	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
2.	felt anxious, worried, or nervous	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
3.	had thoughts of bad things happening, such as family tragedy, ill health, loss of a job, or accidents	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
4.	felt a racing heart, sweaty, trouble breathing, faint, or shaky	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
5.	felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
6.	avoided, or did not approach or enter, situations about which I worry	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
7.	left situations early or participated only minimally due to worries	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
8.	spent lots of time making decisions, putting off making decisions, or preparing for situations, due to worries	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
9.	sought reassurance from others due to worries	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
10.	needed help to cope with anxiety (e.g., alcohol or medication, superstitious objects, or other people)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
						Total/Partial Raw Score:	
						Prorated Total Raw Score: (if 1-2 items left unanswered)	
						Average Total Score:	

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THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.* No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

GREAT PLAINS
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Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
					Part A
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					
					Part B

GREAT PLAINS
MENTAL HEALTH ASSOCIATES

AUTHORIZATION TO RELEASE/REQUEST CONFIDENTIAL INFORMATION

PATIENT NAME:_____DATE OF BIRTH: _____

I request protected health information (PHI) for the above-named client from Great Plains Mental Health Associates (GPMH) to be:_____
Released and/or _____Requested
Send Information to/from:
NAME: _____

AGENCY (if applicable): _____

PHONE:_____ FAX: _____

This information is requested for the purpose of:

_____Further Treatment Services _____Insurance Eligibility/Benefits _____Legal Action/Proceedings

_____Personal/Request of Service Recipient _____Treatment Coordination/Progress

_____Other (Please Specify): _____

_____*Substance Use (For Dual Treatment Only): _____

*Signature of minor required for release of substance abuse records

NOTICE TO RECIPIENTS: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information in this record that identifies a patient as having or having had a substance use disorder either directly, or by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by CFR-42, 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 investigate or prosecute with regard to a crime a patient with a substance use disorder. Source: 42 CFR 2.1 to 2.67 (October 1, 2000 ed.)

Information to be released:

_____Treatment Summary_____Psychological Evaluation/Testing_____All Available Information

_____Other: _____

Release Method:_____Fax_____Mail _____Pick Up _____Verbal _____Other

By signing this authorization form, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing to GPMH provider at the address listed above. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless revoked, this authorization will expire in one year from the date signed or on the following date, whichever occurs sooner. Date:

_____

- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization; I understand that I have the right to refuse to sign this authorization.
- Any disclosure of information has the potential for re-disclosure and may not be protected by federal confidentiality rules.
- Requests for copies of records may be subject to fees in accordance with applicable law.

Patient printed name and signature:

_____**Date:** _____

Custodian printed name and signature (if above patient is a minor):

_____**Date:**_____