

# Catalyst

BEHAVIORAL HEALTH

5539 S. 27<sup>th</sup> St., Suite 104  
Lincoln, NE 68512

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## Client Information

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Name (Last, First, MI): \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Type (Home, Cell, Work, etc.): \_\_\_\_\_

Permission to Leave Voicemails:  Yes  No      Permission to Send Text Messages:  Yes  No  N/A

Secondary Phone (*if applicable*): (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Type (Home, Cell, Work, etc.): \_\_\_\_\_

Permission to Leave Voicemails:  Yes  No      Permission to Send Text Messages:  Yes  No  N/A

E-Mail Address: \_\_\_\_\_

Gender: \_\_\_\_\_ Ethnic/Racial Identity or Heritage: \_\_\_\_\_

Social Security Number (SSN): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship: \_\_\_\_\_

**Relationship Status (check all that apply):**

Single       In a Relationship       Engaged       Married       Separated       Divorced       Widow(er)  
 Other: \_\_\_\_\_

**Employment Status (check all that apply):**

Employed (Full/Part-Time)       Unemployed       Disabled       Student  
 Other: \_\_\_\_\_

**Highest Educational Grade Completed:**

Elementary School       High School       College       Graduate/Professional School

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Do You Have Medical Insurance Coverage?  Yes       No

**Primary Insurance Company:**

Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_

Policy Holder's Employer's Name \_\_\_\_\_ Employer's Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer's Address: \_\_\_\_\_

If Other than Self:

Policy Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

Policy Holder's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_

Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_

Policy Holder's Employer's Name \_\_\_\_\_ Employer's Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer's Address: \_\_\_\_\_

If Other than Self:

Policy Holder's Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Policy Holder's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Responsible Party or Guarantor (If Other than Client):**

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

Address: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS**

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature of this document authorizes Eric J. Harnes M.A. LIMHP/PLADC to submit claims for benefits for services rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize and assign payment of all/any insurance benefits to Eric J. Harnes M.A. LIMHP/PLADC that is otherwise payable to me for his services as described on the assigned payment forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Eric J. Harnes M.A. LIMHP/PLADC will be credited to my account in accordance with the above assignment.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Signature of Patient/Guardian (Note: If the patient is under the age of 19, the parent/guardian must sign)

\_\_\_\_\_  
Date Document Signed



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## Consent for Treatment

Patient's Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_

I, \_\_\_\_\_, hereby give my consent to Eric J. Harmes M.A. LIMHP/PLADC to provide mental health services to me;

and/or I, \_\_\_\_\_ (Parent/Guardian) to the above named patient, hereby give my consent for treatment.

\_\_\_\_\_ I understand that:

- Eric J. Harmes M.A. LIMHP/PLADC may send my medical record information to my insurance company.
- I must pay my share of the costs (e.g., co-pays, amounts until a met deductible, etc.)
- If I do not have insurance, or if my insurance does not cover mental health services, I must pay for these services in full.

\_\_\_\_\_ I understand that:

- I have the right to refuse any treatment.
- I have the right to discuss all treatments with my provider.
- There may be a charge for late cancellations or no-show appointments.

\_\_\_\_\_ While I anticipate benefits through treatment, I am aware of unforeseen factors that may hinder my counseling and mental health treatment; I realize particular results cannot be guaranteed.

\_\_\_\_\_ Counseling and/or mental health treatment may escalate my emotional, mental, or physical conditions; I may experience new stressors during treatment and while attempting to make life changes.

\_\_\_\_\_ If I experience a life-threatening mental health emergency, I am to contact 911 or go to my nearest emergency room.

\_\_\_\_\_ Issues discussed with my clinician will remain confidential, *with a few exceptions*. There are some special circumstances that limit confidentiality including: a) a statement of intent to harm myself or others; b) statements indicating harm or abuse of children or vulnerable adults; c) issuance of a subpoena from a court of law; d) when your insurance company is involved; e) when you have signed a Release of Information allowing for your information to be discussed with an identified party.

I know of no reason why I should not or cannot undertake this mental health treatment and agree to participate fully and voluntarily.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## Billing Policy

The fees for services provided by Eric J. Harmes M.A. LIMHP/PLADC will be in accordance with the reasonable value set forth by established community guidelines and standards. At the present time, the fee for a diagnostic interview/initial session (CPT Code: 90791) is \$250 after which the billing rate for a licensed mental health provider is \$180 per 60-minute individual therapy (CPT Code: 90837).

**Clients are required to provide a valid credit card at the time of their first initial session for the office to keep in their file.** Co-pays are the client's responsibility and are required to be paid at the time of service. Clients are also responsible for any deductible, co-insurance and/or out-of-pocket balances remaining after insurance benefits have been applied. Client statements are available for viewing on the Patient Portal. If no payment is received within 30 days of the statement date, a payment will be automatically charged to the client's credit card on file. The client will be notified in advanced of the transaction. Eric J. Harmes M.A. LIMHP/PLADC does offer payment plans to those who need assistance with their balances. Uninsured clients or self-pay clients are required to pay for services in full at the time of their appointment before they can be seen. Uninsured or self-pay clients are responsible for the first initial session fee of \$250, followed by adjusted rates on follow-up sessions. Eric J. Harmes M.A. LIMHP/PLADC reserves the right to delay, defer, or discontinue services for any reason, including if the balance owed is not paid at the time it is due.

Sessions that are cancelled without at least 24 hours notice before the session will be considered late cancellations. Two late cancellations will be allowed before a warning letter will be sent out. One No Show appointment will be allowed before a warning letter will be sent out. After this, any appointment that is not cancelled with 24-hour notice, or any No Show appointment will be charged a \$50 fee. The client is required to pay this fee in full prior to scheduling the next appointment. This charge is also not billed through insurance. Should a client discontinue their services with Eric J. Harmes M.A. LIMHP/PLADC they are responsible for the payment of any remaining balance for services rendered. Eric J. Harmes M.A. LIMHP/PLADC reserves the right to forward any unpaid accounts to a collection agency to be recovered.

I, \_\_\_\_\_, understand that I am ultimately liable for the balance on my account for any services provided by Eric J. Harmes M.A. LIMHP/PLADC regardless of the status of my insurance situation. With my signature, I agree to adhere to the agency's billing policies and procedures, and to pay any fees that I owe the agency based upon such policies. I hereby authorize direct payment and all benefits due under my insurance policy to Eric J. Harmes M.A. LIMHP/PLADC. I authorize the release of medical or other protected health information necessary to process insurance claims.

Signature of Patient/Guardian

Printed Name

Date Document Signed

### **Credit Card Information:**

Card Holder Name: \_\_\_\_\_ Account Number: \_\_\_\_\_

Exp. Date: \_\_\_\_\_ Security Code: \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_

# Eric J. Harmes M.A. LIMHP/PLADC

**\*\*If you are filling this out on behalf of the patient,  
please answer from the patient's perspective. \*\***

## PERSONAL INFORMATION

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex: Female \_\_\_\_\_ Male \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

May I have permission to mail to this address? YES \_\_\_\_\_ NO \_\_\_\_\_

Telephone (Contact will be attempted in order of numbers listed)

1. (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (circle one) cell/home/work/other

2. (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (circle one) cell/home/work/other

May I have permission to leave a phone message? YES \_\_\_\_\_ NO \_\_\_\_\_

Is discretion needed when contacting or leaving a phone message for you? YES \_\_\_\_\_ NO \_\_\_\_\_

Email (Please avoid using work emails as possible for your own confidentiality)

\_\_\_\_\_ (circle one) personal/work

Preferred form of communication: Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

## Insurance

Primary Insurance Company: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_

Policy Holder Address: \_\_\_\_\_

Policy Holder SSN: \_\_\_\_\_ Copay Amount: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

# Eric J. Harmes M.A. LIMHP/PLADC

What is the primary reason(s) you are seeking services?

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How long have you been experiencing the problems that you are seeking treatment for?

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## Stressors

Given the list of categories below, how much stress is each currently causing you?

	None	Mild Stress	Moderate Stress	Severe Stress
Family				
Friends				
Relationships				
Educational				
Economic				
Occupational				
Housing				
Legal				
Health				

## Mental Health History

Have you ever been diagnosed with a mental health disorder?      Yes                  No

Please list any diagnosis you have experienced in the past and if that diagnosis is still a concern for you:

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Do you have a history of inpatient psychiatric treatment?      Yes                  No

# Eric J. Harmes M.A. LIMHP/PLADC

Please list any past inpatient treatment history below. Start with most recent and list each episode of treatment as a separate line.

<b>Hospital/Facility</b>	<b>Treatment Voluntary?</b>	<b>Primary reason for hospitalization</b>	<b>How old were you?</b>	<b>Treatment Outcome</b>	<b>Additional Comments</b>

Do you have a history of outpatient psychiatric treatment?                      Yes                      No

Please list any past outpatient treatment history below. Start with most recent and list each episode of treatment as a separate line.

<b>Provider</b>	<b>Primary reason for seeking treatment</b>	<b>Age of first treatment</b>	<b>Age of last treatment</b>	<b>Outcome</b>	<b>Additional Comments</b>

Have you ever taken any medication for psychiatric treatment?                      Yes                      No

# Eric J. Harmes M.A. LIMHP/PLADC

If YES, please fill out the table below to the best of your knowledge:

Medication name	Dose	How long? (months)	End Date	Therapeutic effect	Side Effects	Reason for stopping?

Have you ever tried to harm or kill yourself?      Yes                  No  
 If you answered "no," skip the rest of this question.

Was your intent to die?      Yes                  No  
 Elaborate below, if desired:

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How many times in your life has this occurred? \_\_\_\_\_

Please describe your most severe episode including date, method, and level of medical attention needed as a result:

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Please describe your most recent episode including date, method, and level of medical attention needed as a result:

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# Eric J. Harmes M.A. LIMHP/PLADC

Did you receive any treatment for substance abuse?      Yes                  No

If YES, please fill out the table below to the best of your knowledge:

<b>Treatment Type</b>	<b>YES</b>	<b>NO</b>	<b>How many episodes of treatment?</b>	<b>Age of first treatment?</b>	<b>Age of last treatment?</b>	<b>Any additional treatment information?</b>
Inpatient						
Intensive Outpatient						
Outpatient						
12-Step Program						

Have you experienced any of these consequences as a result of alcohol consumption or abuse of substances?

(Please Circle all that apply)

No consequences

- Felt that you needed to cut down on your drinking
- Been annoyed by others criticizing your drinking
- Felt guilty about drinking
- Needing a drink first thing in the morning
- Increased tolerance
- Withdrawal (shakes, sweating, nausea, rapid heart rate)
- Seizures
- Blackouts
- Effects on physical health
- Using/consuming more than intended
- Unintentional overdose
- DUI
- Arrests
- Physical fights or assaults
- Relationship conflicts
- Problems with money
- Job loss or problems at work/school
- Other: \_\_\_\_\_

# Eric J. Harmes M.A. LIMHP/PLADC

Medical History

Who is your primary care physician? \_\_\_\_\_

Are you taking any medications currently? (Excluding medications for psychiatric treatment)

Yes                      No

If YES, please include these medications below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please look at the list of physical symptoms below and circle any that you have experienced in the last several days.

Constitutional	Eyes	Ears, Nose, Mouth, and Throat
Chronic pain	Eye pain	Earache
Loss of appetite	Eye discharge	Tinnitus (Ringing in ears)
Increase in appetite	Eye redness	Decreased hearing or hearing loss
Unexplained weight loss	Blurred or double vision	Frequent ear infections
Weight gain	Visual change	Frequent nose bleeds
Fatigue/Lethargy	History of eye surgery	Sinus congestion
Unexplained fever	Sensitivity to light	Runny nose/Post-nasal drip
Hot or Cold spells	Scotomas (Blind spots)	Difficulty swallowing
Night sweats	Retinal hemorrhage (Floaters in vision)	Frequent sore throat
Sleeping pattern disruption	Amaurosis fugax (Feeling like a curtain is pulled over vision)	Prolonged hoarseness
Malaise (Flu-like or Vague sick feeling)		Pain in jaw or tooth
		Dry mouth
Other:	Other:	Other:
None of the above constitutional issues	None of the above eye issues	None of the above ear, nose, mouth or throat issues

# Eric J. Harmes M.A. LIMHP/PLADC

Cardiovascular	Respiratory	Musculoskeletal
Chest pain	Pain with breathing	Swelling in joints
Pacemaker	Chronic cough	Redness of joints
Palpitations (fast or irregular heartbeat)	Chronic shortness of breath	Other joint pains or stiffness
Swollen feet or hands	Chronic wheezing/Asthma	Muscle pain or cramping
Fainting spells	Excessive phlegm	Muscle weakness
	Coughing blood	Muscle stiffness
Shortness of breath with exercise	Nocturnal Dyspnea (Shortness of breath at night)	Decreased range of motion
		Back pain or stiffness
		History of fractures
		Past injury to spine or joints
Other:	Other:	Other:
None of the above cardiovascular issues	None of the above respiratory issues	None of the above musculoskeletal issues

Gastrointestinal		
Excessive flatulence or belching	Heartburn	Change in appearance of stool
Diarrhea	Difficulty swallowing solids or liquids	Blood in stool
Constipation	Recent loss in appetite	Dark/Tarry stool
Persistent nausea/vomiting	Sensitivity to milk products	Loss of bowel control/soiling
Abdominal Pain	Jaundice (yellow skin)	
Other:		None of the above gastrointestinal issues

Allergic/Immunologic	Endocrine	Hematologic/Lymphatic
Frequent infections	Severe menopausal symptoms	Blood clots
Hives	Cold or heat intolerance	Excess/easy bleeding (surgery, dental work, brushing teeth, scrapes)

# Eric J. Harmes M.A. LIMHP/PLADC

Allergic/Immunologic	Endocrine	Hematologic/Lymphatic
Anaphylactic reaction	Excessive appetite	History of blood transfusion
	Excessive thirst or urination	Excessive bruising
	Excessive sweating	Swollen glands (neck, armpits, groin)
Other:	Other:	Other:
None of the above allergic or immunologic issues	None of the above endocrine issues	None of the above hematologic or lymphatic issues

Genitourinary (General)	Genitourinary (Women)	Genitourinary (Men)
Loss of urine control (including bed-wetting)	Unusual vaginal discharge	Slow urine stream
Painful/Burning urination	Vaginal pain, bleeding, soreness, or dryness	Scrotal pain
Blood in urine	Genital sores	Lump or mass in the testicles
Increased frequency of urination	Heavy or irregular periods	Abnormal penis discharge
Up more than twice/night to urinate	No menses (Periods stopped)	Trouble getting/maintaining erections
Urine retention	Currently pregnant	Inability to ejaculate/orgasm
Frequent urine infections	Sterility/Infertility	Any other sexual or sex organ concerns
	Any other sexual or sex organ concerns	
Other:	Other:	Other:
None of the above general genitourinary issues	None of the above sex-specific genitourinary issues	None of the above sex-specific genitourinary issues

Neurological	Integumentary (Skin/Breast and Hair)	Psychiatric
Paralysis	Lesions	In-depth review of psychiatric system appears earlier in document (to be checked by clinician only)
Fainting spells or blackouts	Unusual mole	Feeling depressed
Dizziness/Vertigo	Easy bruising	Difficulty concentrating

# Eric J. Harmes M.A. LIMHP/PLADC

Neurological	Integumentary (Skin/Breast and Hair)	Psychiatric
Drowsiness	Increased perspiration	Phobias/Unexplained fears
Slurred speech	Rashes	No pleasure from life anymore
Speech problems (other)	Chronic dry skin	Anxiety
Short term memory trouble	Itchy skin or scalp	Insomnia
Memory difficulties (loss)	Hair or nail changes	Excessive moodiness
Frequent headaches	Hair loss	Stress
Muscle weakness	Breast tenderness	Disturbing thoughts
Numbness/Tingling sensations	Breast discharge	Manic episodes
Neuropathy (numbness in feet)	Breast lump or mass	Confusion
Tremor in hands/shaking		Memory loss
Muscle spasms or tremors		Nightmares
Other:	Other:	Other:
None of the above neurological issues	None of the above integumentary issues	None of the above psychiatric issues

Please list any health problems and surgeries you have a history of experiencing.

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**Family History**

Do you have any family members with a history of psychiatric illness?      Yes                  No

If YES, please elaborate below:

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Is there any additional family medical history?

# Eric J. Harmes M.A. LIMHP/PLADC

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## Developmental and Educational History

During your pregnancy/birth, did your mother have any problems with any of the following:

None of these

Exposure to drugs or alcohol during pregnancy

A difficult pregnancy

Problems with delivery

Other: \_\_\_\_\_

Did you have any complications after your birth? (e.g. premature birth, jaundice, breathing difficulties)    Yes                  No

Did you have any delays or difficulties in reaching the following developmental milestones?

None of these

Walking

Talking

Toilet training

Sleeping alone

Being away from parents

Making friends

Other: \_\_\_\_\_

Which options below best describe your childhood home atmosphere?

Normal

Supportive

Parental fighting

Parental violence

Financial difficulties

Frequent moving

Other: \_\_\_\_\_

Which of the following challenges were experienced during your childhood?

None of these

Tantrums

Enuresis (bed wetting)

Encopresis (fecal incontinence)

Running away from home

Fighting

# Eric J. Harmes M.A. LIMHP/PLADC

Which options below best describes your social situation?

Supportive social network

Few friends

Substance-use based friends

No friends

Distant from family of origin

Family conflict

Other: \_\_\_\_\_

What is your current marital status? \_\_\_\_\_

What is the status of your intimate relationship? \_\_\_\_\_

What is the satisfaction level of your intimate relationship? \_\_\_\_\_

What is your sexual orientation? \_\_\_\_\_

What is your current living situation? \_\_\_\_\_

Who do you currently live with?

Live alone

Roommates

Partner/Spouse

Parent(s)

Sibling(s)

Children

Other: \_\_\_\_\_

Do you currently participate in spiritual activities? \_\_\_\_\_

What is your current occupation status? \_\_\_\_\_

What is your current yearly income? \_\_\_\_\_

What is your longest period of continuous employment? (Please include dates and description)

Employment start: \_\_\_\_\_

Employment end: \_\_\_\_\_

Description:

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# Eric J. Harmes M.A. LIMHP/PLADC

What is your longest period of continuous unemployment?

Unemployment start: \_\_\_\_\_

Unemployment end: \_\_\_\_\_

Description:

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Is there anything else you would like me to know about you?

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