Catalyst
BEHAVIORAL HEALTH

Client Information – Adult Form

Name (Last, First, MI): _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: (_____) _____-_____ Type (Home, Cell, Work): _____
Permission to Leave Voicemails? ☐ Yes ☐ No

Secondary Phone: (_____) _____-_____ Type (Home, Cell, Work): _____
Permission to Leave Voicemails? ☐ Yes ☐ No

Email Address: _____
Permission to e-mail link to Client Portal? ☐ Yes ☐ No

Gender: _____ Race/Ethnicity: _____

Preferred Language: _____ Soc. Security #: _____

Referred by: _____
Permission to contact the referral source? ☐ Yes ☐ No

Emergency Contact

Name: _____ Phone: ( ) _____-_____

Relationship to Client:_____

Do You Have Medical Insurance? ☐ Yes ☐ No (Self Pay)

Primary Insurance Company: _____

Member ID #: _____ Group #: _____

Does this insurance require authorization prior to the first session? ☐ Yes ☐ No ☐ Unknown
If yes, have you contacted the company? ☐ Yes. ☐ No

Policy Holder's Name & Relationship _____

Policy Holder's Soc. Security #: _____-_____-_____ Policy Holder's DOB:_____/_____/_____

Policy Holder's Employer _____ Employer's Phone #: ( ) _____- _____

Employer's Address_____

Megan N. Basnett, Psy.D. – Licensed Psychologist
M. B. Psychological Services, LLC
5539 S. 27th St., Suite 104 Lincoln, NE 68512
Phone: (402) 261-8313 Fax: (402) 939-0437

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Secondary Insurance Co._____

Member ID #: _____ Group #: _____

Does this insurance require authorization prior to the first session? ☐ Yes ☐ No ☐ Unknown
If yes, have you contacted the company? ☐ Yes ☐ No

Policy Holder's Name & Relationship_____

Policy Holder's Soc. Security #: _____-_____-_____ Policy Holder's DOB:_____/_____/_____

Policy Holder's Employer _____ Employer's Phone #: (_____) _____-_____

Employer's Address_____

Responsible Party or Guarantor (if other than patient): _____

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 my physician to submit claims for benefits for services rendered for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that 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 M. B. Psychological Services, LLC that is otherwise payable to me for her 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 M. B. Psychological Services, LLC will be credited to my account in accordance with the above assignment.

Client Name (Print): _____

Client/Guardian Signature: _____ Date: _____

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Office Policies, Information & Agreements

Welcome! Before we begin out work together, it is important that you have information about my professional services and business policies. This document is our working agreement that we both understand the parameters of our work together.

CONFIDENTIALITY: The law protects the privacy of communication between a patient and therapist. In most situations I can release information about your treatment to others only if you sign a written authorization form that meets the HIPAA requirements. There are some situations in which I am legally bound to disclose information without a signed release of information. If any of these situations, arise, I will discuss the situation with you before taking action if possible, and definitely after. I will limit my disclosure to only what is necessary. Please see the Notice of Privacy Practices for full details.

LENGTH OF SESSION: The initial session is 1 hour. After that, sessions are either 45 – 50 minutes (90834) or be 55-60 minutes (90837). The length depends on need and insurance coverage (if applicable).

PROFESSIONAL FEES/PAYMENT: See Billing Policy

CANCELLATIONS/NO SHOW: Your time is set aside just for you. If you need to change your appointment, please provide as much notice as possible. There will be a $50.00 fee for appointments that are cancelled with less than 24-hour notice. This fee is not covered by insurance and must be paid prior to your next visit. If you cancel *two* consecutive appointments before rescheduling, or have a history of cancelling multiple times, we will need to discuss your treatment goals and whether you are able to commit to counseling at this time. Three no-show/late cancellations in one year may be cause for automatic discharge from therapy. Appropriate referrals will be provided if needed.

PHONE CALLS / EMERGENCIES: I will not answer the phone when I am with a client, but you may leave a message with the Office Manager during office hours. If outside of office hours or the Officer Manager is not readily available, you may leave a voicemail. I will make every effort to return your call within 24 hours, except on weekends and holidays. It is helpful to provide me with several alternate times to call you back. You can also reach me by email. I prefer that you use email primarily to arrange or modify appointments or to let me know you are running late. I check emails several times throughout the day and less frequently on the weekend.

In an emergency, you may call the Catalyst Behavioral Health Crisis Line at 1-800-247-4941 and they will forward your message to me or a staff member. If you are unable to reach me and feel that you cannot wait for a return call, contact your family physician, go to the nearest emergency room, or call 9-1-1. You can also utilize the National Suicide Prevention line at 1-800-273-8255.

INCLEMENT WEATHER

If the roads are dangerous and the city has issued a traffic advisory, we will not meet, and you will not be billed for the session. For those who do not use insurance and for those whose insurance covers telehealth, we can do a telehealth session instead of meeting in person, if you would like. We will discuss this when the situation arises.

OFFICE HOURS

Catalyst Behavioral Health's office hours are typically Monday - Thursday 9:00am - 4:00pm, and Friday 9:00am - 12:00pm during which the Office Manager may be reached. My office hours may vary and are posted on catalystbehavioralhealth.com.

PROFESSIONAL RECORDS
Upon written request you may examine and/or receive a copy of your Clinical Record, unless I believe that access would be harmful to you. In most situations I am allowed to charge a copying fee of $0.25 per page up to 100 pages. Your records are stored for 7 years from the date of the record. Should I be required to provide the insurance company with your PHI, I make every effort to release only the minimum information that is necessary for the purpose requested. This information will become part of the insurance company files. It is my policy to review any report to an insurer with you prior to submitting it.

ADDITIONAL DISCLOSURES
I may find it helpful to consult other health and mental health professionals about your case. During consultation, I will protect your identity. Consultations are noted in your Clinical Record (PHI) to protect the privacy of your information. I will need to share protected health information with the Catalyst Behavioral Health staff for both clinical and administrative purposes, such as scheduling, billing and quality assurance. These other professionals are bound by the same rules of confidentiality. Staff members have been given training about protecting your privacy and will not release any information without the approval of a professional staff member.

THERAPIST VACATION, SICK TIME, JURY DUTY
If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Signing this document indicates that you have read, had the opportunity to ask questions, and understand and agree to these policies.

Client Name: _____

Client/Guardian Signature: _____ **Date:** _____

Clinician Signature: _____ **Date:** _____

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Informed Consent

I, _____ (Client/Guardian) hereby give my consent to **M. B. Psychological Services, LLC** to provide _____ (Client) with mental health services. *Please initial the following:*

_____ I understand that:

- M. B. Psychological Services, LLC will 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.) for mental health services.
- If insurance does not cover mental health services or I am uninsured, 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.
- I may be charged 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 that particular results cannot be guaranteed.

_____ Counseling and/or mental health treatment may escalate my emotional, mental, or physical conditions and 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. In the event of other emergencies outside of business hours, I am aware that I can contact the crisis line at 800-247-4941.

_____ 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 yourself 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.

Client Name (Print): _____ Date of Birth: _____

Client/Guardian Signature: _____ Date: _____

Clinician Signature: _____ Date: _____

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Billing Policy

The fees for services provided by M. B. Psychological Services, LLC will be in accordance with the reasonable value set forth by established community guidelines and standards. M. B. Psychological Services, LLC has the right to raise the fee at any time, though usually once per year. At the present time, the fee for the first initial 60-minute session (90791) is $250, after which the billing rate is $240 per 60+-minute individual therapy session (90837), $160 per 45-minute individual therapy session (90834), $100 per 30-minute individual session (90832), and $175 per 45-minute family therapy session with or without client present (90847 and 90846).

Clients are required to provide a valid credit card at the time of their initial session for the office to keep in their file. Once uploaded into our secure system, this information is immediately shredded. This information will be updated yearly or when a card has expired. Client statements are available for viewing on the Client Portal. If no payment is received within 30 days of the statement date, a payment will be automatically charted to the client's credit card on file. The client will be notified in advance of the transaction. If payment is not received for two consecutive sessions, the client may not schedule an appointment until the fees owed are paid in full. Balances that are 90 days past due will begin accruing 1.33% finance charges every 30 days. M. B. Psychological Services, LLC offers payment plans to those who need assistance with their balances. M. B. Psychological Services, LLC 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. M. B. Psychological Services, LLC reserves the right to forward any unpaid accounts to a collection agency to be recovered.

Insurance and Co-pays

You are responsible for finding out what mental health services your insurance policy covers. Co-payments are the client's responsibility and required to be paid at the time of service. Clients are also responsible for deductible, co-insurance and or out of pocket balances remaining after insurance benefits have been applied. For insurances not accepted, your provider will give you an insurance acceptable receipt for fees paid (i.e. a "superbill"). It is your responsibility to find out what mental health services their insurance policy covers (i.e. copay, deductible, etc.). Your contract with your health insurance company requires information relevant to the services provided, which includes a clinical diagnosis. Sometimes additional information may be requested, such as treatment plans, progress notes, or copies of your clinical record. I make every effort to release only the minimum information that is necessary for the purpose requested.

Additional Fees: If additional reports or meetings not covered by the insurance company are needed, you agree to pay for the time it takes to write these reports and/or attend these meetings. Reports that would incur a fee include, but are not limited to: disability claim, Workman's Compensation, or review of treatment for an attorney. Meetings that would incur a fee include but are not limited to: attending an IEP meeting, speaking with an attorney and testifying at court. If I am needed for court, fees may include time lost for cancelled sessions, time for preparation, travel, or waiting, even if the need for testimony is cancelled.

I understand that I am ultimately liable for the balance on my account for any services provided by M. B. Psychological Services, LLC 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 M. B. Psychological Services, LLC for services provided. I authorize the release of medical or other protected health information necessary to process insurance claims.

Client Name (Print): _____

Client/Guardian Signature: _____ Date: _____

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CREDIT CARD AUTHORIZATION FORM

For your convenience, you may use a credit card to pay for your psychotherapy and any services related to psychotherapy.

This credit card authorization covers payment for _____ (client name).

I, _____(name of card holder), give M. B. Psychological Services, LLC, permission to charge my credit card. I understand that my credit card number will be kept on file to cover copays, co-insurance, deductibles, no show/late cancellations, and any out of pocket expenses that may occur that are not covered by insurance.

Please read and initial:

_____ I understand that payments are due and charged at the beginning of each session.

_____ I understand that I will not be notified prior to my credit card being charged.

_____ I understand that I will receive a Paid Statement of Receipt by mail if my card is charged.

_____ I understand that my card will be stored in a way that is HIPAA compliant; either in a locked file, a password protected and encrypted computer or an electronic health system.

_____ If the card holder is not the client, cardholder agrees that M. B. Psychological Services, LLC can charge this credit card in the manner described above for the client named above.

_____ I understand that my signature authorizes M. B. Psychological Services, LLC to charge my credit card in the manner described above.

CREDIT CARD INFORMATION
Card Type: ☐ Master Card ☐ Visa ☐ Discover
CREDIT CARD #:
Expiration Date: _____/_____ **Security Code:** _____ **Cardholder Zip Code:** _____

Card Holder Signature: _____ **Date:** _____

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Acknowledgement of Receipt

Authorization for Treatment
I acknowledge that I have been given the opportunity to review the **Informed Consent** and **Patient Rights & Responsibilities**. I may obtain a current copy upon request. I understand that M. B. Psychological Services, LLC has the right to change the Authorization for Treatment at any time.

Acknowledgement of Receipt of Privacy Notice
I acknowledge that I have been given the opportunity to review the **Notice of Privacy Practices for Protected Health Information**. I may obtain a current copy upon request. I understand that M. B. Psychological Services, LLC has the right to change the Notice of Privacy Practices at any time.

Office Hours and Phone calls
I have been advised that office staff is available Monday through Thursday, 9:00am – 4:00pm, and Friday, 9:00am – 12:00pm to address any questions or concerns. I understand my provider does not answer the phone when I am with a client. I may leave a message with the Office Manager during office hours. Every effort will be made to return your phone call as soon as possible. If I call outside of office hours or the Officer Manager is not readily available, I understand that I may leave a voicemail. If my call is urgent, I will note this with the office staff or when I leave a message on Catalyst Behavioral Health's confidential voicemail. In an emergency, you may also contact the Catalyst Behavioral Health Crisis Line at 1-800-247-4941 and I will be contacted. However, if you are unable to reach me and feel that you cannot wait for a return call, contact your family physician or the nearest emergency room.

Appointment No-Show Fee
I have been advised that this office requires a 24-hour prior notice on all appointment cancellations, and I have reviewed the Extended Billing Policy. I have been advised that there will be a $50.00 no show fee for appointments that are canceled with less than 24-hour notice. This fee is not covered by any insurance plan and must be paid prior to my next visit. I understand that three no-show/late cancellations in one year may be cause for automatic discharge from the clinic.

Billing Policy/Copayments
I acknowledge that I have been given the opportunity to review the **Billing Policy** for M. B. Psychological Services, LLC. I understand that co-pays, if appropriate, must be paid at the time of visit. I understand that I am responsible for all fees not paid by my health insurance. Payment is due 30 days after receipt of statement. I understand that M. B. Psychological Services, LLC offers financial assistance in the form of payment plans. 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. M. B. Psychological Services, LLC does reserve the right to submit any unpaid balances to a collection agency for recovery. **Clients are required to provide a valid credit/debit card at the time of their first initial session for the office to keep in their electronic file.** Cards will not be charged without prior notification and opportunity to provide an alternate payment will be offered at that time. Please direct any questions about insurance, billing, and payment plans to our office manager, Gina Pashby.

Client Name (Print): _____

Client/Guardian Signature: _____ Date Signed: _____

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Client History

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

2. What are your goals for therapy?
   _____
   _____
   _____

Mental Health History

3. Have you participated in therapy or counseling before? *If **Yes,** please list previous providers, approximate start/end date, and reason for treatment:* _____
   _____
   _____

4. Please list previous mental health diagnoses and/or conditions (if applicable): _____
   _____
   _____

5. Have you ever been hospitalized for a psychiatric/mental health reasons? *If **Yes,** please specify:* _____
   _____
   _____

6. Please list any psychiatric medications you have taken in the past. _____
   _____
   _____

7. Have you ever had thoughts of harming yourself (or attempted to)? ☐ Yes ☐ No

   If **Yes,** please elaborate: _____
   _____
   _____

8. Have you ever experienced any of the following?
   a. ☐ Physical abuse ☐ Emotional abuse ☐ Sexual Abuse ☐ Domestic Violence

9. Have you ever had thoughts of or attempted to harm someone else? ☐ Yes ☐ No

   If **Yes,** please elaborate: _____
   _____

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10. Family history of mental health/psychiatric conditions/diagnoses:
_____
_____

Medical History

11. Primary care provider: _____

12. Current Medications (psychiatric and other):
_____
_____
_____

13. Please check any of the following medical conditions that apply:

___ Headaches	___ Dizziness	___ Hepatitis
___ High blood pressure	___ Faintness	___ Asthma
___ Head injury or concussion	___ Bone or joint problems	___ Arthritis
___ Hormone-related problems	___ Urinary tract problems	___ Thyroid issues
___ Fibromyalgia	___ HIV/AIDS	___ Gastritis or esophagitis
___ Angina or chest pain	___ Numbness and tingling	___ Cancer
___ Irritable bowel	___ Shortness of breath	___ Seizures
___ Chronic pain	___ Diabetes	___ Chronic fatigue
___ Loss of consciousness	___ History of heart attack	___ Kidney-related issues

___ Other _____

14. Please list previous surgeries (and approximate dates):
_____
_____
_____

15. Please list any family history of medical conditions (e.g. cancer, diabetes, heart disease):
_____
_____
_____

Substance Use History

16. Please list past and/or current alcohol or recreational drug use (please include whether past/current, how much, and how often): _____
_____
_____

17. Have you ever received treatment for substance use? *If **Yes**, please elaborate:* _____
_____
_____

Family/Social History

18. Where were you born/raised? _____

19. What is your current relationship status?

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ In a Relationship ☐ Engaged

☐ Other _____

20. Please list all family members:

Name _____ Age _____ In Home? ☐ Yes ☐ No

Name _____ Age _____ In Home? ☐ Yes ☐ No

Name _____ Age _____ In Home? ☐ Yes ☐ No

Name _____ Age _____ In Home? ☐ Yes ☐ No

Name _____ Age _____ In Home? ☐ Yes ☐ No

21. Please list anyone else who currently resides in your home? _____

_____

22. Which best describes your current relationships?

☐ Supportive social network
☐ Few friends
☐ Substance-use based friends
☐ No friends
☐ Distant from family of origin
☐ Family conflict
☐ Other: _____

23. Do you have any religious and/or spiritual beliefs or practices? If **Yes,** please specify: _____

Developmental History

24. Did your biological mother have any problems with any of the following? (check all that apply):

___ A difficult pregnancy
___ Exposure to drugs or alcohol during pregnancy
___ Other: _____
___ Problems with delivery
___Premature birth
___ Unknown

25. Did you have any delays or difficulties in reaching the following developmental milestones? (check all that apply)

___ None of these
___ Walking
___ Talking
___ Toilet Training
___ Sleeping alone
___ Being away from parents
___ Making friends
___ Others: _____

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26. Which best describes your childhood home atmosphere?

___ Supportive
___ Violence between parents
___ Fighting between parents
___ Frequent moving
___ Financial stress
___ Other: _____

Educational, Occupational, & Legal History

27. Highest Level of Education:

☐ Grade _____ ☐ High school diploma ☐ Associate's degree ☐ Some college ☐ Bachelor's degree
☐ Master's degree ☐ Doctorate

28. What is your current occupation status?

☐ Employed part-time ☐ Employed full-time ☐ Unemployed ☐ Retired ☐ Disabled

29. Where are you employed and how long have you been employed at your current job (if applicable)?

_____

30. Do you have any past or current military service? ☐ Yes ☐ No

31. Have you ever been arrested, convicted of any crimes, incarcerated, or on probation? ☐ Yes ☐ No
If **Yes,** please specify: _____
_____

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

_____
_____
_____

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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	

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