Catalyst
BEHAVIORAL HEALTH

Registration Form

Name (Last) _____ (First) _____ (Middle Initial) _____

Address: _____ Cell # ( ) _____ - _____

City: _____ State: _____ Zip: _____ Soc. Sec # _____-_____-_____

Date of Birth: _____/_____/_____ Male: ☐ Female: ☐ Preferred Language: _____

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

Email Address: _____

Parent/Spouse/Guardian's Name: _____ Soc. Sec # _____-_____-_____
Purpose of Visit: _____
Emergency Contact: _____ Phone: (_____) _____- _____
Primary Care Physician: _____ Phone: (_____) _____- _____
Were you referred to our office? Yes: ☐ No: ☐ Referral Source: _____

Do you have Medical Insurance? Yes: ☐ No: ☐ **(If Yes Please Answer ALL Questions Below)**
Primary Insurance Company: _____
Member ID #: _____ Group #: _____
Policy Holder's Name: _____ Relationship: _____
Policy Holder's Soc. Sec #: _____- _____- _____ Policy Holder's Date of Birth: _____/_____/_____
Policy Holder's Employer's Name: _____ Employer's Phone (_____) _____-_____
Employer's Address: _____

Secondary Insurance Company: _____
Member ID #: _____ Group #: _____
Policy Holder's Name: _____ Relationship: _____
Policy Holder's Soc. Sec #: _____- _____- _____ Policy Holder's Date of Birth: _____/_____/_____
Policy Holder's Employer's Name: _____ 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 provider to submit claims for benefits for services rendered without obtaining my signature on 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 claim. I authorize and assign payment of all/any insurance benefits to Dr. Tracy K. List, Ph.D., 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 Tracy K. List, Ph.D., LLC will be credited to my account in accordance with the above assignment.

_____ _____ _____

(Print Name of Patient) (Authorized Signature of Patient/Parent/Guardian) (Date)

Note: If the patient is under the age of 19, the parent or guardian must sign all legal documents.

Tracy K. List, Ph.D., LLC
2001 Pine Lake Road, STE 200, Lincoln, NE 68512
Phone: (402) 261-8313 Fax: (866) 321-6448
www.catalystbehavioralhealth.com

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Consent For Treatment

Patient's Name: _____ **Patient's DOB:** _____

I, _____, hereby give my consent to Tracy K. List, Ph.D., LLC 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:

- Tracy K. List, Ph.D., LLC 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.
- I am aware this consent does not include court testimony by my provider.

While I anticipate benefits through treatment, I am aware of unforeseen factors that may hinder my counseling and mental health treatment; I realize 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. In the event of other emergencies outside of business hours, I am aware that I can contact that after-hours crisis line at 1-800-247-4941.

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 me or others; b) statements indicating harm or abuse of children/vulnerable adults; c) issuance of a subpoena from a court of law; d) when your insurance company is involved; e) when you have a signed 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:** _____

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Billing Policy

Authorization for Treatment
I acknowledge that I have been given the opportunity to review the Consent to Treatment and Confidentiality Statement. I may obtain a current copy upon request. I am aware this authorization to treat does not include court testimony by my provider. I understand Tracy K. List, Ph.D., 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 Tracy K. List, Ph.D., LLC has the right to change the Notice of Privacy Practices at any time.

Office Hours and Phone Calls
The office staff is available 9 am-4 pm Monday through Thursday, and 9 am-12 pm on Friday, to address any questions or concerns you have. Phone calls received after 3 pm may not be returned until the next business day. We will make every effort to return a phone call as soon as possible, but if your call is urgent, please note that with our office staff or when you leave a message on our confidential voicemail.

Billing Policy/Copayments
I acknowledge that I have been given the opportunity to review my Tracy K. List, Ph.D., LLC's billing policy. I understand that co-pays, if appropriate, must be paid at the time of our visit. I understand that I am responsible for all fees not paid by my health insurance. Payment is due 30 days after receipt of the statement. A return check fee will be applied to my account in the case of a returned check. Electronic payment is offered as an option and includes a $5 convenience fee. To avoid paying this additional fee, please use cash or a check made payable to your provider. A 1.33% finance charge will accrue on any unpaid balances that are 90 days or more past due. I understand Tracy K. List, Ph.D., LLC does offer financial assistance in the form of payment plans. I understand that uninsured/self-pay clients are required to pay for services in full at the time of their appointment before they can be seen. If Tracy K. List, Ph.D., LLC is out of network with my insurance, additional payment arrangements can be made. We reserve the right to submit any unpaid balances to a collection agency for recovery. **Clients are now required to provide a valid credit card at the time of their initial session for the office to keep in their electronic file.** Once uploaded into our secure system, this information is immediately shredded. This information will be updated yearly or when a card has expired. I understand that if no payment is received within 30 days, payment will be automatically charged to my credit card on file. Cards will not be charged without prior notification, and the opportunity to provide alternate payment will be offered at that time. Billing policies may be updated or modified throughout the calendar year. Please direct any questions about insurance, billing, and payment plans to our office manager.
(Continued on back)

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Billing Policy (Cont'd)

Provider Rates

The fees for services offered by Tracy List, Ph.D., will be in accordance with the reasonable value set forth by established community guidelines and standards. At the present time, the fee for the first initial diagnostic interview CPT Code 90791 is $350 after which the billing rate for a psychologist is $300 for individual therapy CPT Code 90837, $250 for individual therapy CPT Code 90834, $200 for an individual session CPT code 90832, $250 for a family session with or without patient present CPT Codes 90846 and 90847. Tracy List, Ph.D., reserves the right to raise her rates at any time.

Appointment No-Show Fee

I have been advised that this office requires 24-hour prior notice on all appointment cancellations, and I have reviewed Tracy K. List, Ph.D., LLC's billing policy. I have been advised that there will be a $75 Late Cancel/No Show fee for appointments that are missed/cancelled with less than 24-hour notice as required. This fee is not covered by any insurance plan and must be paid prior to my next visit. I understand that 3 no-show/late cancellations in one year may result in an automatic discharge from the clinic. Exceptions to this policy are solely based on my provider's discretion.

Credit/Debit/HSA Number: _____

Expiration Date: _____

Security Code: _____

Patient/Guardian Signature: _____

Printed Name: _____

Date: _____

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Extended Billing Policy

The fees for services provided by Tracy List, PHD will be in accordance with the reasonable value set forth by established community guidelines and standards. At the present time, the fee for the first initial session, CPT code 90791, is $350 after which the billing rate for a Ph.D. provider is $300 for an individual therapy CPT code 90837, $250 for an individual therapy CPT code 90834, $200 for individual therapy CPT code 90832, $250 for family therapy CPT code 90847 and $250 for family therapy CPT code 90846. The fees for Neuropsychological testing will be $300 for CPT code 96116, $250 for CPT code 96132, and $200 for CPT code 96136. Tracy List, PHD reserves the right to raise her rates at any time. **Clients are required to provide a valid credit card at the time of their initial session for the office to keep in their electronic file.** Copays 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. I understand that extended sessions that are over 60-minutes along may not be covered by my insurance, and I am responsible for any amounts not covered by my insurance. Client statements are mailed out on the first of the month. If no payment is received within 30 days of the statement date, a payment will automatically be charged to the client's credit card on file. The client will be notified in advance of the transaction. Electronic payment is offered as an option and includes a $5 convenience fee in addition to your payment for processing fees. To avoid paying this additional fee, please use cash or a check made payable to Tracy List, Ph.D. For any returned checks for non-sufficient funds, a return check fee will be applied to your account. 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. Tracy K. List, Ph.D., LLC, 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. Tracy K. List, Ph.D., LLC, does reserve the right to forward any unpaid accounts to a collection agency to be recovered.

Sessions that are cancelled without 24-hour notice will be considered late cancellation. Two late cancellations/no show appointments will be allowed before a warning letter is sent out. After this, an appointment that is not cancelled with 24-hour notice, or any no show appointment will be charged a $75 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. Exceptions to this policy are solely based on Dr. Tracy List's discretion. Should a client continue their services with Tracy K. List, Ph.D., LLC., that are responsible for the payment of any remaining balance for services rendered. Tracy K. List, Ph.D., LLC., does reserve the right to forward any unpaid accounts to a collection agency to be recovered.

I understand that I am liable for the balance on my account for any services provided by Tracy K. List, Ph.D., 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 on such policies. I hereby authorize direct payment and all benefits due under my insurance policy to Tracy K. List, Ph.D., LLC., for services provided. I authorize the release of medical or other protected health information necessary to process insurance claims.

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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 Tracy K. List, Ph.D., 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 Tracy K. List, Ph.D., LLC has the right to change the Notice of Privacy Practices at any time.

Office Hours and Phone Calls
The office staff is available 9 am-4 pm Monday through Thursday, and 9 am-12 pm on Friday, to address any questions or concerns you have. We will make every effort to return a phone call as soon as possible. If my call is urgent, I will not this will the office staff or when I leave a message Catalyst Behavioral Health's confidential voicemail.

Professionals or Agencies to be Contacted During a Crisis:
Center Point Crisis Response Phone: (402) 475-6695
Suicide Prevention Lifeline Phone: 1(800) 273-8255
Bryan West Mental Health Emergency Center: (402) 481-1111
Address: 2300 S 16th St, Lincoln, NE 68502

Appointment No-Show Fee
I have been advised that this office requires 24-hour prior notice on all appointment cancellations, and I have reviewed the Tracy K. List, Ph.D., LLC's Extended Billing Policy. I have been advised that there will be a $75 no-show fee for appointments that are cancelled 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 3 no-show/late cancellations in one year may result in an automatic discharge from the clinic.

Billing Policy/Copayments
I acknowledge that I have been given the opportunity to review Tracy K. List, Ph.D., LLC., Extended Billing Policy. I understand that co-pays, if appropriate, must be paid at the time of our visit. I understand that I am responsible for all fees not paid by my health insurance. Payment is due 30 days after receipt of the statement. I understand Tracy K. List, Ph.D., LLC., does offer 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. Tracy K. List, Ph.D., 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 sessions for the office to keep in their electronic file.** Once uploaded into our secure system, the information is immediately shredded. This information will be updated yearly or when a card has expired. Cards will not be charged without prior notification and the opportunity to provide an alternate payment will be offered at that time.

Print Patient Name: _____ **DOB:** _____

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

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Patient Rights and Responsibilities

As a person receiving mental health services here at Catalyst Behavioral Health, you have the right to:

- Be treated with dignity and respect.
- Ask questions and get answers about services offered here to determine the most appropriate treatment program. You can get information about treatment procedures, costs, and risks. You can request a change in your treatment or service as well.
- Participate fully in decisions regarding your health care service, including having your family involved in your treatment.
- Not be subject to verbal, physical, sexual, emotional, or financial abuse; harsh or unfair treatment.
- Make complaints, have them heard, get a prompt response, and do not receive any threats or mistreatments as a result, or file a grievance if you are not satisfied with the response to a complaint.
- Be assisted by an advocate of your choice, for example, family, friend, case manager, member of a consumer advocacy committee or organization, etc.
- Not to be discriminated against on the basis of race, age, gender, religion, national origin, sexual orientation, disability, or marital status.

All patients, to the extent capable, have the responsibility to:

- Pursue healthy lifestyles. Patients should pursue lifestyles known to promote positive health results, such as proper diet, nutrition, adequate rest, and regular exercise. Simultaneously, they should avoid behaviors known to be detrimental to one's health, such as smoking, excessive alcohol consumption, and drug abuse.
- Actively participate in decisions about their health care and cooperate on mutually accepted courses of treatment. Patients should comply with treatment regimens and regularly report on treatment progress. If serious side effects, complications, or worsening of the condition occur, they should notify their providers promptly. They should also inform providers of other medications and treatments they are pursuing simultaneously.

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Telehealth Consent

I, _____ (Client/Guardian), hereby give my consent to

Dr. Tracy K. List, Ph.D., LLC to provide _____ (Client) with medically necessary live, interactive video telehealth services located at the following distant site location: **2001 Pine Lake Rd, Suite 200, Lincoln, NE 68512**

I understand that:

a. There are potential benefits and risks of telehealth video services (e.g., limits to patient confidentiality) that differ from in-person services.
b. I retain the right to refuse telehealth video services at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
c. All existing confidentiality protection shall apply to my telehealth video services and I agree to receive an email with a link attached to join telehealth sessions as appropriate.
d. I shall have access to all medical information resulting from telehealth communication, as provided by law.
e. Information from the telehealth services (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my written consent.
f. If I decline telehealth video services for any reason (e.g., technological difficulties, etc.), I will work with my provider to find alternative treatment options, including telephone sessions or in-person services on a case-by-case basis.
g. I will be informed if this telehealth service will be recorded.
h. I will be informed if any additional people beyond my provider will be present at all sites during my telehealth video service.
i. I retain the right to exclude anyone from either the originating or distant site.
j. A safety plan is needed that includes at least one emergency contact and the closest emergency room to you location, in the event of a crisis.
k. My provider may determine that due to certain circumstances, telehealth services are no longer appropriate and that we should resume our services in-person or through other alternative options.
l. This consent is valid for six months for follow-up telehealth services with Dr. Tracy List, Ph.D., LLC.

I have read this document carefully and my questions have been answered to my satisfaction.

Print Name: _____ **DOB:** _____

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

Email Address: _____ **Phone Number:** _____

* If the client is under the age of 19, the parent/guardian must sign all legal documents. Additionally, if you choose to sign this document electronically, you agree your electronic signature is the legal equivalent of your manual signature on this document.

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Telehealth Patient Rights & Responsibilities for Participation in Telehealth Services

Prior to starting video-conferencing services, we discussed and agreed to the following:

- Confidentiality still applies for telehealth services, and nobody will record the session without permission from the client.
- We agree to use the video-conferencing platform selected for our virtual sessions and the provider will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phones or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your telehealth appointment, you must notify the provider in advance by phone or email.
- We need a backup plan (e.g., a phone number where you can be reached) to restart the session or reschedule it, in the event of technical problems.
- You should confirm with your insurance company that the video session will be reimbursed or covered. If they are not covered, you are responsible for full payment.

What you can expect:

- Therapists are utilizing the platform MYIO which is HIPAA compliant.
- Clients will need to register for an online portal account through Valant.
- Once the provider has initiated/started the session, the client will see a yellow banner on their portal account page which when clicked, will launch the session. If the client logs into their account prior to the clinician starting the session, they will have the option to do a self-check-in.
- If the client attempts to log in more than 15 minutes prior to their appointment, the self-check-in button will not be available.

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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	

Medication List

Client Name: _____ DOB: _____

1.) Please list any medications and any herbal or over-the-counter medications that you are taking. Please include the dosage, how often you take them, and who prescribed them.

2) Have you ever taken any antidepressants or other psychiatric medications that are not listed with your current medications? Please list those below.

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