Methodist Community Counseling Program Registration Packet

Welcome to the Methodist Community Counseling Program.

We have proudly served the Omaha community and area schools with the best care for over 25 years. Our behavioral health therapy services are provided by Licensed Mental Health Practitioners located in your neighborhood.

In order to serve you, please complete and submit the following forms:

- Client Registration (include insurance information)
- Authorization and Consent for Treatment
- Privacy Notice Acknowledgment
- Provide a copy/picture of both sides of insurance card
- Release of Information to Primary Care Physician

The Methodist Community Counseling Program accepts most major private insurance, Medicaid and/or self-pay. Financial assistance is available to those who qualify to ensure **no one is turned away due to the inability to pay**. If you have any questions or need further assistance, please call (402) 354-6891.

Thank you for choosing the Methodist Community Counseling Program where we care about you.

COMMUNITY COUNSELING PROGRAM

9239 W Center Road, Suite 201
Omaha, NE 68124-1900
402.354.6891
Fax: 402.354.8046
www.BestCare.org/CCP

COMMUNITY COUNSELING PROGRAM

2021-2022

Methodist Hospital Community Counseling Program

Client Registration

REASON FOR REQUESTING COUNSELING_____

REFERRAL SOURCE _____

CLIENT INFORMATION

Client Name _____
(Last) (First) (MI)

Preferred Name _____Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Gender _____ Date of Birth _____ Age _____ Social Security # _____
mm/dd/yyyy

Primary Care Physician _____

Race: ☐White ☐Hispanic/Latino ☐Black or African American ☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian/Pacific Islander ☐ Other

How did you hear about our services: ☐ School ☐ Agency ☐ Previous Client ☐ Promotional Materials/Web Site ☐ Community

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____
May we call/leave message? ☐ Yes ☐ No May we call/leave message? ☐ Yes ☐ No

Personal email _____ OPS Email address (if applicable) _____

Responsible Billing Party/Guarantor

☐ **Same as Client- OR- Please complete the following:**

Relationship to Client_____ Name _____

Gender _____ Date of Birth _____ Social Security # _____
mm/dd/yyyy

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____EXT_____
May we call/leave message? ☐ Yes ☐ No May we call/leave message? ☐ Yes ☐ No

Employment Status: ☐Active Military ☐Full-Time ☐ Not Employed ☐Part-Time ☐Retired ☐Self-Employed ☐Unknown

Employer _____

Legal Guardian (Complete if different from Client and/or Responsible Billing Party)

Relationship to Client _____ Name _____

Home Phone _____ Cell Phone _____ Work Phone _____EXT_____
May we call/leave message? ☐ Yes ☐ No May we call/leave message? ☐ Yes ☐ No

Email _____

INSURANCE INFORMATION

Does the client/guardian have an insurance provider? ☐ Yes ☐No
Does the client have Medicaid? ☐ Yes ☐No Medicaid Number _____
Is Medicaid the ☐ Primary or ☐Secondary Insurance coverage

Medicaid Plan: ☐ Healthy Blue Policy Number _____
☐ UHC Community Plan Policy Number _____
☐ NE Total Care Policy Number _____

☐ I have Medicare/Medicare replacement plan and am aware they will not reimburse for services.

PRIMARY INSURANCE INFORMATION

Complete information below and include a copy of both sides of your insurance card(s) for billing.

Insured's Relationship to Client: ☐Self ☐Spouse ☐Child ☐Other _____ Name: _____

Date of Birth _____ Social Security # _____
mm/dd/yyyy

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Employment Status: ☐Active Military ☐Full-Time ☐ Not Employed ☐Part-Time ☐Retired ☐Self-Employed ☐Unknown

Employer _____

Insurance Company Name _____ Phone Number _____

Group # _____ Effective Date _____ Member ID# _____

SECONDARY INSURANCE INFORMATION

Insured's Relationship to Client: ☐Self ☐Spouse ☐Child ☐Other _____ Name: _____

Date of Birth _____ Social Security # _____
mm/dd/yyyy

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Employment Status: ☐Active Military ☐Full-Time ☐ Not Employed ☐Part-Time ☐Retired ☐Self-Employed ☐Unknown

Employer _____

Insurance Company Name _____ Phone Number _____

Group # _____ Effective Date _____ Member ID# _____

For counselor use only

CCP COUNSELOR _____*Counseling Location*_____
Paperwork Reviewed by: _____ Date Scanned _____

Business office Use only Entered into EAP X _____Scanned documents to EAPX _____

COMMUNITY COUNSELING PROGRAM

2021-2022

Methodist Hospital Community Counseling Program

Authorization and Consent for Treatment

I, the undersigned client, parent and/or legal guardian of_____(minor's name), hereby give my authorization and consent for and acknowledge the following, for the duration of counseling care.

CONSENT TO COUNSELING CARE

I consent, either on behalf of myself, or on behalf of the minor listed above, to receive counseling care and treatment. I understand that the sessions may either be face to face or through telehealth.

Which includes or may include;

Please check all that apply: ☐ Individual, ☐ Family, ☐ Couples/relational counseling, ☐ Group _____
Group Topic

I understand the possible psychological risks involved in psychotherapy and understand that psychotherapy is not an exact science and that the results cannot be guaranteed. Psychotherapy is often beneficial, but as with any treatment, there are inherent risks. During therapy, the client may have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress and specific problem solving. No promise has been made to me about the results of treatment.

I authorize, either on behalf of myself, or on behalf of the minor listed above to having electronic records for the purpose of staff training and supervision.

I further authorize Methodist Hospital Community Counseling Program (MHCCP), any insurance company, or any other institution or organization to release any information necessary for the completion of insurance forms for the determination of benefits payable. A photocopy of this authorization shall be as valid as the original.

I have been informed of the staff's credentials, licensure, experience, professional associations, specialization, and limitations.

I understand that I need to provide accurate information about myself and/or the minor listed above to my clinician so that effective treatment will be obtained. I also agree to play an active role in my treatment process.

The risks, benefits, side effects, alternatives of treatment as well as the consequences of noncompliance with treatment have been discussed with me and I have had the opportunity to ask questions.

☐ I have read and understand the items above and have received an explanation of this consent form:

Signature of Client	Print Name of Client	Date
Signature of Parent/Guardian	Print Name of Parent/Guardian	Date
Signature of Witness	Print Name of Witness	Date

PERMANENT PART OF MEDICAL RECORD

COMMUNITY COUNSELING PROGRAM

2021-2022

Methodist Hospital Community Counseling Program
Clinical Rights and Responsibilities

Methodist Hospital Community Counseling Program (MHCCP) respects the basic rights of each person to personal dignity, independence of expression, decision-making and action. MHCCP affirms each person's right to make decisions regarding his/her counseling. MHCCP will assist the person in the exercise of his/her rights and will inform the individual of any responsibilities incumbent upon him/her in the exercise of those rights.

Your Responsibilities as a Client

As a MHCCP client, your responsibilities include**:**

1. Complying with the rules and regulations affecting your care and conduct. You are also responsible for keeping appointments or notifying your counselor when you are unable to keep an appointment.

2. Following the counseling plan recommended by your counselor. When you refuse counseling services or do not follow the recommended directions, you are responsible for your actions.

3. Providing complete and accurate information to your counselor throughout the counseling process. You will also inform your counselor about unexpected matters, or changes in an expected course of treatment. You will make it known to your counselor if you do not understand your course of care or what you are expected to do to aid in your care.

4. Treating your counselor, as well as any others involved in your care, with respect and consideration. You are also expected to respect the property of others and of the counseling office/area.

Your Rights as a Client

As a MHCCP client, you have the right to:

1. Impartial access to counseling services regardless of race, creed, sex, gender identity or expression, age, national origin, religious orientation, disability, sexual orientation or source of payment for care.

2. Be treated with dignity and respect.

3. Privacy and confidentiality, within the limits of the law, including the right to:
   - Have your counseling sessions in a private office
   - Access information contained in your counseling records
   - Have your counseling record read only by individuals directly involved in your care, planning or the monitoring of its quality.

4. Participate in the planning of your care, including
   - Collaboration with your professional, licensed counselor to develop, review and implement your counseling plan.
   - The right to accept or refuse counseling care and to be informed of the consequences of such refusal.

5. Have your guardian, next of kin, or legally authorized responsible person, exercise your rights on your behalf if you are a minor.

6. Reasonable personal safety in the counseling setting.

7. Contact MHCCP management at 402-354-6891 if you have a complaint or concern about your care.

8. A thorough explanation to you and your representative if there is a need for transfer to another professional for additional or continuing care.

BEST CARE EMPLOYEE ASSISTANCE PROGRAMS
NOTICE OF PRIVACY PRACTICES

2021-2022

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

This Notice applies to the following programs or services that are affiliated as part of Methodist Health System, Best Care Employee Assistance Program (Best Care EAP), and share similar information practices:

- Methodist Health System
- Nebraska Licensee Assistance Program
- Best Care EAP
- Community Counseling Program

The contact information of the MHS Privacy Officer is found below:

Privacy Officer – (402) 354-6863
compliance@nmhs.org

The programs and services listed above will share your clinical information with each other, as applicable, to carry out treatment, payment and health care operations.

Understanding Your Record/Clinical Information
Every time you have an appointment with a counselor from one of the programs listed above, a record of your visit is made.

Your Rights
Although your client record belongs to the program or service that compiled it, you do have certain rights with regard to your clinical information. To exercise any of the following rights, please contact the Privacy Officer at the above number:

- You have a right to expect that your clinical information will be kept secure and used only for legitimate purposes.
- You have a right to receive this privacy notice that explains how your clinical information may be used or disclosed.
- You have a right to know who has seen your clinical information during the previous six years, and for what purpose. If you make additional requests for such an accounting during any 12- month period, we may charge you a reasonable, cost-based fee.
- You have a right to view, and receive a copy or summary of, all of your clinical records in the format you request (electronic and/or paper), except for psychotherapy notes. Your request for a copy of your record must be in writing. We may charge you a reasonable, cost-based copying or labor fee for such copy.
- You have the right to ask for correction or amendment of anything in your records that you feel is in error. If we are unable to comply with your request we will notify you why in writing within 60 days. You also have the right to request that a statement of disagreement be included in your record. Your request must be in writing and include supporting documentation.
- You have a right to request we not use or share certain clinical information you consider especially sensitive for counseling, payment or our health care operations. You also have the right to request that we not share information with your health insurer if you pay for a service or item out-of-pocket in full. However, we are not required to accommodate your request except as provided below.
- You have the right to be notified of a breach of your unsecured protected clinical information.
- You have the right to request confidential communications by asking us to contact you in a specific way or to send mail to a different address. We will honor all reasonable requests.
- You have the right to choose someone to act for you. If you give someone medical power of attorney or if someone is your legal guardian, we will confirm the person has this authority and can act for you before we take any action.

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Your Choices
You have the right and choice to tell us to:

- Share information with your family, friends or others involved in your care;
- Share information in a disaster relief situation;
- Contact you for fundraising efforts.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes;
- Sale of your information;
- Most sharing of psychotherapy notes

We must disclose your health information to you, as described in this Notice. You may also give us written authorization to use your health information or to disclose it for any purpose. You may revoke your authorization at any time by contacting the Privacy Officer at the number listed above, but your revocation will not affect any use or disclosure made by us in reliance on your authorization. Without your written authorization, we may not use or disclose your medical information for any reason except those described in this Notice.

Our Responsibilities
We also have certain responsibilities. These include:

- Maintaining the privacy and security of your clinical record;
- Providing you with a copy of this Notice;
- Abiding by the terms of this Notice;
- Notifying you if a breach occurs that may compromise your information;
- Not using or sharing your information other than as described in this Notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time; let us know in writing if you change your mind.

We may revise this Notice as our information practices change. Any revision will be effective for all information in the record, regardless of whether it was gathered before or after the change took effect. However, before we change our practices, a copy of our new Notice will be posted at all Best Care EAP offices and on our web site. The effective date of our Notice will always appear at the end of the Notice.

Our Uses & Disclosures for Treatment, Payment and Health Care Operations
When state or federal law requires us to obtain your written permission to use or disclose your information for your treatment, payment or health care operations, we will do so. However, there are also situations where we may use or disclose your information for treatment, payment and health care operations without your permission.

We may use or disclose your information for clinical purposes.

For example: Information obtained by members of your clinical team will be documented in your record and used to determine the course of your clinical care. Your clinician, his/her clinical supervisor, and Best Care EAP management may communicate with one another personally and through your client record to coordinate your care. These exchanges may be done through electronic information networks.

We may use or disclose your information for payment purposes.

For example: We may provide your physician or other service provider with copies of reports that may help determine your future treatment. We may also disclose your information to another service provider for its payment purposes or its health care operations. We may send your bill to you or your insurance company. Your bill may contain information that identifies you, as well as your diagnosis, procedures and supplies used. However, if you pay for a clinical service out-of- pocket in full and request in writing that we not provide information to your health insurer, we will comply with your request unless a law requires us to share that information with them.

We may use or disclose your clinical information for program operations purposes and internal business practices.

For example: Members of the clinical staff or members of the quality improvement team may use information in your health record to assess your care and outcomes. This information is used in our ongoing efforts to improve the quality and effectiveness of the health care and services we provide.

Other Disclosures That May be Made Without Your Authorization
Unless we are otherwise restricted from doing so, we may also use or disclose your information for the following purposes without your authorization:

Affiliate Providers: Some services of our program are provided through contractual arrangements with affiliate providers. These include assessments, counseling, training, consultation, coaching, and other related services. When services are provided by an affiliate, we may exchange your information with each other so that we can provide the services that we have been asked to provide and they can bill us for those services. Our affiliate providers must use appropriate safeguards to protect your clinical information.

Business Associates: Some services of our organization are provided through contractual arrangements with business associates. When services are provided by a business associate, we may disclose your clinical information to our business associate so that they can perform the job we have asked them to do. In addition, we may disclose your clinical information to accrediting agencies and certain outside consultants. Our business associates must use appropriate safeguards to protect your clinical information.

Public Health: When required or permitted by law, we may disclose your clinical information to public health or legal authorities responsible for preventing or controlling disease, injury, or disability or performing other public health functions. In addition, we may disclose your clinical information in order to avert a serious threat to health or safety.

Specialized governmental functions: We may disclose your clinical information for military and veteran's activities, national security and intelligence activities, and similar special governmental functions as required or permitted by law.

Law enforcement: We may disclose your clinical information for law enforcement purposes as required or permitted by law or in response to a valid subpoena, court order or other binding authority.

Disclosures required by law: We may use or disclose your clinical information as required by law provided such use or disclosure complies with and is limited to the relevant requirements of such law.

Health Oversight Agencies: We may disclose your health information to an appropriate health oversight agency, public health authority or attorney involved in health oversight activities.

Judicial and Administrative Proceedings: We may disclose your clinical information for judicial or administrative proceedings as required or permitted by law or in response to a valid subpoena, court order or other binding authority.

Workers' Compensation: We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care about your location and general condition.

Communication with Family: We may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

For More Information or to Report a Problem
If you have questions or would like additional information, you may contact the Methodist Health System (MHS) Privacy Officer at (402) 354-6863 or compliance@nmhs.org. If you believe your privacy rights have been violated, you can file a complaint with the MHS Privacy Officer using the contact information above or with the Office of Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201, calling 1-877- 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Effective Date: October 2019

Nebraska Methodist Health System complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 844-599-4863.

注意：如果您使用繁體中文， 您可以免費獲得語言援助服務請致電 844-599-4863。

2021-2022

Methodist Hospital Community Counseling Program

Privacy Notice Written Acknowledgement

☐ I have received the Methodist Hospital Community Counseling Program Notice of Privacy Practices (Note: My signature does not indicate that I have read, understood or agree with the Notice, only that it has been provided to me.)

_____ _____

Signature of Client (or Parent/Legal Guardian if client is a minor) Date

_____

Relationship to client (If client is a minor)

For Methodist Hospital Community Counseling Program use only

Documentation of Good Faith Effort

☐ Attempted to distribute the Notice of Privacy Practices to the client/parent/legal guardian, but the client/parent/legal guardian declined to acknowledge the receipt of the Notice of Privacy Practices.

☐ Sent the Notice of Privacy Practices home with the *Consent for Counseling Services* form for client/parent/legal guardian.

☐ The Notice of Privacy Practices was mailed to the client/parent/legal guardian on_____.
(Date)

☐ Other _____

_____

_____

_____ _____

Methodist Hospital Community Counseling Program Counselor Date

_____

Location