Amber Fry Counseling, PC
*1710 N. 144th St. * Suite 4 * Omaha, NE * 68154*
Phone: (402) 315-3522

Registration Information

Contact Information:

Home Phone: _____
Cell: _____

Mom work #: _____
Employer: _____
Cell #: _____

Dad work #: _____
Employer: _____
Cell #: _____

Step-Parent: _____
Employer: _____
Work #: _____
Cell #: _____

Preferred contact Phone #:
_____

Email address:
_____

PERSONAL INFORMATION:

(Complete on behalf of the Client)

Name: _____
First M. Last
DOB: _____ Male ☐ Female ☐ **SS#:** _____

Street Address: _____

City: _____State: _____ Zip: _____

If a student, your school: _____

Marital status (circle): single married divorced widow

How did you hear about us? _____

PERSON(s) RESPONSIBLE FOR THIS ACCOUNT:

Name: _____DOB: _____

Address: _____ SS#: _____

FAMILY MEMBERS/SIBLINGS:

Name: _____DOB:_____ Name: _____ DOB:_____

Name: _____DOB:_____ Name: _____ DOB:_____

Name: _____DOB:_____ Name: _____ DOB:_____

EMERGENCY CONTACT:_____ PHONE:_____

Family Physician: _____ Phone: _____ Okay to Contact? _____

Medication/Dosage**:**_____

INSURANCE:

Do you wish this office to file claims? Yes ☐ No ☐

Primary Insurance (Name & Address): _____

Name of Subscriber:_____ DOB: _____

ID#: _____ Group#: _____ Employer: _____

Secondary Insurance (Name & address): _____

Name of Subscriber: _____ DOB: _____

ID#: _____ Group#: _____Employer: _____

ASSIGNMENT OF INSURANCE BENEFITS:

☐ I hereby authorize **Amber Fry Counseling, PC** to release information necessary to process insurance claims relating to my treatment.

☐ I authorize my insurance company to pay directly to **Amber Fry Counseling, PC** all benefits otherwise payable to me.

☐ **I will be responsible for all expenses related to treatment not paid under this plan(s).**

Client signature: _____ Date: _____

Guardian (if a minor): _____Witness: _____

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Office Financial Policy and Billing Agreement

Name (*print)*: _____Soc.Sec. _____

Insurance Coverage:

- I agree to contact my **Insurance Company to verify the Mental Health benefits**. (You pay for your insurance. It is your responsibility to know the benefits of your policy). _____ *initial*
- Should a dispute arise on a claim, **it is generally the clients' responsibility to clarify and resolve the dispute with the insurance company.** _____ *initial*
- If insurance *is* being filed, any deductible not yet met is **due at the time of service.** _____ *initial*
- I understand any **co-pay is due at the time of service**. If a minor, the person that accompanies the child will pay the co-pay. _____ *initial*

Payment:

- If Insurance *is not* being filed, **payment is expected at the time of service. _____** *initial*
- **I agree to provide a 24-hour notice to cancel an appointment.** A **late charge of $50.00 may be assessed if notice is not provided.** If you have **Medicaid, the charge is $10.00.** _____ *initial*
- If a client does **not show for a scheduled appointment,** there is a **no-show charge of $50.00.** If you have **Medicaid, the charge is $10.00. _____** *initial*
- A service requested by the client, but not covered by the client's Insurance plan, may be arranged under a separate written agreement with the office. _____ *initial*
- Phone calls are **not** billable to your insurance. Phone calls are **billed for the amount of time spent on the phone, at the hourly rate**. (See fee schedule). _____ *initial*
- Statements will **NOT** be sent to a third party, without their **written agreement to pay**, on file. _____ *initial*
- Accounts are **NOT** carried **beyond 90 days,** without payment. I understand my account may be sent to a Collection Agency if it becomes delinquent. _____ *initial*
- Fees are subject to change at the discretion of the practice. A fee schedule in available upon request. _____ *initial*
- There is a $20 administration charge for checks that do not clear the bank. _____ *initial*
- Questions regarding your account should be directed to the Billing Office at 398-1138. _____ *initial*

I certify that I have read, understand and agree to the foregoing. The undersigned is the client or is duly authorized by or on behalf of the client to execute the above and accept its terms.

_____ _____

Signature of Client or Responsible Party **Date**

_____ _____

Signature of Witness **Date**

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Fee Schedule

(effective February 1, 2014)

CPT CODES (filed to Insurance) **LIMHP**

90791.....Psychiatric diagnostic evaluation.....$160.00
90832..... Psychotherapy w/patient or family member; 30 min..... 50.00
90834.....Psychotherapy w/patient or family member; 45 min... 95.00
90837.....Psychotherapy w/patient or family member; 60 min... 120.00
90846.....Family Therapy (w/out client present)..... 110.00
90847.....Family Therapy (with client present) 115.00

Crisis session:
90839……Psychotherapy for patient in crisis; 60 minutes……..120.00
+90840…….crisis add-on code for each 30 minutes……. 50.00

H0031**……Mental Status Exam…… 100.00**
H0002**……..Pre-Treatment Assessment …… 195.00**
(Required by Medicaid/Magellan only)

Self Pay Charges:

Consultation **(hourly rate) $120.00**
Phone calls/phone consultations (charged for time spent, @ pro-rated hourly rate)
Letters..... (charged for time spent @ pro-rated hourly rate)
Reports..... (charged for time spent @ pro-rated hourly rate)
School Conference..... **(charged for time spent @ pro-rated hourly rate)**
Travel Time.....(charged for time spent @ pro-rated hourly rate)
No Show and Late Cancellation Charge..... 50.00
No Show and Late Cancellation Charge (Medicaid clients)..... 10.00

Thank you for your business!

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GUIDELINES FOR THERAPY INVOLVING CHILDREN AND THEIR FAMILIES

- By signing this Agreement to Treat, you have consented to have your child, and possibly other family members, participate in therapy. In situations where parents have joint custody, either parent can consent to treatment, and either parent can withdraw consent and terminate therapy. Efforts will be made to obtain consent from both parents, if possible. Using age appropriate language, the ideas of consent and the limits of confidentiality will be explained to your child.

- Persons whom I consider to be part of my family and whom I wish to include in the treatment process include:

_____ _____

_____ _____

_____ _____

- Therapy needs to be a safe place for all participants, including your child. Therefore, the therapist will keep most information learned from and about your child confidential, unless the child agrees that it will be shared. Parents will be made aware of a child's progress in therapy either by their direct participation in family sessions, or by receiving summaries of the child's progress and issues. In any event, parents will be provided information about their children that allows them to fulfill their parental responsibilities.

- If the therapist believes that the child is at serious risk of harm or is at serious risk of harming another, the therapist may break the child's confidentiality and inform the parent(s). Other potentially serious issues about which parents may want to be informed (alcohol/drug use, sexual relationships, gang involvement, use of pornography, pregnancy/abortion, self-harm, and other high-risk behaviors) will be discussed at the beginning of therapy, and a plan regarding how to handle them will be addressed.

- When a family is confronted by a parental separation or divorce, it can be very hard on everyone. It may be particularly hard on children. When the parental relationship is unsafe, it is even more important that therapy present a safe environment. That safety is particularly endangered where a child has to worry that what he/she says in therapy will be revealed in court and used against one of his/her parents. In order to protect that safety, it should be agreed that the therapist will not be called as a witness by either party. It should be understood, however, that a judge may decide not to honor this agreement and that the therapist may be required to be a witness, although Amber Fry Counseling, PC will try to prevent this from happening.

Thank you for taking the time to read the above information. Your signature below indicates that you have received and read the guidelines and have authorization to consent to therapy for the child named below.

_____
Name of Client

_____
Parent/Guardian Signature Date

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CLIENT NAME: _____DOB: _____

PROBLEM/ISSUE CHECKLIST

Please place a checkmark next to any of the following problems or concerns that your child may be experiencing.

Mood/depression problems or issues or issues

__Depression
__Withdrawal
__Crying spells
__Loss of interest in activities
__Fatigued, low energy level
__Suicidal thoughts, actions, attempts
__Low self-esteem, self-confidence
__Harmful behaviors to self
__Grief, loss issues

Impulse control problems

__Hyperactive
__Restless
__Doesn't think before acting
__Accident prone
__Difficulty concentrating
__Difficulty organizing tasks
__Easily distracted, no follow-through
__Takes risks that may be dangerous

Emotional problems or issues

__Sleep problems
__Nightmares
__Anxiety, excessive worry
__Panic attacks or intense fears
__Anger or temper outbursts
__Rapid or dramatic mood swings others do not
__Irritable
__Isolates self or withdraws from others
__Won't talk about what may be bothering him/her

Thought problems or issues

__Repeated actions child cannot stop (e.g., washing hands, counting things)
__Disturbing thoughts child cannot stop
__Problems remembering things
__Odd, bizarre thoughts or actions
__Sees or hears things others do not
__Believes others are out to get him/her

Social/Personal problems or issues

__Bed wetting, soiling
__Socially Immature

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__Poor appetite or diet

__Dependent on parents
__Significant change in peer group
__Difficulty making and keeping friends
__Hanging out with friends of whom you disapprove of
__Attention-seeking
__Whiny
__Feelings hurt easily
__Selfish, self-centered
__Complains that others don't like him/her
__Blames others for own problems
__Difficulty adapting to new situations
__Avoids trying new things
__Follows the crowd or easily influenced by peers

Conduct problems or issues

__Fighting with peers
__Aggressive or assaultive behavior
__Stealing
__Lying
__Noncompliant, disrespectful
__Cruelty to animals
__Fire-setting
__Sexual acting out
__Law violations
__Drug/alcohol use
__Doesn't follow curfew
__Gang involvement

School problems or issues

__Truancy
__Anxious about attending school
__Suspended
__Expelled
__Detentions
__Disruptive in the classroom
__Difficulties getting along with classmates
__Difficulties getting along with teachers
__Problems in daycare setting
__Learning disability
__Behavioral Disability
__Trouble paying attention or listening
__Not doing homework
__Working below grade level

Other problems/issues

__Sexual abuse victim
__Physical abuse victims
__Emotional abuse victim
__Frequent moves, changes in schools, changes in placement
__Death or loss of a loved one

__Speech, language, reading, writing disorder

Family problems or issues

__Conflicts with mother/stepmother
__Conflicts with father/stepfather
__Fighting with siblings
__Divorce/separation issues
__Marital problems
__Witnessed domestic violence
__Parental substance abuse
__Running away
__Difficulty with basic routines (e.g. hygiene, bedtime)
__Difficulty following rules or doing chores
__Experiencing racial/ethic discrimination

Please identify any other concerns that you may have with your child (or family).

_____

_____

_____

_____

Please list the major goals that you have for your child/family counseling.

1. _____

_____

2. _____

_____

3. _____

_____

CLIENT NAME: _____ **DOB:** _____

_____

FAMILY HISTORY

Biological Mother: _____ Biological Father: _____

_____

Adults child is living with (if different than above):

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_____Relationship to child:_____
_____

_____Relationship to child:_____
_____

Siblings:
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

Others living in the home:
Name: _____Relationship to child:_____
_____
Name: _____Relationship to child:_____
_____

Parents Marital History:
Name: _____Spouse: _____Dates:_
_____
Name: _____Spouse: _____Dates:_
_____

Other significant persons in child's life:
Name: _____Relationship to child:_____
_____
Name: _____Relationship to child:_____
_____

Has your child had an out-of-home placement? No Yes (indicate placement and date)
_____Dates:_____
_____
_____Dates:_____
_____

SOCIAL INFORMATION:

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Please list your child's main strengths or best qualities.

1. _____
2. _____
3. _____

LEGAL HISTORY: Has your child ever been ticketed for law violations or been on probation or parole? Please explain and give dates:

_____

PATIENT NAME: _____ **DOB:** _____

DEVELOPMENTAL HISTORY (please place a checkmark if there are or were difficulties or complications in the following areas.)

__Pregnancy
__Exposure to alcohol/drugs during pregnancy
__Premature/low birth weight
__Labor/childbirth
__Crawling
__Difficult temperament
__Talking
__Walking
__Head Injury
__Toilet Training
__Feeding
__Sleeping
__Difficulty with bonding, attachment disorders
__Infant/early childhood illness or
__Failure to thrive
__Difficulty bonding with parent/caretaker

ACADEMIC/SCHOOL HISTORY:

School: _____ From grade_____ to grade_____

School: _____ From grade_____ to grade_____

School: _____ From grade_____ to grade_____

School: _____ From grade_____ to grade_____

Grades your child usually receives on report cards: _____

Has your child been identified as:

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__Learning disabled __Gifted
__Developmentally disabled __Behaviorally disordered

Please describe any difficulties your child is having in the school setting: _____
_____
_____
_____
_____
_____

MENTAL HEALTH HISTORY (Please list any previous or current mental health or substance abuse services your child has received.)
Therapist/doctor/hospital: _____Date:_____
_____
Therapist/doctor/hospital: _____Date:_____
_____
Therapist/doctor/hospital: _____Date:_____
_____

If possible, please indicate any diagnoses that your child has received: _____
_____
_____

Please identify any history of emotional difficulties on either side of the child's family (e.g., depression, suicides, mood problems, anger control, anxiety, substance abuse, psychiatric hospitalizations, etc.)

_____
_____
_____
_____

Form completed by: _____ _____
Name Relationship

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MEDICAL INFORMATION

Date of last physical:_____

Please list any medical conditions and operations (including head injuries):

Please list any medication allergies: NONE

Please list current medications including non-prescription drugs and supplements:
NONE

MEDICATION	DOSAGE	REASON PRESCRIBED	DATE BEGUN

Previous History of Psychiatric Medications:

Have you ever abused prescription or illegal drugs: □ YES □ NO

If so, what: _____

_____

Do you drink alcohol? □ YES □ NO

If YES, how many times a week? _____ How many drinks each time? _____

_____

Signature of person completing this form: _____

_____

Relationship to child: _____

_____