Phone: 402.937.8323
Fax: 402.937.8324
Website: wellspringbh.com
Address: 1600 S 70th St. Ste. 200
Lincoln, NE 68506

Intake Forms

Acknowledgement of Forms

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

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 understand that Wellspring Behavioral Health 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 Wellspring Behavioral Health has the right to change the Notice of Privacy Practices at any time.

Billing Policy/Co-Payments
I acknowledge that I have been given the opportunity to review the billing policy for Wellspring Behavioral Health. 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 If no payment is received within 30 days, a payment will be automatically charged to my credit card on file. Electronic payment is offered as an option and includes a $5.00 convivence fee. To avoid paying this additional fee, please use cash or check made payable to Wellspring Behavioral Health. I understand Wellspring Behavioral Health does offer financial assistance in the form of payment plans. Uninsured and/or self-pay clients are required to pay for services in full at the time of their appointment. Wellspring Behavioral Health reserves the right to submit any unpaid balances to a collection agency for recovery. Questions about insurance, billing, and payment plans can be directed to Eric Harmes at 402.937.8323.

Appointment No-Show Fee
I have been advised that this office requires a 24-hour prior notice on all appointment cancellations. 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 Wellspring Behavioral Health.

Office Hours and Phone Calls
Wellspring Behavioral Health is open Monday through Friday 9:00am-5:00pm. 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.

Notice of Privacy Practices
See Notice of Privacy Practices page.

Patient/Guardian Signature: _____

Printed Name: _____ Date: _____

Billing Policy

The fees for services provided by Wellspring Behavioral Health will be in accordance with the reasonable value set forth by established community guidelines and standards. At the present time, the fee for a diagnostic intake/initial session for non-medication providers (CPT Code: 90791 Psychiatric Diagnostic Evaluation) is $250 after which the billing rate for a licensed mental health provider is $180 per 60-minute individual therapy (CPT Code: 90837). For an intake/initial session with medication provider (CPT Code: 90792 Psychiatric Diagnostic Evaluation W/ Medication Service or CPT Code: 99204 Office/Outpatient New) is $300. Follow up appointments with a medication provider (CPT Code: 90836 PSYTX W E/M 45 Min) 200, (CPT Code: 90833 PSYTX W E/M 30 Min) is $175, (CPT Code: 90812 Office/Outpatient Visit EST) is $75, (CPT Code: 90813 Office/Outpatient Visit EST) is $115, and (CPT Code: 90814 Office/Outpatient Visit EST) is $175.

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

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

I, _____, understand that I am ultimately liable for the balance on my account for any services provided by Wellspring Behavioral Health 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. hereby authorize direct payment and all benefits due under my insurance policy to Wellspring Behavioral Health. I authorize the release of medical or other protected health information necessary to process insurance claims.

_____

Signature of Patient/Guardian

_____

Printed Name

Continue next page

Date Document Signed

Credit Card Information:

Card Holder Name: _____ Account Number: _____

Exp. Date: _____ Security Code: _____ Billing Zip Code: _____

Consent for Treatment

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

I, _____, hereby give my consent to Wellspring Behavioral Health 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:

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

I understand that:

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

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

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

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

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

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

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____

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 Wellspring Behavioral Health to submit claims for benefits for services rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize and assign payment of all/any insurance benefits to Wellspring Behavioral Health that is otherwise payable to me for his services as described on the assigned payment forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Wellspring Behavioral Health will be credited to my account in accordance with the above assignment.

Patient Name (Print)

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

Date Document Signed

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information.

Each time you receive care at Wellspring Behavioral Health, a record is made of your visit. Your medical record may include symptoms, what was found during your exam, test results, diagnoses, treatment, and a plan for future care. Your billing record may include facts about your bill, insurance, and payment history. Together, this is called your **protected health information** (PHI). In 1996, Congress passed the **Health Insurance Portability and Accountability Act** (HIPPA) to help the government mandate how healthcare plans, providers, and clearinghouses store and transmit PHI. You have health information rights.

Request for Voluntary Restrictions: You have the right to request a restriction on how are use and disclose your health information for treatment, payment, healthcare operations, or to family and friends. We are not required to agree to your request and will notify you if we are unable to agree.

Access to Health Information: You may request to inspect and/or receive a copy of your health information. If you request copies, we may charge a copying fee plus postage. If we agree to provide a summary of your PHI, we will also charge a fee to prepare the summary. This is not covered by your insurance provider.
You may request that we amend health information that are kept in your records. We are not required to make all requested amendments but will give each request careful consideration.

Accounting: You have the right to receive an account of disclosures of your PHI made by us or our business associates.

Confidential Communications: You may request that we communicate with you in a certain way or a certain location. Conversations can be held in private and bills may be sent to different addresses upon your request.

Wellspring Behavioral Health is required by law to do the following:

- ✓ Protect your PHI
- ✓ Provide you with a current copy of the notice of privacy practices
- ✓ Use and disclose your PHI only with your permission, except as described herein or as requested by state or federal law
- ✓ Revise this notice as needed

Uses and Disclosures Without Your Permission:

- ✓ We will use and disclosure of PHI for treatment purposes
- ✓ We will use and disclosure PHI for payment purposes
- ✓ We will use or disclosure PHI for healthcare operations
- ✓ We will allow our business association use or disclose your PHI
- ✓ We will use a disclosure of PHI as required by state and federal law for public health activities, health oversight activities, judicial and administrative proceedings, and law-enforcement
- ✓ We will use and disclose PHI for deceased persons
- ✓ We may disclose PHI to researches when their research has been approved and safeguarded to protect PHI
- ✓ We may disclose PHI to comply with workers compensation laws or similar programs to provide benefits to work related injuries or illnesses
- ✓ There may be incidental uses and disclosures which occur in the course of doing business, however, we make every effort to keep these to a minimum

Complaints and Questions: Complaints and questions about your privacy rights must be made in writing to Eric Harmes of Wellspring Behavioral Health, 1600 S 70th St Ste 200 Lincoln, NE 68506. If you have questions about the process, please call 402.937.8323. If you believe your rights have been violates, you have the right to file a complaint in writing to the Secretary of Health and Human Services.

I acknowledge that I have reviewed and been given a copy (if requested) of the Notice of Privacy Practices of Wellspring Behavioral Health.

Patient Name (Print)

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

Date Document Signed