Methodist Hospital
Community Counseling Program

Dear Parent/Guardian,

Recently, we received a referral for counseling services on behalf of your child. We are sending you this letter with the understanding that a school official has already contacted you, explaining the reason for the referral. We realize that you may have questions or concerns that you would like to discuss with us before we meet with your child. Please understand that we will not assess or counsel your child without your knowledge and authorization unless your child is in emotional crisis.

We appreciate and respect your right to know the nature and goals of the counseling sessions we hope to provide for your child. We need to meet with your child at least one time in order to assess your child's counseling needs and develop an initial counseling plan. We hope to discuss your child's counseling plan with you in person or by telephone. Your participation and input will be greatly appreciated.

The Program has served the students of Omaha Public Schools for over 20 years. All services are provided by Licensed Mental Health Practitioners who are employed by Methodist Hospital. Acceptable forms of payment include Medicaid, private insurance or self-pay. **At this time Blue Cross and possibly other insurance companies will not reimburse for services provided in the school.** Foundation assistance and payment plans are available. We will do our best to limit your financial responsibility. No one will be denied services due to inability to pay.

Please review the enclosed information. Complete and return the following:

- Client Registration
- Authorization and Consent for Treatment
- Omaha Public Schools Consent to Release Student Records
- Privacy Notice Written Acknowledgement
- Copy of both sides of your insurance card if you would like us to file insurance

We are happy to discuss any concerns and answer any questions you may have. Our contact information and additional material describing Methodist Hospital Community Counseling Program are included in the packet. We hope to speak with you soon. Please remember we must have the completed and signed forms listed above in order to provide services to your child.

Thank 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

Methodist Hospital Community Counseling Program

Client Registration

COUNSELOR _____

Client Information

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

Preferred Name _____

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

Race _____White _____Hispanic/Latino _____Black or African American ____American Indian or Alaska Native
_____Asian _____Native Hawaiian or other Pacific Islander ____Other

Preferred Language _____

Marital Status (Circle one) Divorced Legally Separated Married Single Widowed

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____EXT_____

May we call?	Yes	No		Yes	No		Yes	No
Leave message?	Yes	No		Yes	No		Yes	No

Emergency Contact

Relationship to Client _____ Name _____

Home Phone _____ Cell Phone _____ Work Phone _____EXT_____

2nd Emergency Contact

Relationship to Client _____ Name _____

Home Phone _____ Cell Phone _____ Work Phone _____EXT_____

Responsible Billing Party

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_____

Employment Status (Circle One) Active Military Full-Time Not Employed Part-Time Retired Self-Employed Unknown

Employer _____

☐ **Client/I do not have insurance**

☐ **I have Blue Cross Insurance and am aware they will not reimburse for services.**

☐ **I have Medicare and am aware they will not reimburse for services**

IN ORDER FOR INSURANCE TO BE FILED FOR ALL OTHER INSURANCE COMPANIES, THE INFORMATION BELOW MUST BE COMPLETED AND A COPY OF BOTH SIDES OF YOUR INSURANCE CARD(S) INCLUDED.

PRIMARY INSURANCE INFORMATION

Insured's 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_____

Employment Status (Circle One) Active Military Full-Time Not Employed Part-Time Retired Self-Employed Unknown

Employer _____

Insurance Company Name _____ Phone Number _____

Group Name _____ Group # _____ Effective Date _____

Insured's Policy/Certificate # _____ Client's Policy Certificate # _____

SECONDARY INSURANCE INFORMATION

Insured's 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_____

Employment Status (Circle One) Active Military Full-Time Not Employed Part-Time Retired Self-Employed Unknown

Employer _____

Insurance Company Name _____ Phone Number _____

Group Name _____ Group # _____ Effective Date _____

Insured's Policy/Certificate # _____ Client's Policy Certificate # _____

For counselor use only (This must be completed)

Reviewed by: _____ Date Scanned _____

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. 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.

If applicable, I understand that it is beneficial to a child's counseling for the MHCCP counselor and school personnel or School-Based Health Center staff to share information about the child.

Please check one:

☐ Does not apply

☐ I give permission for MHCCP staff to exchange information with school personnel and/or School-Based Health Center staff (if applicable) about my child and/or my child's counseling care for the duration of my child's care.

☐ I do not want all information shared between the MHCCP staff and school personnel and/or School-Based Health Center staff (if applicable), but I would permit the following information to be shared: _____

☐ No, I do not want any information shared with school personnel or School-Based Health Center staff.

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

2017 - 2018

Methodist Hospital
Community Counseling Program
Omaha Public Schools

Consent to Release Student Records

The Omaha Public Schools (OPS) seeks to support students and families and to remove barriers to success in school. OPS works with Omaha area community organizations to provide district identified needs and student and family support programs. Organizations working with OPS are required to monitor and report student progress toward program goals.

Program staff views student information stored by OPS. End of year data is provided and the program uses the information to monitor and evaluate their services. OPS must approve any research to study the impact of participation in this community program using the student information.

The consent of a parent or a legal guardian of the student is required for OPS to release student information from your child's education records. Eligible students age 18 or older may consent to the release of their own student records.

By signing this form, I give consent to the Omaha Public Schools to release all of the student information listed below to the Methodist Hospital Community Counseling Program. (Signature and date required below)

- Student Summary/Family Contact Information
- Attendance
- Communication with school staff regarding progress toward program goals
- Class Schedule
- Grades and Transcripts

This Consent to Release Student Record information is valid for the 2017-2018 academic school year and expires:

- July 31, 2018 or
- When end of year data is released
- You may revoke your consent to release at any time by submitting a letter indicating your revocation to Omaha Public Schools, Student Information Services, 3215 Cuming St., Omaha, NE, 68131.

Student Information	Please print - Only one student per consent form
Student Last Name (legal):	Student Number:
Student First Name (legal):	School: Grade:
Student Middle Name (full):	Birth Date: mm / dd / yy Gender: M / F
Home Address:	Program: **MHCCP**
City: Zip:	Referred By:
Parent/Guardian Information	
Are you the legal guardian of this student? Yes / No - If No do not sign	Relationship to Student:
Parent Last Name (legal):	Home Phone:
Parent First Name (legal):	Cell Phone:
Parent Middle Name (full):	Work Phone:
Parent/Guardian Signature:	**Date:** mm / dd / yy

Office Use Only ☐ Verified ☐ Flags ☐ Sections ☐ Initials

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

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 ● (402) 354-6863
►Best Care Employee Assistance Program ● (402) 354-8000 / (800) 801-4182

►Substance Abuse Expert Services ● (402) 354-8000 / (800) 801-4182

►Nebraska Licensee Assistance Program ● (402) 354-8055 / (800) 851-2336

►Community Counseling Program ● (402) 354-6891

Privacy Contact (402) 354-8096

The programs and services listed above will share your clinical information with each other, as necessary, to carry out counseling, payment and clinical services operations.

Understanding Your Record/Clinical Information
Every time you visit a Best Care Employee Assistance Program clinical service, a record of your visit is made. This record may include your presenting problems, background information, assessments, treatment, and plans for future clinical services. This information - your client record – is used to plan your clinical services.

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.

- You have the right to expect that your clinical information will be kept secure and used only for legitimate purposes.
- You have the right to receive this privacy notice that tells you how your clinical information may be used or disclosed.
- You have the 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 the 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 the right to request we not use or share certain clinical information you consider especially sensitive for counseling, payment or our clinical services operations. You also have a right to request 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 the authority and can act for you before we take any action.

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.

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 Clinical Services, Payment and Program Operations
When state law requires us to obtain your written permission to use or disclose your information for your clinical services, payment or program operations, we will do so. However, there are also situations where we may use or disclose your information for clinical services, payment and program 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.

This information is used in our ongoing efforts to improve the quality and effectiveness of the clinical 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 veterans 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.

For More Information or to Report a Problem
If you have questions or would like additional information, you may contact Best Care EAP's Privacy Contact at the phone number listed at the beginning of this Notice or the Methodist Health System (MHS) Privacy Officer at (402) 354-6863. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Contact, with the MHS Privacy Officer, 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 1, 2016

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)

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