OMAHA
COUPLES CLINIC

ADRIAN MARTIN, MS, LIMFT

CLIENT INFORMATION

Client: (first partner if a couple)_____

(If you are a couple, you can both fill out the same packet. There is room for the other partner's details below)

Gender: _____ Age:_____ Date of Birth: _____

Address:_____ City:_____ State: ____ Zip:_____

Phone: Home: (_____)_____Is it OK to leave a detailed message on this number? □Yes □No

Work: (_____)_____Is it OK to leave a detailed message on this number? □Yes □No

Cell: (_____)_____Is it OK to leave a detailed message on this number? □Yes □No

Email: _____

Is it OK to contact you via this email address with encrypted messages? □**Yes** □**No**
Would you like to receive emailed appointment reminders (un-encrypted)? □**Yes** □**No**

Legal Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er) ☐ Minor (under 19 in NE)

Primary Occupation: _____ Employer/School:_____

Education (highest level): _____ Graduation year: _____

Emergency Contact: _____Relationship: _____

Their phone: Home: (____)_____ Work: (____)_____ Cell: (____)_____

I agree for this person to be contacted in an emergency (initial) _____

Spouse/Partner Name: _____

Gender: _____ Age:_____ Date of Birth: _____

Phone: Home: (_____)_____Is it OK to leave a detailed message on this number? □Yes □No

Work: (_____)_____Is it OK to leave a detailed message on this number? □Yes □No

Cell: (_____)_____Is it OK to leave a detailed message on this number? □Yes □No

Email: _____

Is it OK to contact you via this email address with encrypted messages? □**Yes** □**No**
Would you like to receive emailed appointment reminders (un-encrypted)? □**Yes** □**No**

Primary Occupation: _____ Employer: _____

Education (highest level): _____ Graduation year: _____

Name(s) of Children	Age	Gender	School/College/Employed	Living with you?
1. _____	____	_____	_____	☐ Yes ☐ No
2. _____	____	_____	_____	☐ Yes ☐ No
3. _____	____	_____	_____	☐ Yes ☐ No
4. _____	____	_____	_____	☐ Yes ☐ No
5. _____	____	_____	_____	☐ Yes ☐ No
6. _____	____	_____	_____	☐ Yes ☐ No

Reason for Seeking Services Today: _____

_____

_____

Current Primary Care Physician(s): _____ Phone #: (____)_____

_____ Phone #: (____)_____

Family Medical History & Current Medical/Surgical Problems: _____

_____

Current Medications:

You (or the first partner);_____

_____

Do you take your medications as prescribed? □Yes □No

Your partner's medications; _____

_____

Do they take their medications as prescribed? □Yes □No

Is anyone in the immediate family currently involved in the legal system? □Yes □ No

If Yes, Please give details: _____

_____

Are you, or anyone in the immediate family, <u>currently</u> seeing a Mental Health Professional? □ Yes □ No

Therapist/ Psychiatrist: _____ Phone #: (____)_____

Therapist/ Psychiatrist: _____ Phone #: (____)_____

Have you, or anyone in the immediate family, seen a Mental Health Professional <u>in the past</u>? □ Yes □ No

If Yes, Please list Who?, Symptoms, Diagnosis, and Treatment received: _____

_____

Referred here by: □ Physician □ EAP □ Therapist □ Google search □ Other Internet □ Other

Name of Referral Person /Agency: _____Phone#(____)_____

Signature of Clients (or Legal Guardian): _____

Date: _____

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COUPLES CLINIC

CONTRACT FOR PAYMENT OF SERVICES

I understand that the current rates are $200 for the initial evaluation session and follow-up sessions are $150 per 55-minute session & $225 for 80-minute sessions.

I understand that I am assuming responsibility for payment of my bill at the time of the session, unless other arrangements are made and herein specified. I also understand that should the client account balance remain outstanding that Mr Martin does utilize the services of a collection agency and I agree that Mr. Martin's office may release my name to any necessary party in the course of obtaining payment.

Self-pay fees and insurance copays are expected at the time of service and should be made available at the beginning of each session.

Section 1*: Please choose one of the following options and complete the information requested:*

☐ **Option A: I/we wish to self-pay and choose not to use any insurance benefits. I/we do not give permission for any confidential information about me (or my partner) and my/our treatment to be released to any third party payer, employer or insurance company without prior authorization. Self-payments may also be made from a HSA or FSA account via check or credit card.** *Skip to section 2*

☐ **Option B: I/we wish to use insurance to help pay for services; Blue Cross Blue Shield or Midland's Choice insurance plans (including some Cigna plans) only.** *Please complete all of the following;*

For clients wishing to use their health insurance for treatment, it is the client's responsibility to ensure they have current mental health benefits for outpatient office visits. Insurance companies only quote benefits and do not guarantee payment over the phone. It is worth noting that not all health insurance policies cover marital / couples' therapy, and / or the diagnostic code Z63.0 for partner relational problems. Any disagreement regarding payment of a claim by insurance is between the client and his/her insurance company. **Ultimately, payment of the bill is the Client's responsibility.**

Name of Primary Insurance: _____ Member # _____

Insured's Name: _____ SSN#: _____

Name of Second Insurance: _____ Member # _____

Insured's Name: _____ SSN#: _____

Responsible Party for Billing: _____

If you wish to use your health insurance, please also complete the information below;

I have spoken to my insurance company and confirm I have current mental health benefits for outpatient office visits and I understand my insurance co-pay is $_____ per office visit. (Or co-insurance is _____%).

My insurance company requires pre-authorization: □ Yes □ No, if yes, the authorization # is: _____

I believe I have already met my insurance deductible for this year: □ Yes □ No.

If not, my remaining deductible is $ _____ as of _____ (date).

Assignment of Insurance Benefits

Signature of this contract authorizes payment of medical benefits to Core Conditions, PC for services rendered (assignment of benefits). I understand my insurance company (if applicable) may be billed the full amount for the session and that aside from my co-pay/co-insurance and whether I have met my deductible (if applicable), and providing that Mr. Martin is considered "in-network" for my insurance plan, I am not liable for any difference between the billed amount and the reimbursement amount previously contracted between the insurer and Mr. Martin.

I/we the undersigned acknowledge that my/our insurance company may request clinical information, including diagnosis, prognosis and treatment plans and hereby authorize the release of any appropriate information relating to payment of claims submitted to insurance on behalf of myself/us and/or dependents. I/we further expressly agree and acknowledge that signature of this document authorizes Adrian Martin and Core Conditions, PC to submit claims for insurance benefits, for services rendered, or for services to be rendered, including treatment plans, without obtaining my/our signature to each and every claim submitted for myself/us and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I/we therefore authorize the insurance company to pay and hereby assign directly to Adrian Martin, M.S. of Core Conditions, PC all insurance benefits, if any, otherwise payable to me for services described on the attached forms. I understand that I am financially responsible for all charges incurred whether or not paid for by insurance. I further acknowledge that any insurance benefits, when received by and paid to Mr. Martin will be credited to my account, in accordance with the above said assignment.

Section 2 -All Clients:

I understand that it is important that I provide at least 48-hours' notice of cancellation of a scheduled appointment, and in not doing so I will be liable for a charge of $50.00 for this scheduled time. Missed appointments or same-day cancellations are charged at the full billing rate. This charge will be the responsibility of the client.

It is usual practice, and preferable, to provide payment for the session (or insurance co-pay if applicable) at the start of each session by cash, check, or credit card, however I agree for Adrian Martin to also keep my credit card details on file to pay the balance of any outstanding insurance co-pay amounts, self-pay fees, or cancellation fees not previously paid at the time of service.

In the first session, Adrian Martin will "swipe" your credit card and utilize ***TransArmor*** which stores digital tokens instead of credit card numbers. This allows retention of credit card accounts on file for future transactions without actually storing sensitive credit card numbers.

I authorize Adrian Martin / Core Conditions, P.C. to charge my credit card held on file for any outstanding amounts owed.

Card holder's signature: _____ Date: _____

I/we acknowledge understanding of and agree to the terms of this contract for payment of services;

Client(s): _____ Date: _____

OMAHA
COUPLES CLINIC

CONSENT FOR PSYCHOTHERAPY TREATMENT

I/we authorize the provision of outpatient psychotherapy treatment for myself; _____ and for _____. This treatment may include such services as a pre-treatment assessment, the use of specific assessment instruments, treatment planning, and individual, couple, and/or, family psychotherapy. I understand that my active participation and compliance with psychotherapeutic treatment and recommendations are an important component of a successful outcome of the treatment, and that treatment does not necessarily guarantee successful outcome.

I/we understand that it is reasonable and customary to arrive to appointments on time, to end appointments at the scheduled finish time, and to provide 24-hour notice if I need to cancel a scheduled appointment. I understand that should a pattern of canceling appointments or not showing for appointments develop, that Adrian Martin, M.S. reserves the right to refer me (or my child) to another practitioner.

I/we understand that all information and records generated and obtained in the course of treatment will remain confidential within Mr. Martin's practice and any State mandated supervision processes, and will not be released to other parties without my written consent. This confidentiality will be followed according to the Health Information Portability and Accountability Act (HIPAA) and a separate HIPAA Notice will be reviewed and signed by me and placed in the file. I/we understand that the confidential information may be released under the following specific circumstances:

1. If a client states intention to harm him or herself, or others, it is the Practitioner's legal duty to warn authorities and the person or persons at risk of harm or who have been threatened harm.

2. If a client reveals intent to harm him or herself, it is the Practitioner's duty to take whatever action is necessary and possible to protect that individual. Such action may include notifying the spouse, family, or the appropriate authorities.

3. If a client becomes involved in certain legal processes, medical and behavioral health records may be subpoenaed. The Practitioner's ability to protect a client's confidentiality will be dependent on the legal situation. Records are usually subject to release in these circumstances.

4. If a client, during the course of treatment, informs the practitioner or an office staff member that a child, or elderly, or disabled individual is either currently being abused or neglected, or has been abused or neglected in the past, it is the practitioner's legal and ethical responsibility to advise the authorities.

5. If the client is using insurance benefits to pay for services rendered and the insurer requests clinical information to support claims.

I/we understand that psychotherapy and working towards change may involve experiencing difficult and intense feelings, some of which may be painful in order to reach therapeutic goals. I/we accept that such changes can have both negative and positive effects, and I/we agree to evaluate and clarify the potential effects of changes before I/we undertake them. I/we understand that the psychotherapy process does not guarantee a therapeutic outcome.

I/we understand that if my primary care physician or psychiatrist has referred me to Mr. Martin, they may be routinely informed of my diagnosis, treatment protocol, and treatment progress. I/we understand that staff members and billing personnel may have access to my records.

I/we agree to pay for Adrian Martin's services as an agreed upon fee for service.

I/we have read and understand the contents of this consent form and accept the conditions of this agreement.

Signature of Client(s) (or Legal Guardian): _____
(Signature of both clients if a couple)

Date:_____

11225 DAVENPORT ST., SUITE 103 • OMAHA • NEBRASKA • 68154
Ph. (402) 577-0727 • Fax (402) 881-8332 • www.OmahaCouplesClinic.com

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COUPLES CLINIC

CLIENT ORIENTATION

As a professional psychotherapist, providing you with whatever assistance you need is important. I am committed to the highest ethical standards of my profession and invite you to discuss any questions related to your therapy or the policies of my practice. In seeking services through our office, I want you to know you have the right:

1. To ask questions at any time.
2. To be fully informed of the therapist's qualifications to practice, including training and credentials, years of experience, etc.
3. To be fully informed regarding the therapist's therapeutic orientation, areas of specialization, and limitations.
4. To ask questions relevant to your therapy, such as therapist's values, background and attitudes, and to be provided thoughtful, respectful answers.
5. To be fully informed of the extent of written or taped records of therapy and their accessibility.
6. To be fully informed of your diagnosis (if the therapist uses one).
7. To specify or negotiate therapeutic goals and to renegotiate these goals when necessary.
8. To be fully informed regarding the therapist's estimation of length of treatment to meet your agreed-upon goals.
9. To be fully informed regarding specific treatment strategies employed by the therapist.
10. To refuse any intervention or treatment strategy.
11. To request that the therapist evaluate the progress of therapy.
12. To discuss any aspect of your treatment with others, including consulting another mental health professional.
13. To be provided with written summaries of written records at your request.
14. To require the therapist to send a written report regarding services rendered to a qualified mental health practitioner or mental health organization at your request.
15. To give or refuse permission for the therapist to use aspects of your case for a presentation or publication.
16. To refuse to answer any questions.
17. To know the ethics code to which the therapist adheres.
18. To solicit help from the ethics committee of the appropriate professional organization in the event of doubt or grievance regarding the therapist's conduct.
19. To terminate therapy at any time.

CONFIDENTIALITY

Records of the identity, prognosis or treatment of any client are confidential and will be disclosed only with the written consent of the client, the client's legal guardian, by order of the court of competent jurisdiction, or as otherwise required by law. It should be noted that we are required by law to report any information which we receive pertaining to child or elder abuse or neglect. In addition, if we become aware that a client is acutely suicidal or is intending to harm another individual, we are required to take the steps necessary to prevent this action, including notification of the police or the threatened party.

OFFICE/FINANCIAL PROCEDURES

Psychotherapy sessions are 55 minutes in length, unless otherwise arranged or circumstances warrant. Following the first session, an attempt is made to establish a regularly scheduled appointment time consistent with the frequency of appointments needed. Please provide at least 48-hours notice of a canceled appointment to avoid incurring a cancellation fee of $50 (Full fee for missed appointments or same day cancellation).

There is generally no charge for one brief (5 minute) telephone consultation between sessions with your therapist, unless the contact is occurring on a regular basis (typically more than once a week). For extended or frequent emergency contacts between sessions, additional charges will be assessed to the client at the rate normally charged. Please note, Adrian Martin, only returns messages during office hours (see the website for current office hours) and does not provide an out-of-hours emergency service. Messages left outside of office hours are usually returned the next working day. If you are experiencing a mental health emergency, please call the Boys Town 24 hour Crisis Line on (800) 448-3000, or call 911, or go to the nearest emergency room.

Additional charges may also be made for the administration and scoring of tests, writing reports, scheduled consultations with a psychiatrist, other professionals or family members, or involvement of a co-therapist.

The client/guardian is responsible for payment of the fee for each session at the time of the session, unless other arrangements are made in advance. We will submit claims to your insurance company for you. Responsibility for payment of the bill remains with the client/guardian and not an insurance company. You will receive a statement as long as a balance exists regardless of your insurance company status. There is a $25.00 charge for returned checks, this will cover bank charges and additional paperwork required in the office.

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COUPLES CLINIC

NOTICE OF PRIVACY PRACTICES

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to Adrian Martin, M.S. and his staff.

Our Legal Duty
Mr. Martin and his staff are required by applicable federal and state law to maintain the privacy of your health information. We are also required to provide you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (09-28-2017) and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy, we will change this Notice and make it available to you upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Use and Disclosure of Health Information
We use and disclose health information about you for treatment, payment for services, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician, psychologist, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provided you. If your payment balance is outstanding and unresolved, we utilize the services of a collection agency.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conduct training programs, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment of services provided, or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Your Family and Friends: We must disclose your health information to you, as described in the clients' rights section of this Notice. We may disclose your health information to a family member or friend, but only if you agree we may do so.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of some other crime. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate client under certain circumstances.

Appointment Reminders: We may use or disclose health information to provide you with appointment reminders such as voicemail messages, emails, SMS texts, or letters. When you elect to receive email appointment reminders you acknowledge that such reminders may not be encrypted and as such may not be considered a secure form of communication. We may use password protected online services with encrypted data transmission.

Client Rights

Access: You have the right to look at or obtain copies of your health information, with limited exceptions. You may request we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access. If you request copies we will charge $0.75 for each page and $20.00 per hour for staff time to locate and copy your health information, and postage if you want the health information mailed to you. If you request an alternative format, we will charge a cost-based fee for providing health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure. Records pertaining to couples therapy can only be released with the permission of both partners.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other operations, for the last 6 years, but not before November 1, 2006. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in an emergency.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or alternative locations. You must make this request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail, digital audio file), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about your access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Adrian Martin, M.S.
Telephone: (402) 577-0727 Fax: (402) 881-8332
Address: 11225 Davenport St, Suite 103, Omaha, NE, 68154

I have been given a copy of Adrian Martin's Client Orientation and Notice of Privacy Practices which covers topics including, but not limited to, treatment, financial procedures, healthcare operations, disclosure accounting, health information amendment, and concepts of confidentiality and privilege.

Client(s) Printed Name(s): _____

Signature(s) below confirms receipt of this information

Client Signature(s) (or legal guardian): _____

Date: _____

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COUPLES CLINIC

Ethical Practice

Adrian Martin, M.S., CMFT, LIMHP, is licensed in the State of Nebraska as an INDEPENDENT MENTAL HEALTH PRACTITIONER & certified as a MARRIAGE & FAMILY THERAPIST. I understand that Adrian Martin routinely engages in case consultation both as part of maintaining an ethical practice and to meet the requirements of State law, and in such professional consultations my case may be discussed and that all reasonable precautions will be taken to maintain the highest level of confidentiality throughout that process.

Signature of Client(s) (or Legal Guardian): _____

Date:_____

Statement of understanding for Couple's / Marriage Therapy

Couple's therapy starts with an assessment of your relationships, past and present. We understand that any information discussed as part of couple's therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving the partners. We agree not to subpoena Adrian Martin, to testify for or against either party, or to provide records in a court action. By entering into couple's therapy, we both understand and accept that working towards change may involve experiencing difficult and intense feelings, some of which may be painful in order to reach our goals. We accept that such changes can have both negative and positive effects, and agree to evaluate and clarify the potential effects of changes before we undertake them. There may be times when Adrian Martin appears to be on either person's side, but in reality is always on the side of our relationship. If the relationship breaks up, or couple's therapy terminates, and either or both of us wishes to re-contract with Adrian Martin for individual therapy, the decision with whom Adrian Martin continues to work with is at his sole discretion. In some circumstances a referral may be made.

Contact with Adrian Martin between sessions should be limited to making appointments or for emergencies. If there are individual sessions conducted as part of the couple's therapy, secrets will not be kept, and Adrian Martin reserves the right to make the clinical judgment to pass on information in the couple's therapy that furthers the therapeutic goals.

Since session time is generally limited to 55 minutes, try to be concise in communicating your thoughts and feelings. Therapy seems to work best if you strive for closure in your communication, that is, a point of satisfaction that you have said what you need to say, and have asked for what you need to ask for.

We agree to the above guidelines.

Signature of both partners;

Signed:_____ Signed: _____

Date: _____