The Insight Program, P.C.
Behavioral Healthcare

CLIENT INTAKE & INFORMATION

PERSONAL INFORMATION				Date:
Client Name:_____ *First* *Middle Initial* *Last*				Identified Gender: _____
DOB: / /		Social Security Number:		
Address:		City:	State:	Zip:
Phone:	*Cell/Home/Work*	OK to Call? **YES** or **NO**	Where to leave confidential voicemail: ☐ Work ☐ Home ☐ Cell	
	Cell/Home/Work	OK to Call? **YES** or **NO**		
	Cell/Home/Work	OK to Call? **YES** or **NO**		

EMERGENCY CONTACT	
Name:	Number: *Cell/Home/Work*
Relationship:	

WORK/SCHOOL STATUS	
Occupation:	Employer:
Student: *Where, Major, Status*	
Significant Details: *Include future goals, satisfaction, or other significant job/life history as it relates to work.*	

RELATIONSHIP STATUS *With whom do you live? What is the nature of the relationships? Are there other individuals significant to you, who do not reside with you?*	

HEALTH STATUS & MEDICAL INFORMATION	
Primary Physician:	Phone:
Address:	Date of Last Exam:
How would you describe your overall health?	
Other Physicians or Providers:	
Name:	For What:
Name:	For What:
Name:	For What:
Major/Chronic Illnesses:	
Surgeries, Operations, Procedures significant to your current Health Status:	

MEDICATIONS

Please list your CURRENT MEDICATION:

Name	*Dose/Frequency*	*Effectiveness*

OTHER MEDICATIONS:
Are there medications you have been prescribed, which you have chosen to not take? YES/NO
If YES, what are they, and please explain why you choose not to take these medication(s)?

How do you view the use of medication?

PREVIOUS MENTAL HEALTH INFORMATION

Have you previously been treated for mental health concerns or engaged in therapy? **YES/NO**
If yes, please describe:

When:	Where:	Outcome:

Have you ever been hospitalized for a psychiatric, mental health or substance abuse issues? **YES/NO**
If yes, please describe:

When:	Where:	Outcome:

Have you ever been given a mental health diagnosis? **YES/NO** If yes, please describe:

Diagnosis:	Do you agree, disagree or are you unsure?

Is there any other information about your previous experience that is important for me to know?

HOW DID YOU HEAR ABOUT INSIGHT BEHAVIORAL HEALTHCARE

CURRENT CONCERNS
What concerns have led you to seek counseling?
How long have you had these concerns?
Has anyone else encouraged you to seek counseling? YES / NO If yes, whom?
If someone else has been involved, do you agree?
How have you tried to resolve these issues?
Have you sought any other help with these concerns? If yes, with whom:
What would you like to be different after engaging in therapy?
What are your expectations for therapy?
What else is important for me to know?

ABOUT YOU:
How would you describe yourself?
What strengths do you have?
What obstacles or struggles have you encountered recently?
What roles/responsibilities do you have? How competent do you feel in these roles?
What else is important for me to know about you:

PLEASE USE THIS AREA FOR ANY EXTRA INFORMATION YOU COULD NOT FIT IN OTHER AREAS.

Thank you for taking the time to complete the information in this packet.
This information will be part of your clinical record and will be kept confidential.

The Insight Program, P.C.
Behavioral Healthcare

CLIENT RIGHTS & RESPONSIBILITIES

Welcome to Insight Behavioral Healthcare!

This is a new relationship, so let's get this off to a great start. This document is to let you know what rights and responsibilities you have as a client, and to help you understand the process of counseling.

APPOINTMENTS

- To make an appointment, call (402)488-1032 and indicate that you wish to schedule an appointment.
- Appointments cannot be scheduled via email due to privacy standards. Email and texting are not private means of communication, and therefore my default practice policy is to not use them at all for any communications with clients. This is both to keep up HIPAA compliance ***and*** for ethical practice.
- Clients are expected to provide a 24-hour notice to cancel an appointment.
- Late cancellations and no-shows will be charged a fee equal to the rate of the scheduled session.
- Clients who do not show up for scheduled appointments will be assessed a no-show fee equal to the rate of the scheduled session.

PLEASE NOTE: Insurance does typically not cover late cancellations and no-shows.

YOU will be responsible for payment.

COMMUNICATION

Talking to Your Therapist:

Occasionally you may wish to speak directly with your therapist. However, sometimes the opportunity to talk with you immediately, or return your phone call quickly does not present itself until later in the evening or the next day. Although my voicemail and receptionist notifies me of your call as soon as possible, you may feel you have waited a long time for a return call. This is unavoidable when I am in session with others. This problem may also occur because I am not in clinic every day of the week and therefore not immediately available.

- Phone calls will be returned within 72 hours.
- Phone calls are not billable to insurance. Phone calls over 10 minutes are billed for time spent on the phone, at the pro-rated hourly rate (FEES FOR PROFESSIONAL SERVICES).
- When you become my client, you will be informed of services to be used in case of an emergency. If the situation is a medical or mental health emergency, you need to call 911 or go to your nearest hospital.
- In this day of electronic communication, please understand that under HIPAA (*Health Insurance Portability and Accountability Act of 1996*) **things such as electronic mail (e-mail), social media contact and text messages from a cellular device are not consistent with the recommended standard and are therefore prohibited**. I consider your confidentiality to be of utmost importance and therefore adhere to the recommended standard.

USE OF INSURANCE

It is important to understand that you are responsible to pay for my professional services. If you request (and I accept your insurance), my billing service (Midwest Medical Billing Services) will contact your insurance or managed care company, submit claim forms, and make every effort to get them to reimburse me for the professional services provided. However, there are two important things you should understand:

- First, depending on the coverage of your policy, your insurance or managed care company may not pay for psychotherapy or mental health counseling services. ***It is necessary for you to confirm ahead of time with your insurance company to determine whether your policy includes such services, and whether the company will pay for services provided to you. Whenever pretreatment approval is required, except in urgent circumstances, you should obtain approval in advance of treatment. However, if for any reason your insurance or managed care company does not cover or reimburse for services, you are still responsible to pay for those services. If I accept your insurance*** and you wish for my billing service to submit a claim on your behalf, it is your responsibility to provide us with current insurance information at the time of your first visit and whenever there is a change in your insurance or managed care company.

- Second, there are many issues people and families encounter for which they seek advice and counseling that would not be defined as a "mental health condition". I want to alert you to the fact that occasionally when a family is receiving services I sometimes determine it is inappropriate to identify an individual or one member of the family as having a mental health condition as defined by terms of insurance policies. The result may be that your insurance policy does not provide coverage. Once again, please understand that in this type of situation you will be responsible to pay for services.

INSURANCE CO-PAYMENTS

Many insurance companies require co-payments. The co-pay is due each time you come in for individual or family sessions. You are responsible for your co-pay, as well as the deductible. To find out what your co-pay is, you may contact your insurance or managed care company directly.

CANCELLATION POLICY & LATE ARRIVAL

- If you are unable to keep an appointment you have scheduled, you must phone this office and cancel your appointment. Appointments of all types: group, family, and individual sessions, **must be cancelled 24 hours in advance.** Because other clients are waiting for openings and because of the cost to me if you do not arrive for a scheduled appointment, it is necessary to charge you for an appointment that has not been cancelled.
- Clients who do not show up for scheduled appointments will be assessed a no-show fee equal to the amount of the session scheduled.
- **Late for Appointment:** If you arrive late to your scheduled appointment, please be advised that it may be necessary to reschedule at my discretion. For example, it is impossible to condense a 45-minute session into a remaining 20 minutes and would not be advisable under best care practices.

FEES FOR PROFESSIONAL SERVICES

It is important that you, as my client, know the cost of all services available to you. The following is a summary of fees for specific types of services provided in this office. Remember, you are responsible for paying these fees if they are not covered by your insurance or in the case that I do not accept your insurance.

	Code	Description	Minutes	Fee
	90791	Diagnostic Evaluation	60	$185
	90832	Individual Psychotherapy	16-37	$ 90
	90834	Individual Psychotherapy	38-52	$120
	90837	Individual Psychotherapy	53+	$150
	90846	Psychotherapy Family w/o client	38-52	$175
	90847	Psychotherapy Family w/ Patient	60	$200
	90839	Psychotherapy for Crisis	60 or less	$250.00
	90840	Add-on for time – Crisis	30	$125.00
		Preparation of Reports	(per hour)	$150
	99371	Telephone Consultation (Brief)	10 – 20	$50
	99372	Telephone Consultation (Medium)	20 – 30	$85
	99373	Telephone Consultation (Lengthy)	30 – 60	$100
	99075	Court Testimony	Per Hour	$200
	99080	Deposition	Per Hour	$200
		File/Data Review/Analysis	60	$100
		Un-cancelled Appointment		$90-$250
		Clinical Supervision	Per Hour	$150

CLIENT RIGHTS & RESPONSIBILITIES

ACCOUNT BALANCES

_____
Name of Person Financially Responsible for Your Account

PERSONAL INFORMATION FOR THE PERSON FINACIALLY RESPONSIBLE FOR YOUR ACCOUNT:				Date:
Name: _____ *First* *Middle Initial* *Last*				Gender:_____
DOB: / /		Social Security Number:		
Address:		City:	State:	Zip:
Phone:	*Cell/Home/Work*	OK to Call? **YES** or **NO**	Where to leave confidential voicemail: ☐ Work ☐ Home ☐ Cell	
	Cell/Home/Work	OK to Call? **YES** or **NO**		
	Cell/Home/Work	OK to Call? **YES** or **NO**		
Employer:				
How is this person related to you?				

We will submit to you a statement for services at the end of each month. Your account should be kept current. This is done by making regular payments. Past due payments will accrue interest at 18% per annum. If payments fall behind more than one month, we will send you a letter to be sure that you are aware of the fact and ask that you work with us to return your account to paid status. In those rare instances where an account becomes past due more than three months, or accumulates a large balance, we will be required to take further action to get your account current. This action may include submitting your account to a collection agency.

By my signature, I acknowledge that I accept financial responsibility for the mental health services provided to:

_____ beginning on this date: _____
by: Anne M. Muth, LIMHP LPC of Insight Behavioral Healthcare. I further agree to keep this account current and recognize that services may be suspended and/or terminated if the account falls into arrears.

ACKNOWLEDGEMENT
I have read all the above responsibilities and policies. I accept and agree to abide by them. I understand that any questions or concerns are my responsibility to bring forth to my clinician.

_____ _____
Signature of Client Date

The Insight Program, P.C.
Behavioral Healthcare

FINANCIAL POLICY & BILLING AGREEMENT

Name (print): -

_____

Please read carefully and initial each item and sign at the bottom:

Insurance Coverage:

_____ Client agrees to contact Insurance Company to verify benefits for services rendered. You pay for your Insurance. It is your responsibility to know the benefits of your policy.

_____ Should a dispute arise on a claim**, it is the clients' responsibility to clarify and resolve the dispute with the insurance company**.

_____ If Insurance is being filed, any deductible not yet met is **due at the time of service as well as any co-pay**.

Appointments:

_____ Appointments will only be made via phone calls. Appointments cannot be scheduled via email. Phone calls will be responded to within 72 hours.

_____ Clients are expected to provide a 24-hour notice to cancel an appointment. Late cancellations and no-shows will be charged a fee equal to the rate of their session.

_____ Clients who do not show up for a scheduled appointment will be assessed a no-show fee equal to the rate of their session. Be advised, insurance typically does not cover this and YOU will be responsible for payment.

Payment:

_____ If Insurance is *not* being filed, payment is expected at the time of service.

_____ Phone calls are not billable to insurance. Phone calls over 10 minutes are billed for time spent on the phone, at the pro-rated hourly rate.

_____ There is $75.00 administration charge for checks that do not clear the bank.

_____ 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 provider.

_____ Fees are subject to change at the discretion of the practice. A fee schedule is available upon request.

_____ Questions regarding your account should be directed to the Billing service. Midwest Medical Billing can be reached at 402.889.3033

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

_____ _____

Signature of Client Date

_____ _____

Signature of Financially Responsible Party Date

The Insight Program, P.C.
Behavioral Healthcare

ELECTRONIC PAYMENT COMMUNICATIONS DISCLOSURE

If you wish, you may pay fees electronically (through funds transfer or using a payment card) using the following service:

- ***Square Card Reader***

Please Be Aware of the Following:
We have a duty to uphold your confidentiality, and thus we wish to make sure that your use of the above payment service is done as securely and privately as possible.

After using the above services to pay your fees, that service may send you receipts for payment by email or text message. These receipts will include our business name, and would indicate that you have paid for a therapy session.

It is possible the receipt may be sent automatically, without first asking if you wish to receive the receipt. We are unable to control this in many cases, and we may not be able to control which email address or phone number your receipt is sent to. So before using one of the above services to pay for your session(s), please think about these questions:

- At which email address or phone numbers have I received these kinds of receipts before?
- Are any of those addresses or phone numbers provided by my employer or school? If so, the employer or school will most likely be able to view the receipts that are sent to you.
- Are there any other parties with access to these addresses or phone numbers that should not be seeing these receipts? Would there be any danger if such a person discovered them?

In addition to these possible emails or text messages, payments made by credit card will appear on your credit card or bank statement as being made to ***Insight Program, P.C.***

Please consider who might have access to your statements before making payments by credit card.

Health Savings Accounts and Flexible Spending Accounts
If you are using a Health Savings Account (HSA) or Flexible Spending Account (FSA) payment card, please be aware that even if your payment goes through and is authorized at the time that we run your card, there is a possibility that your payment could later be denied. In the event of this happening, you are responsible for ensuring that full payment is made by other means.

ACKNOWLEDGEMENT
I have read all the above warning me about paying fees electronically. My clinician has reviewed my rights to privacy and I understand that any questions or concerns are my responsibility to bring forth to my clinician. I accept the risk and request that my clinician to accept my electronic payment.

_____ _____
Signature of Client Date

_____ _____
Signature of Financially Responsible Party *(If not client)* Date

The Insight Program, P.C.
Behavioral Healthcare

NOTICE OF PRIVACY PRACTICES

Effective Date: 01/2006; Revised 09/2017

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

If you have any questions about this notice, please contact
Insight Behavioral Healthcare Privacy Officer at 402.488.1032

Definitions

Notice of Privacy Practices (The Notice) – a written notice in compliance with the requirements of Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009, made available from Insight Behavioral Healthcare, P.C. to an individual or the individual's personal representative at the first delivery of service, or at the individual's next visit following a revision to the Notice, that describes the uses and disclosures of protected health information that may be made Insight Behavioral Healthcare and the individual's rights and Insight Behavioral Healthcare's legal duties with respect to protected health information.

Protected Health Information (PHI) - individually identifiable health information that is transmitted or maintained in any form or medium, including electronic media.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

For Treatment:
We will use your health information to provide you with health care treatment and to coordinate or manage services with other health care providers, including third parties. We may disclose all or any portion of your health information to your attending physician, consulting physician(s), nurses, technicians, health profession students, or other facility or health care personnel who have a legitimate need for such information to take care of you. Different departments of the facility will share your health information to coordinate the health care services you need, such as prescriptions, lab work and X-rays. We may disclose your health information to family members or friends, guardians or personal representatives who are involved with your health care. We may also use and disclose your health information to contact you for appointment reminders and to provide you with information about possible treatment options or alternatives and other health-related benefits and services. We also, may disclose your health information to people outside the facility who may be involved in your health care after you leave the facility, such as other physicians involved in your care, specialty hospitals, skilled nursing care facilities, and other healthcare-related services. We may use and disclose your health information to prescription networks to obtain your prescription benefits from payers, to obtain your medication history from different health care providers in the community such as pharmacies, and to send your prescriptions electronically to your pharmacy.

For Payment:
We will use and disclose your health information for activities that are necessary to receive payment for our services, such as determining insurance coverage, billing, payment and collection, claims management, and medical data processing. For example, we may tell your health plan about a treatment you are planning to receive for approval or to determine whether your plan will pay for the proposed treatment. We may disclose your health information to other health care providers so they can receive payment for health care services that they provided to you, such as your personal physician, and other physicians involved in your health care such as an anesthesiologist, pathologist, radiologist, or emergency physician, and ambulance services. We may also give information to other third parties or individuals who are responsible for payment for your healthcare, such as the named insured under the health policy who will receive an explanation of benefits (EOB) for all beneficiaries who are covered under the insured's plan.

For Health Care Operations:
We may use and disclose your health information for routine facility operations, such as business planning and development, quality review of services provided, internal auditing, accreditation, certification, licensing or

credentialing activities (including the licensing or credentialing activities of health care professionals), medical research and education for staff and students, assessing your satisfaction with our services, and to other healthcare entities that have a relationship with you and need the information for operational purposes. We may use and disclose your health information to the external agencies responsible for oversight of health care activities such as The Joint Commission, external quality assurance and peer review organizations, and credentialing organizations. We may also disclose health information to business associates we have contracted with to perform services for or on our behalf such as patient satisfaction survey organizations. We may also disclose your health information to medical device manufacturers or pharmaceutical companies for those companies to carry out their legal obligations to state and federal agencies.

Insight Behavioral Healthcare Health Information Exchange:
Your health information is maintained electronically and healthcare providers, employed, under contract, or otherwise associated with Insight Behavioral Healthcare may access, use, and disclose your health information for treatment, payment, and healthcare operations.

Future Communications:
We may provide communications to you with newsletters or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our facility is participating.

Research:
We may use and disclose your health information to researchers when you authorize the use and disclosure of your health information.

USES AND DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW

Subject to requirements of federal, state, and local laws, we are either required or permitted to report your health information for various purposes. Some of these reporting requirements and permissions include:

Public Health Activities:
We may disclose your health information to public health officials for activities such as for the prevention or control of communicable disease, bioterrorism, injury, or disability; to report births and deaths; to report suspected child, elder, or spouse abuse or neglect; to report reactions to medications or problems with medical products; to report information to the federal Centers for Disease Control or to authorized national or state cancer registries for their data aggregation.

Disaster Relief Efforts:
We may disclose your health information to an entity assisting in a disaster relief effort, such as the American Red Cross, so that your family can be notified about your condition and location.

Health Oversight Activities:
We may disclose your health information to a health oversight agency for activities authorized by law. Such agencies include federal Centers for Medicare and Medicaid Services, and state medical or nursing boards. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor activities such as health care treatment and spending, government programs, and compliance with civil rights laws.

Judicial or Administrative Proceeding:
We may disclose your health information in response to a legal court or administrative order, a subpoena, discovery request, civil or criminal proceedings, or other lawful process.

Law Enforcement:
We may release your health information if we have a legal obligation to notify the appropriate law enforcement or other agencies:

- In response to a court order, subpoena, warrant, summons or similar legal process;
- Regarding a victim or death of a victim of a crime in limited circumstances;

- In situations in which we believe a child or elderly person to be in danger;
- If we believe you to be dangerous to yourself or another

Coroners, Medical Examiners, and Funeral Directors:
We may release health information to a coroner or a medical examiner. This may be necessary to identify a person who died or to determine the cause of death. We may release health information to help a funeral director to carry out his/her duties.

Workers' Compensation:
We may release your health information for workers' compensation benefits or similar programs that provide benefits for work-related injuries or illnesses if you tell us that workers' compensation is the payer for your visit(s). Your employer or their workers' compensation carrier may request the entire medical record pertinent to your workers' compensation claim. This medical record may include details regarding your health history, current medications you are taking, and treatments.

To Avert a Serious Threat to Health or Safety:
We may disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public.

National Security:
We may disclose your health information to federal official(s) for national security activities and for the protection of the President and other Heads of State.

Military and Veterans:
If you are a member of the armed forces, we may release your health information as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Inmates:
If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may release your health information to the institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

OTHER USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Other uses and disclosures of your health information not covered by this notice or the laws that apply to Indigo Tree Counseling will be made only with your written authorization. If you provide us with authorization to use or disclose your health information, you may revoke that authorization in writing at any time. When we receive your written revocation we will no longer use or disclose your health information for the purpose of that authorization. However, we are unable to retrieve any disclosures already made based on your prior authorization.

Insight Behavioral Healthcare will obtain your authorization to use and disclose your health information for these specific purposes:

Psychotherapy Notes:
Psychotherapy notes are notes by a mental health professional that document or analyze the contents of a conversation during a private counseling session or a group, joint, or family counseling session. If psychotherapy

notes are maintained separate from the rest of your health information they may not be used or disclosed without your written authorization, except as may be required by law.

Sale of PHI:
Insight Behavioral Healthcare will obtain your authorization for any disclosure of your information in which Insight Behavioral Healthcare directly or indirectly receives remuneration in exchange for the information.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding your health information:

Right to Inspect and Copy.
You have the right to inspect your health information and receive a copy of medical, billing, or other records that may be used to make decisions about your care. The right to inspect and receive a copy may not apply to psychotherapy notes that are maintained separately from your health information. Your request to inspect and receive a copy of your health information must be submitted in writing. We may charge a fee for document requests to cover the costs of copying, mailing, or other supplies.

You have the right to request your health information in electronic format. Insight Behavioral Healthcare will provide your health information in the form and format you request, if available or in a mutually agreeable form and format. In limited circumstances, we may deny your request to inspect or receive a copy of your health information. If you are denied access to your health information, you may request that the denial be reviewed. A licensed health care professional chosen by Insight Behavioral Healthcare will review your request and the denial. The person who conducts the review will not be the same person who denied your request. We will comply with the outcome of the review.

Right to Amend.
You have the right to request an amendment to your health information that you believe is incorrect or incomplete. Submit your request in writing, including your reason for the amendment, using our "Request for Amendment to PHI" form and send to:

Insight Behavioral Healthcare
Health Information Management
8101 'O' Street, Suite 214
Lincoln, NE 68510

Or call: 402.488.1032 or 800.488.1043

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend information that:

- Was not created by Insight Behavioral Healthcare unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for Insight Behavioral Healthcare;
- Is not part of the information that you would be permitted to inspect and copy;
- Is accurate and complete.

Right to an Accounting of Disclosures.
We are required to maintain a list of certain disclosures of your health information. However, we are not required to maintain a list of disclosures that we made by acting upon your written authorizations. You have the right to request an accounting of disclosures that are not subject to your written authorization.

Submit your request in writing using our "Request for Accounting of Disclosures of PHI" form and send to:

Insight Behavioral Healthcare
Health Information Management
8101 'O' Street, Suite 214
Lincoln, NE 68510

Or call: 402.488.1032 or 800.488.1043

Your request must state a period of time, not longer than six years from the date of request. Insight Behavioral Healthcare will attempt to accommodate the form as requested (e.g. paper or electronic file). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

Right to Request Restrictions.
You have the right to request a restriction or limitation on how much of your health information we use or disclose for treatment, payment, or health care operations. You also have the right to request a restriction on the disclosure of your health information to someone who is involved in your care or payment for your care, such as a family member or friend. We are not required to agree to your request. However, if we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. You have the right to request to restrict the disclosure of your information to a health plan regarding a specific health care item or service that you, or someone on your behalf (other than a health plan), has paid for in full. We are required to comply with your request for this specific type of restriction. For example, if you sought counseling services and paid in full for the services rather than submitting the expenses to a health plan, you may request that your health information related to the counseling services not be disclosed to your health plan.

Submit your request in writing or request and submit a "Request for Restrictions to Use or Disclose Protected Health Information" form and send to:

Insight Behavioral Healthcare
8101 'O' Street, Suite 214
Lincoln, NE 68510

Or call: 402.488.1032 or 800.488.1043

You must include: a description of the information that you want to restrict, whether you want to restrict our use or disclosure or both; and to whom you want the restriction to apply.

The Insight Program, P.C.
Behavioral Healthcare

ACKNOWLEDGMENT:
RECEIPT OF NOTICE OF PRIVACY PRACTICES

INDIVIDUAL

I have been provided a copy of Insight Behavioral Healthcare's Notice of Privacy Practices effective 01/2006; revised 09/2017.

Name (please print): _____

Signature: _____ Date: _____

PARENT/GUARDIAN

I am a parent or legal guardian of _____ (patient name). I have been provided a copy of Insight Behavioral Healthcare's Notice of Privacy Practices effective 01/2006; revised 09/2017.

Name (please print): _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____ Date: _____

STAFF USE FOR NO SIGNATURE

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective 01/2006; revised 09/2017.
Given to individual on _____.
(date)

☐ In Person ☐ Mail ☐ Email ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. **More than one attempt must be made**.

☐ In person conversation _____
☐ Telephone contact _____
☐ Mailing _____
☐ Email _____
☐ Other _____

Staff Name *(please print):* _____ **Title:** _____

Signature: _____ **Date:** _____

8101 'O' Street, Suite 214 Lincoln, NE 68510
402.488.1032 / 800.488.1043