12020 Shamrock Plaza
Suite 200
Omaha NE 68154

Phone: 402.819.9186
E-mail: info@senseofhope.org

CLIENT INFORMATION

Client Name: ____

Date of Birth: ____________________________ Age: __________ Gender: ☐ M ☐ F

Street Address: ____

City: ________________________________ State: ________ Zip: ____________

I am aware that there are privacy risks associated with the following forms of communication (phone/voicemail/text/e-mail) and indicate my agreement by checking the following boxes:

☐ Phone 1: ______________________ Cell / Home / Work ☐ OK to text

☐ Phone 2: ______________________ Cell / Home / Work ☐ OK to text

☐ E mail: ____

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse/Partner: __________________________ Home/Cell: ____________________

A. Person to Contact in Case of Emergency:

Name: ____________________________________ Relationship: ______________

Phone 1: ______________________ Cell / Home / Work

Phone 2: ______________________ Cell / Home / Work

B. Person to Contact in Case of Emergency:

Name: ____________________________________ Relationship: ______________

Phone 1: ______________________ Cell / Home / Work

Phone 2: ______________________ Cell / Home / Work

Employer: ____

Occupation: ____

Person(s) giving consent for outpatient psychotherapy services for this minor:

Name(s): ________________________________ Relationship: __________________

Reason(s) for Therapy Referral:

____

____

How did you hear of Sense of Hope? ____

May I thank this person for your referral? ☐ Y es ☐ N o

Previous Mental Health/Substance Use Treatment History:

____

____

Primary Care Physician: ________________________________ Phone: ______________

Psychiatrist: ____ Phone: ______________

Current Health Issues: ____

Current Medications: ____

____

PAYMENT INFORMATION

☐ Private Pay ☐ Credit Card

☐ Cash

☐ Insurance: Co-Payment Amount $__________

Deductible Amount $__________

Insurance Provider Name: _______________________________________

Policy Number: ____

Insurance Policy Holder Name: ___________________________________

Insurance Policy Holder Date of Birth: ____________________________

PERMISSION STATEMENT: I give permission to be treated and for the Clinician to be directly reimbursed by my Insurance Provider

Signature: ____ Date: ______________

Printed Name: ____

C O M P A N Y

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HIPPA NOTICE of PRIVACY PRACTICES

Receipt & Acknowledgement of Notice

Name of Client: ____

DOB: ______________________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the HIPPA Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Stephanie Voss for additional information.

____ ______________

Signature of Client Date

____ ______________

Signature of Parent/Guardian/Personal Representative* Date

*If you are signing as a Personal Representative of a client, please describe your legal authority to act for this person on the line below. (i.e.: Power of Attorney, Health Care Surrogate, etc.)

____

☐ Client refuses to acknowledge receipt.

____ ______________

Stephanie Voss, LMHP, PLADC, CPC Date

C O M P A N Y

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Omaha NE 68154

Phone: 402.819.9186
E-mail: info@senseofhope.org

RELEASE of INFORMATION

I, ______________________________, on behalf of myself and/or minor child,

________________________________, consent to the exchange of information

between Stephanie Voss, LMHP, PLADC, CPC and

____
Individual/Hospital/School/Other Facility

____
Address

____
Phone

In regard to:

- ☐ All available medical information
- ☐ All available psychological information
- ☐ All available psychiatric information
- ☐ All available school information including transcripts, test results & attendance records.
- ☐ All available social and case history information
- ☐ All available legal information
- ☐ All treatment history
- ☐ Other:

Signature: ____ Date: ____________________

Printed Name: _____________________________________

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- ☐ All available social and case history information
- ☐ All available legal information
- ☐ All treatment history
- ☐ Other:

Signature: ______________________________ Date: ______________

Printed Name: ______________________________