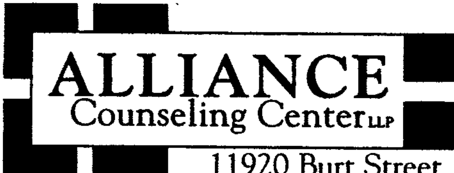


11920 Burt Street • Suite 190 • Omaha, NE 68154 • 402.965.4004 • Fax: 402.965.4232

Date: ___________________________

## New Client Information

Name:______________________________________________ Birth Date: ______________

Name you prefer to be called: ________________________ SS#: ____________________ Sex: M ☐ F ☐

Address: ____________________________________ City: ____________ State: ____ Zip: _______

Home Phone: (____)_______________ Work Phone: (____)_______________ Cell Phone: (____)_______________

Where may we contact you? Home Work Cell

In case of emergency, contact:

Name: ________________________________ Relationship: __________________ Phone:(___)__________

Referral Source: ______________________________ May we thank this person for referring you? Yes ☐ No ☐

**Insurance Information:**

Name of subscriber as it appears on insurance card: ______________________________ Birth date: __________

Address: ____________________________________ City: ____________ State: ____ Zip: ______

Phone: (___)__________ SS##: _______________ Relationship to client: _______________ ID No.: ____________

Insurance company name:______________________________ Employer: __________________________

**Medical Information:**

Name of primary care physician: ________________________________ Phone: ____________________

List prescribed medications you are taking: _______________________________________________

_________________________________________________________________________

List over-the-counter medications you are taking, including herbal products: ___________________________

_________________________________________________________________________

Name of psychiatrist (if any): ________________________________ Phone: ____________________

Previous counseling/therapy? Yes ☐ No ☐

Name of therapist: ______________________________ When? ______________________

Inpatient psychiatric hospitalizations? Yes ☐ No ☐

When? __________________ Where? ______________________________________________

THIRD PARTY CONSENT

I authorize Alliance Counseling Center to communicate with my insurance company to coordinate treatment, to facilitate quality of treatment, and to obtain reimbursement. By not signing consent, I am agreeing to full payment at the time of service. Initial: ______

I understand and agree that regardless of insurance status, I am responsible for the balance on this account for any professional services rendered. I certify the information provided is true and correct. I will notify Alliance Counseling Center of any changes in the above information, including insurance coverage, in a timely manner. Initial: _______

PRIVACY PRACTICE

I acknowledge that I have been provided access to Alliance Counseling Center's Notice of Privacy Practices (NPP). I acknowledge that I can obtain a copy of the full NPP from the front office and/or the Alliance Counseling Center website. If I have any questions regarding the NPP, I will ask to speak with the privacy officer. Initial: _______

Please print name (parent if patient is a minor):

_______________________________________________________________

Signature (parent if patient is a minor):

_______________________________________________________________ Date: ________________________

OFFICE POLICIES

Patient's name: _________________________________________________ Patient's date of birth: ____________

Alliance Counseling Center requires 24 business hours (Monday-Friday) notice for appointment cancellations. Otherwise, the patient may be charged up to the full fee of the appointment. For example, if the patient's appointment is at 9:00 AM on Monday, Alliance Counseling must receive a call by 9:00 AM the previous Friday to have given proper 24 business hour notice. Initial: ______

It is the patient's responsibility to know the date and time of his/her appointment.

The office will verify the patient's mental health benefits. This is not a guarantee of payment. It is the patient's responsibility to know his/her benefits, including deductibles, co-pays, and visit limitations. In addition, it is the patient's responsibility to keep track of visits used during his/her benefit year. Initial: ______

Insurance companies require payment of co-pays/coinsurance at the time of service. Patient balances not received within 30 days of a visit will be billed and are subject to a processing fee per month. Initial: ______

Please notify Alliance Counseling in a timely manner of any changes including insurance coverage, address, and telephone number changes. Delay in providing us with accurate insurance information may prevent insurance reimbursement, and the patient will be responsible for fees. Initial: ______

Alliance Counseling submits claims only to the insurance companies with whom we are contracted. All others will be the responsibility of the patient to submit, and payments for those services are due at the time of service. Initial: ______

There will be a $30.00 charge for a returned check. If there is a history of 2 returned checks, our office will only accept cash or credit card payments. Initial: ______

As a client of Alliance Counseling Center, I have read and understand the operating procedures, and hereby give permission to the professional staff at the agency to provide diagnostic and/or therapeutic services. Initial: ______

Signature: ____________________________________________________ Date: ___________________