Origins Health & Wellness, LLC
Health by choice, not by chance.

New Client Intake

Date: _____

Primary client: _____ Date of Birth: _____ Age: _____

SS#: _____ Gender Identification/Sex: _____

Address: _____ City/State/Zip: _____

Preferred phone: _____ OK to call? Y N Leave msg? Y N Text? Y N

Other phone: _____ OK to call? Y N Leave msg? Y N Text? Y N

Email: _____

Emergency Contact Person:

Name: _____ Relationship to you: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Insurance Information **(Please present your insurance card(s) to be copied for our records)**

Symptom Checklist: Please check any of the following that apply to you/the client.

____ depression
____ suicidal though/action
____ anxiety/worries
____ panic attacks
____ anger/temper
____ aggressive behavior
____ low self-esteem
____ irritability
____ sleep problems
____ nightmares
____ sleep walking
____ obsessive thinking
____ compulsive behaviors
____ eating problems
____ mood swings
____ poor concentration
____ racing thoughts
____ restlessness
____ binging/purging
____ gambling
____ compulsive sex
____ sexuality issues
____ computer addiction
____ compulsive shopping
____ alcohol/drug abuse
____ family substance use
____ legal problems
____ financial problems
____ housing issues
____ school/work problems
____ abusive to animals
____ accident prone
____ divorce/separation
____ communication problems
____ major losses/changes
____ death of a loved one
____ loss of a pet
____ emotional abuse
____ physical abuse
____ sexual abuse
____ family conflict
____ sexual problems
____ pornography
____ violence in the family
____ fire setting
____ bed wetting
____ neglect
____ other: _____

Family Information

Who lives in your household?

Name	Relationship to you	Age

What is your marital history?

Spouse's name	Married when	Divorced when

Work/Employment Information

Please list your current employer and describe the work you do. _____
_____
_____
_____

Are there frequent job changes? Yes ___ No ___ If yes, explain _____
_____
_____

Have any of the current problems affected your work? Yes ___ No ___ If yes, how _____
_____
_____

2123 Winthrop Road, Suite B
Lincoln, NE 68502
Phone: 402.489.9990
Fax: 402.261.9202
www.originshealth.org

Education Information

What schools did you attend?

Elementary School: _____
(Name)

High School: _____
(Name) (Grade completed)

Technical/Trade School: _____
(Name) (Year graduated)

College: _____
(Name) (Year graduated)

Graduate School: _____
(Name) (Year graduated)

Are you currently attending an education program? ___ Yes ___ No Explain _____
_____

Have any of your current problems affected your school/educational performance? Yes ___ No ___
Explain: _____
_____

Please list and explain any learning disabilities.
_____
_____
_____

Legal Information

Have there been any legal issues including yourself or any other member of the family? No____ Yes ____ Explain
_____
_____
_____

Please list the consequences that you or your family members have experienced due to the above listed legal issues.
_____
_____

2123 Winthrop Road, Suite B
Lincoln, NE 68502
Phone: 402.489.9990
Fax: 402.261.9202
www.originshealth.org

Medical Information

Please check any of the following medical conditions that apply to the you/the client.

____ asthma	____ visual impairment	____ stomach problems
____ diabetes	____ hearing impairment	____ anorexia/bulimia
____ ulcers	____ physical disabilities	____ obesity
____ stroke	____ seizures	____ sexual difficulties
____ blood pressure	____ migraines/headaches	____ miscarriage/stillbirths
____ heart condition	____ head injury	____ menstrual problems
____ high cholesterol	____ chronic pain	____ gynecological problem
____ bowel disorder	____ back pain	____ fertility issues
____ thyroid problems	____ arthritis	____ difficult pregnancies
____ cancer	____ fibromyalgia	____ abortion
____ anxiety/depression	____ insomnia	____ STD(sexually transmitted disease)

List all allergies: _____

Date of last physical: _____

Other diagnosed medical conditions: _____
_____

Previous medication hospitalizations or surgeries: Yes ___ No ___ If yes, explain _____
_____
_____

Suicidal thoughts or attempts: Yes ___ No ___ If yes, explain _____
_____

Any major medical conditions diagnosed in the family (colon/breast cancer, heart disease): _____
_____
_____

Nutrition/Wellness Activities

Please tell us about the following:

How many times per week do you eat fast food? ___ Do you take a multi-vitamin? ____

How many times per week do you get 30 minutes or more of physical exercise? _____

How much soda do you consume in a day? ____ Energy drinks? ____ Coffee? ____

How many minutes/hours do you spend watching television daily? ____ Computer? ____ Video games? ___

How many ***uninterrupted*** hours of sleep do you get daily? ____

2123 Winthrop Road, Suite B
Lincoln, NE 68502
Phone: 402.489.9990
Fax: 402.261.9202
www.originshealth.org

How many hours do you work per week? ____ Spend with family? ____ Spend with friends? ____

How many minutes/hours do you spend quietly with yourself daily? ____

How do you relax or unwind? _____

What do you like to do for fun? _____

How do you manage stress in your life? _____
_____

How much and how many times per week do you consume alcohol? _____
_____ To the point of intoxication? _____

How many cigarettes do you smoke daily? _____

Mental Health/Substance Abuse Treatment History

Please list any previous mental health and/or substance abuse treatment for yourself or any other family member.

Family Member	Hospital/Agency	Psychiatrist/Therapist	Dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has anyone in your family ever attempted or completed suicide? Yes ___ No _____
Explain _____
_____

Have you or someone in your family experienced a traumatic event? Yes ___ No ____
Explain _____
_____

2123 Winthrop Road, Suite B
Lincoln, NE 68502
Phone: 402.489.9990
Fax: 402.261.9202
www.originshealth.org

Current Medications Over-the-counter and prescribed.

Medication	Dosage/Frequency	Reason	Prescribing Physician

Vitamins or herbs currently taking: _____

Are you satisfied with your current medications and psychiatric care? _____

Anything else you feel is important for us to know?

2123 Winthrop Road, Suite B
Lincoln, NE 68502
Phone: 402.489.9990
Fax: 402.261.9202
www.originshealth.org

Treatment Goals

Please list the goals/changes you hope to achieve in therapy.

1.

2.

3.

What are your strengths?

1.

2.

3.

What are the strengths of your family/support system?

1.

2.

3.

Additional comments: _____

_____

_____

Signature of person completing this form: _____

Print name: _____ Date: _____

2123 Winthrop Road, Suite B
Lincoln, NE 68502
Phone: 402.489.9990
Fax: 402.261.9202
www.originshealth.org

Origins Health & Wellness, LLC
Health by choice, not by chance.

Informed Consent for Treatment

I, _____(client name), agree and consent to

participate in psychological/behavioral health care services offer and provided at/by

_____ (provider name), a behavioral health care provider with

Origins Health and Wellness, LLC.

I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the client. I have been given the opportunity to discuss the concerns I have for my treatment or the treatment of my minor child/ward. I have an adequate understanding of the treatment that is planned and agree to play an active role in this treatment as needed and give this behavioral health care provider permission to begin this treatment as shown by my signature below.

If the client is eighteen or under, or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature of Client: _____ Date: _____

Signature of legal guardian: _____ Date: _____

Relationship to client (if applicable): _____

I, behavioral health care provider, have discussed the treatment recommendations and plan for care with the client and/or parent/guardian. My observations of this person's behavior and responses give me no reason in my professional judgment, to believe this person is not fully competent to give informed and willing consent for their own treatment or that of their minor child/ward.

Signature of Provider: _____ Date: _____

2123 Winthrop Road, Suite B
Lincoln, NE 68502
Phone: 402.489.9990
Fax: 402.261.9202
www.originshealth.org

Insurance Release of Information/Assignments of Benefits

I authorize Origins Behavioral Health and Wellness, L.L.C., to release to my Medicare/Medicaid or any other insurance carrier, any medical information needed for authorization or payment of this or a related claim. I authorize payments directly to this office for the mental health benefits. I understand that I am responsible for all pre-authorizations required by my insurance. Furthermore, I understand that I am financially responsible for all charges whether or not paid by my insurance company.

FINANCIAL AGREEMENT

Pre-Authorization for Mental Health Services:
Most insurance companies require pre-authorization for mental health services. As part of your care, Origins will conduct a verification of benefits to determine your coverage, copays, and deductible information. You will be contacted if your participation in this process is necessary. Should you have any questions, please contact our billing department.

Payment of Services:
Clients are required to pay all co-pays, co-insurance, and balances on account at the time of service. In the event that payment cannot be made, a statement will be mailed and payable within 10 days of receipt. I f payment cannot be made when due, you must contact our billing department and set up a payment plan. After 90 days, if no payment has been received, necessary collection proceedings will begin. It is important that you notify us of any address changes promptly since undeliverable statements are turned over to collections immediately.

Insurance:
If you have insurance and are using it to pay for your services at Origins, we will complete and submit an insurance claim on your behalf. However, you are responsible for all pre-authorization requirements, insurance claim follow up and all charges not covered by your insurance. Origins will conduct an initial verification of benefits. After that, any issues with coverage or payment of services will be your responsibility. It is often the case that insurance benefits for mental health are different from primary care. If you do not receive an explanation of benefits from you insurance company within 30 days of your date of service, please follow up with your insurance on the delayed claim. After you have spoken with your insurance company, please contact our billing department at 402.489.9990 option 1, option 2, to inform us of the progress on the claim. Origins Behavioral Health and Wellness, LLC reserves the right to charge the patient the full amount of the visit if there is no response from the insurance company within 45 days. If you have any questions regarding your account or the filing of your insurance claims, please contact us at 402.489.9990, option 1, option 2. We will be happy to assist you.

Appointment No-Show Fee:
Everyone's time is valuable. In conducting our business, we must schedule clients in advance and assume that those appointment times will be respected. When they are not, other clients who are awaiting an appointment time are forced to wait unnecessarily. In an effort to encourage attendance and/or respectful cancellation of appointments, you will be charged $75.00 for any appointments missed that are not cancelled 24 hours in advance

I have been advised that this office requires a 24-hour prior notice on all appointment cancellations. I have been advised that there will be a $75.00 no show fee for all appointments that are canceled with less than 24 hour notice. This fee is not covered by any insurance plan.

I understand and agree to abide by the above Insurance Release of Information/Assignment of Benefits and the Financial Agreement.

_____ _____
Signature of Client/Guardian/Guarantor Date

2123 Winthrop Road, Suite B
Lincoln, NE 68502
Phone: 402.489.9990
Fax: 402.261.9202
www.originshealth.org

Origins Health & Wellness, LLC
Health by choice, not by chance.

Acknowledgement of Review of Notice of Privacy Practices, Patient Rights and Responsibilities, and Magellan Member Rights and Responsibilities

Client's Name: _____ Client's DOB: _____

☐ **Notice of Privacy Practices:** I have been given the opportunity to review Origins' Notice of Privacy Practices for Protected Health Information. I understand that Origins has the right to change the Notice of Privacy Practices at any time, and that I may obtain a current copy from the front office during normal business hours.

☐ **Patient Rights and Responsibilities:** I have been given the opportunity to review Origins' Client Rights and Responsibilities. I understand that Origins has the right to change the Client Rights and Responsibilities at any time and that I may obtain a current copy from the front office during normal business hours.

☐ **Managed Care Company Rights and Responsibilities**: I have been given the opportunity to review the Rights and Responsibilities or your Managed Care Company and I understand that I may obtain a current copy at the front office during normal business hours.

The undersigned certifies that he or she has read the foregoing, is the client, client's guardian, power of attorney, parent or is duly authorized by or on behalf of the client to execute the above and accept its terms.

Client/Guardian Signature: _____

Printed Name: _____ Date: _____

*HIPPA Privacy Practices, Origins' Client Rights and Responsibilities, and your respective Managed Care Company's Rights and Responsibilities are available at our office for your review. Please let us know at your first appointment if you would like to review these documents. Thank you.

2123 Winthrop Road, Suite B
Lincoln, NE 68502
Phone: 402.489.9990
Fax: 402.261.9202
www.originshealth.org

Origins Health & Wellness, LLC
Health by choice, not by chance.

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between Behavioral Health Providers and your Primary Care Physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share Protected Health Information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan and medication, if applicable.

I, the undersigned, understand that I may revoke this consent at any time. I have read and understand the information and give my authorization:

Patient Authorization

☐ I agree to release any applicable mental health/substance abuse information to my PCP.

My Primary Care Physician is _____.

Address _____.

Telephone Number _____.

☐ I agree to release only medication information to my PCP.
☐ I WAIVE NOTIFICTION of my PCP that I am seeking or receiving mental health services, and I direct you NOT to so notify him/her.
☐ I do not have a PCP and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a PCP that I am seeking or receiving mental health services.

_____

Patient Signature Date

Patient Rights:

- You can end this authorization (permission to use or disclose information) any time by contacting Origins Health & Wellness, LLC at 402.489.9990.
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- You have a right to a copy of this signed authorization. Please keep a copy for your records.
- You do not have to agree to this request to use or disclose information.

Information to be completed by Behavioral Health Provider

☐ PCP letter sent on _____ (date mailed/emailed).
☐ Copy of letter in client file.
☐ Staff initials _____.

2123 Winthrop Road, Suite B
Lincoln, NE 68502
Phone: 402.489.9990
Fax: 402.261.9202
www.originshealth.org