Jeffrey Stormberg, Ph.D.
1403 Farnam Street, Ste. 215
Omaha, Nebraska 68102

Patient Information

Today's Date: _____

Name of Patient: _____

Sex: M F Age: _____ Date of Birth: _____ SS#: _____

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

Phone: Home: _____ Office: _____ Other: _____

Patient is: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widow(er) ( ) Child

Primary Occupation: _____ Employer: _____

Education: _____ SSI/Disability:

Current Living Situation: ( ) Alone ( ) W/ Parents ( ) W/ Spouse/Partner ( ) W/ Children

Spouse/Partner Name: _____ SS#: _____

Primary Occupation: _____ Employer: _____

If Living W/ Parents:

Mother's Name: _____ Age: _____ SS#: _____

Primary Occupation: _____ Employer: _____

Father's Name: _____ Age: _____ SS#: _____

Primary Occupation: _____ Employer: _____

Name(s) of Children	Age	Sex	School/College/Employed
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Referred By: ( ) Family Physician ( ) Yellow Page ( ) EAP ( ) Therapist ( ) Friend ( ) Other

Name of Referral Person/Agency: _____ Phone# _____

Current Family Physician: _____ Phone #: _____

Current Medical/Surgical Problems: _____

_____

Current Medications: _____

_____

Reason for Seeking Services Today: _____

_____

_____

Have you Seen a Mental Health Professional Before? ( ) Yes ( ) No

If Yes, Name & Reason for Changing: _____

Current Psychotherapist/Psychologist/Psychiatrist: _____

Current Pharmacy & Phone #: _____

Name of Primary Insurance: _____

Insured's Name: _____ SS#: _____

Name of Second Insurance: _____

Insured's Name: _____ SS#: _____

Responsible Party for Billing: _____

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any appropriate information relating to payment of claims submitted to insurance on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes Jeffrey Stormberg, Ph.D. to submit claims for insurance benefits, for services rendered or for services to be rendered, without obtaining my signature to each and every claim submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I therefore authorize my insurance company to pay and hereby assign directly to Jeffrey Stormberg, Ph.D. 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 by insurance. I further acknowledge that any insurance benefits, when received by and paid to Dr. Stormberg will be credited to my account, in accordance with the above said assignment.

The undersigned understands that Dr. Stormberg may use and disclose the patient's health information to obtain payment for services provided. The undersigned also understands that should the patient account balance remain outstanding we do utilize the services of a collection agency.

_____ _____

Signature of Patient (or Legal Guardian) Date

Jeffrey Stormberg, Ph.D.
1403 Farnam Street, Ste. 215
Omaha, Nebraska 68102
Office: (402) 393-0642 Fax: (402) 391-2641

Consent to Psychotherapy Treatment

I authorize the provision of psychotherapy treatment for myself, _____
or for _____ . This treatment may include such services as a diagnostic interview, pre-treatment assessment, the use of specific testing instruments, treatment planning, and individual or couple 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.

I understand that it is reasonable and customary to arrive to appointments on time and to provide a 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 Dr. Stormberg reserves the right to discontinue treatment and refer me (or my child) to another practitioner.

I understand that all information and records generated and obtained in the course of treatment will remain confidential within Dr. Stormberg's practice and will not be released 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 understand that the confidential information can be released under the following specific circumstances:

1. If an individual states that s/he intends to harm him/herself or others, it is the practitioner's duty to warn authorities and that person or persons at risk of harm or who have been threatened harm.
2. If an individual states that s/he intends to harm him/herself, it is the practitioner's duty to take whatever action is necessary and possible to protect that individual. Such action may include notifying family or the authorities.
3. If a patient becomes involved in certain legal processes, medical and behavioral health records may be subpoenaed. The practitioner's ability to protect a patient's confidentiality will be dependent on the legal situation. Records are usually subject to release in these circumstances.
4. If a patient, during the course of treatment, informs the practitioner or an office staff member that a child or elderly individual is either currently being abused or has been abused in the past, it is the practitioner's legal and ethical responsibility to advise the authorities.

I understand that if my primary care physician or psychiatrist has referred me to Dr. Stormberg, and may be routinely informed of my diagnosis, treatment protocol, or treatment progress. I understand that staff members and billing personnel will have access to my records. Additionally, my insurance carrier will have access to the records.

I agree to pay for Dr. Stormberg's services in the form of co-payments, deductibles, or co-insurance as determined by the benefits of my insurance carrier, or as an agreed upon fee for service.

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

_____ _____

Patient Name/ Parent or Legal Guardian Date

Jeffrey Stormberg, Ph.D.
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Patient No Show/Late Cancel Policy

It is important that patients provide a 24-hour notice of cancellation of a scheduled appointment. If a patient does not provide this 24-hour notice of cancellation, the appointment will be considered the same as not showing for the appointment. When a patient does not show for a scheduled appointment, or cancels with less than 24 hours notice, there will be a charge of $50.00 for this scheduled time. This charge will be the responsibility of the patient.

I understand the Patient No Show Policy and agree to abide by it.

_____ _____

Patient Signature (Or Legal Guardian) Date

Jeffrey Stormberg, Ph.D.
1403 Farnam Street, Ste. 215
Omaha, NE 68102
(402) 393-0642

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 Dr. Stormberg and his staff.

Our Legal Duty
Dr. Stormberg 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 (9-1-2006) 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 you 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 patients 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 patient under certain circumstances.

Appointment Reminders: We may use or disclose health information to provide you with appointment reminders such as voicemail messages, letters, or postcards.

Patient 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. You may obtain a form to obtain access by using the contact listed 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 by sending us a letter to the address at the end of this Notice. If you request copies we will charge $0.25 for each page and $10.00 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.

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 September 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.

_____
Patient Printed Name

My signature below confirms receipt of this information

_____ _____
Patient Signature (or legal guardian) Date

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Patient 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 request that you discuss any questions related to your treatment 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.

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Patient Orientation (continued)

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 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 45 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. If you cancel a session, an attempt will be made to fill the time with another client. If the time cannot be filled, you will remain responsible for the session and may be charged. Please make every attempt to provide a 24-hour notice of a canceled appointment.

The charge for therapy sessions is set according to the therapist's training and experience. The fee you and your therapist have agreed to is listed on your contract for therapy.

There is generally no charge for brief (5-10 minute) telephone consultations 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.

Additional charges are also made for the administration and scoring of tests, writing reports, scheduled consultations with a psychiatrist, other professional or family member, 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 $10.00 charge for returned checks. This will cover bank charges and additional paperwork required in the office.