Kairos Psychological, P.C.
11905 Arbor Street, Omaha, NE 68144-2970
402-330-8850

CLIENT INFORMATION SHEET

Date______________
Client ID___________
CLIENT INFORMATION

Full Name:___________________________________ Birth Date:______________ Age:________ Sex: Decline to St

Address:_____________________________________ City/State/Zip:_______________________________

Cell Phone:___________________ Home Phone:___________________ Work Phone:___________________

Employer:__________________________ Marital Status:__________ Highest Grade Completed:________ Religious Preference:_______________

In Case of Emergency, Contact: Name:____

Cell Phone:___________ Work Phone:___________ Home Phone:___________

INSURED'S INFORMATION I want Kairos Psychologial, P.C. to file insurance claims: Yes ☐ No ☐

Full Name:_______________________________ Birth Date:_________ Age:________ Sex: Decline to St

Address:______________________________________ City/State/Zip:_______________________________

Cell Phone:___________________ Home Phone:___________________

Relationship to client:_____________________________ Marital Status:______________________

Employer:______________________________________ Work Phone:________________________

Insurance Company:______________________ Ins. ID #____________________ Group#:_______________

FAMILY INFORMATION
Please list everyone living in the client's home:

Name	Age	Sex	Relationship	Name	Age	Sex	Relationship
		Decli				Declin	
		Decli				Declin	
		Decli				Declin	

Does client have children who are not living in the home? Yes ☐ No ☐

OTHER INFORMATION
Is the client seeing another therapist or have an appt. scheduled in the near future with another provider? Yes ☐ No ☐

Has the client had previous counseling/therapy? None ☐ Office (outpatient service) ☐ Hospitalization ☐

Is the client taking prescribed medication? No ☐ Yes ☐ (specify):____

If the client is a minor whose parents are divorced, to which parent has the court given custody?

Mother_____________ Father_______________ Other (specify):____________________

I (or the parent, legal guardian, or authorized representative of the paitent) authorize Kairos Psychological, P.C. to provide reasonable and proper psychological and/or medical treatment; to release information to process insurance claims; to receive from my insurance company directly all benefits otherwise payable to me; and I gree I will be responsible for all expenses related to treatment that are not paid under my insurance plan(s).

Whom may we thank for referring you?____

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Consent to Treatment, and to Use and Disclose, Your Health Information

This form is an agreement between you, ___________________________________ and me/us, Kairos Psychological, P.C. When we use the word “you” below, it will mean your child, relative, or other person if you have written his or her name here ____.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this Consent Form agreeing to it and what is in our Notice of Privacy Practices we cannot treat you.

We have the right to change our Consent and Notice of Privacy Practices and we will notify if we change them. You are always welcome to a copy of our Notice and our Policies and procedures. If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your written request.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

____ ________________________________
Signature of Client or His or Her Personal Representative Date

____ ________________________________
Printed Name of Client or Personal Representative Relationship to the Client

____
Description of personal representative’s authority

Copy given to the client/parent/personal representative_________

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

Shortened Notice of Privacy Practices

Our practice is dedicated to maintaining the privacy of your personal health information. We are required also by law to do this. These laws are complicated, but we must provide you with important information. This Notice is a shortened version of the full, legally required Notice of Privacy Practices which is available in the waiting room, so refer to the Complete Notice for more information. Even in the Complete Notice we can't cover all possible situations so please talk to your provider or our Privacy Officer (see the end of this information) about any questions or problems.

Use and Disclosure of your Protected Health Information (PHI)

We will use the information about your health which we get from you or from others mainly to provide you with **treatment**, to arrange **payment** for our services or for some other business activities which are called, in the law, **health care operations**. After you have read this NPP, we will ask you to sign a **Consent Form** to agree to be treated and to let us use and share your information. **If you do not consent and sign the Consent Form, we cannot treat you.**

If we or you want to use or disclose (send, share, release) your information for any other purposes, we will discuss this with you and ask you to sign an **Authorization** to allow this.

We will keep your health information private but there are times when the laws require us to use or share it, such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We have to report suspected child abuse or adult abuse, some instances of suicidal ideation, and some instances of homicidal ideation. We will only share information with a person or organization whom we believe is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires to do so.

4. For Workers Compensation and similar benefit programs.

There are some other situations which don't happen very often. They are described in the complete version of the Notice of Privacy Practices which is available in the waiting room.

Your Rights Regarding Your Health Information

1. **Restriction on Communication Channel:** You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment.
2. **Restriction of Whom PHI Communicated to:** You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you. You have the right to ask us not to send your information or claims to your health insurance company.
3. **Inspect and Copy:** You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records but we may charge you. Psychotherapy Notes are handled in a very specific way and need a specific Authorization.

4. **Amend:** If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information.
5. **Copy of Notice:** You have the right to a copy of this notice. If we change this NPP we will post it in our waiting room and on our website (if we have one).
6. **Complaint:** You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and/or with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.
7. **Accounting of Disclosures:** When we disclose our PHI, we keep records indicating whom we sent it to, when we sent it, and what we sent. You can get an accounting (a list) of many of these disclosures.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer who is Dr. Karen E. Baumstark and can be reached by phone at (402) 614-8094 or by mail at the above address.

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Summary of your information, your rights, and our responsibilities

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition (we will only do this with your authorization, except in certain cases like emergencies.)
- Provide disaster relief
- Provide mental health care

Our Uses and Disclosures

We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Most sharing of psychotherapy notes
- We will not use your information for fundraising or marketing.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you
We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it if you request it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other

- This notice is effective as of September 23, 2013.
- Our HIPAA Privacy Officer is Karen Baumstark, Ph.D. She can be reached at 402-614-8094.
- We will never market or sell your personal information.
- We will never share any substance abuse treatment records without your written permission.

Signature____ **Date**___________________________

____
Printed Name

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Current Problem Checklist

For each problem listed: Circle “Y” if you have had the problem within the past two weeks. Circle “N” if you have not had the problem in the last two weeks.

Yes Poor concentration…can’t pay attention, easily distracted, my mind goes blank.
Yes Poor memory…cannot remember as well as I should.
Yes Cannot make decisions…can’t tell what to do as well as I could before.
Yes Restless…can’t sit still for long, feel restless.
Yes Unrealistic fears…afraid of things or people I know won’t hurt me.
Yes Impulse control…act too quickly, I don’t think things through.
Yes Self-conscious…with others, I feel very uncomfortable when people watch me.
Yes Loss of Interest…do not care about things like I used to.
Yes Repetitive thoughts…can’t stop thinking about something or someone
Yes Suicidal thoughts…I want to die, I would rather be dead than alive.

Yes Bad habits…keep doing things that could cause a serious problem.
Yes Easily hurt…others seem unfriendly, don’t understand me.
Yes Feelings of regret…I feel ashamed, guilty, or feel like a “bad” person.
Yes Depression…feel blue, low, or down much of the time.
Yes Hopelessness…things just will not work out right in the future.
Yes Tense or anxious…too worried or keyed up about various things.
Yes Feeling fearful…about self or others, I fear something bad will happen.
Yes Feel inferior…feel not as good as others, feel uneasy around others
Yes Loneliness…feeling like no one cares about me.
Yes Irritable…easily upset or angered, I am touchy.
Yes Panic episodes…I become terrified, overwhelmed, very frightened.
Yes Crying episodes…I cry easily, at the wrong times, I can’t stop crying at times.
Yes Suspiciousness...I can’t trust others, I need to be on guard with others.
Yes Angry…I feel like I want to hurt someone or smash and break things.
Yes Loss of control…I feel like someone or something is controlling my mind.
Yes Need to be punished…I feel like my sins are unpardonable.

Yes Social problems...I can't get along with others or I argue and/or fight too much.
Yes No friends...I have no one to talk to or discuss serious things with.
Yes Shyness...I avoid people and/or I am uncomfortable with members of the opposite sex.
Yes Fear of failure...I fear failure at school and/or work. I feel unable to succeed.
Yes Being ignored...I am not getting the credit or recognition I deserve.
Yes Absences...I am missing more work and/or school than is really necessary.

Yes Sexual problems…”bad” habits, feelings, or actions about sexual issues.
Yes Poor appetite...I don’t eat enough and/or I don’t want to eat.
Yes Sleep problems…I have difficulty going to sleep or staying asleep or I have nightmares.
Yes Problems arising…I have difficulty waking up or getting going in the morning.
Yes Chronic pain…I have problems with headaches and/or stomach problems and/or back pain.
Yes Heart problems…I have pounding in my chest or with skipping heart beats or pain or racing heart.
Yes Hot-cold flashes…I have problems with sweating and/or chills not related to the air temperature.
Yes Lack of energy…I am easily tired or fatigued. I feel physically tired often.
Yes Dizziness…I have problems with fainting and/or fear of falling and/or feelings like I am spinning.
Yes Tingling…I have prickly sensations in my hands, feet, or other body parts.
Yes Numbness…I have no sensation in one or more body parts.
Yes Distortions…I have problems with seeing, hearing, feeling things that are not real.
Other physical problems: List: ____________________