INROADS... to Recovery

2808 N 75th St, Omaha, NE 68134 Phone: 402-932-2248 Fax: 402-932-3557
597 Grant St Ste 300, Blair, NE 68008 Fax: 402-932-3557
825 N. 90th St, Omaha, NE 68114 Fax: 402-614-3277
230 E 22nd St, Ste 4, Fremont, NE 68025 Fax: 402-721-0806
933 E Pierce St, Council Bluffs, IA 51503 Fax: 712-396-7943

GENERAL INFORMATION:

First Name:_____ M.I._____ Last Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Primary phone:_____ Alternate phone:_____
Date of Birth:_____ Sex: M F SSN:_____
Marital Status: Single Married Divorced Widowed

Religious Preference (optional):_____
Race (optional):_____

RESPONSIBLE PARTY FOR BILLING'S INFORMATION:

Name:_____
Date of Birth:_____ Sex: M F SSN:_____
Marital Status: Single Married Divorced Widowed
Address:_____
City:_____ State:_____ Zip:_____
Primary phone:_____ Secondary phone:_____
Relationship to patient:_____

INSURANCE AND PAYMENT INFORMATION

Primary Insurance

Name of Insurance Company:_____
ID Number:_____ Group number:_____
Primary card holder:_____
Date of Birth:_____ Sex: M F SSN:_____
Marital Status: Single Married Divorced Widowed

Secondary Insurance

Name of Insurance Company:_____
ID Number:_____ Group number:_____
Primary card holder:_____
Date of Birth:_____ Sex: M F SSN:_____
Marital Status: Single Married Divorced Widowed

EMERGENCY CONTACT:

Name:_____ Relationship:_____
Address:_____
Primary phone:_____ Alternate phone:_____

By signing below, I attest all information is correct to the best of my knowledge.

CLIENT SIGNATURE:_____ **DATE:**_____

GUARDIAN SIGNATURE:_____ **DATE:**_____

BUSINESS OFFICE SIGNATURE:_____ **DATE:**_____

Effective: 07/2013
Revised Date: 08/04/2015

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Consent to Treat and Assignment of Financial Obligation:

I certify that the information provided on the first page of this packet is correct and understand that I am obligated to provide this information to my insurance carrier in accordance with the Certificate of Coverage. Failure to provide complete and accurate information may result in a delay in the payment of benefits.

I authorize to utilize pertinent information to process my insurance claims for treatment rendered by this agency I understand **Inroads to Recovery, Inc**. provides a range of services and levels of care on the premises, including outpatient, intensive-outpatient, and residential. I authorize my insurance company to pay all claims to **Inroads to Recovery, Inc**. for services provided and I understand that I am responsible for all expenses not otherwise covered by my insurance or established through claim limits. Lastly, I understand that any account balances over 60 days without activity may be subject to collections. If my account is placed into collections I am responsible to pay any agency and/or legal fees incurred.

All fees and / or co-payments are due at the time of service. Master Card and Visa are accepted.

In agreeing to pay **Inroads to Recovery, Inc.** I agree to enter into counseling or other related relationship, and do so willingly and openly.

I understand that failure to make payment to **Inroads to Recovery, Inc.** within 60 (sixty) days of my treatment completion or upon my decision to stop treatment will result in my information being given to a collection agency or that legal action may be taken against me to collect funds.

By signing I agree to the above terms and conditions

CLIENT SIGNATURE:_____ **DATE:**_____

GUARDIAN SIGNATURE:_____ **DATE:**_____

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Please read and **sign** or **initial** in the appropriate places.

CLIENT RIGHTS:

Inroads to Recovery, Inc. shall ensure that the rights of each client are protected while receiving services. You have the right to:

- Refuse treatment.
- Be treated with dignity and respect and have an environment safe from all sexual, physical, and emotional abuse.
- Help in the development of your treatment plan and to determine your course of treatment without the approval of a spouse or significant other, as well as be informed of the type of treatment.
- Refuse electronic recording.
- Be informed of your therapist's credentials, licensure, professional association, specialization and limitations.
- Confidentiality as specified by federal law CFR part 42 and HIPAA.
- As a client, you have the right to complain without fear of reprisal. The following is the line of communication that we encourage you as a client to use, so that we can monitor and improve upon our treatment and care to all clients.

COMPLIANT / GRIEVANCE POLICY:

- If you feel you have been treated unfairly, or that your care and treatment at this facility is not up to standards, please report this to your counselor. If you do not feel that the situation was resolved, please speak to the Clinical or Medical Director at 402-932-2248. If you continue to have concerns, please report the information to:

Department of Health and Human Services Regulations
301 Centennial Mall South-Third Floor
PO Box 94986
Lincoln, NE 68505-4986
Phone: 402-471-6417

_____ By initialing here, I certify that I have read the CLIENTS RIGHTS information.

HIPAA INFORMATION:

As of April 14, 2003, Inroads is required to implement policies and procedures with respect to confidential information. These policies are required to comply with HIPAA (Health Insurance Portability and Accountability Act) regulations mandated by Congress.

_____ By initialing here, I agree with that I have received the current HIPAA rules that pertain to confidential information.

(A copy will be provided upon request)

To the best of my knowledge, everything on this form is true.

CLIENT SIGNATURE:_____ **DATE:**_____

GUARDIAN SIGNATURE:_____ **DATE:**_____

BUSINESS OFFICE SIGNATURE:_____ **DATE:**_____

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LIMITS OF CONFIDENTIALITY

Inroads to Recovery, Inc. provides a range of services and levels of care on the premises, including outpatient, intensive-outpatient, and residential. The disclosure of client records is protected under Federal Law and Regulations. These Laws and Regulations (Federal Laws: 42 USC 290dd-3 and 42 USC 290ee-3 and Federal Regulations: 42 CFR Part 2), state that the disclosure of information through verbal, telephonic, written means or transfer of documents is strictly forbidden. However, there are limits to the confidentiality of client's records and information, these limits of confidentiality are:

1. Through written consent by the client or her/his legal representative;
2. By court order;
3. Due to program evaluation or audit by the state government agency or insurance company;
4. Based on medical necessity; or,
5. Imminent danger to:
    a. The client;
    b. Another person; or
    c. The general public.

Federal and State Laws or Regulations are not established nor protect information with regards to abuse or neglect against a child, adult or the elderly. Due to professional ethics, standards and State Laws, all cases of possible abuse or neglect will be reported.

Any information with regards to a crime committed by a client of this agency against a staff member, the agency or any threat against a staff member of the agency is not protected under Federal Laws or Regulations.

Any violation or infringement of an individual's privacy or confidentiality by this agency of its staff may and should be reported to the appropriate authorities as noted in the Grievance Procedure.

Inroads will honor all legal and ethical requirements governing client confidentiality, except those situations:

1. If you report the present, the past or the intent of the abuse of a child or an elder. This also includes reporting from a third party.
2. If you report the intent of bodily harm to yourself or others.
3. Inter-office case management consultation with authorized personnel or medical director.
4. The compiling of anonymous statistical information.

My signature below attests to my reading and understanding the Limits of Confidentiality state above.

CLIENT SIGNATURE:_____ **DATE:**_____

GUARDIAN SIGNATURE:_____ **DATE:**_____

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Please **initial** that you understand each policy and **sign** at the bottom of the page

Policies

No Call/No Show for appointments

_____by initialing here, I understand and I agree to the following:
I am responsible for giving 24-hour notice, if I must cancel an appointment. If I do not give notice, or show up I am responsible for a $40.00 (forty) charge payable before my next appointment. Additionally, three (3) no call / no show appointments may result in being discharged from services.

Refill policy for stimulant medications (Adderall, Ritalin, Concerta, Focalin, etc.)

_____by initialing here, I understand and agree to the following:

1. Stimulant medications will be refilled for no more than 30 days.
2. If a prescription is written and it is lost, you will not be able to get a new prescription until your next prescription is due.
3. An appointment is needed for medication to be refilled

Please plan accordingly to ensure you do not run out of your medication.

Drug screens

_____by initialing here, I understand and agree to the following:
In order to provide thorough care for our patients you may be subject to a drug test at any time and you will be financially responsible. Please see 'lab work' below.

Lab Work

_____by initialing here, I understand and agree to the following:
Lab work is a necessary part of your treatment. Inroads to Recovery, has chosen Aegis Science Cooperation to handle the Drug Screen portion of your treatment. The cost of labs depends on your individual healthcare coverage. Patient Financial assistance is available for those who qualify. You may contact them at 866-496-7052. Any questions or concerns regarding your Urine Drug Screen bill should be directed to Aegis Science Cooperation at 1-800-533-7052 or info@aegislabs.com. We can draw blood work in house. Inroads to Recovery, Inc. have chosen Quest Laboratories to handle the bloodwork portion of your treatment. If you have any questions regarding your bill for blood work, you may contact Quest Diagnostics at 1-800-759-2789 or www.questdiagnostics.com/bill. You may also choose another laboratory to get your blood work drawn at, but it is vital that Inroads to Recovery, Inc. receives results in a timely manner.

Termination of Care

Inroads goal is to provide services to patients until the patient and physician/therapist feel treatment goals have been accomplished. Patients may wish to terminate their care with Inroads at any time. Patients will be considered self-terminated if they are out of service for greater than six months. Inroads may find it necessary to terminate the patient/provider relationship for multiple missed appointments, non-payment of account balances, or inappropriate behavior toward administrative or clinical staff. Inroads will make all notifications of termination of care in writing.

By signing I affirm I have read, understand, and agree to these terms.

CLIENT SIGNATURE:_____ **DATE:**_____

GUARDIAN SIGNATURE:_____ **DATE:**_____

BUSINESS OFFICE SIGNATURE:_____ **DATE:**_____

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AUTHORATION FOR RELEASE OF INFORMATION

1. Patient Identification:
   Name:_____Date of Birth or SSN:_____
   Address:_____
   City:_____State:_____Zip:_____
2. I authorize and direct that Inroads to Recovery, Inc. may release information to and/or receive information from:
   Name:_____
   Address:_____
   City:_____State:_____Zip:_____
   Phone:_____Fax:_____
3. Information to be Released:
   This authorization will cover these particular areas, both written and verbal communication:

_____Entire Medical Record
_____Medical
_____Behavioral Health
_____HIV/STD Test Results
_____Substance Abuse/Chemical Dependency Evaluation, Treatments, and outcomes
_____U/A Results
_____Educational
_____Legal
_____Medicaid
_____Medical Record of last six (6) months
_____Other_____

4. The information is needed for the following purpose._____
   _____
   _____
   You may terminate this authorization at any time except to the extent that the company of person which is to make the disclosure, has acted in reliance upon it. This consent will terminate ninety (90) days after termination of services, or upon this specific date. _____
5. I hereby release Inroads to Recovery Inc from all legal liability that might arise from the release of information requested. I consider a photocopy of this authorization to be as valid as the original.

CLIENT SIGNATURE:_____ **DATE:**_____

GUARDIAN SIGNATURE:_____ **DATE:**_____

BUSINESS OFFICE SIGNATURE:_____ **DATE:**_____

6. State reason if patient is unable to sign his/her own consent release:_____
   _____

NOTICE TO THE INDIVIDUAL OR AGENCY RECEIVING THIS CONFIDENTIAL INFORMATION PURSUANT TO THIS AUTHORIZATION:
You are given specific permission to receive information that may contain confidential information protected by federal and /or state law. If this information is so protected, Federal Regulations (e.g. 42 CFR Part 2) PROHIBIT you from making any FURTHER DISCLOSURE of this information unless disclosure is expressly permitted by written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for release of medical or other information is NOT sufficient for the purpose of releasing HIV/AIDS, drug and/or alcohol information. Furthermore, Federal Regulations (CFR Part 2) restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

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Please fill out completely to help your provider better serve you during your appointment

Patient Name: _____ DOB: __/__/__ Date: _____

1. Who referred you here? _____

2. Check any issues you are having difficulty with.

ADHD
- □ hyperactive
- □ impulsive
- □ under achievement
- □ non-compliant
- □ inattentive
- □ poor concentration
- □ disorganized

Depression
- □ sad
- □ sleep problems
- □ neg. thinking
- □ poor concentration
- □ hopeless/worthless
- □ mood swings
- □ guilt

Anxiety
- □ excessive worry
- □ panic attacks
- □ irrational fear
- □ obsessions
- □ social isolation
- □ phobias
- □ compulsive

Relationship
- □ marital/significant other
- □ parenting
- □ difficulty with friends
- □ work/school problems
- □ personal growth
- □ grief/loss
- □ bullying/teasing

Anger
- □ short-fused
- □ temp. tantruns
- □ impulse control
- □ violent/assaultive
- □ runaway risk
- □ fighting
- □ Irritable
- □ Oppositional

Addictions
- □ alcohol
- □ drugs
- □ gambling
- □ relationships/sex
- □Spending

Abuse
- □ physical
- □ emotional
- □ domestic violence
- □ rape
- □ sexual

Other
- □ agitated
- □ mania
- □ paranoia
- □ delusions
- □ tics/tourettes
- □ dissociative
- □ cutting
- □ appetite changes
- □ nightmares/flashbacks

---

3. Where were you born? _____ Where were you raised? _____

4. How long have you lived at your current address and who lives with you? _____

5. Do you have a religious or spiritual preference? If so, what is it? _____

6. What is your family of origin? (i.e. who raised you, how many siblings, ect)?

---

7. Are you currently married? If so, for how long? _____

8. Any previous marriages? _____

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9. Do you have any children? If so, please list age and sex. _____

_____

10. Have you seen a psychiatric provider in the past? Yes / No

Name: _____ Date: _____

11. Have you seen a therapist or counselor in the past? Yes / No

Name: _____ Date: _____

12. Please list any medications that you have taken in the **past** and their effects.

_____

_____

13. Have you been hospitalized for psychiatric concerns or gone to treatment in the past? Yes / No

Where: _____ Date(s): _____

14. Have you had any suicidal attempts in the past? Yes / No

Number of attempts: _____ Date(s): _____

15. Anyone in your immediate family with a mental illness or substance abuse problem? Yes / No

Who: _____ Diagnosis: _____

Meds: _____

16. Has anyone in your immediate family ever committed suicide? Y/N

17. What is your highest level of education that you completed? _____

18. Do you Work? If so, where and what do you do? _____

19. Who is your primary care provider (i.e. where you go for physical illness), and when was the last time you were seen by them? _____

Females:

Are you pregnant? Y/N If yes who is your provider? _____
Are you breast feeding? Y/N
How many times have you been pregnant? _____ How many births? _____
Do you use a form of birth control? Y/N If so, what? _____

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20. Please check if you have any of the following chronic health conditions:

___Asthma __ Seizures __ Diabetes __ High Blood Pressure __ High Cholesterol
___Thyroid problems __ Cardiac problems __ Chronic Pain __ Other:_____

21. Please list any surgeries and hospitalizations:_____

_____

22. Are you allergic to any medication, foods, or have any environmental allergies? Yes / No

What/Reaction: _____

23. Are you your own legal guardian? If not, please list name of guardian._____

24. Is there any history of disability? _____

25. Has CPS been involved? If so, what is the name of the case worker? _____

26. Do you have any legal offenses or charges? _____

27. Has there been any physical, emotional, or sexual abuse in the past? Y / N

28. Do you drink alcohol? If so, how often and how many do you have? _____

29. Do you use drugs? If so, what drugs and how often do you use? _____

30. Do you use any tobacco products? If so, what kind and how much do you use in a day?

_____

31. Do you drink caffeinated beverages (i.e. soda, coffee, tea, or energy drinks)? If so, what kind and how many of each do you drink in a day? _____

32. Please list three (3) qualities you like about yourself. _____

33. Do you foresee any challenges that may exist in your treatment/care? _____

_____

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34. Please list **ALL** of your current medications and dosages that you are taking as well as any side effects that you are experiencing.

_____

_____

_____

35. What pharmacy do you use? _____

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Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often...
   Swear at you, insult you, put you down, or humiliate you? OR
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1_____
2. Did a parent or other adult in the household often or very often...
   Push, grab, slap, or throw something at you? OR
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1_____
3. Did an adult or person at least 5 years older that you ever...
   Touch or fondle you have you touch their body in a sexual way? OR
   Attempt or actually have oral, anal or vaginal intercourse with you?
   Yes No If yes enter 1_____
4. Did you often or very often feel that...
   No one in your family loved you or thought you were important or special? OR
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1_____
5. Did you often or very often feel that....
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? OR
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1_____
6. Were you parents ever separated or divorced?
   Yes No If yes enter 1_____
7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? OR
   Sometimes often, or very often kicked, bitten, hit with a fist, or hit with something hard? OR
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1_____
9. Was a household member depressed or mentally ill, or attempt suicide?
   Yes No If yes enter 1 _____
10. Did a household member go to prison?
    Yes No If yes enter 1_____

Now add up your "Yes" answers:_____

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Psychiatric Advance Directives

Please mark one of the following categorizes concerning Psychiatric Advance Directives, Thank you!

_____ Yes I do have a Psychiatric Advance Directive

_____ No I do not have a Psychiatric Advance Directive

_____ _____

Client's Name Client's Signature

_____

Date

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Notification to Primary Care Physician

Date: _____

Dear _____,

Primary Care Physician

Re:_____, _____

Client/ Patient Date of Birth

We will be seeing your patient, mentioned above, at one of our locations. Please feel free to contact us, should you like to discuss your patient care coordination.

Sincerely,

_____

Provider Signature (medical/ mental health.SA)

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CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy.

The ePrescribe Program also includes:

• **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.

• **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.

• **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy. The medication history information would include medications prescribed by your health care provider at **Inroads to Recovery, Inc**. as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.

Consent

By signing this consent form you are agreeing that your provider at **Inroads to Recovery, Inc**. may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services.

You also have a right to receive a copy of this form after you have signed it. This consent form will remain in effect until the day you revoke your consent.

You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Inroads to Recovery, Inc. to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____Print Patient Name _____ Patient DOB

_____Signature of Patient/Guardian _____Today's Date

_____Relationship to Patient

Effective: 07/2013
Revised Date: 08/04/2015