

# ADRIAN MARTIN, M.S.

Psychotherapy for Individuals, Couples, & Families

## CLIENT INFORMATION

(Please complete all 7 pages)

Name of Client: \_\_\_\_\_

Sex:  Male  Female Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home: (\_\_\_\_\_) \_\_\_\_\_ Is it OK to leave a detailed message on this number?  Yes  No

Work: (\_\_\_\_\_) \_\_\_\_\_ Is it OK to leave a detailed message on this number?  Yes  No

Cell: (\_\_\_\_\_) \_\_\_\_\_ Is it OK to leave a detailed message on this number?  Yes  No

Is it OK to text you on this cellphone?  Yes  No

Email: \_\_\_\_\_ OK to contact you via this email address?  Yes  No

Legal Status:  Single  Married  Separated  Divorced  Widow(er)  Minor (under 19 in NE)

Primary Occupation: \_\_\_\_\_ Employer/School: \_\_\_\_\_

Education (highest level): \_\_\_\_\_ Graduation year: \_\_\_\_\_

Current Living Situation:  Alone  With Spouse/Partner  With Parents  With Children

Emergency Contact: \_\_\_\_\_

Their phone: Home: (\_\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_\_) \_\_\_\_\_

I agree for this person to be contacted in an emergency (initial) \_\_\_\_\_

Spouse/Partner Name: \_\_\_\_\_

Sex:  Male  Female Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home: (\_\_\_\_\_) \_\_\_\_\_ Is it OK to leave a detailed message on this number?  Yes  No

Work: (\_\_\_\_\_) \_\_\_\_\_ Is it OK to leave a detailed message on this number?  Yes  No

Cell: (\_\_\_\_\_) \_\_\_\_\_ Is it OK to leave a detailed message on this number?  Yes  No

Is it OK to text you on this cellphone?  Yes  No

Email: \_\_\_\_\_ OK to contact you via this email address?  Yes  No

Primary Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Name(s) of Children	Age	Sex	School/College/Employed	Living with you?
---------------------	-----	-----	-------------------------	------------------

1. _____	_____	____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
----------	-------	------	-------	--

2. _____	_____	____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
----------	-------	------	-------	--

3. _____	_____	____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
----------	-------	------	-------	--

4. _____	_____	____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
----------	-------	------	-------	--

5. _____	_____	____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
----------	-------	------	-------	--

6. _____	_____	____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
----------	-------	------	-------	--

Referred By:  Physician  EAP  Therapist  Google search  Other Internet  Other

Name of Referral Person /Agency: \_\_\_\_\_ Phone#(\_\_\_\_\_) \_\_\_\_\_

Reason for Seeking Services Today: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Family Physician: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Family Medical History & Current Medical/Surgical Problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Medications: \_\_\_\_\_  
\_\_\_\_\_  
Are you compliant with meds?  Yes  No

Is anyone in the immediate family currently involved in the legal system?  Yes  No  
If Yes, Please give details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you, or anyone in the immediate family, seen a Mental Health Professional Before?  Yes  No  
If Yes, Please list Symptoms, Diagnosis, and Treatment received: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you, or anyone in the immediate family, currently seeing a Mental Health Professional?  Yes  No  
Current Psychotherapist/Psychologist/Psychiatrist: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
Current Psychotherapist/Psychologist/Psychiatrist: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Name of Primary Insurance: \_\_\_\_\_ Member # \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Name of Second Insurance: \_\_\_\_\_ Member # \_\_\_\_\_  
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 Adrian Martin, M.S. to submit claims for insurance benefits, for services rendered, or for services to be rendered, including treatment plans, 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 Adrian Martin, M.S. 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 Mr. Martin will be credited to my account, in accordance with the above said assignment.

I understand that Mr. Martin may use and disclose the client's health information to obtain payment for services provided. I also understand that should the client account balance remain outstanding that Mr Martin does utilize the services of a collection agency.

Signature of Clients (or Legal Guardian): \_\_\_\_\_

Date: \_\_\_\_\_

# ADRIAN MARTIN, M.S.

Psychotherapy for Individuals, Couples, & Families

## CONSENT FOR PSYCHOTHERAPY TREATMENT

I authorize the provision of outpatient psychotherapy treatment for myself, \_\_\_\_\_ or for \_\_\_\_\_. This treatment may include such services as a pre-treatment assessment, the use of specific assessment instruments, treatment planning, and individual, couple, and/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, and that treatment does not necessarily guarantee successful outcome.

I understand that it is reasonable and customary to arrive to appointments on time, to end appointments at the scheduled finish time, and to provide 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 Adrian Martin, M.S. reserves the right to 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 Mr. Martin's practice and the State and/or Medicaid mandated supervision processes, and will not be released to other parties 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 may be released under the following specific circumstances:

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

I understand that psychotherapy and working towards change may involve experiencing difficult and intense feelings, some of which may be painful in order to reach therapeutic goals. I accept that such changes can have both negative and positive effects, and I agree to evaluate and clarify the potential effects of changes before I undertake them. I understand that the psychotherapy process does not guarantee a therapeutic outcome.

I understand that if my primary care physician or psychiatrist has referred me to Mr. Martin, they may be routinely informed of my diagnosis, treatment protocol, and treatment progress. I understand that staff members and billing personnel will have access to my records, as will the State and/or Medicaid mandated supervisors. Additionally, my insurance carrier will have access to the records.

I agree to pay for Adrian Martin'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.

Signature of Client(s) (or Legal Guardian): \_\_\_\_\_

Date: \_\_\_\_\_

# ADRIAN MARTIN, M.S.

## Psychotherapy for Individuals, Couples, & Families

### CLIENT 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 invite you to discuss any questions related to your therapy 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.

### 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 or elder 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 50 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. Please provide at least 24-hours notice of a canceled appointment to avoid incurring a cancellation fee of \$50.

There is generally no charge for one brief (5 minute) telephone consultation 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. Please note, Adrian Martin, MS only returns messages during office hours (see the website for current office hours) and does not provide an out-of-hours emergency service. Messages left outside of office hours are usually returned the next working day. If you are experiencing a mental health emergency, please call the Boys Town 24 hour Crisis Line on (800) 448-3000, or call 911, or go to the nearest emergency room.

Additional charges may also be made for the administration and scoring of tests, writing reports, scheduled consultations with a psychiatrist, other professionals or family members, 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 \$25.00 charge for returned checks, this will cover bank charges and additional paperwork required in the office.

# ADRIAN MARTIN, M.S.

Psychotherapy for Individuals, Couples, & Families

## 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 Adrian Martin, M.S. and his staff.

### **Our Legal Duty**

Mr. Martin 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 (02-1-2012) 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 your 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 clients' 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 client under certain circumstances.

**Appointment Reminders:** We may use or disclose health information to provide you with appointment reminders such as voicemail messages, emails, SMS texts, or letters. We use password protected online services such as Google Voice, Gmail, and a remotely hosted Microsoft Exchange Server.

**Client 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 by sending us a letter to the address 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. If you request copies we will charge \$0.50 for each page and \$20.00 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 November 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 or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Adrian Martin, M.S.  
Telephone: (402) 577-0727 Fax: (402) 881-8332  
Address: 11225 Davenport St, Suite 103, Omaha, NE, 68154

I have been given a copy of Adrian Martin’s Client Orientation and Notice of Privacy Practices which covers topics including, but not limited to, treatment, financial procedures, healthcare operations, disclosure accounting, health information amendment, and concepts of confidentiality and privilege.

Client(s) Printed Name(s): \_\_\_\_\_

My signature below confirms receipt of this information

Client Signature(s) (or legal guardian): \_\_\_\_\_

Date: \_\_\_\_\_

# ADRIAN MARTIN, M.S.

Psychotherapy for Individuals, Couples, & Families

## CONTRACT FOR PAYMENT OF SERVICES

I understand that the amount billed will be \$130.00 per 50 minute individual, couple or family session, and \$200.00 for an initial evaluation/pre-treatment assessment.

I understand that I am assuming responsibility for payment of my bill at the time of the session, unless other arrangements are made and herein specified. I agree that Mr. Martin's office may release my name to any necessary party in the course of obtaining payment.

Mr. Martin's office may check on client insurance coverage as a courtesy to the client, but it is the client's responsibility to ensure they have current mental health benefits for outpatient office visits. Insurance companies only quote benefits and do not guarantee payment over the phone. Any disagreement regarding payment of a claim by insurance is between the client and his/her insurance company. Ultimately, payment of the bill is the Client's responsibility. **Payment of copayments, or self-pay fees, are expected at the time of service and should be made available at the beginning of each session.**

*Please complete the following:*

**I wish to use my insurance**, which is \_\_\_\_\_ and having spoken with my insurance company on phone # \_\_\_\_\_. I confirm I have current mental health benefits for outpatient office visits and I understand my insurance co-pay is \$\_\_\_\_\_ per office visit. (Or co-insurance is \_\_\_\_\_%). My insurance company requires pre-authorization:  Yes  No, if yes, the authorization number is: \_\_\_\_\_ I believe I have already met my insurance deductible for this year:  Yes  No. If not, my remaining deductible is \$\_\_\_\_\_ as of \_\_\_\_\_ (date).

Signature of this contract authorizes payment of medical benefits to this office for services rendered.

I understand my insurance company (if applicable) will be billed the full amount for the session and that aside from my co-pay (if applicable), and providing that Mr. Martin is considered "in-network" for my insurance plan, I am not liable for any difference between the billed amount and the reimbursement amount previously negotiated between the insurer and Mr. Martin.

**I wish to self-pay and not use insurance.**

I understand that it is important that I provide a 24-hour notice of cancellation of a scheduled appointment and that by not providing this notice of cancellation, the appointment will be considered the same as not showing for the appointment and there will be a charge of \$50.00 for this scheduled time. This charge will be the responsibility of the client.

In order to make payment easier for all concerned, I agree to use my credit card to pay the balance of any outstanding insurance co-pay amounts, self-pay fees, or cancellation fees.

Card type:  Visa  MasterCard

Card Number: \_\_\_\_\_

Expiration date: \_\_\_\_\_ Security Code (3 digits on the back): \_\_\_\_\_

Name as it appears on the card: \_\_\_\_\_ Billing ZIP: \_\_\_\_\_

I authorize Adrian Martin / Core Conditions, P.C. to charge my account for any outstanding amounts owed.

Client(s)/Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

# ADRIAN MARTIN, M.S.

Psychotherapy for Individuals, Couples, & Families

## Ethical Practice

Adrian Martin, M.S., CMFT, LIMHP, is licensed in the State of Nebraska as an INDEPENDENT MENTAL HEALTH PRACTITIONER & certified as a MARRIAGE & FAMILY THERAPIST. I understand that Adrian Martin routinely engages in case consultation both as part of maintaining an ethical practice and to meet the requirements of State law, and in such professional consultations my case may be discussed and that all reasonable precautions will be taken to maintain the highest level of confidentiality throughout that process.

Signature of Client(s) (or Legal Guardian): \_\_\_\_\_

Date: \_\_\_\_\_

## Statement of understanding for Couple's / Marriage Therapy

Couple's therapy starts with an assessment of your relationships, past and present. We understand that any information discussed as part of couple's therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving the partners. We agree not to subpoena Adrian Martin, to testify for or against either party, or to provide records in a court action. By entering into couple's therapy, we both understand and accept that working towards change may involve experiencing difficult and intense feelings, some of which may be painful in order to reach our goals. We accept that such changes can have both negative and positive effects, and agree to evaluate and clarify the potential effects of changes before we undertake them. There may be times when Adrian Martin appears to be on either person's side, but in reality is always on the side of our relationship. If the relationship breaks up, or couple's therapy terminates, and either or both of us wishes to re-contract with Adrian Martin for individual therapy, the decision with whom Adrian Martin continues to work with is at his sole discretion. In some circumstances a referral may be made.

Contact with Adrian Martin between sessions should be limited to making appointments or for emergencies. If there are individual sessions conducted as part of the couple's therapy, secrets will not be kept, and Adrian Martin reserves the right to make the clinical judgment to pass on information in the couple's therapy that furthers the therapeutic goals.

Since session time is limited to 50 minutes, try to be concise in communicating your thoughts and feelings. Therapy seems to work best if you strive for closure in your communication, that is, a point of satisfaction that you have said what you need to say, and have asked for what you need to ask for.

We agree to the above guidelines.

Signature of both partners;

Signed: \_\_\_\_\_ Signed: \_\_\_\_\_

Date: \_\_\_\_\_