Jamie Heng, M.S., LIMHP, CDGC, PLADC

Demographic Information

Name:____
Parent/Legal Guardian (if under 18): ____
Address: ____
Home Phone: ___ ________________________________ May we leave a message? □ Yes □ No
Cell/Work/Other Phone: __________________________ May we leave a message? □ Yes □ No
Email: ____ May we leave a message? □ Yes □ No
Emergency Contact: ________________________________ Phone: ________________________
**Please note: Email correspondence is not considered to be a confidential medium of communication.*
DOB: _______________________________ Age: _______ Gender: ________________
Martial Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed
Referred By (if any): ____

Insurance Information

Primary Insurance Company: ______________________ Policy #: _______________________
Group # (if applicable): _______________________
Policy holder: _______________________ Relationship to Policy Holder: _________________
Policy holder's address: ____
Policy holder's DOB: ___________ Policy holder's Employer: ___________________________

Billing Policies and Information

The fees for services provided by Jamie Heng, M.S., LIMHP, CDGC, PLADC will be in accordance with the reasonable value set forth by the established community guidelines and standards. Here is a list of some, but not all, of the services that Jamie Heng provides. In parentheses are the rates as of March 2018, although rates are subject to change. *Please be aware that not all services are covered by every insurance company, and you will be responsible for the remaining bill.* **Patients are expected to pay fees at the time of service unless other billing arrangements are agreed upon in advance.** For this reason, it is required that a credit/debit card be kept on file and authorized for payment. However, you are welcome to use alternative payment methods. Copayments are expected at each session. If a patient is unable to make on-time payments, the patient may be referred to an alternative provider. Jamie Heng, M.S., LIMHP, CDGC, PLADC reserves the right to delay, defer, or discontinue services for any reason, including if the balance owed is not paid at the time it is due. Statements are sent at the beginning of each month and payment is due by the end of that month. **If payment has not been received by the time a second statement is sent, your account will be assessed a $10.00 fee each month and sent to collections after 60 days from the first statement date.**

CPT Code	Cost	Description
90791	$200	Initial Session
90832, 90834, 90837	$100, $120, $150	Individual therapy, vary by session length
90846/90847	$140	Family therapy
90853	$40	Group therapy
90889	$80	Preparation of documentation (e.g., for another agency, attorney, court, school)
98966, 98967, 98968	$40, $60, $80	Phone calls with therapist, vary by length (5-30 minutes) *May include provider contact with patient, parent, school, attorney, etc.
98969	$40	Email or some other online contact with a therapist

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I understand that I am ultimately liable for the balance on my account for any services provided by Jamie Heng, M.S., LIMHP, CDGC, PLADC regardless of the status of my insurance situation. With my signature, I agree to adhere to the billing policies and procedures, and to pay any fees that I owe Jamie Heng based upon such policies. I hereby authorize direct payment and all benefits due under my insurance policy to Jamie Heng, M.S., LIMHP, CDGC, PLADC for services provided. I authorize the release of medical or other protected health information necessary to process insurance claims.

Printed Name:_______________________

Signature: __________________________ Date: _____________

Credit or debit card:
Card number: #____________________________
Expiration date (MM/YY): _____/_____
CVV security code: ______
Name on card: ____________________________________
Billing street address: _______________________________
City, State, Zip code: _______________________________

"I request that the above charge card transaction be processed in accordance with the card issuer agreement."

Signature: ____________________________________

Appointment Policy

When completing counseling services, continuity is vital to success. Frequent cancellations or failing to schedule appointments can lead to delays between therapy sessions that may impede progress. As a mental health service provider, I try to assist in finding suitable times for us to meet for sessions. Our success is a joint effort; therefore, your cooperation in keeping appointments is critical to your success.

1. To schedule appointments, please call **402-413-6247 or schedule online.**
2. I require a minimum of 24 hours' notice for changes or cancellations of appointments. If you do not cancel with a minimum of 24 hours, you will be responsible for fees accrued. Since I am unable to use this time for another client, please note that you will be billed a $50 fee that is not covered by your insurance, unless such cancellation is due to illness or an emergency.
3. Please contact me as soon as you are aware you need to cancel. (This is also within the minimum of 24 hours.)
4. If you are late for an appointment, the appointment will still end at the scheduled time.
5. If you cancel or do not show up for two consecutive appointments, you will be discharged.

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Consent for Treatment and Limits of Confidentiality

Limits of Services and Assumption of Risks:
Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:
What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances
Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to the clients.
The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.
By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

Electronic Communication Policy

It is expected that all non-emergent contact with your provider will take place during a scheduled session with the exception of scheduling. As such, regular communication via phone, email, or other electronic means is not typically utilized. If an emergent situation arises, please contact me at (402) 413-6247 and if you have to leave a message, please indicate that this is an emergency. In the occasion of an emergency, it is recommended that you call 911 or go to nearest emergency room. On occasion, patients may still choose to email their provider. By signing, you recognize that while your provider utilizes a secure email provider, confidentiality of any information sent online cannot be guaranteed.

I appreciate your help in keeping the office schedule running timely and efficiently.

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PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you hope to address. There are many different methods I may use to deal with those problems. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with me. At the end of the evaluation, I will notify you if I believe that I am not the right therapist for you and, if so, I will give you referrals to other practitioners whom I believe are better suited to help you.

I understand and agree to all information above.

____ ___________________
Client Signature (Client's Parent/Guardian if under 18) Date

Informed Consent for Treatment

I _____________________ (name of patient), agree and consent to participate in behavioral health care services offered and provided at/by Jamie Heng, M.S., LIMHP, CDGC, PLADC, a behavioral healthcare provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within the scope of the provider's license, certification, and training.

If the patient is under age 18 or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature ___________________________________Date ____________
Relationship to Patient (if applicable):____________________________________