Oasis Counseling, LLC
o: 702.294.0433
f: 702.446.8363

Patient Information

Patient Name: _____ DOB: _____
First M Last

Gender: M ☐ F ☐ Other ☐ (specify): _____

Social Security Number: _____
(Will remain confidential)

Home Address: _____

City: _____ Zip: _____

Home: _____ Cell: _____

E-Mail: _____

Employer: _____ Phone: _____

Patient's Relationship Status: Single ☐ Married ☐

Other ☐ (specify): _____

Do we have permission to contact you at home? Yes ☐ No ☐

At work? Yes ☐ No ☐

Emergency Contact/Relationship: _____

Emergency Contact Tel: _____

Appointment Reminders

By marking "Yes" and providing your cellphone and/or e-mail below you consent to receive appointment reminders and request for rescheduling contacts. All messages will be identified as "OASIS."

Would you like to receive appointment reminders? Yes ☐ No ☐

E-mail: _____

Cell: _____

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Financial/Insurance Information

Do you have insurance? Yes ☐ No ☐

If not, please specify payment method: Cash/Check ☐ Credit ☐

Primary Insurance: _____

Insured's Name: _____

Insured's DOB: _____

Relationship to patient: _____

Primary Insurance: _____

Insured's Name: _____

Insured's DOB: _____

Relationship to patient: _____

Patient Signature: _____ Date: _____

(If a child or adolescent, parent or guardian must sign)

Please present your insurance card to create a photocopy to keep on file. Thank you, for your cooperation. The signature above authorizes the release of any information necessary to process the patient's insurance claim and authorizes direct payment of medical benefits to **Oasis Counseling, LLC**. I personally assume full responsibility for payment of any fees not covered by the insurance carrier listed above. I have read, understand and agree to the described disclosure, financial policy and various releases and guarantees.

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Patient Intake Form – Adult 18+ (MH)

In order to provide you with the best possible service that you deserve, we need to begin with information from you. Please, complete the following to the best of your ability:

Patient Name: _____ Date: _____

Briefly describe your reason for obtaining service:

_____

_____

_____

Have you received treatment for this issue or problem in the past?

Yes ☐ No ☐

If yes, please provide the dates of treatment, whether the treatment was inpatient or outpatient, and the name of the provider who treated you.

Inpatient ☐ Outpatient ☐

_____

_____

_____

Primary care physician: _____ Phone: _____

Please list any medications you are currently taking:

_____

_____

_____

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Please list any health (medical) problems for which you have been recently treated:

_____

_____

_____

Please list any serious health (medical) problems you currently suffer from or have suffered from in the past:

_____

_____

_____

Please describe below any special concerns, questions or information you believe will be helpful in developing your treatment program.

_____

_____

_____

Who suggested you contact us?

Self ☐ Physician ☐ Friend ☐ Other ☐

If a physician referred, please complete the following:

Physician Name: _____ Tel: _____

Address: _____

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Adult, 18+ Checklist

Please check any of the following which apply to you.

	Currently	Within the past year		Currently	Within the past year
Feel sad	☐	☐	Muscle aches	☐	☐
Loss of interest	☐	☐	Feeling “on edge”	☐	☐
Feel hopeless	☐	☐	Worry too much	☐	☐
Nothing is fun	☐	☐	Impatient	☐	☐
Weight loss	☐	☐	Dry mouth	☐	☐
Weight gain	☐	☐	Bowel problems	☐	☐
No energy	☐	☐	Hyperventilation	☐	☐
Cry easily	☐	☐	Faintness/dizziness	☐	☐
Can't concentrate	☐	☐	Pounding heart	☐	☐
Can’t fall asleep	☐	☐	Trembling	☐	☐
Sleep too much	☐	☐	Sweating	☐	☐
Feelings of guilt	☐	☐	Choking sensations	☐	☐
Restless	☐	☐	Nausea	☐	☐
Irritable mood	☐	☐	Numbness/tingling	☐	☐
Thoughts of suicide	☐	☐	Chest pain	☐	☐
Waking up early	☐	☐	Fear of dying	☐	☐
Feeling worse in the morning	☐	☐	Fear of going crazy	☐	☐
No need for sleep	☐	☐	*Fear or anxiety in relation to any of the following:*		
Talking too much	☐	☐	Crowds	☐	☐
Racing thoughts	☐	☐	Bridges	☐	☐
Spending sprees	☐	☐	Buses	☐	☐
Reckless driving	☐	☐	Stores	☐	☐
Overactive sexually	☐	☐	Being out of the house	☐	☐
Uncontrollable urges	☐	☐	Heights	☐	☐
Explosive temper	☐	☐	Talking in public	☐	☐
Gambling too much	☐	☐	Choking on food	☐	☐
Drinking too much	☐	☐	Urinating in public	☐	☐

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Consent for Treatment

I, the undersigned, certify that the information below was made available to me:

- Type of treatment to be provided.
- Goals or benefits expected.
- Who will provide that treatment and that therapist's credentials.
- Estimated length of treatment.
- Estimated cost of treatment and my ultimate responsibility for those costs.
- Other available treatment.
- Probable consequences of not receiving treatment suggested.
- Possible risk, if any, associated with treatment suggested.

I understand that information given within a therapeutic relationship shall remain confidential, excepting those circumstances which require a therapist to report that occurrence or likely occurrence of homicide, suicide, physical assault, or child abuse.

I understand that I am actively involved in my treatment plan with my Counselor and/or Psychologist.

I understand that if I disagree with any part, or all of the treatment plan suggested, I can request a second opinion and will be assisted in obtaining that second opinion.

I understand my consent automatically expires at the end of my treatment. I do, however, have the right to withdraw this consent at any time I choose.

I understand that should I ever believe my rights were violated or have a question regarding my treatment, I can contact the President, Barbara Adams, either by telephone or in writing and expect a prompt response.

I understand that in a true emergency, I can contact my therapist. If he/she is not available, I need to immediately call 911 or go to the nearest emergency room.

My signature below indicates my consent to the treatment plan and that my patient rights have been explained to me today. Should I at any time not remember any of the above information, that information will again be provided to me whenever requested.

_____ _____

Patient/Parent or Guardian Signature Date

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Services & Fees

Oasis Counseling LLC provides Psychotherapeutic, Counseling, Behavioral Health and Consultative Services to any person requiring treatment. Sessions are typically 45 minutes to an hour. The rate of $_____ is charged for the initial Evaluation and $_____ per 45 minute Therapy session is the standard and customary fee for your Psychologist or Counselor. Additional fees for services beyond the usual session may result in additional charges which would be discussed with you in advance.

Patient Responsibilities

Patients who carry any form of Outpatient Mental Health Insurance are informed that all Psychotherapeutic and/or Counseling Services performed in this office are charged directly to the patient and/or undersigned parent or guardian. The billing office of Oasis Counseling LLC will prepare the necessary forms to assist the financially responsible party in making collections from the insurance company and will credit any such collections to the patient's account. ***The fees not paid by the insurance company are the responsibilities of the patient and/or undersigned parent or guardian***

Payment

We assist people in billing their insurance companies for payment. However, we do not accept any initiatives set forth by your insurance company nor do we take responsibility for your insurance company to fulfill their obligations to you. Most insurance companies no longer follow standard procedures. Thus, we require that copay be paid in advance for all services. If the portion of your bill that remains after the insurance company has paid, denied coverage or if you are uninsured, we will require payment upon rendering services.

Collections

You are responsible for payment of your therapy fees, regardless of whether or not they are covered by your insurance carrier. You agree to the costs of any action necessary to collect your portion of the fee due. Collection fees are at 35% addition of the FULL fee owed. In addition, court and attorney fees and an interest rate equal to the statutory amount at the time of the debt in accordance with the State of Nevada may also be added to this debt. You will receive appropriate notice of efforts to obtain this debt. Debt is collected by Clark County Collections and signing this agreement allows them to write, call or take any action necessary to collect this debt.

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Cancellation

A specific date and time have been set aside for your appointment. Cancellations without 24 hours advanced notice prevent services to be rendered to other patients in need of treatment. The patient and/or undersigned parent or guardian will be billed for the entire missed appointment at the full fee if cancellation is less than 24 hours. This fee Must Be Paid in Full by cash or check at the time of the next appointment. Note: Insurance cannot be billed for this situation.

Worker's Compensation

As a courtesy to our patients, Oasis Counseling LLC will file Worker's Compensation claims. However, in the event that the claim is denied, unsettled, or unpaid within 60 days, filing of a personal health insurance claim or payment of the charges in full will be required. I have read and understand the Statement of Financial Agreement and consent to the financial responsibilities outlined above. Any exceptions or variations will need to be discussed with my Psychologist or Psychotherapist and added to this form.

_____ _____

Patient/Parent or Guardian Signature Date

_____

Printed Name

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HIPAA Privacy Statement

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations.

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. We are required by law to maintaining the privacy of PHI and to provide you with our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by sending you a copy in the mail upon request at your next appointment.

II. Uses and Disclosures Requiring Authorization.

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes your therapist has made about your conversations during a private, group, joint or family counseling session, which they have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

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III. Uses and Disclosures with Neither Consent nor Authorization.

We may use or disclose PHI without your consent or authorization in the following circumstances: (1) Child Abuse/Neglect; (2) Elder Abuse/Neglect; (3) Health Oversight (Nevada Licensing Board requesting records); (4) Judicial or Administrative Proceedings (court order); (5) Serious Threat to Health or Safety to self or others; and (6) Worker's Compensation (if you file a claim).

If you believe that your privacy rights have been violated and wish to file a complaint with Oasis Counseling LLC, you may send your written complaint to Oasis Counseling LLC or with the Secretary of Health and Human Services at 200 Independence Ave., S.W., Washington, DC 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint. (Effective date 4/14/2003).

_____ _____

Patient/Parent or Guardian Signature Date

_____

Printed Name