OASIS
COUNSELING

Patient Registration

Patient Name:_____ DOB:_____ Sex: M or F
First M Last

Address:_____ City:_____

Zip: _____ Home Tel:_____ Cell: _____

E-Mail: _____ Social Security # :_____
(will be confidential)

Employer:_____ Tel: _____

Patient's Status: Single _____ Married _____ Other (what?)_____

Emergency Contact :_____ Tel: _____

Do we have permission to contact you at home? Yes _____ No _____ At work? Yes _____ No _____

Reminders: By writing your cellphone and/or e-mail below is consent for appointment reminders and request for rescheduling contacts. All messages will be identified as "OASIS":

Cell # for text reminders of appt: _____ E-mail for appt reminders: _____

Financial/Insurance Information

Insurance: Yes: _____ No: _____ If not, payment method: Cash/Check:_____ Credit:_____

Primary Insurance: _____ Insured's DOB: _____

Insured's Name: _____ Relationship: _____

2nd/Supplemental Insurance:_____ Insured's DOB: _____

Insured's Name: _____ Relationship: _____

Please present your insurance card to be photocopied. Thank you, for your cooperation. My signature below authorizes the release of any information necessary to process my 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.

Signature: _____ Date: _____

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

Tel: 702.294.0433 * Fax: 702.446.8363
www.oasiscounselingtoday.com * info@oasiscounselingtoday.com

Financial Agreement

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.

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.

Signature:_____ Date: _____
(If a minor under 18, parent or guardian must sign)

OASIS COUNSELING

MAIN TEL: (702) 294-0433
oasiscounselingtoday.com

HENDERSON-GREEN VALLEY
2360 W. Horizon Ridge Parkway, Ste 120
Henderson, NV 89052

SUMMERLIN
7361 Prairie Falcon Rd, Ste 110
Las Vegas, NV 89128

HENDERSON-GALLERIA
375 N. Stephanie, Ste 811
Henderson, NV, 89014

APPOINTMENT / CANCELLATION / NO SHOW POLICY

At Oasis Counseling, office visits are by appointment only please call (702-294-0433). The receptionist may ask about the reason for your visit. This helps us schedule the provider's time more efficiently. Please arrive 10 minutes early for your appointment. Patients who are late for any appointment more than 20 minutes will be asked to reschedule at the provider's discretion.

Cancellations

We would like to thank you for being a patient at Oasis Counseling. We value all our patients and strive to provide the best care possible and in the most comfortable setting. Please understand that when we schedule your appointment, we are reserving time for your needs. We kindly ask that if you must change an appointment, please give us at least 24 hours' notice. This courtesy makes it possible to give your reserved time to another patient who would like it. We know that your time is valuable. When your appointment is made, the room is reserved and your records are prepared for your visit. Except in the case of emergency treatment for another patient, you can expect us to be running on schedule. If you are unable to keep an appointment, we ask that you cancel at least 24 hours in advance. If this is not possible, call as soon as you can so that another patient can be given your appointment time. Appointments that are cancelled the same day as the appointment will be charged a late cancellation fee of **$45**.

Missed Appointments (Non-Cancelled)

We understand that occasional missed appointments can occur for a variety of reasons. When you miss an appointment without canceling, someone else who could have been seen in your place is delayed unnecessarily. We track missed (non-cancelled) appointments. A "No Show/Late Cancellation" is defined as missing an appointment without cancelling at least 24 hours before scheduled time. **There will be a charge for a missed or non-cancelled appointment. Insurance will not cover charges for no show or late cancellation fees.** The **$45** charge is in addition to any other charges you may have incurred. No refunds will be given. Repeated missed appointments may result in your provider discharging you from their practice, and transferring you to another provider.

Payment

Payment is due in full at the time of service no exceptions.

Patient Name (Print): _____

Patient Signature: _____

Date: _____ / _____ / _____

This policy supersedes previous late cancellation/no show policies. Feel free to contact us at info@oasiscounselingtoday.com.

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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.

_____ _____

Signature of Patient Date

_____

Print Name

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.

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).

_____ _____

Signature of Patient Date

_____

Print Name

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PAYMENT/DEDUCTIBLE/COPAYMENT CREDIT CARD ON FILE POLICY

At Oasis Counseling, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. Our policies require the payments for coinsurance, copayment, and/or cash pay session fees are paid in full prior to the beginning of your session with your provider. Without this authorization, a billing fee of $5 will be added to your account for any balances that we must attempt to collect through mailing monthly statements. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will charge for *each month* that the bill remains unpaid.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Oasis Counseling to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐Amex ☐Visa ☐Mastercard ☐Discover

Credit Card Number _____

Expiration Date _____ / _____ / _____ CCV _____

Cardholder Name _____

Signature _____

Billing Address _____ City _____ State_____ Zip _____

I (we), the undersigned, authorize and request Oasis Counseling to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Oasis Counseling. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60-day notification to Oasis Counseling in writing and the account must be in good standing.

☐ Check Box to *decline* credit or debit card on file. By declining, I understand I am *subject to the above explained fees*.

Patient Name (Print): _____

Patient Signature: _____

Date: _____ / _____ / _____

This in no way will affect your ability to dispute a charge or question your insurance carrier's payments. Feel free to contact us at info@oasiscounselingtoday.com.

Patient Intake Form - Adult (MH)

Name:_____ Date:_____

In order to provide you with the service you expect, we need to begin with information from you. Please complete the following as honestly as possible:

Briefly describe your reason for obtaining service:

_____

_____

_____

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

Please provide dates of treatment and name of provider who has treated you:

Inpatient Out- Patient

_____

_____

_____

What is the name of your primary care physician?

Physician: _____ Telephone:_____

Please list any medications you are currently taking:_____

_____

_____

Please Complete the Next Page

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

Please list any serious health (medical) problems you have had in the past:

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

Please complete as honestly as possible.

Thank you.

OASIS COUNSELING

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	☐	☐