INITIAL CLIENT INFORMATION FORM

DIRECTIONS: Please fill out the following information in its entirety. If the client is under the age of 18, please fill out the Parent/Guardian Information.

This form is being completed by the: ☐ **Client** ☐ **Other (Please Specify): ____________________**

Client Information

Client's Legal Last Name	**First Name**	**Middle**	**Date of Birth**	**Age**

Street Address	**City**	**State**	**Zip Code**

Home Phone Number	**Cell Phone Number**	**Gender** ☐ Male ☐ Female	**Social Security Number**

E-mail Address

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (Select More Than One If Necessary)
- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Black
- ☐ Asian
- ☐ Some Other Race

For Ethnicity and Race, Please Specify Country/Tribe of Origin(s):

Example(s): Ireland, Philippines, Mexico, etc.

Relationship Status (Select More Than One if Necessary)
- ☐ Single
- ☐ Separated
- ☐ With a Partner
- ☐ Divorced, No Children
- ☐ Married, No Children
- ☐ Divorced, with Children
- ☐ Married, with Children
- ☐ Widowed
- ☐ Other: ______________________________

Education Level (Current or Level Achieved)
- ☐ Pre-school or Lower
- ☐ High School Grad
- ☐ Kindergarten – 5th grade
- ☐ GED Equivalent
- ☐ 5th grade – 8th grade
- ☐ Some College
- ☐ 9th grade – 12th grade
- ☐ College or More
- ☐ Other: ______________________________

DIRECTIONS: For Parent/Guardian information, please list all Parent's/Guardian's of the client.

Parent/Guardian Information (Primary)

Relation to Client
☐ Biological Parent ☐ Legal Guardian (Please Specify): ☐ Other (Please Specify):

Parent/Guardian Last Name	**First Name**

Street Address (If Different Than Client's)	**City**	**State**	**Zip Code**

Home Phone Number	**Work Phone Number, Ext**	**Cell Phone Number**	**Fax Phone Number**

E-mail Address

Is the Client in DFS Custody? ☐ **Yes** ☐ **No**
If Yes, Please Specify the Date that the Client was Taken into Custody:
____

Parent/Guardian Information (Secondary)			
Relation to Client ☐ Biological Parent ☐ Legal Guardian (Please Specify): ☐ Other (Please Specify):			
Parent/Guardian Last Name		**First Name**	
Street Address (If Different Than Client's)		**City**	**State** **Zip Code**
Home Phone Number	**Work Phone Number, Ext**	**Cell Phone Number**	**Fax Phone Number**
E-mail Address			

DIRECTIONS: Please answer the following questions to the best of your abilities.

What are the primary concerns that have resulted in the client to seek care (Check off all that apply)?

☐ Anxiety ☐ Panic Attacks ☐ Fear of Places ☐ Fear of Others
☐ Sadness ☐ Depression ☐ Eating Concerns ☐ Sleep Concerns
☐ Thoughts of Hurting Self ☐ Thoughts of Hurting Others ☐ Anger Concerns ☐ Physical Aggression
☐ Concentration Problems ☐ Attention Problems ☐ Hyperactivity ☐ Impulsivity
☐ Memory Problems ☐ Hallucinations ☐ Delusions ☐ Paranoia
☐ Relationship Concerns ☐ Change in Life/Adjustment ☐ Traumatic Incident ☐ Sexual Dysfunction
☐ Alcohol Abuse (Please Specify): ____________________
☐ Substance Abuse (Please Specify): ____________________
☐ Medical Concerns (Please Specify): ____________________
☐ Other: ____________________

Please list any medications that the client is currently taking:

Medication Name	**Dose (Strength)**	**Taken For**	**Prescribed by**

Does the client's family have a history of mental illness? ☐ Yes ☐ No
If "Yes", please specify (the family member's relationship to client and diagnosis): ____________________
____
____
____

What was the level of education achieved by the client's?

Biological Mother		**Biological Father**	
☐ 5th grade – 8th grade	☐ Some College	☐ 5th grade – 8th grade	☐ Some College
☐ 9th grade – 12th grade	☐ College or More	☐ 9th grade – 12th grade	☐ College or More
☐ High School Graduate	☐ Unknown	☐ High School Graduate	☐ Unknown
☐ GED Equivalent	☐ Other:____________	☐ GED Equivalent	☐ Other:____________

Was the client exposed to any harmful substances (cigarettes, alcohol, illegal drugs, and other teratogens) during prenatal care/pregnancy? ☐ Yes ☐ No ☐ Suspected ☐ Unknown

If "Yes", please specify: ____________________

Please describe the manner in which the client was delivered during pregnancy (check all that apply):

☐ Normal ☐ Cesarean Section ☐ Emergency
☐ Pre-mature ☐ Post-mature ☐ Difficult

If other than "Normal", please describe: ____________________

The client's birth weight and height was: ____________________

Did the client reach all of their early childhood milestones within their specified timeframe (sitting up, walking, talking, "potty" training, etc.)? ☐ Yes ☐ No ☐ Unknown

If "No", please specify: ____________________

Has the client had any medical allergies or significant medical conditions? ☐ Yes ☐ No

If "Yes", please specify: ____________________

Has the client ever participated in any of the following mental health services?

☐ Day Treatment
☐ Basic Skills (BST)
☐ Psychosocial Rehabilitation Services (PSR)
☐ Individual Therapy
☐ Family and Marriage Therapy
☐ Group Therapy
☐ Alcohol and Substance Abuse Treatment
☐ In-Patient/Psychiatric Hospitalization
☐ Partial Hospitalization
c Mental Health Residential Treatment

If the client has participated in previous treatment, please specify:

Type of Treatment	**Provider of Treatment**	**Dates of Participation**

**** For office use only **** – Please print and sign your name after document has been reviewed for completion:

Client/Parent or Guardian Date

Screening Specialist Date

INFORMED CONSENT FOR SERVICES

DIRECTIONS: Please "Initial" the lower right hand corner of each page, acknowledging that you have read and understood every page of the Informed Consent for Services.

WHO WE ARE

Mbrace Counseling and Behavioral Services is a community mental health organization that specializes in Neuro and Mental Health Therapy. Individual Therapy, Group Therapy, Psychosocial Rehabilitation Services, and Basic Skills Training. Mbrace Counseling and Behavioral Services has a professional staff consisting of Licensed Mental Health Professionals (Psychologists, Family and Marriage Therapists, Clinical Social Workers, Clinical Professional Counselors), Licensed Mental Health Professional-Interns and other Qualified Mental Health Associates. Mbrace Counseling and Behavioral Services is also encompassed by professionals-in-training (Collegiate/ University Intern and Practicum Students).

CONFIDENTIALITY

Confidentiality means that the mental health professionals and their supervisors have a responsibility to clients in regards to safeguarding information obtained during treatment. Clients of Mbrace Counseling and Behavioral Services should respect each other's confidentiality as well, and not discuss who they see or what they may overhear at Mbrace Counseling and Behavioral Services.

It is important that you understand that all identifying information about your assessment and treatment is kept confidential. Even within the organization, information about your case is only shared with those who will confer with your clinician to enhance the services you receive. These include other professionals-in-training, supervisors at Mbrace Counseling and Behavioral Services, the Clinical Director of Mbrace Counseling and Behavioral Services, and Licensed Mental Health Professional-Interns Board Approved Supervisors.

In order to protect your confidentiality, any written, telephone, or personal inquires about clients will not be acknowledged. You must sign a Release of Information Form before any information about you is given outside of Mbrace Counseling and Behavioral Services. In order for us to coordinate our treatment with other mental health or medical professionals, Mbrace Counseling and Behavioral Services will ask you to sign a Release of Information Form to allow us to discuss or correspond with other professional who may have been involved.

LIMITS OF CONFIDENTIALITY

It is important that you understand that laws in the State of Nevada allow exceptions to confidentiality. In certain situations, mental health professionals are required by the law to reveal information obtained during your sessions to person(s) or agencies without your permission. Also, in these situations we are not required to inform you of our actions. Examples of such limits of confidentiality for Mental Health Professionals are when; client state that they want to hurt themselves (suicidal) and /or hurt another identifiable person(s) (homicidal).

Within the State of Nevada, all Mental Health Professionals are deemed to be "Mandated Reporters". A "Mandated Reporter" is required by law to inform the State of Nevada of any known or suspected forms of Abuse/ Neglect in regards to the following individuals: Abuse/ Neglect of a Child, Statutory Sexual Seduction (A person 18 years of age or older with a person under the of 16***: NRS 200.364 [3]***), Abuse/ Neglect of an Elderly Individual, and Abuse/ Neglect of a Mentally/Physically Handicapped Individual.

If at any time you have questions in regards to the limits of your confidential mental health services, please contact our office or your licensed mental health professional with who you receive mental health services from.

INITIAL ___________

TRAINING AND RESEARCH
Mbrace Counseling and Behavioral Services supports an environment of continual professional growth with all of our professional staff members and professionals-in-training. Therefore, we require permission to record and directly observe the therapeutic services that we provide for our clients. The recordings and direct observation are used for instruction and supervisory input and are necessary to insure our clients receive the highest quality of services possible. The recordings are on a dedicated server and may only be reviewed by professionals-in-training, the Clinical Director of Mbrace Counseling and Behavioral Services and Clinical Supervisor of Mbrace Counseling and Behavioral Services. If a professional-in-training is required to have further professional input provided by their academic supervisors in regards to their progress in skill development with various forms of therapeutic services here at Mbrace Counseling and Behavioral Services, the professional-in-training will require the client's expressed written consent to utilize such recorded therapeutic services. You may inquire at any time as to who is participating in your treatment. The recordings will not be used for any other purpose without your permission and will be deleted when they are no longer useful for educational or supervision purposes.

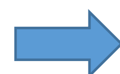
Another primary function of Mbrace Counseling and Behavioral Services is to conduct meaningful research on human problems and treatment that address these problems. This allows us to improve the services you receive and upgrade the services for future clients. Due to this, you may be asked to complete a few questionnaires, assessments, or surveys prior to, during, and after the course of treatment. By participating in these questionnaires, assessments, or surveys, you are allowing Mbrace Counseling and Behavioral Services to use the confidential data you submit for scholarly research/publications.

BENEFITS OF THERAPEUTIC SERVICES
One major benefit that may be gained from therapy treatments is the resolution of concerns. Other possible benefits may be a better ability to cope with marital, family, and other relationships, or a greater understanding of personal goals and values.

RISKS OF THERAPEUTIC SERVICES
To allow you to make an informed decision about your treatment, we have chosen to discuss the possible risks of therapy. You may experience discomfort such as anger, depression, or frustration during your treatments as you remember and resolve unpleasant events. Seeking to resolve concerns between family members, marital partners and other people can similarly lead to discomfort as well as relationship changes that may not be originally intended.

The greater risk of therapy is that it may not by itself resolve your concerns. We do our best to assess progress on a week-to-week basis. If a situation fails to improve or a situation deteriorates, we will provide a referral to another professional for consultation or treatment.

FEES AND APPOINTMENTS
Payment of fees, including any required co-pays, is expected at the time of each appointment. We request that payment be made before your session begins. If you are using insurance benefits, Mbrace Counseling and Behavioral Services will file insurance claims for you. We will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, we expect full payment at the time of service, and we will provide you with a statement for services rendered. Monthly payment arrangements are available if needed for clients who have established a payment record over three months.



INITIAL ____________

CONTRACTING MBRACE COUNSELING AND BEHAVIORAL SERVICES
Due to the nature of the mental health profession, clinical judgment is often made by a mental health professional in regards to the safety and security of a client's personal well-being. However, with the advancement of technological communications, some forms of technological communication that are often beneficial for instant communication hinder a mental health professional's ability to assess clinical judgment for the safety and security of a client's personal well-being. Therefore, text messaging (i.e, texting) and electronic communications (i.e, electronic mail, instant messaging) are not permitted forms of communication by a client be limited to direct telephone communications. You may contact the Mbrace Counseling and Behavioral Services Office at the following number: 702-749-6926.

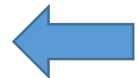
DISCLOSURE STATEMENT

I hereby acknowledge that I have read, have been completely explained, and understood all aspects of Mbrace Counseling and Behavioral Services *Informed Consent for Services*. By signing this *Informed Consent for Services*, I agree to participate in the following forms of therapeutic services during the course of treatment. 1. Comprehensive Psychological Assessment (CPA), 2. Individual Therapy, 3. Family Therapy, 4. Group Therapy, and 5. Biofeedback.

I also acknowledge that I may withdrawal from any or all participation of these therapeutic services at any time during the course of treatment with expressed, written consent to Mbrace Counseling and Behavioral Services.

Client Printed Name: ____

Client or Parent/ Guardian Signature: _________________________________ Date: _____________



Signature of Personal Representative: _________________________________ Date: _____________

*Description of relationship between Client and Personal Representative: _______________________

Signature of Staff/ Witness: ____ Date:_____________

Staff/ Witness Printed Name and Credentials: ____

INITIAL ___________

NOTICE OF PRIVACY PRCTICES

THIS NOTICE DESCIBES HOW MEDICAL INFORMATION ABOUT YOU, THE CLIENT, MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW THE NPTICE CAREFULLY.

Your health record ("the client") contains personal information about you and your health. This information, which may identify you and relates to your past, present, or future physical or mental health condition(s) and related health care service(s), is referred to as "Protected Health Information" (PHI). This Notice of Privacy Practices describes how we, the Mbrace Counseling and Behavioral Services, may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

Mbrace Counseling and Behavioral Services is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and Privacy Practices with respect to PHI. Mbrace Counseling and Behavioral Services is required to abide by the terms of this Notice of Privacy Practices. Mbrace Counseling and Behavioral Services reserves 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 Mbrace Counseling and Behavioral Services maintains at the time. Mbrace Counseling and Behavioral Services will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:
Mbrace Counseling and Behavioral Services may utilize your Protected Health Information in any of the following ways:

For Treatment; your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant not with your authorization.

For Payment; we may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection process due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for collection purposes.

For Health Care Operations; we may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or tying services) provided we have a written contract with the business requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law; under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of The Department of Health and Human Services for the purpose of investigating or determination our compliance with the requirements of the Privacy Rule.

The following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	**Judicial and Administrative Proceedings**
Emergencies	**Law Enforcement**
National Security	**Public Safety (Duty to Warn)**

Without Authorization; Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as state licensing boards or health department).
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person of the public. If information is disclosed to prevent or lesson a serious threat, it will be disclosed to a person or party reasonably able to prevent or lessen the treat, including the target of the threat.

Verbal Permission; we may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization; uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI:

You have the following rights regarding your personal PHI maintained by our organization. To exercise any of these rights, please submit your request in writing to our Privacy Officer at 3030 S. Jones Blvd Ste.110, Las Vegas, NV 89146.

Right to Amend; if you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.

Right to an Accounting of Disclosures; you have the right to request an accounting of certain types of disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions; you have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree with your request.

Right to Request Confidential Communication; you have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

Right to a Copy of this Notice; you have the right to a copy of this Notice.

COMPLAINTS:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing to our Privacy Officer at 3030 S. Jones Blvd Ste. 110, Las Vegas, NV 89146 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, DC.20201 or contact (202)619-0257.

We will not retaliate against you for filling a complaint

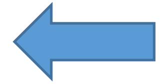
The effective date of this Notice is 2015-01-15

NOTICE OF PRIVACY PRACTICES RECEIPT

CLIENT NAME: ________________________________ **DATE:** ___________________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Mbrace Counseling and Behavioral Services, Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at 702-749-6926.

Client Printed Name: ____



Client or Parent/ Guardian Signature: _______________________________ Date: ____________

Signature of Personal Representative: _______________________________ Date: ____________

*Description of relationship between Client and Personal Representative: _____________________

Signature of Staff/ Witness: _______________________________________ Date:____________

Staff/ Witness Printed Name and Credentials: ____

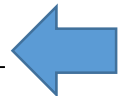
CANCELATION/ NO SHOW POLICY

Counseling is a two way effort entailing mutual respect, responsibility and consideration between you and your counselor. Counseling is most effective when appointments are kept consistently. At Mbrace Counseling and Behavioral Services we will make every effort to accommodate your scheduling needs. In return we ask that you help us by keeping your scheduled appointments and following these simple guidelines:

Please read and sign our policy as indicated below:

- When you schedule an appointment, you have reserved this time in our schedule and we place it aside to meet with you. If you must cancel or change your appointment, we require that you contact our office at 702-749-6926 at **least 24 hours in advance**. This will allow our staff to contact clients on our waiting list to offer them this appointment time.
- If you **do not** keep your appointment and have **not** called to cancel or reschedule this will be classified as a **No Show Appointment.**
- **First No Show Appointment**– your chart will be marked as "No Show" and you will receive a call informing you of your missed appointment; we will at that time offer you the opportunity to reschedule your appointment.
- **Second No Show appointment**- Your chart will be marked as "No Show" and you will receive a call informing you of your missed appointment; we will at that time remind you of the consequences of missing a subsequent appointment.
- **Third No Show Appointment** – A letter will be mailed to you and placed in your chart. The letter will state that you have missed your third appointment and you will be advised that you can no longer schedule any future appointments.

Client Printed Name: ____

Client or Parent/ Guardian Signature: _________________________________ Date: _____________ 

AUTHORIZATION TO OBTAIN, USE, AND DISCLOSE PROTECTED HEALTH INFORMATION

This document allows Mbrace Counseling and Behavioral Services, or its authorized representatives to obtain, use and disclose Protected Health Information (PHI) as described below. Uses and disclosures of PHI will be consistent with Nevada and Federal laws concerning the privacy of PHI.

PATIENT NAME:____ **DOB:**____________________ **SSN:**_____________________

ADDRESS:____

From: Clinic/Hospital/Health Care Provider

Name:____

Address:____ **Phone:**_________________________

City:__________________________________ **State:**_________________ **Zip Code:**_________________

To:

Mbrace Counseling and Behavioral Services
3030 S. Jones Blvd Suite 110
Las Vegas, NV 89146
Phone: (702) 749-6926
Fax: (7020 272-2011

Purpose of diclosure: ____

Expiration of disclosure:_____________________ **Disclose by:** ☐ **Mail** ☐ **Fax** ☐ **Phone**

Types of information to be disclosed: ☐ **Email** ☐ **Other** _______________________

• **Medical Records**	• **Mental health records**	• **Progress notes**
• **HIV/AIDS status**	• **Substance/Alcohol use diagnoses, treatment, referral**	• **Brain Imaging**
• **Psychological testing**	• **Electroencephalogram (EEG)**	• **Laboratory reports**
• **Assessment summary**	• **Discharge Summary**	• **Attendance record**
• **Neurofeedback progress notes**	• **Medication Record**	

Notice of rights and other information:

I may refuse to sign this authorization. I understand that the person or entity that receives this information may not be covered by the fereal privacy regulations; in that case, the information described above may be disclosed again and no longer be protected by these regulations. I may cancel this authorization at any time. I must give written notice of such cancellation and the notice must be signed by me (or on my behalf) and delivered to **Mbrace Counseling and Behavioral Services** *or its authorized representative. Cancellation of this authorization will not apply to information disclose priorto the date of cancellation. I have a right to receive a copy of this authorization, and one will be furnished upon my request. I have a right to receive a copy of the health information I am asking to disclose. I acknowledge that I have read this authorization, that the terms have been explained to me, that I understand all of the terms, and I am competent to sign this authorization for myself or that I am authorized as a parent, guardian or legal representative to sign for the patient above.*

Patient/Parent/Guardian/Legal Representative Signature **Date**

Witness Signature **Date**

Releasing Provider's Signature **Date**

HIPAA/CONTACT DISCLOSURE AUTHORIZATION

HIPAA CONTACT DISCLOSURE in the event Mbrace Counseling and Behavioral Services may need to give your results or medical information, may we ……(check all that apply) _____ Leave a detailed voice message on this phone, the number is ___________________________. _____ Call you at work, the number is _________________. ________Speak to you directly. Only I, ____________________________

(DOB)______________, give Dr. ________________________ and staff authorization to disclose my protected health information to the following family, friends and/ or caregivers:

Name:_______________________________Relationship: ________________ Phone:______________

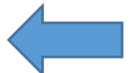
Name:_______________________________Relationship: ________________ Phone:______________

Name:_______________________________Relationship: ________________ Phone:______________

Name:_______________________________Relationship: ________________ Phone:______________

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Medical Records Department. I understand that the revocation will not apply to information that has already been release in response to the authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment or healthcare operations as sighted in the Notice of Privacy Practices. I understand that authorizing the disclosure of this health information is voluntary. HealthCare Partners and its entities will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization. I understand that any disclosure of information carried with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy Practices, which I obtained from my doctor's office. Unless, otherwise revoked, this authorization will expire on the following date, event or condition. ______ If I fail to specify a date, authorization will expire one (1) year from the signature on this form.

Client or Parent/ Guardian Signature: ___________________________________ Date: _____________



Signature of Personal Representative: ___________________________________ Date: _____________

Signature of Mbrace Counseling and Behavioral Services Representative:

________________________________ Date: _________________

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508 TO Mbrace Counseling and Behavioral Services 3030 S. Jones Blvd, Suite 110, Las Vegas, NV 89146.

RE: PATIENT NAME: ____

Date of Birth: ___________________ Social Security Number: ______________________

Dates of Treatment: ______________________________

I am requesting that Mbrace Counseling and Behavioral Services allow:

____

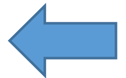
____ Inspect ____Copy ____or Inspect and Copy my medical records.

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of a;; covered entities under HIPPA identified above disclose full and complete protected medical information including the following: All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, impatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, photographs, videotapes, telephone messages, and records received by other medical providers. All physical, occupational and rehab requests, consultations and progress notes. All disability, Medicaid or Medicare records including claim forms and record of denial of benefits. All videos/CDs/films/reels and reports. All pharmacy/prescription records including NDC numbers and drug information handouts/monographs. All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period ____________ to ____________. I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or Human Page 1 of 2 immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information. This authorization is given in compliance with the federal consent requirements for the release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived. You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

I understand the following: See CFR:164.508©(2)(i-iii) a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. c.My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

I understand that Mbrace Counseling and Behavioral Services has (10) working days from date of the request to allow inspection of my records and thirty days to allow copying of my medical file.

Dated: _________________________



Signature of Patient or Legally Authorized Representatives: __________________________________ (see 45CFR:164.508(c)(1)(vi)

Name and relationship of Patient or Legally Authorized Representatives to patient:
(see 45CFR:164.508(c)(1)(vi)
____

Witness Signature Date:_________________________

NEVADA DIVISION OF HEALTH CARE FINANCING AND POLICY

SED/SMI DETERMINATION

DETERMINATION NOTICE FOR SEVERELY EMOTIONALLY DISTURBED (SED) CHILDREN OR SERIOUSLY MENTALLY ILL (SMI) ADULTS

Name: ___________________________ ☐ Original Determination

Medicaid ID: _____________________ ☐ Annual Re-Determination

SSN: ____________________________ SED/SMI Determination Date: _______________

Date of Birth: ____________________ SED/SMI Determination Site: __________________

This individual has been assessed according to the Nevada Division of Health Care Financing and Policy (DHCFP) diagnostic criteria. (For SED/SMI definitions, see Medicaid Services Manual (MSM) Chapter 2500.)

18 YEARS OF AGE AND OLDER:	17 YEARS OF AGE AND UNDER:
___YES, individual determined SMI	___YES, child determined SED
___ Adult no longer SMI	___ Child no longer SED
___ Adult remains SMI	___ Child remains SED

DCFS Custody ___YES ___NO
County Custody ___YES ___NO

Mbrace Counseling and Behavioral Services
Agency

____
Date

____
Name of Assessor

____
Title

(702) 749-6926
Phone Number

____
Agency Unit

3030 S. Jones Blvd. #110, Las Vegas, NV 89146
Agency Address

(702) 272-2011
Fax Number

All pages of this form must be completed and submitted to the DHCFP or its designee within five working days after the SED or SMI determination, to ensure timely notification. **Fax to the DHCFP Business Lines Unit, (775) 684-3774.**

For complete policy regarding SED/ SMI disenrollment from managed care, refer to MSM Chapter 3600, which is available on the DHCFP website at www.dhcfp.nv.gov.

NEVADA DIVISION OF HEALTH CARE FINANCING AND POLICY

SED/SMI CONSENT

This form serves as consent to the evaluator working with the family to communicate determinations with the DHCFP/Medicaid and/or its designee (e.g., contracted Managed Care Organizations (MCOs) or fiscal agent), and, only if applicable, to Nevada Division of Mental Health and Developmental Services (MHDS) and/or the Nevada Division of Child and Family Services (DCFS).

SED CONSENT: (for children under the age of 18):

I hereby authorize Mbrace Counseling and Behavioral Services *(name of agency)* to: 1) Conduct an assessment for the sole purpose of determining whether my child has a severe emotional disturbance (SED) and; 2) Share the results of this assessment and determination only with the above named entities, and me. This Agency has explained fully, and to my satisfaction, the reasons as to why they believe my child requires an assessment at this time. All parties shall keep such assessment information strictly confidential.

______________________________	______________________________	
Print Name of Recipient	Medicaid ID Number	
Signature of Responsible Party	Relationship to Child	Date
Address	Phone Number	

SMI CONSENT: (for adults 18 years of age and older):

I hereby authorize Mbrace Counseling and Behavioral Services (*name of agency*) to: 1) Conduct an assessment for the sole purpose of determining whether I have a Serious Mental Illness (SMI) and; 2) Share the results of this assessment and determination only with the above named entities, and me. This Agency has explained fully, and to my satisfaction, the reasons as to why they believe I require an assessment at this time. All parties shall keep such assessment information strictly confidential.

______________________________	______________________________	
Print Name of Recipient	Medicaid ID Number	
Signature of Responsible Party	Relationship to Recipient	Date
Address	Phone Number	

NEVADA DIVISION OF HEALTH CARE FINANCING AND POLICY

MANAGED CARE ENROLLMENT

This form serves as an account of the recipient's wishes in regards to their Medicaid managed care enrollment. If disenrollment is requested and approved prior to monthly cut-off, the Nevada Division of Health Care Financing and Policy (DHCFP) will disenroll the Medicaid managed care recipient from his/her health plan on the first day of the month following submission of this form. Following disenrollment, all covered medically necessary services, including but not limited to services specific to the recipient's SED or SMI diagnosis, will be authorized and reimbursed through Fee-for-Service Medicaid. If no disenrollment is requested, the recipient will continue to receive services through their health plan. *If the recipient is currently exempt from managed care for reasons other than an SED or SMI determination, the recipient will remain Fee-for-Service Medicaid as long as that exemption is in effect.*

If this is your first determination, please indicate your choice below (choose only one):

__ I wish to disenroll from managed care and be covered under Fee-for-Service Medicaid.

__ I wish to remain in managed care and keep my enrollment with my health plan.

__ I am currently covered under Fee-for-Service Medicaid and wish to remain that way.

If this is a re-determination and you were previously disenrolled from managed care due to your SED or SMI determination, please indicate your choice below (choose only one):

__ I wish to remain Fee-for-Service Medicaid.

__ I wish to return to managed care and be enrolled in a health plan.

______________________________ ______________________________

Print Name of Recipient | Medicaid ID Number

______________________________ ____________________ ____________________

Signature of Recipient or Responsible Party if under 18* | Relationship to Recipient | Date

______________________________ ______________________________

Address | Phone Number

*Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this disenrollment, and 2) documentation of this authority is available upon request.

Disclaimer:

Pursuant to the State of Nevada Title XXI State Plan, Nevada Check Up recipients must remain enrolled with the managed care organization that is responsible for on-going patient care.

Telehealth Informed Consent/ Waiver

I would like to receive teletherapy sessions through Mbrace Counseling and Behavioral Services. I am aware that in order to do so, we may utilize software platforms (such as Skype, Facetime or Facebook Videochat) that may or may not be compliant with the Health Insurance Portability and accountability Act ("HIPAA"), or other privacy statues or regulations, local and/or federal. This means that my Protected Health Information ("PHI") may be less secure and private than in-person sessions, or using other types of telehealth platforms. I hereby acknowledge this, and give my consent to proceed regardless.

Client Signature: ______________________________ **Date:** ___________________