Jack D. Dross, LMHP
8031 West Center Rd, Ste 302, Omaha, NE 68124
Phone: 402-334-6869
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Registration Information

PERSONAL INFORMATION:
(Complete on behalf of the Patient/Client)

Name: _____DOB: _____ Sex: Male Female

Street Address: _____City/State/Zip: _____

Home phone: _____ Cell: _____ Work: _____ Email: _____

Preferred contact #: _____**Emergency Contact (Name & Phone):** _____

Marital status (circle): single married divorced widow

If the client is a minor whose parents are divorced, which parent has legal custody? _____
Additional Information: _____

How did you hear about us? _____

PERSON(s) RESPONSIBLE FOR THIS ACCOUNT:

We cannot bill a 'third-party' without their signature on file

Name: _____DOB: _____ Phone: _____

Address: _____ SS#: _____

FAMILY MEMBERS/SIBLINGS:

Name: _____DOB:_____ Name: _____ DOB:_____

Name: _____DOB:_____ Name: _____ DOB:_____

Name: _____DOB:_____ Name: _____ DOB:_____

Name: _____DOB:_____ Name: _____ DOB:_____

Family Physician: _____ Phone: _____

Medication/Dosage**:**_____
Has client had previous counseling? _____

INSURANCE: **Are you using an EAP? Yes No** **Do you wish this office to file claims? Yes No**

Primary Insurance (Name & Address): _____

Name of Subscriber:_____ DOB: _____

ID#: _____ Group#: _____ Employer: _____

Secondary Insurance (Name & address): _____

Name of Subscriber: _____ DOB: _____

ID#: _____ Group#: _____Employer: _____

ASSIGNMENT OF INSURANCE BENEFITS:

☐ I hereby authorize **Jack D. Dross, LMHP** to release information necessary to process insurance claims relating to my treatment.

☐ I authorize my insurance company to pay directly to **Jack D. Dross, LMHP** all benefits otherwise payable to me.

☐ **I will be responsible for all expenses related to treatment not paid under this plan(s*).***

Client signature: _____ Date: _____

Guardian (if a minor): _____Witness: _____

Informed Consent for Treatment

I _____, agree and consent to participate in behavioral health care services offered and provided by Jack Dross, LMHP, a behavioral health care provider.

I understand that I am consenting and agreeing only to those services that Jack Dross, LMHP is qualified to provide within: (1) the scope of the provider's license, certification and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient.

If the patient is under the age of eighteen 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 of Client or Responsible Party (relationship) Date

_____ _____

Signature of Witness Date

Office Financial Policy and Billing Agreement

Name (*print)*:_____Soc.Sec. _____

Insurance Coverage:

❖ I agree to contact my **Insurance Company to verify the Mental Health benefits**. (You pay for your insurance. It is your responsibility to know the benefits of your policy). _____ *initial*

❖ Should a dispute arise on a claim, **it is generally the clients' responsibility to clarify and resolve the dispute with the insurance company.** _____ *initial*

❖ If insurance *is* being filed, any deductible not yet met is **due at the time of service.** _____ *initial*

❖ I understand any **co-pay is due at the time of service**. If a minor, the person that accompanies the child will pay the co-pay. _____ *initial*

Payment:

❖ If Insurance *is not* being filed, **payment is expected at the time of service. _____** *initial*

❖ **I agree to provide a 24-hour notice to cancel an appointment.** A **late charge of $50.00 may be assessed if notice is not provided.** _____ *initial*

❖ If a client does **not show for a scheduled appointment,** there is a **no-show charge of $50.00. ___** *initial*

❖ A service requested by the client, but not covered by the client's Insurance plan, may be arranged under a separate written agreement with the office. _____ *initial*

❖ Phone calls are **not** billable to your insurance. Phone calls are **billed for the amount of time spent on the phone, at the hourly rate**. (See fee schedule). _____ *İnitial*

❖ Texting or email may only be used for scheduling or cancelling appointments. _____ *initial*

❖ Statements will **NOT** be sent to a third party, without their **written agreement to pay**, on file. _____ *initial*

❖ Accounts are **NOT** carried **beyond 90 days,** without payment. I understand my account may be sent to a Collection Agency if it becomes delinquent. _____ *initial*

❖ Fees are subject to change at the discretion of the practice. A fee schedule in available upon request. _____ *initial*

❖ There is a $20 administration charge for checks that do not clear the bank. _____ *initial*

❖ Questions regarding your account should be directed to the Billing Office at ***402.398.1138***. _____ *initial*

I certify that I have read, understand and agree to the foregoing. The undersigned is the client or is duly authorized by or on behalf of the client to execute the above and accept its terms.

_____ _____

Signature of Client or Responsible Party Date

_____ _____

Signature of Witness Date

Fee Schedule

(effective October 1, 2017)

CPT CODES (filed to Insurance)

90791.....Psychiatric diagnostic evaluation.....$165.00
90832..... Psychotherapy w/patient or family member; 30 min..... 85.00
90834.....Psychotherapy w/patient or family member; 45 min... 110.00
90837.....Psychotherapy w/patient or family member; 60 min... 155.00
90846.....Family Therapy (w/out client present)..... 125.00
90847.....Family Therapy (with client present) 130.00

Crisis session:
90839……Psychotherapy for patient in crisis; 60 minutes……..160.00
+90840…….crisis add-on code for each 30 minutes……. 75.00

Self Pay Charges:

Initial Consultation (first visit) ……. $165.00/hr
Consultation (after first visit)……..… 155.00/hr
Phone calls *…… 155.00/hr
Reports & Letters * ……..…… 155.00/hr
School Conference *…… 155.00/hr
Travel* …… 155.00/hr
Note: Phone calls, reports and conferences are billed for actual time spent @ hourly rate, pro-rated
No Show ……. failed appointment without 24-hour notice…… $50.00
Late Cancel…cancelled appointment without 24-hour notice ….. $50.00

********** These fees are effective June 2019 **********