Hope and Wellness Center
Client Information

Name:_____ Date:_____
Parent's Name *(if the client is a minor)*:_____
Address: _____
City: _____ State: _____ Zip Code: _____
Permission to send mail: □Yes □ No Client's Date of Birth: _____
Legal Gender: □ M □ F Pronouns: _____
Preferred Name:_____ Social Security Number: _____
Phone Number: (____) ____-____ Permission to call & leave message: □Yes □ No
Permission to text message? □Yes □ No Permission to Email? □Yes □No
Email Address: _____
Marital Status: □ Single □ Married □ Divorced □ Widowed
Spouse's Name: _____ Date of Birth: _____
Phone Number: (____) _____-_____
May we speak with spouse/significant other for billing purposes: □ Yes □No
Any privacy or safety concerns? _____
Presenting Problem:

_____

_____

_____

Currently in any treatment? □Yes □ No If yes, where and with whom?

_____

Emergency Contact: Same as spouse/parent listed above: □Yes □ No
If not, please provide alternative contact information.
Name:_____
Relationship: _____ Phone Number: (____) ____-_____
Address: _____
City: _____ State: _____ Zip Code: _____

How did you hear about us?

_____

Hope and Wellness Center
Benefits Verification Form

Hope and Wellness Center Information:
11414 W Center Rd Ste #300
Omaha, NE 68144
Tel. 402-639-2901 Fax 402-502-9538
Tax Identification Number: 81-2744483
Group NPI: 1801349642

Please complete this form prior to your first appointment or at the time of any change in your insurance.

Information from your insurance card:

Primary Insurance

Client Name: _____ DOB: _____

Insured's Name: _____ DOB: _____

Insurance Company: _____

Member ID# _____ Group#_____

Employer_____

Mental Health Phone/Customer Service Phone #_____

Claims Mailing Address:_____

Secondary Insurance (if applicable)

Client Name: _____ DOB: _____

Insured's Name: _____ DOB: _____

Insurance Company: _____

Member ID# _____ Group#_____

Employer_____

Mental Health Phone/Customer Service Phone #_____

Claims Mailing Address:_____

Call to insurance company for Mental Health or Behavioral Health:

1. Call the toll free number on the back of your card.
2. Ask for "Outpatient Mental Health Benefits" or "Behavioral Health Benefits."
3. When asked for the provider's name, tell the person your therapist's name at "Hope and Wellness Center." *Please record all the information below.*

Name of insurance customer service representative: _____

Date of phone call: _____ Coverage period: From _____ to _____

Deductible: Amount $_____ Per _____ How much has been met? $_____

Is this the primary or secondary insurance? _____

Is there a session limit?_____ If yes, allowed # of sessions _____ per _____ (calendar year, etc.)

Covered Credentials: ☐ PLHMP ☐ LMHP ☐ LCSW ☐ LIMHP ☐ LICSW ☐ APRN

Provider Name: _____ Is provider in or out of network?_____

Are the following services covered (*please circle all that apply*):

Initial diagnostic visit CPT Code: 90791 (therapy) 90792 (Psychiatric Med)

Individual therapy/counseling CPT Codes: 90832 90834 90837

Family therapy/counseling CPT Codes: 90846 90847 96153

Group Therapy/Bx Health CPT Code: 90853 96153

Is authorization/Pre-cert needed (please circle): Yes No

Pre-cert Phone #: _____ Auth# _____ from ____ to _____

Covered services for authorization:_____

Benefit Information:

	In-Network	Out-of-Network
Co-pay		
% of Coverage		

EAP or Other Insurance Information:

If this is an EAP benefit please provide the following information:

EAP Plan Name: _____ Employer: _____

Billing/Claims Address: _____

Authorization Number: _____ Number of sessions: _____

CPT codes with modifiers if necessary: _____

I understand that this is the information provided to me by my insurance company and that Hope and Wellness Center can not guarantee the accuracy of this information or any other information from third party payors. I understand that it is my responsibility to understand these benefits and how they will impact my financial responsibility for services at Hope and Wellness Center. I understand that I am responsible for any charges not covered by a third party payor including, but not limited to, co-pays, coinsurances, deductibles, non-covered services, returned check fees, late cancelation fees and no-show fees.

_____ _____

SIGNATURE DATE

_____

PRINTED NAME

Hope and Wellness Center, P.C.

Informed Consent

Hope and Wellness Center's modalities are mental health counseling/consultation, wellness and medication management, life/nutritional/spiritual coaching, massage, and psychological testing, that are used based on your needs and desired care. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will address your questions. When you sign this document, it will represent an agreement between us.

I, _____, hereby acknowledge and agree to the following:

Authorization for Treatment: I, the undersigned, consent for HWC to provide mental health counseling and/or therapy as may be necessary or advisable in my diagnosis and treatment. I understand that a positive outcome cannot be guaranteed. While I understand that HWC will be providing certain therapy and counseling services, I acknowledge that numerous factors can affect the overall outcome and that such therapy and/or counseling services may not be effective in accomplishing the goals or other desired outcomes discussed. I acknowledge and agree that there may be circumstances that presently, or in the future, require treatment or other health care services that are outside the scope of the services that can be provided by HWC. With full knowledge of the risks and benefits of engaging in therapy and/or counseling services with HWC, I give my informed consent by signing this document on the following page. ***____Initial if you read and agree**

Nurse Practitioner and Medical Services: I consent to meeting with a Hope and Wellness nurse practitioner to discuss my integrative care treatment plan. I understand, and consent, that a Hope and Wellness nurse practitioner may prescribe medication, or adjust current medications, to provide the best treatment for integrative care. ***_____ Initial if you read and agree**

Optional Consent to Address Spirituality: I, the undersigned, consent for HWC to address spirituality. This is an optional approach based on our mission to provide such services - mind, body, and spirit. In an effort to better understand your preference concerning the spiritual aspects of the service you receive please initial any of the following statements you are requesting (initialing items does not necessarily mean the content in those categories will be included in every session, or that other relevant approaches or interventions will not be utilized):

___1. Counseling that includes general conversation about spiritual and moral values.

___2. Discussion of my concepts of and relationship with God.

___3. Discussion of my spiritual support system (pastor, small group, etc.).

___4. Discussion, in counseling, of direct Biblical quotations and or passages.

___5. Prayer including my counselor praying out loud.

I understand that I have the option to change any part or all of this consent at any time by informing my counselor. ***____Initial signifies you understand this option.**

Financial Payment Policy: I understand that the services rendered to me are solely my financial responsibility. HWC may, as a courtesy, bill my insurance company. I understand that I will be required to pay my co-pay prior to each session. If the insurance company has failed to pay within a 45-day period, I will pay the balance of my bill in full. It will be my responsibility to then collect from the insurance company. *If fees for services are not paid in a reasonable amount of time, and attempts have been made to resolve the financial matter to no avail, a client account may be sent to a collection service.* ***____Initial if you read and agree**

No Show/Cancellation Charges: A reminder of my upcoming appointment will be sent to me 48-hours before the appointment. If I fail to give 24-hour notice of cancellation of my scheduled appointment, or if I fail to show up for my scheduled appointment, I agree to pay a fee of $50.00. If there is a late cancellation three times or no show three times, I will be taken off the schedule until I pay my bill in full and contact my clinician about scheduling. ***____Initial if you read and agree**

Payment: I understand payment is due at the time of each counseling appointment/session, unless other arrangements have been made with HWC in advance. Making a payment may be paying your bill in full, paying a self-pay balance, and/or paying a copay on insurance. If you choose to pay with a check and it is not honored for any reason by your bank, there will be a $30 charge added to your balance due and shown on your statement. ***____Initial if you read and agree**

Assignment of Professional Benefits: I hereby assign all insurance benefits and/or Medicare/Medicaid benefits to HWC. This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. This assignment includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injuries caused by a third party. I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original. ***____Initial if you read and agree**

Confidentiality: I acknowledge information discussed in therapy is held confidential and will not be shared without written permission except as set forth in the Notice of Privacy Practices, a copy of which has been provided to me, and in accordance with State and Federal Law. Having read and understood the above, I agree to these limits of confidentiality. ***____Initial if you read and agree**

Authorized Representative: I hereby authorize HWC to act on my behalf to recover benefit claims, adverse appeal benefit determinations, and to take any action deemed necessary to obtain payment for services provided to me by HWC. ***____ Initial if you read and agree**

Statement of Responsibility: I understand that I am financially responsible to HWC, as the patient, parent, guardian, and conservator or insured for all charges not covered by the above assignments. Charges may include medical insurance deductibles, co-insurance, or out-of-pocket expenses. ***____Initial if you read and agree**

Supervision and Consultation: Some of the providers and practitioners may be under supervision. At times, the supervisor will be consulted for a variety of reasons. In addition, the supervisor will review medical records and case notes. The supervisor is bound by the same confidentiality standards as the counselor/therapist. ***____Initial if you read and agree**

The undersigned certifies that he or she has read the foregoing, is the patient, the patient's parent/guardian, power of attorney, parent or is duly authorized by or on behalf of the parent, to execute the above and accept its terms. If terms are not accepted, HWC has the right to deny services with the client.

_____

Client Signature Date

_____

Parent/Guardian Signature *(If applicable)* Date

_____

Counselor Signature Date

Hope and Wellness Center, P.C.
Client Services Information

Welcome to Hope and Wellness Center (HWC) and thank you for giving us the opportunity to be of help to you! HWC is owned and operated separately from other independent professionals at 11414 W. Center Road, Suite 300. HWC employs quality practitioners and utilizes the services of affiliate practitioners as part of HWC's commitment to compassionate, excellent integrative care. This document answers some of the questions clients often ask about counseling. It is important to HWC that you know how we will work together. This is to inform you of the policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and HWC will address your questions.

This document talks about the following in a general way:

- What the risks and benefits of integrative care are
- What the goals of integrative care are and what methods of treatment are like
- How long integrative care might take
- How much our services cost and how HWC handles money matters
- Other areas of the client/clinician relationship

This document is yours to keep and refer to later. Please read all of it. When you have read and understand it, HWC will ask you to sign it. An HWC representative will sign it as well and make a copy so we each have one.

Psychological Services/Testing

We will plan our work together. There are many different methods our therapists may utilize to address your concerns. This collaboration and active work together will support the results you hope to achieve. We will together to formulate a treatment plan. An important part of your treatment plan is practicing new skills that you will learn in your sessions. You may also be given homework assignments or other tasks to deepen your learning. You will probably have to work on relationships in your life and make long-term efforts to get the best results. These are important parts of personal change.

Therapy can have benefits and risks, not all of which are listed here. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as fear, sadness, guilt, anger, anxiety, frustration, loneliness, and helplessness, and these may recur at various points of treatment. On the other hand, therapy can teach you new ways of looking at your problems that can be very helpful for changing your feelings and reactions. Your therapy experience is important and we value your feedback.

Therapy Sessions

HWC therapists normally conduct an evaluation that will last from 1-3 sessions. During this time you and your therapist can both decide whether he/she is the best person to provide the services you need in order to meet your goals. Once therapy has begun, we will determine the frequency of your visits. HWC therapists will usually schedule one 45-60 minute session per week at a time we agree on (a therapy "hour" is 45 or 60 minutes in duration). If you wish to stop therapy at any time, you will review your goals, the work we have done, any future work that needs to be done, and your choices with your therapist. Most clients will be seen once a week for 1-4 months. If you have young children, we recommend that you do not bring them with you unless you have someone available to watch them for you.

Nurse Practitioner and Medical Services

Our nurse practitioners are licensed to prescribe and manage medications for clients who have been assessed by one of our nurse practitioners. The client's first initial appointment with a nurse practitioner will be 60 minutes. Any follow up appointments will be 30 minutes. Our nurse practitioners are in network with various insurance companies. Please see the front desk to see if your appointments will be insured.

Massage Services

Our massage therapists are trained and licensed to provide massage therapy. A variety of massage techniques will be tailored to your specific integrative care needs to best help you relax from fatigue and stress. Prices and times vary for each massage therapist. To schedule an appointment with a massage therapist, please ask the front desk for times and prices.

Cancellations, No-Show Charges, and Late Arrivals

Once an appointment is scheduled, that is your time slot. Please call HWC at least 24 hours in advance if you need to cancel your scheduled appointment. If a cancellation has not been made prior to this time, the session is a loss for someone else wishing to use that therapy time. If you fail to cancel or show up for your appointment, you will be charged a $50.00 fee. This fee must be paid in full before any future appointments will be scheduled. (Genuine emergencies can be discussed). Also, if you are late for an appointment, the appointment will still end at the scheduled time and you will be charged the full appointment time. If a no show or late cancellation occurs three times you will be taken off of the schedule. Your balance will need to be paid and your clinician will need to be contacted before scheduling again.

Communication

Our therapists are often not immediately available by phone, however, HWC strives to answer all phone calls within 24 business hours (Monday through Friday from 9:00 am – 5:00 pm.). Texts are reserved for scheduling communication only, not clinical or urgent needs. If you have a life-threatening emergency, you will need to call 911 or go to your nearest emergency room. Any urgent calls will be returned as quickly as our schedule allows. HWC reserves the right to implement a prorated charge for therapy consultations conducted over the phone that require more than 10 minutes or for excessive texts. This will be billed at the same rate as a private face-to-face session.

Social Media Policy

In order to maintain your confidentiality and our respective privacy, we do not interact with current or former clients on social networking websites. We do not accept friend or contact requests from current or former clients on any social networking sites including; Twitter, Facebook, LinkedIn, etc. We will not respond to friend requests or messages through these sites.

We will not solicit testimonials, ratings or grades from clients on websites or through any means. We will not respond to testimonials, ratings or grades on websites, whether positive or negative, in order to maintain your confidentiality. Our hope is that you will bring concerns about our work together to the therapy session so we can address concerns directly.

Please do not contact us through text messages or emails regarding clinical issues. These are not secure communications, and there is a possibility that we will not get the message in a timely manner. If you need to contact your therapist between sessions, please call 402-639-2901.

Ethics and Professional Standards

Our professional counselors work to uphold the most responsible and ethical standards as possible, and are accountable to you. If you have any questions or concerns about your counseling experience, please discuss these concerns with your counselor.

Professional Records & Confidentiality

Both law and the standards of our profession require that we keep appropriate treatment records. Please see our Notice of Privacy Practices for additional information about our obligations and the release of your information.

Minors

If you are under 19 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to request parents respect our privacy in working together. If they agree, our therapists provide them only with the general information about the work done with your therapist, unless they feel there is a high risk that you will harm yourself or someone else. In this case, HWC therapists will notify them of our concern. HWC therapists will also provide them with a summary of your treatment when it is complete if requested. Before giving them any information, our therapists will discuss the matter with you, if possible, and do our best to respond to any objections you have about what they are prepared to discuss.

Court Related Services

We do not provide or perform evaluations for custody, visitation or other forensic matters. Therefore, it is understood and agreed that we cannot and will not provide any testimony or reports regarding issues of custody, visitation or fitness of a parent in any legal matters or administrative proceedings.

If we are contacted by an attorney regarding your treatment (either at your behest or related to a legal matter you are involved in) please note the following:

- We charge $1,000 for a retainer fee.
- We charge $160/hour to prepare for and/or attend any legal proceeding and for all court related services.
- Charges for court related services are not covered by insurance.
- Court related services include: talking with attorneys, preparing documents, traveling to court, depositions and court appearances.
- If the court or attorneys do not pay our fee, you will be charged for the time we spend responding to legal matters.
- You will also be charged for any costs we incur responding to attorneys in your case, including but not limited to fees we are charged for legal consultation and representation by our attorneys.

Thank you again for giving us the opportunity to be part of your journey! Please keep this document and refer back to it to answer any questions you may have.

Hope and Wellness Center Team

SIGNATURE PAGE TO FOLLOW

ACKNOWLEDGMENT OF RECEIPT OF CLIENT SERVICES INFORMATION

I have been given and read a copy of Hope and Wellness Center's Client Services Information. I understand HWC has the right to change such information at any time. I may obtain a current copy at the HWC office. The undersigned does hereby acknowledge receipt of HWC's Group Client Services Information.

Client Name: _____

Client Signature: _____Date: _____

Parent/Guardian Signature (if minor): _____Date: _____

Parent/Guardian Signature (if minor): _____Date: _____

Hope & Wellness Center, P.C.
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AS WELL AS HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Client Health and Wellness/Information

Each time you receive counseling services from Hope and Wellness Center, P.C. ("HWC"), a record of your services is made. This record may include your presenting problems, background information, assessments, treatment, and plans for future counseling or other services. This information – your client record – is used to plan your counseling service. Although your client record belongs to HWC, you do have certain rights with regard to your counseling information.

Our current Notice is posted online at hopeandwellnessomaha.com. You also have the right to receive a paper copy of this Notice and may ask us to give you a copy of this Notice at any time. If you received this Notice electronically, you are entitled to a paper copy of this Notice. We must follow the privacy practices that are described in this Notice while it is in effect. If you have any questions about this Notice, please contact our Office Manager at 402-639-2901.

Your Rights

- You have a right to receive a paper copy of this privacy notice at your request.
- You have a (limited) right to know who has seen your counseling information, and for what purpose. If you make additional requests for such an accounting during any 12month period, we may charge you a reasonable, cost-based fee.
- You have a right to see, and to keep a copy of, your counseling records (except psychotherapy notes). Your request for a copy of your record must be in writing. We may charge you a reasonable, cost-based, copying fee. You may not inspect or copy psychotherapy notes, information compiled in anticipation of litigation, or information subject to a law that prohibits access. The decision to deny access may be reviewable in certain cases.

- You have a right to ask for correction -- or inclusion of a statement of disagreement -- for anything in your records that you feel is in error. Your request must be in writing and include supporting documentation. We may, under certain circumstances, deny your request.
- You have a right to request, in writing, that we not use or disclose your information for treatment, payment, or administrative purpose, or to persons involved in your care except when specifically authorized by you, when required by law, or in emergency situations. To request a restriction on who may have access to your protected health information, you must submit a written request HWC. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request, unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we do agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.
- You have a right to request extra protections for counseling information you consider especially sensitive, and to request that we communicate with you by alternative means.

Our Responsibilities

We reserve the right to change this Notice of Privacy Practices and to make the new provisions effective for all health information we maintain. Should our privacy practices change, we will provide a revised Notice of Privacy Practices at your next appointment.

HIPAA generally permits use and disclosure of your health information without your permission for purposes of health care treatment, payment activities and health care operations. These uses and disclosures are more fully described below. The following categories describe the different ways that we may use and disclose your protected health information. These examples are not meant to be exhaustive, but to illustrate the types of uses and disclosures that may be made by us. However, we may never have a reason to make some of these disclosures:

We will use and disclose your information for treatment purposes.
For example: Information obtained by your counselor will be recorded in your record and used to determine the course of your counseling services. Your counselor and other qualified mental health team members may communicate with one another personally and through the client record to coordinate your counseling services and assess your counseling and outcomes. This information is used in our ongoing efforts to ensure the quality and effectiveness of our counseling and services we provide.

We will use and disclose your health information for payment purposes.
For example, a bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis and/or procedures. If you do not wish for us to disclose information to a third-party payer, you understand that you will be required to pay for the full amount of your services at the time such services are rendered.

We will use and disclose your health information for healthcare operations.
We may use or disclose your health information to carry out our daily activities as they relate to the provision of healthcare. Healthcare operations include but are not limited to quality assessment activities, and licensing activities. For example, we may disclose your information with third parties that perform various business activities (e.g., billing or computer software services) provided we have a written contract with the business that requires it to safeguard the privacy of your protected health information.

Other Disclosures That May be Made Without Your Authorization

Unless we are otherwise restricted from doing so, we may also use or disclose your information for the following purposes without your authorization:

Notification: In an emergency situation, we may use or disclose your health information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location, and general condition.

Public Health: When required or permitted by law, we may disclose your counseling information to public health or legal authorities responsible for preventing or controlling disease, injury, or disability or performing other public health functions. In addition, we may disclose your counseling information in order to avert a serious threat to health or

Abuse or Neglect: If we believe you have been a victim of abuse or neglect or are engaging in behavior that is abusive toward children or other “vulnerable” persons as defined by applicable federal and/or state laws, we may disclose your health information to an authorized governmental entity or agency. The disclosure will be made pursuant to the requirements of federal and state laws. We may also disclose your information to a public health entity that is authorized to receive reports of child abuse or neglect.

Healthcare Oversight Activities: We may disclose your health information to appropriate authorities for activities including but not limited to monitoring, investigating, inspecting, and disciplining or licensing those who work in the healthcare system or for government benefit programs.

Judicial and Administrative Proceedings: We may disclose your health information that is expressly authorized by an administrative proceeding, in response to an order of a court or administrative tribunal, and under certain conditions in response to a subpoena, discovery request or other lawful process.

Specialized governmental functions: We may disclose your counseling information for military and veteran activities, national security and intelligence activities, and similar special governmental functions as required or permitted by law.
Law enforcement: We may disclose your counseling information for law enforcement purposes as required or permitted by law or in response to a valid subpoena, court order or other binding authority.

Disclosure About Decedents: We may disclose health information about decedents to coroners and medical examiners for the purpose of identifying a deceased individual, determining a cause of death, or carrying out other duties permitted by law. Additionally, we may disclose decedent's information to funeral directors as authorized by law.
Avoid Threat to Health or Safety: We may disclose information to specified authorities if we believe in good faith that a disclosure of your health information is necessary to prevent or minimize a serious threat to you or the public's health or safety.

Disclosures required by law: We may use or disclose your counseling information as required by law provided such use or disclosure complies with and is limited to the relevant requirements of such law.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by the law.

Charges Against Provider: In the event you should file a suit against us, we may disclose health information necessary to defend such action. Also, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate and determine our compliance with the law.

Uses and Disclosures of Protected Health Information Requiring an Authorization: In situations other than those listed above, we will request your written authorization before using or disclosing protected health information about you. If you choose to sign such authorization to disclose information, you may, in writing, revoke that authorization to stop any future uses and disclosures except to the extent that action has been taken in reliance on the use or disclose, or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Additionally, if a use or disclosure of protected health information described above in this Notice is prohibited or materially limited by other laws that apply to use, it is our intent to meet the requirements of the more stringent law.

BREACH NOTIFICATION

This Notice also reflects federal breach notification requirements in the event that your "unsecured protected health information" is acquired by an unauthorized party. We will notify you following the discovery of any "breach" of your unsecured protected health information as defined in the HITECH Act (the "**Notice of Breach**"). Your Notice of Breach will be in writing and provided via first-class mail, or alternatively, by email if you have previously agreed to receive such notices electronically. If the breach involves:

- 10 or more individuals for whom we have insufficient or out-of-date contact information, then we will provide substitute individual Notice of Breach by either posting the notice on our website or by providing the notice in major print or broadcast media where the affected individuals likely reside.
- Less than 10 individuals for whom we have insufficient or out-of-date contact information, then we will provide substitute Notice of Breach by an alternative form.

Your Notice of Breach will be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach and shall include, to the extent possible:

- A description of the breach.
- A description of the types of information that were involved in the breach.
- The steps you should take to protect yourself from potential harm.
- A brief description of what we are doing to investigate the breach, mitigate the harm, and prevent further breaches.
- Our relevant contact information.

Additionally, for any substitute Notice of Breach provided via web posting or major print or broadcast media, the Notice of Breach shall include a toll-free number for you to contact us to determine if your protected health information was involved in the breach.

For More Information or to Report a Problem

If you have questions or would like additional information, you may contact Hope and Wellness Center, P.C. via telephone at (402) 639-2901 or in writing at the address below. If you believe your privacy rights have been violated, you have the right to file a complaint with Hope and Wellness Center, P.C. or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

[SIGNATURE PAGE TO FOLLOW]

Notice of Privacy Practices

PLEASE SIGN BELOW TO ACKNOWLEDGE THAT YOU HAVE READ THE NOTICE OF PRIVACY PRACTICES.

I have been given and read a copy of Hope and Wellness Center's Notice of Privacy Practices. I understand HWC has the right to change such Notice at any time. I may obtain a current copy at the HWC office. The undersigned does hereby acknowledge receipt of HWC's Notice of Privacy Practice.

Client Name: _____

Client Signature: _____ Date: _____

Parent/Guardian Signature (if minor): _____ Date: _____

Parent/Guardian Signature (if minor): _____ Date: _____

If the individual did not sign above, describe below the good faith attempt made to obtain the individual's signature and why it was not obtained:

_____

_____

Hope & Wellness Center, P.C.

Credit Card Signature Form

Hope & Wellness Center, P.C. requires all clients to provide a credit or debit card to keep on file in the office. A credit card is kept on file with Hope & Wellness Center, P.C. in order to pay for any copays, co-insurance, deductibles, or out of pocket expenses. Please understand that payment is due at the time services are rendered unless other arrangements have previously been made. You also have the option to pay with cash or check at the time services are rendered. All credit cards will be charged on or about the day of service. Please be aware that we will not notify you of your credit card being charged ahead of time, and you will receive a statement by mail reflecting your payment if your credit card is charged. Please note that balances that are thirty (30) days past due may be charged to your credit card on file. A $25 late fee will be applied to past due balances.

HWC accepts VISA, MasterCard, American Express and Discover. Thank you for your cooperation. We appreciate your business.

Please initial and sign below. Please be sure to complete all sections:

_____Please charge my card for all balances in full that accrue each month (30 days). Charges will be made the day services are rendered for co-pays.

Client name:_____

Card Holder Name: _____

Credit Card Number: _____

Expiration Date:_____ Billing Zip Code: _____

Security Code (3 digits on back of card, 4 digits on front if AmEx):_____

I understand that by signing below, I am authorizing Hope & Wellness Center, P.C. to charge my card in the manner indicated by my initials above. These balances may include copays, co- insurance amounts, out of pocket payments, or deductibles.

Card Holders' Signature _____ Date: _____