Legacy Health and Wellness

Las Vegas Office
2921 N. Tenaya Way
Las Vegas, NV 89128
Ph 702-942-1774 Fax 702-942-1773

Reno Office
850 Mill Street, Suite 301
Reno, NV 89502
Ph 775-562-1115 Fax 775-562-1116

Client Information

Last Name_____First_____Middle_____

DOB_____/_____/_____Age_____Gender: _____

Social Security Number ----------_____

Marital Status:___Single___Married___Divorced___Widowed Race: _____

Mailing Address_____City_____

State_____Zip Code_____Home Phone _____

Mobile Phone_____Preferred Contact Method:___Home Phone___Mobile Phone

Email _____

Employer_____Occupation_____

Work Address_____City_____State_____Zip Code _____

Parent/Guardian Information

If Patient is a Minor (under the age of 18), please complete the following

Parent/Guardian Name_____DOB_____/_____/_____

Parent/Guardian Relationship to Patient:_____Gender:_____

Mailing Address_____ City_____

State_____Zip Code_____Home Phone_____Mobile Phone _____

Work Phone_____

Employer_____Occupation _____

Emergency Contact(s)

By providing emergency contact information in the space below, I authorize Legacy Health and Wellness to contact my emergency contact in case of emergency or missed appointment.

Name_____Relationship to Patient _____

Home Phone_____Mobile Phone_____Work Phone _____

Name_____Relationship to Patient_____

Home Phone_____Mobile Phone_____Work Phone_____

Date of Service_____**Clinician** _____

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Insurance Information & Financial Responsibility Statement

All client-pay portions are estimates based on the information provided to Legacy Health and Wellness by the client and his or her insurance carrier. The client/guarantor must understand that having an insurance benefit does not guarantee payment. The insurance carrier makes the final decision as to whether payment will be made after it receives and reviews the claim. When a client is treated at Legacy Health and Wellness, Legacy Health and Wellness' staff contacts the client's third-party payor to check insurance and as a courtesy, will bill the client's insurance carrier for applicable services.

The client/ guarantor is responsible for all outstanding balances, should the insurance company fail to pay all or any part of the charges. Legacy Health and Wellness staff must be informed of all insurance coverage prior to the first visit. Any non-payment as a result of the client's /guarantor's failure to provide insurance information prior to the first visit is also the client's/guarantor's financial responsibility. It is the client's/guarantor's responsibility to ensure that all insurance premiums, dues, and COBRA payments are current throughout the client's treatment at Legacy Health and Wellness. Any payment denied by the insurance carrier for services provided is the financial responsibility of the client/guarantor.

The client's insurance coverage is a contract between the client and insurance carrier - not between Legacy Health and Wellness and the insurance carrier. As such, the client should be aware that their insurance policies often change. It is the client's sole responsibility to know his or her coverage. Any costs due to a change in the client's insurance policy is the sole responsibility of the client/guarantor.

The client understands that certain services may not be covered by insurance and will be the direct financial responsibility of the client/guarantor (court preparation, testimony, letters, forms completed outside of session, consultations on the client's behalf, court evaluations, etc.)

The client acknowledges that Legacy Health and Wellness will bill third party payors (and work toward treatment authorizations) on the client's behalf understanding that Legacy Health and Wellness will release certain information to the insurance company of record pertaining to the treatment, treatment plan, diagnosis, progress, prognosis, etc. in order to obtain authorizations and to bill for services rendered. The client authorizes third party payors to make payments for services directly to Legacy Health and Wellness.

Client Name: _____

Signature:_____ Date:_____
Client/Legal Guardian/Parent if client is a minor

Primary Insurance

Insurance Co Name_____

Ins. Phone#_____

Copay_____Group ID #_____

Member ID #_____

Address_____

City_____State____Zip_____

Policy Holder Information

Policy Holder Name

DOB____/____/____SS#_____

Relationship to Patient:___Self___Spouse_____
Parent/Guardian___Other: _____

Mailing Address

_____

City_____State_____Zip_____

Home Phone_____

Mobile Phone_____

Employer _____

Secondary Insurance

Insurance Co Name_____

Ins. Phone#_____

Copay_____Group ID #_____

Member ID #_____

Address_____

City_____State____Zip_____

Policy Holder Information

Policy Holder Name

DOB____/____/____SS#_____

Relationship to Patient:___Self_ Spouse_
Parent/Guardian____ Other: _____

Mailing Address

_____

City_____State_____Zip_____

Home Phone_____

Mobile Phone_____

Employer _____

Client's Name: _____

By signing below, I,_____acknowledge the information provided to Legacy Health & Wellness and its authorized representatives is true and correct, understand that I am financially responsible for all charges for all medical services rendered to the above-named patient, and that I have read, understand and agree to all of the terms of this Financial Responsibility Statement.

Signature:_____Date:_____
Client/Legal Guardian/Parent if client is a minor

Legacy Representative: (Please Print): _____

Legacy Representative Signature:_____Date: _____

Legacy Health and Wellness

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Client Rights

As recipients of services from Legacy Health and Wellness, you are entitled to the following rights:

- To receive services without regard to your race, color, religion, sex, age, marital status, national origin, veteran's status, or disability.
- To be treated with respect, consideration, and dignity.
- To receive prompt, appropriate treatment and services, in accordance with the laws and standards governing the health care industry.
- To inquire and learn about the professional skills and qualifications of those who will provide your services.
- To participate in the planning and periodic review of your individual treatment plan.
- To be informed about available treatment options and the effectiveness of any such options.
- To have your conversations and communications with your provider remain confidential, to the extent permitted by laws and professional standards.
- To receive a copy of your medical record, in accordance with our policies and procedures.
- To sign an informed consent if you desire to participate in any clinical services.
- To receive information about the methods available to file a complaint or grievance regarding our provision of services to you and know that you will not be retaliated against for filing any such grievance.
- To receive a copy of your rights at any time.
- You have the right to receive services in a safe place. To ensure this, no weapons of any sort are allowed on the property at any point. This includes firearms regardless of right to carry status.

Client's Name: _____

By signing below, I,_____acknowledge that Legacy Health and Wellness has provided me with the Bill of Rights written above and that I have reviewed and understand all of the terms therein.

Signature:_____ Date:_____

Client/Legal Guardian/Parent if client is a minor

Legacy Representative: (Please Print): _____

Legacy Representative Signature:_____Date: _____

To file a formal grievance, contact:
Rande Paige, Director
Legacy Health & Wellness
2921 N Tenaya Way
Las Vegas, Nevada 89128
Office: 702-942-1774 Fax: 702-942-1773

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Informed Consent

Name of Client:_____Date of Birth: _____

Treatment Approach. Treatment services may consist of initial assessments, individual, couple, family and group therapy, recreational therapy, role play, drama, evaluation, art, play, other projective therapy, tele-therapy, and milieu behavioral therapy. Issues identified for treatment may include grief and loss, angermanagement, adjustment disorders, self-esteem, family separation, reunification, depression, mood disorder, post-traumatic stress, anxiety, as well as others identified in the Treatment Plan.

Participation in Treatment. As a client of Legacy Health and Wellness, you have the right to be involved in the development of the Treatment Plan, which will identify specific goals, objectives and various therapeutic interventions to help resolve your/your child's progress. Keep in mind that progress occurs at different rates for different individuals and symptoms may initially increase when addressing painful issues. However, if at any time you are experiencing significant distress or are dissatisfied with your/your child's progress or the services you or your child are receiving, it is important to discuss this with your treatment provider. We also ask that you do not terminate treatment without a final meeting with your provider to ensure appropriate closure and to provide you with any necessary referrals.

Length of Treatment. Projected time to complete the treatment process is determined by the client's progress and assessed on an individual basis.

Progress Measures. Documented improvement toward goals identified in the initial Treatment Plan as well as the measurable objectives in the plan, will be used to measure progress.

Benefits. General Benefits which can reasonably be expected: Improved self-esteem, social skills, emotional well-being, and/or increased ability to express needs and wants from others.

Risks. Potential risks of treatment: Your/your child's behaviors may get worse before getting better. There may be discussions of topics that are emotionally difficult. There may be no improvement of behavioral or emotional issues and relationships with the family and/or a need for further treatment in another setting may be recommended.

Discharge. The discharge process will be developed between you and your therapist and if the client is a minor, the legal guardian for the child will also be involved in conjunction with the Legacy treatment team.

Implications of Diagnosis. In order to receive treatment, a diagnostic evaluation will be conducted and an appropriate diagnosis assigned. This diagnosis and all tests, reports, and notes will become part of a clinical record.

Confidentiality. Privacy and confidentiality are both rights which are protected by state and federal laws. Therefore, all information disclosed in session will be kept strictly confidential unless you provide written authorization to release information. However, Legacy Health and Wellness is mandated by law to disclose confidential information to appropriate authorities under the following circumstances:
If there is reasonable suspicion of abuse or neglect of a dependent elder or minor child; 2) when a court order is issued for records; 3) when the client or another is in clear and immediate danger. If you or a child who is a minor threatens to harm self, someone else, or the property of others, your treatment provider is required to call the proper authorities and to take reasonable steps to warn the potential victim and prevent the threatened harm. In these cases, only the minimal amount of information necessary will be shared with the appropriate family members or authorities to ensure your or your child's safety and that of others. Additionally, when submitting claims to Medicaid or other insurance carriers, information such as presenting symptoms, diagnosis and treatment progress must be included in order to have services authorized.

Protected Health Information: In the course of treatment, information regarding your care may be created and/or received by us. Information which can be used to identify you and which relates to your past, present of future physical or mental condition, receipt of care or payment for care is considered protected information and is protected by federal and state law.
Federal law imposes certain obligations and duties upon providers of services with respect to your protected information. Specifically, we are required to:

- Provide you with notice of our legal duties and policies regarding the use and disclosure of your protected information;
- Maintain the confidentiality of your protected information in accordance with state and federal law;
- Honor your requested restrictions regarding the use and disclosure of your protected information, unless under the law we are authorized to release your protected information without your authorization;
- Allow you to inspect and copy your protected information;
- Act on your request to amend protected information within thirty (30) days and notify you of any delay which would require us to extend the deadline by an additional thirty (30) day period;
- Accommodate reasonable requests to communicate protected information by alternative means or methods; and
- Abide by the terms of this notice.

Telehealth Treatment. All rights and protections afforded to you via in-person therapy are also in place should you elect to utilize telehealth. The telehealth platform utilized by Legacy Health and Wellness uses network and software security protocols in order to protect your confidentiality and protected health information. This service is provided by technology, and is susceptible to unique benefits and risks as a result. These include but are not limited to: greater convenience in service delivery, requiring access to an electronic device with video and microphone capabilities, and the possibility of disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies. Telehealth sessions are not and may not be recorded by any party. All confidentiality practices pertaining to in-person sessions, including documentation practices and exceptions to confidentiality, apply to telehealth treatment. If you or a child who is a minor is experiencing active psychosis or a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate to your treatment needs and alternative treatment approaches will be provided. Should such a crisis occur during a telehealth session,

your therapist may need to contact your emergency contact or appropriate authorities. Differences in language, culture, or technological capability may also inhibit the ability to utilize telehealth services. Should technical difficulties occur during a session and result in a disruption in services, you are responsible for ending and reconnecting to the session. If you are unable to do so within ten minutes, you may contact your therapist to coordinate re-scheduling the session, to explore alternative treatment options, and/or to ensure appropriate closure for the session. Legacy Health and Wellness staff will act in accordance with the legal rights and limitations outlined in the state and jurisdiction of treatment providers.

Treatment Providers. The clinical staff at Legacy Health and Wellness is comprised of Licensed Marriage and Family Therapists, Licensed Clinical Social Workers, Licensed Clinical Professional Counselors, and Licensed Interns. All clinicians including interns, hold a Master's degree or higher and are currently licensed by their respective state boards. Additionally, Licensed Interns receive supervision through supervisors approved by the Nevada Board of Examiners. The professional level of the provider assigned to you or your child is dependent upon the needs of the individual and family.

Right to Refuse. Unless under court order, as an adult client or as a legal guardian you have the authority and legal right to refuse treatment. The consequences of refusing the services outlined by this agency in the Treatment Plan will be explained verbally and in writing to you at the time of refusal and alternative interventions will be discussed with you. Refusal of services for treatment will be documented in the clinical record.

Fee for Service. Legacy Health and Wellness accepts Medicaid and non-Medicaid Insurances. Upon application for services, Legacy will check your eligibility for services. If eligible for Medicaid funded insurance, all fees for services will be paid by Medicaid and there will be no charges, deductibles or co-pays that you or your child will be required to pay. If you are covered by a non-Medicaid insurance, a co-pay may be required depending on your insurance benefits.

Appointments/Cancellations. Legacy Health and Wellness strives to provide you the best personalized care available and we are dedicated to help you meet your therapy goals. Appointments are mutually arranged between you and the treatment provider. For treatment to be most effective, attendance and participation should be regular and consistent. We realize that there are times when unforeseen circumstance makes it impossible to attend your schedule appointment. If you are unable to keep your appointment, please contact the provider at least 24 hours in advance so we can reschedule your appointment and open that time slot for another client. You may leave a message at 702-942-1774, if you are calling after hours. Failure to show or call to cancel a scheduled appointment and/or canceling or rescheduling multiple times will result in removal of any future appointments scheduled. You will either be put on your therapist's wait list or need to schedule future appointments weekly. If your therapist has the need to cancel or reschedule your appointment, your therapist or our office staff will contact you to notify you and reschedule the appointment. If your therapist or our office staff are unable to reach you, you will be instructed to call the office during office hours and our staff will ensure that you are placed in your therapist's next available appointment. In the event your therapist has a wait list, you will be provided the opportunity to see a new therapist at their soonest availability, and you may then choose to continue therapy with the alternative clinician or return to your original therapist. In the event your therapist has canceled sessions two times consecutively, you will be provided the option to change therapists immediately to avoid any disruptions in your clinical care. If you are in crisis at the time of cancellation, you will be transferred to speak with a clinician to assess the acuity of the crisis, and you will be scheduled/referred accordingly.

Cancellation policy for individuals requiring special accommodations. ADA interpreter services require a two-hour minimum at $85.00 per hour. This service is at no cost to the client or client's parent/ guardian unless cancellation of the client's appointment does not occur within the required 48-hour notice. In the event cancellation occurs in less than 48 hours required, the client or parent/guardian will be responsible for any changes incurred.

After Hours Emergency Contact Procedures

Legacy Health and Wellness has an afterhours answering system in order for clients to leave a message, which will be responded to the next business day. To
leave a message, please call our office at 702-942-1774. However, in the event of an emergency, calls should be directed to the local emergency center by calling 911 or the community resources that have been given to you.

Text Appointment Confirmations
By enrolling in text appointment confirmations, you are authorizing Legacy Health and Wellness to send text message appointment reminders to you on your provided cell phone number. You also agree that all individuals associated with your account may receive alerts referencing appointments. Text message charges from your cell phone carrier may apply. Data obtained from you in connection with the text message system may include, but not limited to, your name, address, cell phone number, future appointment dates and times. Legacy Health and Wellness is not liable for any delays that may be experienced during the transmission of any messages, as delivery is based on the speed and effectiveness of your wireless provider.

Text appointment reminders: Yes ◯ No ◯ Phone # to text: _____

Acknowledgement of Privacy Practices.
I have reviewed Legacy Health and Wellness Client Rights and Informed Consent and fully understand my rights. If I have any questions regarding these consent forms or about the services offered by Legacy Health and Wellness, I may discuss them with my therapist. I consent to participate in the evaluation and treatment offered to me by Legacy Health and Wellness. I understand that I may stop treatment at any time. I acknowledge that I have the right to access my health information and may request a summary of services received by completing a Health Record Request form. I am aware that I can withdraw this consent at any time and that my consent is necessary for treatment services to be provided.

This document is to be signed by an adult having authority to consent to services provided to the client listed above (an adult Client, a legal guardian or the Parent of a minor).
This document provides the express written consent for the psychiatric, psychological and associated treatments that are offered by Legacy Health and Wellness.
This permission is given with the understanding that the goal of Legacy Health and Wellness is to facilitate improved functioning, healthy relationships and the development of effective coping mechanisms. Other specific goals will be fully described in the client's Treatment plan.

I,_____acknowledge that the above information was explained to me during the intake process at Legacy Health and Wellness.

Client Name: _____

Signature:_____Date:_____
Client/Legal Guardian/Parent if client is a minor

Legacy Representative: (Please Print): _____

Legacy Representative Signature: _____

CONSENT FOR LEAVING MESSAGES

I understand that my healthcare information is protected. I understand, that in order for us to leave detailed messages containing specific mental health information on my voicemail or answering machine, I need to give permission for us to do so.

I give permission for messages to be left on my phone number(s) below:

◯ Cell#_____ ◯ Home#_____ ◯ Work #_____

◯ I give permission for the following information to be included on any messages:

◯ Appointment Changes ◯ Account Payments/ Balances

It will be my responsibility to keep this information up to date. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time.

◯ I prefer not to have voice mail messages from the office

_____	_____	_____
Printed Name (Patient/Parent)	Signature (Patient/Parent)	Date

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Additional Information

Please list members of your household (everyone living in your home - related or not) :

Name of Persons Living in the Home	Age:	Date of Birth:	Relationship to Client:

Siblings, parents or children who have moved out of the home or who are not living in the home:

Name of Person(s) Not in the Home:	Age:	Date of Birth:	Relationship to Client

Who referred you for services and/or why are you here for services? _____

_____

_____

_____

When did the problem/s first start? _____

Does anyone you know receive services at this clinic? / Who? _____

If applicable, what is your relationship to this person? _____

Clinical History:

ALL previous mental health treatment: outpatient or inpatient, substance abuse or gambling:

Date/s	Reason/Type of Treatment	Doctor, Place, State?

List any medications you are taking for **mental health issues** only: Doctor _____

Medication	Dose	Frequency	Response	Start Date	Side Effects
	/mg				
	/mg				
	/mg				
	/mg				
	/mg				

List any medications you are taking for **medical issues** only: Doctor/s: _____

Medication	Dose	Frequency	For what condition	Start Date	Side Effects
	/mg				
	/mg				
	/mg				
	/mg				
	/mg				

Have you been diagnosed with a mental health disorder? Yes / No

Diagnosis	Doctor	Date, Place, State?

Family History: - For Adults and Children

List all family and then make a note of any major illnesses including symptoms: psychiatric, neurologic, alcoholism, drug abuse, suicide, suicide attempts, divorces and relationship issues:

_____

_____

_____

_____

_____

_____

Current Symptoms:

☐ Adjustment difficulties	☐ Trauma	☐ Worthlessness
☐ Cultural issues	☐ High levels of anxiety	☐ Loss of interest
☐ Academic problems	☐ Shortness of breath	☐ Loss of energy
☐ Death of friend/family (circle)	☐ Trembling / shaking	☐ Feel persecuted
☐ Violating the rights of others	☐ Heart pounding	☐ Paranoia (fear of others)
☐ Repeating actions often	☐ Fear of being around others	☐ Hallucinations
☐ Dependency in relationships	☐ Panic attacks	☐ Caffeine use
☐ Fear of abandonment	☐ Difficulty leaving the house	☐ Nicotine use
☐ Aggression / hurtful	☐ Nervousness	☐ Drug use (not prescribed)
☐ Argumentative / defiant	☐ Excessive talking	☐ Alcohol use
☐ Impulsive / reactive	☐ Excessive activities	☐ Forgetfulness
☐ Binge / excessive eating	☐ Rapid change of ideas	☐ Confusion
☐ Purposeful vomiting / purging	☐ Low Self-esteem	☐ Poor memory
☐ Poor eating / not eating	☐ High self-esteem	☐ Poor attachment
☐ Sexual dysfunction	☐ Elevated mood	☐ Encopresis (soiling)
☐ Sexual activity (child/teen)	☐ Excessive energy	☐ Enuresis (wetting)
☐ Sense of detachment	☐ Depressed mood	☐ Hyperactivity
☐ Flashbacks to trauma	☐ Moodiness / irritability	☐ Distractibility
☐ Frightening waking images	☐ Mental retardation	☐ Learning disorder
☐ Nightmares	☐ Lying	☐ Gambling
☐ legalissues or involvement	☐ Truancy/no work or school	☐ Suicide attempts
☐ Chronic physical pain	☐ Loss of relationship _____	☐ Tantrums, length: _____
☐ Financial stress	☐ Mood swings	☐ Poor sleep (not enough)
☐ Physical abuse history	☐ Fire setting (# times____)	☐ Excessive (too much) sleep
☐ Emotional abuse history	☐ Cruelty to animals	☐ Cutting self
☐ Sexual abuse history	☐ Theft / stealing	☐ Burning self
☐ Victim of neglect	☐ Homicidal (killing) thoughts	☐ Head banging
☐ Runaway / disappearances	☐ Suicidal (self-harm) thoughts	☐ Other injuries to self
☐ Domestic violence abuser	☐ Sexual abuse perpetrator	☐ Developmental disability
☐ Asperger's disorder	☐ Autism spectrum disorder	

Please place a number 1, 2 and 3 next to the items checked above to indicate the areas of MOST concern.

Additional information pertaining to the issues identified above:

_____

_____

_____

_____

*If this form is completed on behalf of a child or adolescent or another person, please tell us the **Name of the person completing this form**: _____

**If client is a minor child, please list either biological parents below or guardian/s if the child is not in parent's custody. Guardians, you will need to submit an official document detailing your custody in order to schedule an appointment. Without such document, we will be unable to schedule your child*.

Please note who has LEGAL custody and who has PHYSICAL custody: ***Circle:***

Guardian:_____Relationship:_____Custody: legal or physical

Guardian:_____Relationship:_____Custody: legal or physical

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Informed Consent for Court Appearances and/or Paperwork

Since the client-therapist relationship is built on trust with the foundation of that trust being confidentiality, it is often damaging to the therapeutic relationship for the therapist to be asked to present records to the court, and testify, whether to present facts or provide insight as an expert in a court deposition. The therapist asks that clients only request a court appearance in extreme cases. Court appearances may result in the need to terminate the therapeutic relationship and refer you to another therapist who is more appropriate to make court appearances. In the event that it is necessary for the therapist to testify before any court, arbitrator, or other hearing officer, whether the testimony is factual or expert, or to present any or all records pertaining to the counseling relationship to a court official, the client agrees to pay the agency for this service as the agency will be reimbursing the therapist for his or her services, including travel, preparation, and necessary expenditures. Court appearances are billed at $100 per hour, with a minimum charge of three (3) hours. All additional expenditures will be billed after the court appearance.

Other letters and paperwork requested by the client will be completed at a charge of $50 per hour, rounded to the nearest hour, with a minimum 1-hour charge. This includes letters to court officials or attorneys, short-term disability paperwork, FMLA and any other similar documentation requested by the client. This does not include copies of your bill, missed work or school letters, Release of Information Forms, nor any other documents used in the day to day operation of the office.

The guardian/client agrees to pay the $300 two weeks prior to the appearance, presentation of records, or testimony requested. Fees for additional paperwork requests is due at the time of the request and may require up to 3 business days to be completed.

Client Name: _____

Signature:_____Date: _____
Client/Legal Guardian/Parent if client is a minor