



☐ Las Vegas Office

☐ Reno Office

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

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 _____

Reason for Seeking Services: _____ Individual Counseling _____ Substance Use _____ Couples/Family Counseling _____
_____ PCIT _____ EMDR/Parts and Memory _____ Other: _____

Is the client a minor (under the age of 18)? If yes, please checkmark to indicate you will be signing documents on the behalf of the client _____ Yes _____ No

Parent/Guardian Information

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 _____

Clinician Signature _____ See Clinician Signature Page _____ Date of Service _____ See Clinician Signature Page _____



Legacy Health and Wellness
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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 because 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. 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 _____
Insurance 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 _____
Insurance 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): _____ See Clinician Signature Page

Legacy Representative Signature: _____ See Clinician Signature Page Date: _____ See Clinician Signature Page



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 the 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 the terms therein.

Signature: _____ Date: _____

Client/Legal Guardian/Parent if client is a minor

Legacy Representative: (Please Print): _____ See Clinician Signature Page

Legacy Representative Signature: _____ See Clinician Signature Page Date: _____ See Clinician Signature Page

To file a formal grievance, contact:
Rande Paige, Director
Legacy Health and Wellness
2921 North Tenaya Way
Las Vegas, NV 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, anger management, 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. The 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 behavior 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: 1) 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 to have services authorized.

Protected Health Information: During 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 or 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 the 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 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.

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 non-Medicaid insurance, a co-pay may be required depending on your insurance benefits.

Appointments/Cancellations. Legacy Health and Wellness strives to provide you with the best personalized care available and we are dedicated to helping 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 circumstances make it impossible to attend your scheduled 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 charges incurred.

Copies of your records. You have the right to access your clinical record. Legacy Health and Wellness charges .20 cents per page. A copy of the record cannot be faxed or emailed to ensure confidentiality. You can pick up your records or they can be mailed certified mail at your expense.

After Hours Emergency Contact Procedures

Legacy Health and Wellness has an after-hours answering system 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.

By signing this document, I declare that I understand that paper copies of my patient records will be kept on file six years after discharge.

By signing this document and as a part of receiving treatment at Legacy Health and Wellness, I authorize consent to the use of my personal health information (PHI) for treatment, payment, and health care operations.

Client Name: _____

Date: _____

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): _____ See Clinician Signature Page

Legacy Representative Signature: _____ See Clinician Signature Page Date: _____ See Clinician Signature Page

CONSENT FOR LEAVING MESSAGES

I understand that my healthcare information is protected. I understand that 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



Legacy Health and Wellness
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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 Family/Friends	Trembling/Shaking	Feeling Persecuted
Violating the Rights of Others	Heart Pounding	Paranoia
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	Cognitive Impairment	Learning Disorder
Nightmares	Lying	Gambling
Legal Issues or Involvement	Truancy/No Work or School	Suicide Attempts
Chronic Physical Pain	Loss of Relationship	Tantrums
Financial Stress	Mood Swings	Poor Sleep
Physical Abuse History	Fire Setting	Excessive Sleep
Emotional Abuse History	Cruelty to Animals	Cutting Self
Sexual Abuse History	Theft/Stealing	Burning Self
Victim of Neglect	Homicidal Thoughts	Head Banging
Runaway/Disappearances	Suicidal Thoughts	Other Injuries to Self
Domestic Violence Abuser	Sexual Abuse Perpetrator	Development Disability
Asperger's Disorder	Autism Spectrum Disorder	

Please check items 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 to schedule an appointment. Without such a document, we will be unable to schedule your child.*

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

Guardian: _____ Relationship: _____

Custody: _____ Legal _____ Physical

Guardian: _____ Relationship: _____

Custody: _____ Legal _____ 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.



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Policies for a Successful Relationship

Legacy Health and Wellness strives to provide you the best personalized care available. We are dedicated to helping you meet your therapeutic goals. To do this, it is important that you attend all scheduled therapy appointments.

Consistency in attendance allows you and your therapist to work together toward meeting your treatment goals and provides the same opportunity for others as well. To make this possible we adhere to a set of very important guidelines.

We realize that there are times when unforeseen circumstances make it impossible to attend your scheduled appointment. If this happens, we ask that you show us consideration by calling at least 24 hours prior to your appointment 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. Cancelling an appointment with short notice or no showing an appointment takes up clinic time that could benefit another person. In addition, your insurance requires us to discharge anyone who has not been seen for 30 days. Below you will find the policy pertaining to no call/no shows and repeated rescheduling.

Please read all policies carefully, initial next to each, and indicate your agreement by signing at the bottom.

_____ **Late Policy**

If you are late by more than 10 minutes, this will result in your treatment time being reduced. After 15 minutes, your appointment will be rescheduled.

_____ **No-Shows/Cancellation**

If you fail to show for an appointment (and do not call) or cancel/reschedule an appointment two consecutive times, our front office staff will be required to remove all future appointments and you will be discharged. If you wish to return for therapy, it will cause delays.

_____ **No Contact for 30 Days**

Your insurance requires clients to be discharged for 30 days. Should you be discharged due to this restriction, you may experience a delay in returning to therapy.

_____ I have read and agree to Legacy Health and Wellness' policies listed above.

Client Name: _____

Signature: _____ Date: _____

Client/Legal Guardian/Parent if client is a minor.

Clinician Signature _____ See Clinician Signature Page _____ Date: _____ See Clinician Signature Page _____