MERIDIAN
MENTAL HEALTH & TMS CENTER OF OMAHA

6910 Pacific Street, Suite 100
Omaha, NE 68106
Phone: (402) 504-3707
Fax: (402) 504-3714
www.mmhaomaha.com

PATIENT INFORMATION

Date: _____

Legal Name: _____

Preferred Name: _____

Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ Home: _____ Work: _____

E-Mail: _____ Best way to reach you: _____

Social Security # _____ Gender: _____

Relationship: ☐Married ☐Single ☐Divorced ☐Widowed

Spouse's Name: _____ Date of Birth: _____

Employer: _____

Referred by: _____

Primary Care Physician: _____ Phone # _____

INSURANCE INFORMATION

☐ I verify I **DO NOT** have Medicaid
☐ If I have Medicare, I verify that that I have a secondary policy

Insurance Co. _____ ID # _____ Group # _____
Name of Insured: _____ DOB: _____ Relationship: _____
Secondary Insurance Co. _____ ID # _____ Group # _____

☐ **I also understand it is my responsibility to immediately notify Meridian Mental Health of any new insurance changes and/or updates.**

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____ Phone # _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Patient Name:_____

Patient DOB:_____

Meridian Mental Health and TMS Center of Omaha

Which and Where is the pharmacy you use?

_____

_____

Allergies:_____

List all current prescription medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dosage	Estimated Start Date

List all current over-the-counter supplements and how often you take them: (if none, write none)

Name	Total Daily Dosage	Estimated Start Date

Past Psychiatric Medication: Please indicate the medications you have taken by (circling) it and listing the estimated date of usage, as well as your response.

Antidepressants

	Dates	Response		Dates	Response
Prozac:			Remeron:		
Zoloft:			Viibryd:		
Luvox:			Trintellix:		
Paxil:			Pristiq:		
Celexa:			Fetzima:		
Lexapro:			Doxepin:		
Effexor:			Emsam:		
Cymbalta:			Elavil:		
Wellbutrin:					

Mood Stabilizers / Antipsychotics

	Dates	Response
Lithium:		
Depakote:		
Lamictal:		
Tegretol:		
Topamax:		
Oxcarbazepine:		
Seroquel:		
Zyprexa:		
Geodon:		
Abilify:		

	Date	Response
Haldol:		
Risperdal:		
Rexulti:		
Saphris:		
Fanapt:		
Invega:		
Latuda:		
Vrylar:		
Other:		

Sedative / Hypnotics

	Dates	Response
Ambien:		
Sonata:		
Rozerem:		
Restoril:		

	Date	Response
Trazodone:		
Lunesta:		
Belsomra:		
Other:		

ADHD Medications

	Dates	Response
Adderall		
Concerta:		
Ritalin:		
Other:		

	Date	Response
Strattera:		
Vyvanse:		
Adzenys:		
Focalin:		
Mydayis:		
Zenzedi:		

Anti-Anxiety Medications

	Dates	Response
Xanax:		
Ativan:		
Klonopin:		
Valium:		
Buspar:		
Other:		

Signature of Completion: _____ Date: _____

Meridian Mental Health & TMS Center of Omaha

6910 Pacific Street, Suite 100

Omaha, NE 68106

Phone: 402-504-3707 FAX: 402-504-3714

Release of Information

Patient's DOB: _____

Patient's SS #: _____

Patient's Address: _____

** ** ** **** ** ** **** ** ** **** ** ** **** ** **

I, _____, hereby authorize Meridian Mental Health to disclose and/or receive the following protected health information to/from:

Provider Name: _____

Provider Address: _____

Provider Phone/Fax number: _____

Please check information you would like released:

- o Treatment Summary
- o Psychological Evaluations
- o Discharge Summary
- o Substance Abuse and/or Addiction
- o Mental/Behavioral Health
- o Other _____
- o All of the above

This authorization shall be in effect for one year from the date the authorization was signed.

I understand that I have the right to revoke this authorization in writing, at anytime, by sending such written notification to Meridian Mental Health, 6910 Pacific St., Suite 100, Omaha NE 68106.

I understand that the information used or disclosed with this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal law. Meridian Mental Health will not condition my treatment, payment enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

Signature: _____ Date: _____

Meridian Mental Health & TMS Center of Omaha

6910 Pacific Street, Suite 100

Omaha, NE 68106

Phone: 402-504-3707 FAX: 402-504-3714

Release of Information

Patient's DOB: _____

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I understand that I have the right to refuse to sign this authorization.

Signature: _____ Date: _____

PATIENT CONSENT FOR TELEPSYCHIATRY

PATIENT: _____

DOB: _____

LAST 4 SSN: _____

In agreeing with this consent, I hereby agree to engage in telehealth psychiatry/mental health therapy with Meridian Mental Health and TMS Center of Omaha." This may include the practice of health care delivery, diagnosis, consultation, treatment transfer of medical data, and education using interactive audio, video or: data communications that may include communication of my medical/mental information to health care practitioners involved in my care.

I understand that I will need to download a HIPPA protected telehealth application and/or software to use this platform. I will be given applicable instructions by my provider. I may contact them via phone to coordinate alternative methods of treatment.

I understand that I have the following rights and responsibilities with respect to telepsychiatry:

1. I have the right to withhold or withdraw consent at any time without affecting my right for future care with my provider.

2. The laws that protect the confidentiality of my medical information also apply to telehealth. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to reporting certain types of abuse, expressed threats of violence toward any victim, certain legal proceedings as established by statute, and as part of a contractual agreement with your insurance Provider.

3. Charges for telepsychiatry services will be submitted to your insurance carrier, but there is no guarantee that such services will be covered. My provider's staff has made every effort to verify coverage but the ultimate responsibility to verify my out-of- pocket fees will be mine. I am entitled to all appeal processes with my insurance carrier as Is the usual process. If my insurance denies coverage, I will be charged a "self-pay rate" of $185 for a standard 30-minute appointment that is inclusive of evaluation and medication management.

4. I understand that there may be limitations in the technological experience related to telepsychiatry that may be disrupted or distorted by technical failures and that the transmission of my medical information could be interrupted by unauthorized persons and/or that the electronic storage of my medical information could be accessed by unauthorized persons beyond protection provided by my provider and the telehealth platform. At no time will my telepsychiatry encounter be taped without my prior approval.

5. I have a right to access my mental health records of telepsychiatry services in accordance with the state laws of Nebraska.

PATIENT NAME/SIGNATURE: _____

NAME OF LEGAL PERSONAL REPRESENTATIVE: _____

SIGNATURE WITNESS ONE: _____

SIGNATURE WITNESS TWO {if necessary}: _____

DATE: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

Generalized Anxiety Disorder 7- Item (GAD-7) Scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score = Add Columns ___ + ___ + ___

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

FINANCIAL RESPONSIBILTY

It is the patient's responsibility to understand their insurance benefits prior to being seen at Meridian Mental Health. I understand and agree that if my insurance company denies services provided by Meridian Mental Health, it is my responsibility. Balances on my account are expected to be paid in full within 90 days of service. Self-pay patients and copays are required to be paid in full on the date of service with NO exceptions.

Signature: _____ **Date:** _____

HIPAA RELEASE

I was given a copy of my HIPAA rights to read and review. I understand that it is my right as a patient to receive a copy of my HIPAA rights at any point of being a patient of Meridian mental Health. Please acknowledge that this information was given to you by signing and dating the line below.

Signature: _____ **Date:** _____

NO SHOW/SAMEDAY CANCELATION POLICY

It is our number one priority at Meridian Mental Health to provide the best quality of care to all of our patients. We understand that situations come up in life that are out of your control, however we do have cancellation lists full of patients that would like to be seen as soon as possible. Please call and cancel your appointment more than 24 hours in advance if possible. We will not charge a fee for the first no show/same day cancelation. The 2nd no show/same day cancelation will cause a $100 fee to be added to your account that must be paid at your next date of service. The third no show/same day cancelation will cause a $150 fee added to the account and may result in termination of care. By signing and dating below, I acknowledge and understand this policy at Meridian Mental Health.

Signature: _____ **Date:** _____

MERIDIAN MENTAL HEALTH OFFICE PRACTICES

I received the office practices provided to me by Meridian Mental Health. I commit to read and abide by them as outlined in the packet.

Signature: _____ **Date:** _____

Welcome to Meridian Mental Health & TMS Center of Omaha

I acknowledge that I have received and have read the enclosed information. I understand that this information is essential to my coordinated care at Meridian Mental Health & TMS Center of Omaha. I understand that it is my responsibility to ask questions or clarify any concern I may have about this information. Furthermore, I acknowledge this information of the enclosed policies apply to my clinical care.

Patient: _____

Witness: _____

Date: _____

Mary Jo Hanigan, M.D., P.C., d/b/a Meridian Mental Health & TMS Center of Omaha

Name of Patient: _____

Patient Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of September 2013 and updated October 2018.

_____ _____

Signature of Patient/Patient Representative Date

_____

Relationship to Patient

Documentation of Good Faith Efforts To obtain patient's acknowledgement that they received provider's Notice of Privacy Practices

(For use when acknowledgement cannot be obtained from the patient.)

The patient was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgment was not obtained because:

- ☐ Patient refused to sign.
- ☐ Patient was unable to sign or initial because:

  _____
- ☐ The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.
- ☐ Other reason (describe below):

  _____

Signature of Employee Completing Form: _____

Date: _____

Mary Jo Hanigan, M.D., P.C.

d/b/a Meridian Mental Health & TMS Center of Omaha

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

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

Meridian Mental Health is required to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. We will not use or disclose your health information except as described in this Notice. This Notice applies to all of the medical records generated by **Meridian Mental Health**, as well as records we receive from other providers.

USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION IN TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

Treatment: **Meridian Mental Health** may use and disclose your protected health information in the course of providing or managing your health care as well as any related services. For the purpose of treatment, we may coordinate your health care with a third party. For example, we may disclose your protected health information to a pharmacy to fulfill a prescription for medication, to a radiology facility to order an X-ray, or to another physician who is assisting in your health care. In addition, we may disclose protected health information to other health care providers related to the treatment provided by those other providers.

Payment: When needed, **Meridian Mental Health** will use or disclose your protected health information to obtain payment for its services. Such uses or disclosures may include disclosures to your health insurer to get approval for a recommended procedure or to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. When obtaining payment for your health care, we may also disclose your protected health information to your insurance company to demonstrate the medical necessity of the care or for utilization review when required to do so by your insurance company. Finally, we may also disclose your protected health information to another provider where that provider is involved in your care and requires the information to obtain payment.

Operations: **Meridian Mental Health** may use or disclose your protected health information when needed for the practice's health care operations for the purposes of management or administration of the practice and for offering quality health care services. Health care operations may include: (1) quality evaluations and improvement activities; (2) employee review activities and training programs; (3) accreditation, certification, licensing, or credentialing activities; (4) reviews and audits such as compliance reviews, medical reviews, legal services, and maintaining compliance programs; and (5) business management and general administrative activities. For instance, we may use, as needed, protected health information of patients to review their treatment course when making quality assessments regarding ophthalmologic care or treatment. In addition, we may disclose your protected health information to another provider or health plan for their health care operations.

Other Uses and Disclosures: As part of treatment, payment, and health care operations, **Meridian Mental Health** may also use or disclose your protected health information to: (1) remind you of an appointment; (2) inform you of potential treatment alternatives or options; or (3) inform you of health-related benefits or services that may be of interest to you.

USES & DISCLOSURES TO WHICH YOU MAY OBJECT

Family/Friends: **Meridian Mental Health** may disclose your protected health information to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose protected health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you have any objection to the use and disclosure of your protected health information in this manner, please tell us.

USES & DISCLOSURES THAT ARE REQUIRED OR PERMITTED WITHOUT YOUR AUTHORIZATION

Research: Under certain circumstances, **Meridian Mental Health** may use and disclose your protected health information to approved clinical research studies. While most clinical research studies require specific patient consent, there are some instances where a retrospective record review with no patient contact may be conducted by such researchers. For example, the research project may involve comparing the health and recovery of patients who received one medication for their medical condition to those who received a different medication for that same condition.

Regulatory Agencies: **Meridian Mental Health** may disclose your protected health information to government and certain private health oversight agencies, e.g., the Department of Public Health and Environment or the Board of Medical Examiners, for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary to monitor compliance with the requirements of government programs.

Law Enforcement/Litigation: Meridian Mental Health may disclose your protected health information for law enforcement purposes as required by law or in response to a court order or other process in litigation.

Public Health: As required by law, **Meridian Mental Health** may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, we are required to report the existence of a communicable disease, such as acquired immune deficiency syndrome ("AIDS"), to the Department of Public Health and Environment to protect the health and well-being of the general public.

Workers' Compensation: **Meridian Mental Health** may release protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Military/Veterans: **Meridian Mental Health** may disclose your protected health information as required by military command authorities, if you are a member of the armed forces.

Organ Procurement Organizations: To the extent allowed by law, **Meridian Mental Health** may disclose your protected health information to organ procurement organizations and other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

As Otherwise Required or Permitted By Law: **Meridian Mental Health** will disclose your protected health information in any situation in which such disclosure is required by law (e.g., child abuse, domestic abuse) or any other use permitted under HIPAA, its amendments or regulations.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION:

Other than the circumstances described above, **Meridian Mental Health** will not disclose your protected health information unless you provide written authorization. An authorization is specifically required in most situations involving uses or disclosures of protected health information for marketing purpose, for the sale of protected health information, or for psychotherapy purposes. You may revoke your authorization in writing at any time except to the extent that we have already taken action in reliance upon the authorization.

YOUR RIGHTS RELATED TO YOUR HEALTH INFORMATION:

Although all records concerning your treatment obtained at **Meridian Mental Health** are the property of **Meridian Mental Health**, you have the following rights concerning your protected health information:

- *Right to Confidential Communications:* You have the right to receive confidential communications of your protected health information by alternative means or at alternative locations. For example, you may request that we contact you at work or by mail.
- *Right to Inspect and Copy:* You generally have the right to inspect and copy your protected health information, except as restricted by your physician or by law. Further, if we maintain your health records on an electronic health records system, you have the right to request an electronic copy of your health records.
- *Right to Amend:* You have the right to request an amendment or correction to your protected health information. If we agree that an amendment or correction is appropriate, we will ensure that the amendment or correction is attached to your medical record.
- *Right to an Accounting:* You have the right to obtain a statement of the disclosures that have been made of your protected health information other than by your authorization, other than to you and other than for the purpose of treatment, payment or routine operational purposes.
- *Right to Request Restrictions:* You have the right to request restrictions on certain uses and disclosures of your protected health information. If we agree, we will abide by the restrictions. Additionally, if you (or anyone on your behalf besides a health plan) pay for the care or services at issue in full out of your own pocket, we are required to comply with your request not to disclose your protected health information to a health plan, unless required by law to do so.
- *Right to Receive a Copy of this Notice:* You have the right to receive a paper copy of this Notice, upon request, if this Notice has been provided to you electronically.
- *Right to Revoke Authorization:* You have the right to revoke your authorization to use or disclose your protected health information, except to the extent that action has already been taken in reliance on your authorization.

- *Right to Notice of Breach of Security:* You have the right to be notified in the event of a breach of unsecured protected health information occurs.
- *Right to Opt Out:* You may be contacted for certain fund-raising purposes and you have the right to opt out of receiving such communications.

FOR MORE INFORMATION REGARDING HOW TO EXERCISE THESE RIGHTS: If you have questions or would like more information regarding any of the rights listed above, please contact the **Compliance Officer at 402-504-3707.**

IF YOU BELIEVE THAT YOUR RIGHTS HAVE BEEN VIOLATED: You may file a complaint with **Meridian Mental Health** or with the U.S. Secretary of Health and Human Services. To file a complaint with **Meridian Mental Health,** please contact the **Compliance Officer at 402-504-3707.** All complaints must be submitted in writing. There will be no retaliation for filing a complaint.

NOTICE EFFECTIVE DATE: This Notice is effective for all protected health information created on or after September 23, 2013.