Client Orientation to Services

Welcome to Heartland Counseling Services, Inc. The following document is a guideline to our agency's Mission, Philosophy, Services and Procedures. Please read this carefully. If you have questions, or if this material needs to be read to you, please inform our receptionist.

Mission: Our mission is to provide quality outpatient counseling, education, community service programs and prevention services to individuals, groups, and families. We provide consultation to community organizations in Dakota, Dixon, Burt, Thurston, Boyd, Brown, Cherry, Holt, Keya Paha and Rock Counties and the Siouxland area.

Philosophy: Heartland Counseling Services, Inc. believes that people suffering from mental, emotional, and behavioral disorders can most efficiently and most effectively be treated and receive services that are highly professional and involve professionals from several different disciplines. The people served will receive the highest standard of care. We believe that all individuals should have access to those services which are necessary to establish, maintain or restore normal functioning. These services are available to all individuals regardless of his/her diagnosis or disability, socioeconomic level, age, race, sex, religious affiliation, or any other characteristics. We believe that particularly in rural areas where other professional support is likely to be less readily available, professional staff should be the most highly trained and the most experienced obtainable.

HOURS, ADDRESS, AND PHONE NUMBERS OF OUR LOCATIONS.

South Sioux City
1201 Arbor Drive
PO Box 355
South Sioux City Ne 68776
Phone: 402-494-3337
Fax: 402-494-3356
Monday – Thursday
8:00am – 8:00pm
Friday – 8:00 – 12:00

O'Neill
221 W Douglas St
PO Box 246
O'Neill Ne 68763
Phone: 402-336-2800
Fax: 402-336-2849
Monday - Thursday
8:00am – 6:00pm

Ainsworth
938 E Zero ST
PO Box 246
Ainsworth NE 69210
Phone: 402-336-2800
Fax: 402-336-2849
Monday - Thursday
8:00am – 6:00 pm

Crisis Response Line: 1-877-958-7776 or
1-402-494-7655

AFTER HOURS PHONE NUMBERS ARE AVAILABLE FOR EMERGENCY ACCESS ONLY.

Programs/Services Available:

Outpatient Mental Health and Substance Abuse Programs: Include individual, group, family, and couple's therapy. We provide services to ages 3 years and older.

Assessments and evaluations: Include mental health, substance abuse, and psychiatric evaluations.

Community Support, Recovery Support, and Peer Support Services: These services provide support and wraparound services for individuals struggling with either mental health and/or substance abuse issues. Services included, but are not limited to are, transportation to doctors' appointments, budgeting, skill building, life management and daily living activities learning, job seeking and community referrals.

The Life Center: Day Rehab and Day Support in South Sioux City: The Life Center is a safe place for individuals to attend Monday through Friday to assist them in maintaining recovery, this includes both mental health and/or substance abuse. The goal of the program is to assist individuals in developing skills and provide support that promotes successful community living and minimizes hospitalizations.

Crisis Response Program for Youth and Adult: This program is a short-term service which aims to assist those in crisis and to prevent hospitalization and Emergency Protective Custody by wrapping appropriate services around the individual to allow them the opportunity to remain in the community. The crisis responder will access appropriate services to assist the individual which may include, but not be limited to, local law enforcement, therapists, medical facilities, domestic violence or homeless shelters, substance abuse treatment, food banks, etc. They will also coordinate hospitalization if needed. Works closely with law enforcement. Face to face crisis assessments with a licensed mental health practitioner will make recommendations and wrap services with a written crisis plan that is very detailed. Each crisis plan is individualized to the situation, but may include a phone check-in with crisis responder or family member every few hours, meeting with individual in person next day, setting up doctor appointment, meet with teacher, etc. Crisis responder and LMHP will accompany individuals to hospital if needed or may be able to provide funds for family/friends to take individual to hospital out of town if needed. After discharge from hospital, crisis responders will follow individual up to 90 days before transferring to community support services.

Intensive Outpatient Treatment and Continuing Care Services: This program is based on a total of 10 -12 weeks. The evening program meets from 6:00 P.M. – 8:15 P.M. Monday through Thursdays. Upon the participant completion of the intensive treatment phase, they then transfer to participation into the aftercare group. The aftercare group will meet once per week for approximately one hour. This group will be facilitated by a substance abuse counselor/Licensed Mental Health Therapist with experience in Substance Abuse.

PRIME for Life Classes: This program is a class held once a month for 12 hours. This program meets the requirements for Iowa and Nebraska DOT. This class is typically held on Friday evening from 5:00 P.M. – 9:00 P.M. and on Saturday from 9:00 A.M – 5:30 P.M. This class is not covered by insurance. This class must be paid for in advance before signing up.

Tele-psychiatry and Tele-health: Heartland Counseling Services, Inc. is a host site for tele-psychiatry with Richard Young Outpatient Clinic in Kearney, Nebraska. Our clients receive their medication management with providers from Kearney. Our care coordinator checks in clients, does their vitals, faxes over to Kearney and then the provider meets with the client via the web. Tele-psychiatry is done in the O'Neill and South Sioux offices. Heartland Counseling Services, Inc. also offers tele-health therapy sessions between sites and in the comfort of your home. Our clients are supplied with a link to connect to their therapist through a HIPAA secure link.

The CODE OF ETHICS and YOUR RIGHTS AND RESPONSIBILITIES as well as HEARTLAND COUNSELING SERVICES, INC. POLICIES, are posted in the reception area.

What to Expect: You will be asked to complete the "Personal Data Form" before you see a therapist. *THIS PAPERWORK IS MANDATORY FOR ALL CLIENTS. IF YOU REFUSE, WE CANNOT PROVIDE YOU WITH SERVICES.* The purpose of the initial intake session is to have the therapist obtain as much background information as possible. This will clarify problem areas and determine what services you need. If therapy is needed, you and your therapist will decide what the goals of therapy will be and develop a treatment plan which is a map for you and the therapist to follow to fulfill your purpose/goal in coming to this agency. It will be reviewed every 3 months to determine if you are achieving your goals. This agency uses a TEAM approach. You and your therapist will have certain responsibilities to assist you in achieving your goals. Sometime family members and others may be involved in your treatment.

A discharge plan/goal will also be developed when the treatment plan is developed. This is the "BIG PICTURE" of what you want to achieve from our services. To be sure we are properly serving you, you will be asked to complete a semi-annual SATISFACTION SURVEY. This will assist us in better serving you.

Restrictions: Please do not attend sessions or this agency under the influence of alcohol of illegal drugs. If you cannot make it to your appointment, we ask that you notify us as soon as possible so that we can offer that time to another client in need. We will be glad to reschedule your appointment for another time. If you miss 3 appointments WITHOUT reasonable excuses, you will not be allowed to reschedule without talking to your therapist and you may also be discharged from this agency.

If at any time you have questions regarding fees and financial arrangements, please ask. This agency works with Region 4 Behavioral Health Systems, Medicaid, Medicare, most Insurance companies, and self-pay. For those who qualify, we offer sliding fee reduction based off your income.

Auditing/Surveys: Because this agency receives STATE and FEDERAL dollars, we must comply with specific auditing and surveying procedures. This includes reviews of client files. Any client information disclosed through these audits and/or surveys may only be disclosed back to this agency to carry out the audit or evaluation process.

Confidentiality: What you tell your therapist is confidential – any information you give will not be released without your written consent, or in the case of minors, parental consent.

Notice of Privacy Practices: This notice describes how medical information about you may be used or disclosed and how you can get access to this information. If you have any questions about this Privacy Notice or want more information, please contact our Corporate Compliance Officer at 402-494-3337or in writing at PO Box 355, South Sioux City NE 68776.

Protected Health Information (PHI): While receiving care from Heartland Counseling Services, Inc., information regarding your medical history, treatment, and payment for your behavioral health care may be originated and/or received by us. Information which can be used to identify you, and which relates to your past, present, or future health condition, receipt of behavioral health care or payment for behavioral health care. All this information is your PHI.

Your PHI will not be sold, used, or disclosed for marketing or fundraising. Except in certain situations outlined below, we shall obtain your specific written authorization to release your PHI. Your authorization will be obtained to release psychotherapy notes for most uses and disclosures. You may revoke any authorization at any time, but you must do this in writing.

Our Responsibilities: Federal and State laws impose certain obligations and duties upon us as a covered health care provider with respect to your Protected Information. Specifically, we are required to:

1. Provide you with notice of our legal duties and Heartland's policies regarding the use and disclosure of your Protected Information.
2. Maintain the confidentiality of your Protected Information in accordance with state and federal law.
3. Abide by the terms of this notice.
4. Respect your rights regarding requests for restrictions of uses and disclosures, requests for access to your information, requests for amendment, requests for accountings of disclosures, requests for revoking authorizations, and requests for alternative communications.

How will your PHI be used and disclosed? Generally, your PHI will not be disclosed without prior written authorization. However, we may disclose your PHI without your consent in the following situations:

1. You waive your right to confidentiality of mental health records when you assert your mental or emotional condition as a claim or defense.
2. Mental Health and Substance Abuse Information may be disclosed for the purpose of providing additional treatment if you have made a written request. Additionally, we may

disclose mental health and/or substance abuse information to other providers of professional services who may be involved in your *care*.

3. We may also contact you to provide appointment reminders which may be by telephone, including leaving a message on an answering machine or by mailing you a reminder.
4. We may also contact you to provide information about treatment alternatives or related services that may be of benefit to you.
5. Custody of Children: Unless otherwise ordered by the court in the custody decree, or other court order, both parents shall have legal access to information concerning the child including but not limited to medical, educational, and law enforcement records.
6. Emergencies: Mental health information may be disclosed at any time to another facility, physician, or mental health professional in cases of a medical emergency.
7. Payment and Operations: Heartland Counseling Services, Inc. may disclose information to other Business Associates for Healthcare Operation purposes including our Auditor, Legal Counsel, or any Business Associate that performs services on our behalf. Where possible the information will be de-identified or the minimum necessary information will be disclosed. Confidentiality and use and disclosure laws as set out in this Notice and any other applicable law as specified by the Business Associate Agreement.
8. Collections: Information necessary to collect payment on an unsettled account. You will receive special notice prior to us disclosing information to collection agencies.

Specific authorization by law:

1. When otherwise specifically required by other states or the federal government by laws that specifically relate to the protection of human health and safety.
2. Child or Dependent Adult Abuse: Heartland Counseling Services, Inc. employees are mandatory reporters of child abuse and must disclose information necessary to report any known incident of child or dependent adult abuse under requirements by law.
3. Court Order: Court orders may authorize disclosures.
4. Mental Health Board Commitment: Disclosure may be required by the state to determine civil commitment proceedings.
5. Victims of abuse and neglect: If we feel disclosure is necessary to prevent serious harm to you or others, we may disclose information if you are incapacitated and unable to agree to the disclosure. Disclosure will be made only if failure to release the information would adversely affect a law enforcement activity and only if the information will not be used, in any way, against you.
6. Law enforcement: We may release your PHI to law enforcement for the following purposes: Pursuant to a court order, subpoena, or warrant. Identifying or locating a suspect, fugitive, or material witness or missing person. If you are a crime victim, but only if you consent, or if you are unable to consent and the information is necessary to determine if a crime has occurred, non-disclosure will significantly hinder the investigation, and disclosure is in your best interest. To alert law enforcement if a person's death was caused by suspected criminal conduct. By emergency care personnel if the

information is necessary to alert law enforcement of a crime, the location of a crime, or characteristics of the perpetrator.

Your Rights: Federal and state laws grant you certain rights with respect to your PHI. Specifically, you have the right to:

1. Receive notice of our policies and procedures used to protect your PHI.
2. Request that certain uses and disclosures of your PHI be restricted.
3. Have access to your PHI; however, we have the right to deny this request in certain instances. Requests for review or copies of your information need to be done in writing.
4. Revoke any prior authorizations for use or disclosure except to the extent the action has already been taken. Revocations can be done in writing and given to Heartland Counseling Services, Inc.
5. Request copies of Medical Records; however, we have the right to charge a fee for copies.
6. Receive notice from Heartland of any unauthorized release of your unsecured PHI.
7. Receive information on the Voter Registration Bill (LB76) passed in 1994 and given the opportunity to sign up to vote.

Other Rights: It is your right to receive services without regard to race, color, sex, national origin, religion, age, disability or ability to pay; to provide written consent to release information contained in your file; to receive information contained in your own file by requesting same from your therapist; to refuse service for any reason; to file a grievance; and to request an explanation if services are denied to you. It is the staff's responsibility to treat you with respect, to provide you with quality service and to act in a professional and ethical manner. If at any time you have concerns about our services, talk to your therapist or to a receptionist. If you desire to file a grievance, you may do so in any of the following ways: by phone, in person, by letter or by completing a grievance form (available in the waiting) which is addressed to the Executive Director.

<u>Client Responsibility:</u> Your responsibility is to keep the appointment which has been reserved for you, protect the privacy of other clients, especially if you are involved in group therapy. You will treat clinical and support staff with respect as no physical or verbal abuse will be tolerated. You will uphold the financial agreement between you and this agency (a copy of the payment plan will be provided to you upon request). Please, for the safety of other consumers and staff, we ask for your cooperation in canceling your appointment when you have a communicable disease (i.e., flu, measles, chicken pox, etc.).

<u>Termination of Services:</u> We may deny you services if you come to the agency intoxicated, use nicotine products in the agency, bring a lethal weapon to the agency, stalk a staff or board member, or refuse to work with the treatment plan established for you.

Revised April 2014/July 2015/February 2016/December 2017/Jan 2018

Notice of 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. This notice applies to the following clinics:

Heartland Counseling Services, Inc. (South Sioux City, Nebraska)
Heartland Counseling Services, Inc. (O'Neill, Nebraska)
Heartland Counseling Services, Inc. (Ainsworth, Nebraska)

The above-named offices will use and distribute this notice as their Notice of Privacy Practices and will follow the information described in this notice when using or disclosing records and information. The above clinics will share information with each other to carry out treatment, payment or health care operations as described in this notice.

Understanding your health information:
Each time you visit a clinic, psychiatrist, psychologist, therapist, or other health care provider, a record of your visit is made. This health record contains your medical history, symptoms, examinations, evaluation, test results, diagnosis, treatment, treatment plan, insurance billing, and employment record. This record also serves as a means of communication among other health care professionals who contribute to your care. The health record information is used by insurance companies and other third-party payers to verify the appropriateness of the billed service.

Our responsibilities:

- We have certain responsibilities, these include:
- Maintaining the privacy of your health record.
- Providing you with a copy of this notice.
- Abiding by the terms of this notice.
- Notifying you if we are unable to agree to a requested restriction and accommodating reasonable requests you may have to communicate health information by alternative means or alternative locations.

If our information practices change, we may change this notice. However, before we change our practices, we will post a copy of our new notice at all our satellite offices for your review. The effective date of the notice will always appear at the end of the notice. We will not use or disclose your health information without your authorization, except as described in this notice.

Examples of using health Information for Treatment, Payment and Health Care Options are:

Treatment Purposes:
We will use and disclose your health information for treatment purposes. For example: Information obtained by a therapist, psychologist, psychiatrist, or other members of your health care team will be recorded in your health record. This record will be used to determine the appropriate course of treatment. Health care team members will communicate with one another personally and use the health record to coordinate your care. We will provide your physician or health care providers with copies of various reports that assist him/her in treating you in the future.

Payment Purposes:
We will use and disclose your health information for treatment purposes. For example: A statement will be sent to you or a third-party payer. The information on the statement may include information that identifies you as well as your diagnosis and/or procedures. We may also disclose health information about you to other qualified parties for their payment purposes. This might include the ambulance that will be transporting you to another facility. We may disclose your health information to the ambulance provider for billing purposes.

Health Care Operations:
We will use and disclose health information for health care operations. For example: Members of the medical staff and the quality improvement manager. The information will be used to obtain the record access the care and outcomes of your care. This information will assist us in improving the quality and effectiveness of the programs.

Teaching:
As a teaching clinic, therapy students may be assisting with your care under the supervision of a licensed health care provider as part of their personal health care training program.

Other Uses and Disclosures of Your Health Information:
We may use or disclose health information to notify or assist in not notifying a family member, personal representative, or another person responsible for your care of your location and general condition.

Communication with Family and Others:
We may disclose relevant health information to a family member, friend, or other persons involved in your care. We will only disclose this information if you agree or if in our professional judgement, it would be in your best interest to allow the person to receive the information or act on your behalf.

Business Associates:
There are some services provided at our satellite clinics that are provided through contracts with business associates. When these services are contracted, we may disclose your health

information to our business associates. We require the business associates to appropriately safeguard your information.

Appointment reminders:
Our agency may contact you as a reminder that you have an appointment for treatment or medical care.

Health Related Benefits and Services:
We may use and disclose health information to tell you about health-related benefits or services that may be of interest to you.

Public Health:
We may disclose health information about you for public health activities. These activities may include the following:

- To prevent or control disease, injury, or disability.
- To appropriate authorities authorized to receive reports of abuse and neglect.
- To report reactions to medications or problems with products.
- To notify people about recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a client has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Our agency may disclose health information about you for workers compensation or similar programs. These programs provide benefits for work related injuries or illness.

If you are under custody of law or an inmate of a correctional facility, we may disclose to the institution or the law enforcement official your health information. This release would be necessary for the institution to provide you with health care to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

National Security and Intelligence Activities:
We may release medical information about you to an authorized federal official for intelligence, and other national security activities authorized by law. We may disclose health information if asked to do so by law enforcement official as required or permitted by law or in response to subpoena. We may disclose health information for activities authorized by law. These might include audits, inspections, licensure, and investigations. Our agency may disclose your health information if it is necessary to avoid a serious threat to the health and safety of another individual. We will disclose your health information as required by federal, state, or local law.

Lawsuits and Administrative Proceedings:
We may release your health information in response to a court or administrative order. In addition, we may provide information in response to a subpoena or other discovery request only after we have made efforts to tell you about this request or obtain an order protecting the information requested.

There are certain incidental uses or disclosures of your health information that may occur while we are conducting routine business. This might include identifying your name in a waiting area where other individuals may hear your name called. We will make all reasonable efforts to limit these incidental uses and disclosures.

As a Client You Have the Following Rights Regarding Your Health Information:

- You may request to look at your medical and billing records.
- You may request a copy. You are required to submit your request to medical records. If you request a copy of your records, you will be charged a fee for the cost of copying and mailing.

You may request that your health information be amended if you feel the information is not correct. Your request must be in writing, and you must provide a rationale for the amendment. We have the right to deny your request and we will notify you in writing of our decision. We may deny your request if you ask us to amend information that was not created by us, is not part of the health information kept by or for the agency, is not part of the health information which you would be permitted to inspect and copy and is accurate and complete.

Right to Request Restrictions:
You may request restrictions on how your health information is used for payment, treatment or health care options. We may deny your request. If we agree to a restriction, the restriction may be lifted if use of the information is necessary to provide emergency treatment. To request a restriction, you must send a written request to Medical Records informing us of the information you wish to restrict and to whom the restriction applies.

Right to Request Private Communication:
You may request that we contact you at a certain location or in a certain way. You must request in writing to the receptionist where and how you would like to be contacted.

Right to a Paper Copy of This Notice:
You may request an additional paper copy of this notice at any time from the receptionist.

You May Contact Medical Records at:
Heartland Counseling Services, Inc.
Attn: Medical records
PO Box 355
1201 Arbor Drive
South Sioux City Nebraska 68776

Heartland Counseling Services, Inc.
Attn: Medical Records
PO Box 246
221 West Douglas Street
O'Neill Nebraska 68763

Revised March 2014, July 2015

Member Rights and Responsibilities

It is the fundamental belief of Heartland Counseling Services, Inc. that the person who receives services to have certain rights. The rights you have as a receiver of our services are:

Right to dignity and respect at all times.

Right to services which are responsive to your age, gender, social supports, socioeconomic status, cultural background, psychological needs, sexual orientation, physical abilities and spiritual beliefs.

Right to be greeted and treated with a positive attitude.

Right to receive ethical treatment from all staff.

Right to be free from any physical abuse including sexual abuse, physical punishment, psychological abuse, retaliation, humiliation, neglect, exploitation, and/or fiduciary (financial) abuse by the staff.

Right to be safe from behaviors of other clients.

Right to be involved in all aspects of the services you receive.

Rights of Informed Consent (See Policy on Informed Consent)

Rights to have services explained in a manner which is understandable and allows for timely decisions about participation.

Right to know how much our services cost, including being aware of the sliding fee scale.

Right to refuse any particular treatment.

Right to receive services in a crisis.

Right to voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed.

Right to confidentiality of all records, communications and personal information with some exceptions. Please read Privacy Policy.

Right to be treated by a competent staff and to know the staff's credentials and experience qualifications.

Right to a physically safe environment.

Right to review what is in your record.

Right to not be involved in research.

Right to provide consent to participate in research.

Right to know that this agency adheres to all applicable federal, state/provincial laws or regulations.

Right to be referred to consumer advocacy services or other beneficial services.

Right to receive treatment with the aid of an interpreter.

Right to access other programs at Heartland Counseling Services, Inc. such as Community Support Programs, Intensive Outpatient Treatment, and Day Rehabilitation.

Right to receive information on HIPAA (Notice of Privacy Rights & Practices)

Right to self-directive activities and participate in decisions regarding care and treatment.

Right to be informed in advance about care and treatment and of any changes in care and treatment that may affect the client's well-being.

Right to examine the results of the most recent survey of the facility conducted by representatives of the Department.

Right to lead a normal life within the least restrictive environment possible.

Right to exercise his/her rights as a client of the facility and as a citizen of the United States of America.

Right to be free from arbitrary transfer or discharge.

Right to be free from involuntary treatment unless the client has been involuntary committed by appropriate court order and except in cases of civil protected custody.

Right to have medication administered for treatment by assuring that the consumer is receiving the right drug to the right recipient in the right dosage by the right route at the right time.

Right to self-administer medications if it is safe to do so.

Right to be informed of changes in agency policies, procedures, and changes for service or have his/her designee receive this information.

Revised March 2014, July 2015/October 2015

Policy on Informed Consent

Purpose:
To provide guidelines for the process of obtaining informed consent which will foster rational decision making by the client while protecting individual autonomy.

Policy:
Heartland Counseling Services, Inc. affords all clients the right to consent to or decline services based on full disclosure of the nature, risks and benefits of the services.

The Primary Components of This Policy Are:

A client cannot be forced to participate in services.

Each client has the right to either grant consent to proposed interventions or refuse to undergo them by withholding his/her consent, (i.e. medications, family therapy, marital therapy).

A client's consent is invalid if the client was not provided with the necessary information to access the benefits and burdens of the proposed treatment (i.e. the side effects of medication, the prognosis without medication, prescreening assessments).

Genuine informed consent requires active communication between care provided and patient.

A client's consent is invalid if the patient is not competent to consent.

Finally, informed consent can never be perfect. Misunderstanding may occur. People easily get confused about what is wrong and what will help. Some clients hold tight to false hopes. Many fears will never be voiced and therefore cannot be addressed by the care giver. The same is true of the questions and anxieties.

Perfection is not possible but the goals of an ethically adequate informed consent are sufficiently important to make this agency's involvement in the process worthwhile.

The Executive Director/Management staff will be responsible for the education of the staff and enforcement of this policy.

Revised March 2014, July 2015

Grievance Procedure

If you want to appeal a decision of the staff or file a complaint, or grievance, these are the steps we recommend you follow:

Talk to your provider of services.

If uncomfortable doing this or not satisfied with the results, ask the receptionist to have the Corporate Compliance Officer contact you by phone or schedule an appointment with him/her. The contact should occur within three business days.

If uncomfortable doing this or not satisfied with the results, please obtain a Client Grievance Form available in all reception areas or write a letter expressing your concern.

Fill out the form or write the letter and give it to the receptionist or mail it to the agency.

Heartland Counseling Services, Inc.
Corporate Compliance Officer
PO Box 355
South Sioux City Nebraska 68776

You will receive a written response from the Corporate Compliance Officer within 7 business days. The Board of Directors will respond if the Executive Director is the source of the complaint.

If not satisfied with this, you may request your grievance be forwarded to the Consumer Advocacy Services.

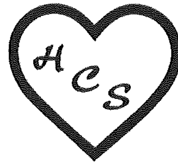
All persons served have the right to confidentiality throughout the entire treatment process. This agency provides rooms for confidentiality activities at all clinics. (See policy on confidentiality)

If this agency becomes involved in research projects, the person served will be asked to sign releases, informed consent forms, and a thorough explanation of the research project.

This is because this agency believes no research should be completed by anyone without his/her approval. This would violate a person's integrity and rights to confidentiality. It is the policy of this agency that all persons served shall feel safe in the environment of this agency. It is also the policy of this agency to not use restraints or seclusions because of it being an inappropriate method of treatment for an outpatient facility. (See policy on Violence in the Workplace).

This agency adheres to the laws of the Department of Health & Human Services Public Health Services. 43CFR part 2 Confidentiality of Alcohol & Drug Abuse, patient records, the agency's policy on confidentiality, and all other applicable federal and state regulations.

Revised March 2014, July 2015



HEARTLAND
COUNSELING
SERVICES INC

Good Faith Estimate

Heartland Counseling Services, Inc. NPI#1033292784

Heartland Counseling Services, Inc. TAX ID# 470763769

This Good Faith Estimate was created for services out-of-pocket (either the uninsured or those not using their health insurance coverage to pay for services). This letter provides you with information about your self-pay costs.

Although we cannot anticipate exactly what services you will need during your visit, we've indicated that the cost of the office visit and any possible additional services are sometimes necessary. You will be notified in advance before any additional services (other than the office visit) are provided during your visit.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

This Good Faith Estimate is based on our understanding of your needs as of today. While caring for you, our providers may recommend additional services that are not listed here. Your actual charges may vary from this estimate. This estimate is not a contract and does not require you to get services from Heartland Counseling Services, Inc. If your actual charges are more than $400.00 above this estimate, you can initiate a provider patient dispute resolution process. Starting a dispute resolution process will not reduce the quality of health services you receive at Heartland Counseling Services.

Disclaimer
This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

Self-Pay Rates 2023-2024

Code	Service	Rate
90791	Initial Diagnostic Interview	$258.00
90832	16-37mins – Individual Session	$93.00
90834	38-52mins - Individual Session	$124.00
90837	53 mins+ - Individual Session	$186.00
99354	Prolonged Session over 90 mins	$186.00
90839	Crisis Session – first hour	$124.00
90840	Crisis – any additional hours	$83.00
90846	Family Session without client present	$135.00
90847	Family Session with client present	$141.00
90849	Continuing Care group, Grief group, Jail group	$42.00
90853	Intensive Outpatient Program & Groups- per hour	$42.00
H0015	Intensive Outpatient Program - Medicaid- per hour	$38.69
99409	Substance Abuse Evaluation	$258.00
H0001	Substance Abuse Evaluation – Medicaid	$275.00
H0038	Peer Support Individual - per 15 mins	$15.30
H0039	Peer Support Group - per 15 mins	$15.30
H2015	Community Support - per 15 mins	$32.86
Q3014	Telehealth w/ Richard Young	$26.60
98966	5-10min phone call, GT modifier	$14.44
98967	11-20min phone call, GT modifier	$25.41
98968	21-30min phone call, GT modifier	$39.85
PSYCHOSEXUAL	Psychosexual Evaluation	$1236

Created Aug 2023

Nebraska Power Of Attorney for Health Care

1. I appoint____, whose address is

________________________________and whose telephone number is

______________________ as my attorney-in-fact for health care. I appoint.

____________________________________ whose address is.

____, as my successor attorney-in-fact for health care. I authorize my attorney-in-fact appointed by this document to make health care decisions for me when I am determined to be incapable of making my own health care decisions. I have read the warning which accompanies this document and understand the consequences of executing a power of attorney for health care.

2. I direct that my attorney-in-fact comply with the following instructions or limitations:

____

____

____

____

3. I direct that my attorney-in-fact comply with the following instructions on life-sustaining treatment: (optional)

____

____

____

4. I direct that my attorney-in-fact comply with the following instructions on artificially administered nutrition and hydration:

(Optional)____

____

I HAVE READ THIS POWER OF ATTORNEY FOR HEALTH CARE. IUNDERSTAND THAT IT ALLOWS ANOTHER PERSONTO MAKE LIFE AND DEATH DECISIONS FOR ME IF I AM INCAPABLE OF MAKING SUCH DECISIONS. IALSO UNDERSTAND THAT ICAN REVOKE THIS POWER OF ATTORNEY FOR HEALTH CARE AT ANY TIME BY NOTIFYING MY ATTORNEY -IN-FACT, MY PHYSICIAN, OR THE FACILITY INWHICH IAM A PATIENTOR RESIDENT. IALSO UNDERSTAND THAT ICAN REQUIRE IN THISPOWEROFATTORNEYFORHEALTHCARETHATTHEFACTOFMYINCAPACITYINTHEFUTURE BE CONFIRMED BY A SECONDPHYSICIAN.

____

(signature of person making designation/date)

____________________________________ ____________________________________

Client/Parent/Legal Guardian Signature Date

____________________________________ ____________________________________

Witness Signature Date

Declaration of Witnesses

We declare that the principal is personally known to us, that the principal signed or acknowledged his or her signature on this power of attorney for health care in our presence, and that the principal appears to be of sound mind and not under duress or undue influence, and that neither of us nor the principal's attending physician is the person appointed as attorney in fact by this document.

Witnessed By:

_______________________________ _______________________________

(Signature of Witness/Date) (Printed Name of Witness)

_______________________________ _______________________________

(Signature of Witness/Date) (Printed Name of Witness)

OR

State of Nebraska

) ss,

County of _______________________________

On this__________day of________________20_, before me,____, a notary public in and for__________________________County, personallycame.

____, personally known to be the identical person whose name is affixed to the above power of attorney for health care as principal, and I declare that he or she acknowledges the execution of the same to be his or her voluntary act and deed, and that I am not.

the attorney-in-fact or successor attorney-in-fact designated by this power of attorney for health care.

Witness my hand and notarial seal at____in such county the day and year last above written.

____

Notary Public

Print Your Return Address

____

____

____

First Class
Postage Required

To: ______________________________ **County Election Official**
(County)

____
(Address)

______________________________ **, Nebraska**
(City or Town)

____
(Zip)

Find your county listed in red below. Print the name & address in the space provided above. Detach, stamp and mail.

- Adams / POB 2067, Hastings / 68902-2067
- Antelope / PO Box 26, Neligh / 68756-0026
- Arthur / POB 126, Arthur / 69121
- Banner / POB 67, Harrisburg / 69345
- Blaine / 145 Lincoln Ave, Brewster / 68821
- Boone / 222 S 4th St, Albion / 68620-1247
- Box Butte / POB 678, Alliance / 69301
- Boyd / POB 26, Butte / 68722
- Brown / 148 W 4th St, Ainsworth / 69210
- Buffalo / POB 1270, Kearney / 68848
- Burt / POB 87, Tekamah / 68061
- Butler / 451 N 5th St, David City / 68632
- Cass / 201 Main St, Plattsmouth / 68048
- Cedar / POB 47, Hartington / 68739
- Chase / POB 1299, Imperial / 69033
- Cherry / POB 120, Valentine / 69201
- Cheyenne / POB 217, Sidney / 69162
- Clay / 111 W Fairfield St, Clay Center / 68933
- Colfax / 411 E 11th St, Schuyler / 68661
- Cuming / 200 S Lincoln St. Rm 100 / West Point / 68788
- Custer / 431 S 10th St, Broken Bow / 68822
- Dakota / POB 39, Dakota City / 68731
- Dawes / 451 Main St, Chadron / 69337
- Dawson / 700 N Washington Rm A / Lexington / 68850
- Deuel / POB 327, Chappell / 69129
- Dixon / POB 546, Ponca / 68770
- Dodge / 435 N Park Rm102, Fremont / 68025
- Douglas / 225 N 115 St, Omaha / 68154
- Dundy / Box 506, Benkelman / 69021-0506
- Fillmore / POB 307, Geneva / 68361
- Franklin / POB 146, Franklin / 68939
- Frontier / POB 40, Stockville / 69042
- Furnas / POB 387, Beaver City / 68926
- Gage / POB 429, Beatrice / 68310
- Garden / POB 350, Oshkosh / 69154
- Garfield / POB 218, Burwell / 68823-0218
- Gosper / POB 136, Elwood / 68937
- Grant / Box 139, Hyannis / 69350
- Greeley / Box 287, Greeley / 68842
- Hall / 121 S Pine St, Grand Island / 68801
- Hamilton / 1111-13th St Ste 1, Aurora / 68818-2017
- Harlan / Box 698, Alma / 68920-0698
- Hayes / POB 370, Hayes Center / 69032
- Hitchcock / POB 248, Trenton / 69044
- Holt / POB 329, O'Neill / 68763
- Hooker / Box 184, Mullen / 69152
- Howard / POB 25, St Paul / 68873
- Jefferson / 411-4th St, Fairbury / 68352
- Johnson / Box 416, Tecumseh / 68450
- Kearney / POB 339, Minden / 68959
- Keith / 511 N Spruce Ste 102, Ogallala / 69153
- Keya Paha / POB 349, Springview / 68778
- Kimball / 114 E 3rd St Ste 6, Kimball / 69145
- Knox / POB 166, Center / 68724
- Lancaster / 601 N 46th St, Lincoln / 68503
- Lincoln / 301 N Jeffers Rm 101, North Platte / 69101
- Logan / POB 8, Stapleton / 69163
- Loup / POB 187, Taylor / 68879
- Madison / POB 290, Madison / 68748
- McPherson / PO Box 122, Tryon / 69167
- Merrick / POB 27, Central City / 68826
- Morrill / POB 610, Bridgeport / 69336
- Nance / POB 338, Fullerton / 68638
- Nemaha / 1824 N St Ste 201, Auburn / 68305
- Nuckolls / POB 366, Nelson / 68961
- Otoe / POB 249, Nebraska City / 68410
- Pawnee / POB 431, Pawnee City / 68420
- Perkins / POB 156, Grant / 69140
- Phelps / Box 404, Holdrege / 68949
- Pierce / 111 W Court Rm 1, Pierce / 68767
- Platte / PO Box 513, Columbus / 68602-0513
- Polk / POB 276, Osceola / 68651
- Red Willow / 502 Norris Ave, McCook / 69001
- Richardson / 1700 Stone St Room 203 / Falls City / 68355
- Rock / POB 367, Bassett / 68714
- Saline / POB 865, Wilber / 68465
- Sarpy / 501 Olson Dr Ste 4, Papillion / 68046
- Saunders / POB 61, Wahoo / 68066
- Scottsbluff / 1825 10th St, Gering / 69341
- Seward / POB 190, Seward / 68434
- Sheridan / POB 39, Rushville / 69360
- Sherman / POB 456, Loup City / 68853
- Sioux / POB 158, Harrison / 69346
- Stanton / POB 347, Stanton / 68779
- Thayer / 225 N 4th Rm201, Hebron / 68370
- Thomas / POB 226, Thedford / 69166
- Thurston / POB 159, Pender / 68047
- Valley / 125 S 15th St Ste 202 / Ord / 68862
- Washington / POB 466, Blair / 68008
- Wayne / 510 Pearl St Ste 5 / Wayne / 68787
- Webster / POB 250, Red Cloud / 68970
- Wheeler / POB 127, Bartlett / 68622
- York / 510 Lincoln Ave, York / 68467

NEBRASKA VOTER REGISTRATION APPLICATION

1. Are you a citizen of the United States of America? Yes ☐ No ☐
2. Are you at least 18 years of age, or will you be 18 years of age on or before the 1st Tuesday following the 1st Monday in November of this year? Yes ☐ No ☐

If you marked NO to either of the questions above, STOP. Do not complete this application.

Print your full and complete Legal Name to avoid errors and duplicate registrations

First Middle Initial Last Suffix or Previous Last Name

____

Date of Birth (MM/DD/YYYY) ☐/☐/☐ Place of Birth ____________________

Nebraska Driver's License Number ☐☐☐☐☐☐☐☐☐ Last 4 digits SSN, if no Neb. DL# ☐☐☐☐

Registered at: Print your Street Number, Street Name, City, State, Zip

____

Mailing Address, if different: ____________________

Please print your previous registration information *(Providing this information avoids errors and duplicate registrations)*

____________________ / ____________________

Name Address

Important - Party Affiliation - Please Mark One

Democratic ☐ Republican ☐ Libertarian ☐ Nonpartisan ☐

Other ☐ ____________________

If checking other, print the name of the party

Note: If you wish to vote in both partisan and nonpartisan primary elections for the state and local offices, you must indicate a political party affiliation on the registration application. If you register without a political party affiliation (nonpartisan), you will receive only the nonpartisan ballots for the state and local offices at primary elections. If you register without a political party affiliation (nonpartisan), you may vote in partisan primary elections for congressional offices.

Optional - To assist in verifying information, please provide: *Check the box if any are private.*

☐ Phone Number ( ) ____________ ☐ Cell Number ( ) ____________

☐ Email ____________________

Applicant's Oath: To the best of my knowledge and belief, I declare under penalty of election falsification, that: (1) I live in the State of Nebraska at the address provided in this application; (2) I have not been convicted of a felony or, if convicted it has been at least two years since I completed my sentence for the felony, including any parole term; (3) I have not been officially found to be non compos mentis (mentally incompetent); and (4) I am a citizen of the United States.

Applicant's Signature: ____________________ Date: ____________

WARNING: Any registrant who signs this application knowing that any of the information in the application is false shall be guilty of a Class IV felony under section 32-1502 of the statutes of Nebraska. The penalty for a Class IV Felony is up to five years imprisonment, a fine of up to $10,000.00 or both.

Source: **V O T E** Form 07012013

Date Application Received in Election Office: ____________ Registration Taken by: ____________

Nebraska Secretary of State's
Official Voter Registration Application

Instructions for Registering to Vote Using this Application

1. Complete the application only if you check 'yes' to questions 1 and 2.
2. Use this application to register to vote in Nebraska or to update your name, address, or party on your Nebraska voter registration record.
3. Clearly print all the requested information in the designated spaces.
4. Read the oath, verify the information by signing and dating the application.
5. Return the completed form to your county election office.

   By Mail - must be postmarked the 3rd Friday prior to the election. (If you are mailing this application and are a first time registrant in Nebraska, statutes require a copy of a current and valid photo id or other dated personal government document.)

   By personal messenger/agent - must be delivered to your county election office by the 3rd Friday prior to the election.

   In person - must appear at your county election office by 6 p.m. on the 2nd Friday prior to the election.

6. The County Election office will send either:

   An acknowledgment to you verifying the information on your application and advising you of your polling location, or

   An incomplete notice to you requesting additional information to ensure your voter registration record is accurate, or

   A request for valid photo id, or government document if you are a first time registrant in Nebraska, registering by mail.

7. If you have questions, you may contact your local election office, or you may contact the Nebraska Secretary of State by phone at 402-471-2555 or toll free at 888-727-0007; via our website: www.sos.ne.gov; or email SOS.ELECT@nebraska.gov.
8. Mailing addresses for the Nebraska County Election Offices may be found on the back of this application.