



**Ponca Tribe of Nebraska
Behavioral Health**

Business Office Hours and Contact Information

Monday—Friday 8:00 a.m. – 4:30 p.m.

Omaha: (P) 402.738.3167
(Fax) 402.933.0471

Lincoln: (P) 531.248.3030
(Fax): 531.500.44530

Norfolk/Sioux City/Niobrara: (P): 402.371.8834
(Fax): 402.939.0482

Psychiatry: (P): 402.738.3165
(Fax): 402.939.0471

Welcome to the Ponca Tribe of Nebraska! The following information is provided to acquaint you with our department's policies and procedures.

Communication

Ponca Tribe of Nebraska (PTN) does not have on-call coverage and is not a crisis center and may not be immediately available by telephone during regular business hours due to working with clients or other obligations. You can leave a message on confidential voice mail and your call will be returned as soon as possible, within 2 business days. **If you are in crisis, please 1) go to your nearest Emergency Department or 2) Call 911 and ask for assistance.** Your provider will make every attempt to inform you in advance of any planned absence and provide you with the name and phone number of the mental health professional providing coverage.

We use text messaging and secure digital tools to improve communication and to provide access to mental health screening instruments. These tools help us stay connected, remind you of appointments, and allow you to complete assessments conveniently.

Available Services

At PTN, our primary goal is to help our clients improve their overall daily functioning and subjective experience of wellness. We also recognize that it is important to help Native Americans process and resolve intergenerational trauma. We provide individual therapy for children, adolescents, adults, and elders. We offer outpatient substance use therapy which includes individual and group sessions. Psychiatric services and medication assisted treatment for substance use is also offered. Additional services include psychological evaluations, mental status examinations, mental health and substance use evaluations, case management and peer support. All services can be conducted in person or via telehealth.

During your first session you will complete an evaluation, and your provider will be able to offer you some initial impressions of what ongoing therapeutic work might include. Over the next three sessions you and your provider will identify your treatment goals and create an initial treatment plan. Your individual sessions will be scheduled with your individual counselor.

Groups are typically held Tuesdays 10 a.m. - 12 p.m. If you are participating in group, attendance and timeliness is important and expected, unless arrangements have been made with your therapist.

Appointments

Appointments will be 45-50 minutes in duration, typically once per week. The time scheduled for your appointment is assigned to you and you alone. ***We request that if you need to cancel or reschedule an appointment, you provide at least 24-hours' notice by contacting your therapist.*** Your provider will try to find another time to reschedule your appointment. Please note that it may not be possible to be rescheduled within the same week. In addition, you are responsible for coming to your session on time; if you arrive 15 minutes late to your appointment, it will be rescheduled by your individual provider for the next time available.

No Show/Late Cancellation Policy: Your commitment to services is important. We require 24-hours' notice for cancellation and rescheduling appointments. A *No Show* is defined as not arriving for your scheduled appointment and not contacting your provider prior to the appointment. Your appointment will be considered a *no show* if you are 15 minutes late and have not contacted your provider. If you *No Show* for three consecutive appointments, you will receive a letter informing you of your discharge from treatment with your provider. To resume services, you will need to attend a walk-in clinic to re-establish services. When attending walk-in clinics, it is important to note that you may not be scheduled with your previous provider.

A *Late Cancel* is defined as not providing 24-hours' notices for cancellation. If you demonstrate consistent *Late Cancel* appointments, your therapist may move you *Same Day Status (SDS)* or Discharge you from treatment. When on SDS, you will be unable to schedule appointments in advance and will need to call your provider on the day you are hoping to be seen and check if there is availability. Appointments will be offered only if there is an open time slot that day. After 3 maintained appointments while on SDS, your provider can remove you from SDS and you may resume regular scheduling privileges.

Discharge from Treatment

Ending therapy is typically a mutual decision, based on the degree to which your goals have been met. Although you have the right to terminate care at any time, we ask that you let us know this so that we can:

- a) Problem-solve; and,
- b) Understand that you will no longer be in care and provide alternatives if appropriate.

There are times when your therapist may make the decision to terminate your care:

- a) When it becomes reasonably clear that you no longer need the service, are not likely to benefit, or is being harmed by continued service; or,
- b) When lack of communication with your provider and/or treatment non-compliance becomes evident. Treatment non-compliance is defined as no communication with your provider for 30 days and/or 3-show appointments; or,
- c) If your provider were to feel threatened or otherwise endangered by your actions or the actions of another person with whom the client has a relationship.

To the extent that it is appropriate, your therapist will provide pre-termination care and suggest alternative service providers. You will be informed of your discharge verbally when possible and in writing. After discharge, you can resume services by contacting the behavioral health department. Due to high utilization, it is possible that you will be placed on a waiting list to resume services.

Confidentiality

To protect your privacy, all information discussed in the context of our work with you stays within Ponca Tribe of Nebraska and your provider, unless we have your written consent to release information. There are exceptions to this rule, however, which include the following:

- *Staffing with other PTN employees:* Ponca Health Services is an integrated clinic which means that client needs are often staffed with a multidisciplinary team (i.e. medical providers, case managers, therapists, etc.).
- *Safety Concerns:*
 - If we believe that a person who is under the age of 19, over the age of 60, or considered disabled is being harmed. We are legally required to report this to the appropriate state agency.
 - If we believe that you are threatening serious bodily harm to someone else, we are legally required to take steps to protect you and the person at risk.
 - If we believe that you are at risk of harming yourself, we may be obliged to seek additional care, which may mean releasing information without your permission.
- *Legal Proceedings:* In most legal proceedings, you have the right to withhold permission for us to provide any information about your treatment. In some proceedings, a judge may order our testimony via a subpoena.
- *For those involved in substance abuse treatment:* Records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Pts. 160 & 164, and cannot be disclosed without written consent unless otherwise provided for in the regulations. Disclosure may be made to persons within the criminal justice system that have made participation in this program a condition of the disposition of any criminal proceedings against me or of my parole/probation or other release from custody.

Minor children (under the age of 19): Your therapist will provide parents/guardians with general information about treatment status. However, to effectively provide care, children and adolescents need to feel that their privacy is being respected. Therefore, although parents/guardians have a legal right to information, it is our policy to maintain your child's privacy. You will, however, be informed if there is any reason to believe that your child is at serious risk of harming him/herself or others. These issues are taken very seriously and with the intent to maintain everyone's safety. We will make every effort to fully discuss these issues with you before taking any action, to the extent that we're able to do so.

Professional Records

We are required to keep appropriate records of the services provided. Your protected health records are maintained. Your records may consist of scheduled appointments, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis (if applicable), topics discussed, your medical, social, and treatment history, records received from other providers, copies of records sent to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended that you initially review them with your therapist or have them forwarded to another mental health professional to discuss the contents. If your request for access to your records is refused, you have a right to have this decision reviewed by another mental health professional, which will be discussed with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

Client Rights & Responsibilities

As a client of PTN, you have the right to:

- Respectful and non-discriminatory care: Receive considerate, safe, and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, abilities, age, religion, national origin, or source of payment.
- Equal access to services: Disability will not be a factor in your admission if PTN can provide the type of services requested. If PTN cannot provide these services, reasonable steps will be taken to ensure you are referred to an agency that is able to provide the requested care. You will not be denied admission solely because of the number of previous admissions. If PTN cannot meet your needs, you will be referred to an appropriate level of care.
- Participation in your care: Ask questions about any aspect of therapy, including the provider's training and experience. You may request a referral to another therapist and are free to end therapy at any time.
- Confidentiality and privacy: Expect that your records and information shared in therapy will be kept confidential, consistent with legal and ethical requirements.
- Informed consent: Receive clear information about the purpose, risks, benefits, and alternatives of therapy services before agreeing to participate.
- Access to records: Request to review your treatment records, within legal guidelines.
- Grievance process: Have concerns taken seriously and handled with care and respect. If you feel your concerns are not adequately addressed, you are entitled to file a formal grievance. A Client Grievance Form is available at the front desk, and the procedure is outlined in PTN's Client Grievance Policy.

As a client of PTN, you are expected to:

- Provide accurate and complete information relevant to your care.
- Actively participate in your treatment and follow the plan you and your therapist agree upon.
- Treat staff, other clients, and program property with courtesy and respect.
- Keep scheduled appointments or notify PTN promptly if you are unable to attend.
- Ask questions if you do not understand any part of your treatment or your rights.

CONSENT FOR TREATMENT

I _____ (patient name), consent to behavioral health and/or substance abuse evaluation and/or treatment through Ponca Health Services ("PHS") by Behavioral Health providers and staff. I also authorize such treatment or diagnostic studies as, in the judgement of behavioral health staff, may reasonably be necessary to preserve and protect my health and wellbeing.

I am consenting and agreeing only to those services that the Behavioral Health provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the Behavioral Health providers directly supervising the services I receive.

No guarantee is being made to me regarding results of treatment or services. I understand that, if used, there are inherent risks in pharmacologic treatment and that there may be adverse side effects and results that are not anticipated. I consent to be treated with knowledge of possible risks and understand that I will be informed of possible adverse effects when applicable.

Communications between a professionally licensed Behavioral Health provider and a patient are confidential. Confidentiality prohibits the disclosure of information related to the provider-patient relationship without consent from the patient or as authorized or required by applicable law. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164, and Ponca Tr. of Neb. Code tit. XVIII protect my health information from disclosure. In addition, substance use disorder records are protected under federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I have read and agree to the policies and procedures of PHS and its Behavioral Health Program.
I understand that:

- I have the right to revoke this consent at any time by providing written notice to PHS Behavioral Health staff, but, if I do revoke it, it will not have any effect on (1) any actions taken prior to the PHS receiving the revocation or (2) to the extent that action has been taken in reliance on this consent.
- Signing this form is voluntary, but, if I do not sign this form, PHS may not be able to provide me behavioral health and/or substance abuse evaluation and/or treatment.
- Neither PHS nor Behavioral Health providers or staff assume any responsibility or liability, and will not be held responsible or liable for, any services provided to me outside of PHS. If I am referred out of PHS to see a different provider, PHS is not liable for any charges that are billed, except as may be properly authorized pursuant to a valid Purchased/Referred Care authorization.

Signature of Client, Parent or Guardian

Date

Relationship

If I am signing this consent on behalf of minor or incapacitated patient, I declare under penalty of perjury that I have the legal authority and authorization to initiate and consent to treatment on behalf of the patient named above as provided in Ponca Tribe of Nebraska Code § 18-5-3 or § 18-5-5 or pursuant to other applicable law.

CONSENT BY MINORS: Pursuant to Ponca Tribe of Nebraska Code § 18-5-7, a minor who is at least 12 years old may consent to medical care and counseling relating to the diagnosis and treatment of a substance use problem, subject to the requirements and limitations in that Section. In addition, pursuant to Ponca Tribe of Nebraska Code § 18-5-8, a minor who is at least 12 years old may also consent to mental health treatment or counseling if the provider determines the minor is sufficiently mature and if the minor either would present a danger of serious physical or mental harm to self or others without the mental health treatment or counseling, or the minor is the alleged victim of incest, child neglect or abuse, or domestic or family abuse. Pursuant to Ponca Tribe of Nebraska Code § 18-5-9, the parent, guardian, custodian, or other representative of a minor is not entitled to inspect or obtain copies of the minor's patient records or receive information about a minor's counseling when a minor consents to their own medical care or counseling as authorized under the laws of the Tribe. If you are a minor at least 12 years old and believe you meet these conditions, speak to your provider to determine if you can sign this form without a parent, custodian, or guardian.

ACKNOWLEDGMENTS

Patient Rights and Responsibilities

☐ I have read and understand my rights and responsibilities as a client

Client Initials

Citizenship Attestation

☐ I declare under penalty of perjury, under the laws of the United States of America, that I am a citizen of the United States.

Client Initials

AI-Assisted Clinical Documentation

☐ Our providers may use AI-assisted tools within our EHR to help with clinical documentation. These tools support note-taking only and do not replace provider judgment. All information remains protected under privacy laws.

Client Initials

Consent to Text Messaging

By signing below, I consent to receiving text messages from Ponca Behavioral Health for the following purposes:

- Appointment reminders
- Follow-up communications related to services
- Links to screening instruments or assessments

I understand that:

- Standard text messaging rates may apply.
- Text messages are not a secure form of communication and confidentiality cannot be guaranteed.
- I should not use text messaging for emergencies or urgent concerns. Instead, I will call 911 or go to the nearest emergency room.
- My responses will be kept confidential and become part of my health record.
- The results will be reviewed by my provider and used to support my care.
- I may choose not to complete a screening without affecting my eligibility for services.
- I may withdraw my consent at any time by notifying Ponca Behavioral Health in writing.

Client Initials

Appointment Policy

Appointments are 45–50 minutes and require at least 24-hours' notice for cancellation or rescheduling. Missing appointments (No Show) or repeated late cancellations (less than 24-hours) may result in Same Day Status or discharge from services.

- Three consecutive No Shows will result in discharge
- Consistent Late Cancels may result in discharge from treatment or limit your ability to schedule in advance.

I have read and understand the Appointment, No Show, and Late Cancellation policies.

Client Initials



Fred LeRoy Clinic • 2602 J St, Omaha, NE 68107 • (402) 733-1325
Lincoln Clinic • 1600 Windhoek Dr, Lincoln, NE 68512 • (531) 248-3030
Ponca Hills Health & Wellness Clinic • 1800 Syracuse Ave, Norfolk, NE 68701 • (402) 371-8780

HEALTH INFORMATION EXCHANGE CONSENT FORM

Patient's Name	Date of Birth	Chart #	
Address	City	State	Zip

Ponca Health Services ("PHS") participates in one or more health information exchanges ("HIE"). HIEs are a way of allowing your health information to be shared by participating healthcare providers, hospitals, emergency rooms, pharmacies, and labs ("participating providers") through secure, electronic means. The purpose of an HIE is to give each of your participating providers the benefit of having access to all of your health information that is maintained by the participating providers when providing healthcare to you.

You participation in an HIE that PHS uses is voluntary. Your receipt or payment for treatment will not be conditioned on whether or not you participate in the HIE. Even if information is in the HIE, PHS and the HIE may only disclose information in accordance with privacy laws that apply to them, such as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and 42 C.F.R. Part 2, and including, where required, obtaining your consent to re-disclose any protected information.

If you opt-in to participate in HIEs that PHS uses, any participating provider in the HIE or other healthcare provided who is a member of an HIE that is connected to an HIE that PHS uses can electronically access and share your health information through the HIE in the provision of care to you. If you do not opt-in, PHS will not be authorized to provide your health information to any HIE, but it will not affect whether other participating providers you may have provide information to the HIE.

☐ I **opt in** to my health information being shared by PHS through any HIE that PHS participates in. This includes emergency care situations.

By signing this form, I understand and agree:

- I have the right to revoke this authorization at any time by notifying PHS in writing at its address, but, if I do revoke it, it will not have any effect on (1) any actions taken prior to the PHS receiving the revocation or (2) to the extent that action has been taken in reliance on this authorization or (3) any health information participating providers in the HIE already accessed and copied, or (4) if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- If I do not sign this form, my health care, treatment, payment, enrollment, or eligibility for benefits will not be affected.
- My participating providers in the HIE, including PHS, are authorized to disclose my health information to the HIE and share my health information with all participating providers of the HIE that are involved in my care. The HIE may also share my health information with members of other health information exchanges to which the HIE connects who are involved in my care. It may take between 2-5 business days after receipt to process my consent and for the HIE to make my information available for sharing through the HIE.
- My health information that will be shared through the HIE will include health information from both before and after today's date and includes information about my diagnoses, test results (like x-rays or laboratory), and medications that have been prescribed to me. Such information may also include health information that may be considered particularly sensitive to me, including:
 - Mental health information
 - HIV/AIDS information and test results
 - STD treatment and test results
 - Alcohol/drug abuse treatment information
 - Genetic information and test results
 - Family planning information
- Information shared through an HIE may indicate the presence of a communicable or sexually transmitted disease, such as hepatitis, syphilis, gonorrhea, tuberculosis, the human immunodeficiency virus ("HIV"), and Acquired Immune Deficiency Syndrome ("AIDS"). I expressly consent to the release of my health information and history through HIEs even when it indicates the presence of such a disease or condition.
- The purpose of sharing and disclosing my information through the HIE is to give my participating providers the benefit of having access to my health information in order to treat me and provide healthcare to me.
- Participating providers who receive health information about me through the HIE, including PHS, may copy or include my health information into their own records when caring for me. From then, such providers may further disclose such information only in accordance with privacy laws and rules that apply to the provider, such as HIPAA and 42 C.F.R. Part 2.
- Records related to alcohol and drug abuse which are protected under 42 C.F.R. Part 2 cannot be disclosed without my written consent unless otherwise provided for by law. Whenever a participating provider requests records of PHS related to a substance use disorder subject to 42 C.F.R. Part 2 through the HIE, the disclosure must include a notice that re-disclosure is prohibited under federal law, except with my consent or when required by law. In addition, Ponca Tr. of Neb. Code tit. XVIII requires that any disclosure of my health information must include a notice that re-disclosure is prohibited unless expressly authorized by PHS or otherwise required or permitted by applicable law.
- If I previously exercised my right to opt-out of the HIE, I have changed my mind and hereby revoke my prior decision to opt out of my health information being shared by PHS through the HIE.

Tell your provider if you do not understand this authorization, and the provider will explain it to you.

I have read and fully understand the intent and purpose of this authorization and am signing it without reservation.

Signature of Patient/Parent/Guardian

Date

Printed Name of Patient/Parent/Guardian

Relationship to patient (or "Self," if signed by patient)

If I am signing this consent on behalf of minor or incapacitated patient, I declare under penalty of perjury that I have the legal authority and authorization to initiate and consent to treatment on behalf of the patient named above as provided in Ponca Tribe of Nebraska Code § 18-5-5 or pursuant to other applicable law.

FOR HEALTH SERVICES USE ONLY

Date revoked	Staff initials
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Fred LeRoy Clinic • 2602 J St, Omaha, NE 68107 • (402) 733-1325
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AUTHORIZATION FOR TELEMENTAL HEALTH SERVICES

Patient's Name	Date of Birth	Chart #	
Address	City	State	Zip

I consent to participate in telemental health with Ponca Health Services providers as part of my behavioral health services, which may include, but are not limited to, assessment, individual mental health or substance use therapy, medication management, consultation, and psychoeducation. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1. I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2. My provider will assess whether telemental health is clinically appropriate for my needs and my provider may recommend in-person services when necessary.
3. While telemental health offers benefits such as increased accessibility, convenience, and continuity of care, there are risks and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, reduced effectiveness in certain clinical situations, and/or limited ability to respond to emergencies.
4. There will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
5. Privacy laws that protect the confidentiality of my protected health information (PHI) and substance use history also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding). My provider will take reasonable steps to ensure the security and confidentiality of all communications, consistent with applicable privacy laws.
6. If I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
7. During a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at _____ to discuss since we may have to re-schedule.
8. I will not use telemental health in an emergency or other situation that needs immediate attention. If a life-threatening crisis should occur, I will contact 911 or go to the nearest emergency room.
9. My provider may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

Your provider needs to know your location in case of an emergency. You agree to inform your provider of the address where you are at the beginning of each session. Your provider also needs a contact person who they may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my emergency contact person is:

Name	Relationship		
Address	City	State	Zip
Phone Number	Email		

Tell your provider if you do not understand this authorization, and the provider will explain it to you.

I have read the information provided above, discussed it with my provider, and had the opportunity to ask questions about telemental health services. I understand the information contained in this form and the nature, potential risks, and benefits of receiving behavioral health care through this medium. All of my questions have been answered to my satisfaction and I am signing this authorization without reservation.

Signature of Patient/Parent/Guardian

Date

Printed Name of Patient/Parent/Guardian

Relationship to patient (or "Self," if signed by patient)

If I am signing this consent on behalf of minor or incapacitated patient, I declare under penalty of perjury that I have the legal authority and authorization to initiate and consent to treatment on behalf of the patient named above as provided in Ponca Tribe of Nebraska Code § 18-5-3 or § 18-5-5 or pursuant to other applicable law.

FOR HEALTH SERVICES USE ONLY

Date revoked	Staff initials
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