FAMILY SOLUTIONS SERVICES, INC.

Orange City Office: 712-707-9222
1217 Hwy 10 W., PO Box 258

Cherokee Office: 712-707-9222
795 N. 2nd St.

Le Mars Office: 712-707-9222
19 2nd Ave. NW

Sioux City Office: 712-258-4553
2910 Hamilton Blvd. Lower A

CLIENT INFORMATION FORM:

NAME:_____ DATE OF BIRTH:_____AGE:_____

GENDER: □ Male □ Female Gender Identity (Optional):_____ RACE:_____

MARITAL STATUS:_____ LANGUAGE SPOKEN:_____

EMPLOYER: _____

CLIENT CONTACT INFORMATION:

HOME ADDRESS:_____ CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____ CELL PHONE:_____

EMAIL ADDRESS:_____WORK PHONE:_____

LEGAL GUARDIAN ADDRESS:_____CITY:_____STATE:_____ZIP:_____

LEGAL GUARDIAN HOME PHONE:_____CELL PHONE:_____

LEGAL GUARDIAN EMAIL ADDRESS:_____WORK PHONE:_____

PLEASE MARK ALL FORMS OF COMMUNICATION WE MAY USE TO CONTACT YOU OR LEGAL GUARDIAN:

□ TEXT □ EMAIL □ HOME PHONE □ WORK PHONE □ CELL PHONE □ MAIL

MAY WE LEAVE A VOICE MESSAGE: □ YES □ NO

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY:_____

POLICY NUMBER:_____ GROUP NUMBER:_____

POLICY HOLDER NAME:_____ POLICY HOLDER DATE OF BIRTH:_____

POLICY HOLDER ADDRESS (IF DIFFERENT):_____

*SECONDARY INSURANCE COMPANY:_____

POLICY NUMBER:_____GROUP NUMBER:_____

POLICY HOLDER NAME:_____POLICY HOLDER DATE OF BIRTH:_____

POLICY HOLDER ADDRESS (IF DIFFERENT):_____

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HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and also how you can get access to this information. Please review it carefully, and if you have any questions, ask your therapist. If the client is a minor child, in most cases, the child's parent(s)/legal guardian(s) are the personal representatives for a minor child, and can exercise their individual rights on behalf of the child. However, in certain cases, neither parent is considered the personal representative. If the Iowa Department of Human Services, or Human Services from another state, or the courts do not permit parental involvement and access, then a personal representative, legally authorized to make health care decisions on the child's behalf who is in good standing may be involved.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

Your protected health information may be used and disclosed by our agency staff and others outside of our agency that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the agency's practice, and any other use required by law.

1. TREATMENT:

We may use and disclose your protected health information to provide, coordinate or manage your health care and any related services without consent or authorization unless otherwise required by law or in those situations limited in our confidentiality policies and procedures, a copy which will be given to you at time of admission or intake. This includes the coordination or management of your health care with a third party.

2. PAYMENT:

Your protected health information will be used, as needed, to obtain payment from other sources for your health care services.

3. HEALTH CARE OPERATIONS:

We may use or disclose your protected health information without your authorization, in the following situations, including but not limited to:

1) those as required by state and federal law or regulation,
2) public health activities as required by law and rule,
3) Iowa department of human services activities as required by law and rule,
4) health oversight, including monitoring of communicable diseases,
5) reporting abuse, neglect or domestic violence,
6) food and drug administration requirements,
7) as required by judicial and administrative proceedings,
8) law enforcement purposes,
9) purposes related to coroners, medical examiners or funeral directors,
10) during times of serious threat to health or safety,
11) national security activities authorized by law,
12) determining eligibility or conducting enrollment in certain government benefit programs, and
13) when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with HIPAA requirements (Section 164.500).
14) Insurance Functions,

15) Business planning development and Administration,
16) Quality assessment and improvement activities, including case management and care coordination,
17) Competency assurance activities, including provider evaluation, credentialing or accreditation,
18) Conducting or arranging for reviews, audits or legal services, including fraud and abuse detection, and compliance programs
19) Business management and general administrative activities, including but not limited to, de-identifying protected health information, employee review activities, training of student interns, licensing, certification and contracting, and conducting or arranging for other business activities.

4. OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES:

Other permitted and required uses and disclosures will be made only with your authorization or opportunity to object, unless required by law. You may revoke this authorization at any time, in writing, except to the extent that our agency or others outside who are involved in your care have taken an action in reliance on the use or disclosure indicated in the authorization.

5. YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION:

1) You have the right to inspect per our agency's policies and procedures as outlined in the Informed Consent.
2) You have the right to request a restriction or limitation on the use of your protected health information, per our agency's policies and procedures.
3) You have the right to request to receive confidential communication from us by alternative means or at an alternative location.
4) You have the right to obtain a paper copy of this notice from us.
5) You may have the right to request an amendment to records of your protected health information.
6) You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

6. COMPLAINTS:

You will not be retaliated against for filing a complaint. You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Director(s) of Family Solutions Services 1, Inc., Denise Driesen 712-541-0107 or Nichole Hanks at 712-898-1245. You may also file a complaint with the Secretary of Health and Human Services by notifying Health and Human Services at 200 Independence Avenue, SW, Washington, D.C. 20201 or by calling (202) 619-0257 or toll free 1-877-696-6775.

Further information on HIPAA requirements for smaller agencies and related HIPAA information can be found electronically at http://www.hhs.gov/ocr/hipaa/smallbusiness.html

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HIPAA CONSENT SIGNATURE:

The attached *HIPAA Notice of Privacy Practice* form for Family Solutions Services 1, Inc. has been made available to our family and the form has been read. We understand our rights as a client of Family Solutions Services 1, Inc. and have been given a copy of the *HIPAA Notice of Privacy Practice,* if requested.

Signature of Client or Legal Guardian:_____ Date:_____

Witness Signature:_____ Date:_____

This agreement terminates upon termination of services unless otherwise requested in writing by the client or legal guardian.

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Informed Consent for Services

I request Family Solutions Services 1, Inc. provide diagnostic, treatment or other services for: _____.
(Client's Name)

DESCRIPTION OF SERVICES:

The following is a brief explanation of each service that is provided by Family Solutions Services 1, Inc.:

- **Psychotherapy** is a service that assists individuals of all ages who are experiencing problems such as depression, anxiety, difficulty in work/school, marital/family conflict, irritability, anger, difficulty in social/peer relationships, stress, drug/alcohol problems, children at risk. After an initial assessment a plan of treatment is developed jointly by the provider and you (and parent/guardian in the case of a minor). Frequency and duration of services is based upon individual needs. Therapy is provided by a master's level therapist. Intake session lasts 45-60 minutes and ongoing therapy sessions are 25-60 minutes depending on need.

- **Behavioral Health Intervention Services** provides skill development and crisis intervention to children and their families to minimize or eliminate behavioral symptoms associated with a psychological disorder. Skill development targets problem solving, conflict resolution, social skills, effective communication, anger management and interpersonal relationship skills. Services are provided in the home or in the community.

INFORMED CONSENT:

I understand as in the case of medical services, no guarantee can be provided that the concerns or issues for which I am seeking services will be resolved. Because mental health treatment is a cooperative effort between me and my provider, I will work with my provider in a cooperative manner to resolve my concerns.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my concerns.

I understand that confidentiality of records of information collected about me will be held or released in accordance with state and federal laws regarding confidentiality of such records and information, as is outlined in the HIPAA notice provided to me.

I understand that my provider may disclose any and all records pertaining to my treatment if necessary for claims processing, care management, coordination of treatment, quality assurance or utilization of this facility and to the extent necessary to facilitate the provision of administrative and professional services.

I understand that state and local laws require that my provider report all cases in which there exists a danger to self or others.

I understand there may be other circumstances in which the law requires my provider to disclose confidential information and this is outlined in the Privacy Notice provided to me.

I understand my records will be kept for a period of ten years after the last date of services with Family Solutions Services 1, Inc. In the case of minors, records will be kept until the age of 25 or ten years after the last date of service which ever is longer.

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CLIENT RESPONSIBILITIES:

I have read and understand my responsibilities as a client of Family Solutions Services 1, Inc. They are as follows:

1. I understand that it is my responsibility to inform my therapist of any medication I am currently taking, past and present medical/health problems or illness, and any unusual changes in my health.
2. I understand it is my responsibility to keep my appointments and give at least 24 hours of notice if I am not able to keep my appointment. I further understand I may be declined services or be subject to same day scheduling if I have 3 no shows.
3. I understand that I am responsible for any balances my insurance does not pay.
4. I understand it is my responsibility to provide honest and accurate information.
5. I understand that counseling is a cooperative effort between myself and my therapist, and I will work with my therapist to resolve my difficulties.
6. I understand it is my responsibility to follow my treatment plan, established by my therapist and I. I agree to notify my therapist of any changes in condition or circumstance that may affect my treatment plan.
7. I understand I must respect the rights, privacy and property of staff and other clients I may come into contact with in the office.
8. I understand I must refrain from making unreasonable demands on the time and services of Family Solutions Services 1, Inc personnel.

CLIENT RIGHTS:

I have read and understand the basic right of individuals who undergo treatment at Family Solutions Services 1, Inc. These rights include:

1. All clients will receive the same quality of care without regard to race, color, creed, age, sexual orientation, social or economic status, political belief or type of problem.
2. The right to be informed of the various steps and activities involved in receiving services.
3. The right to confidentiality under federal and state laws relating to the receipt of services.
4. The right to humane care and protection from harm, abuse or neglect.
5. The right to make an informed decision whether to accept or refuse treatment.
6. The right to review my records by making an appointment to review the record with the agency director. No notes, photos, videos or other copies of records may be taken without court orders. You may be charged for any copies of records that are disseminated. Psychotherapy notes cannot be amended as they are the therapist's interpretation regarding what was discussed in the session.
7. Family Solutions Services, Inc. will not perform any research without written and informed client consent.
8. The right to file a complaint regarding your care or services. You may file a complaint by contacting the Executive Directors.

TREATMENT OF MINOR CHILDREN

I understand that both parents retain a legal right to receive information about their child unless Family Solutions Services 1, Inc. is presented with legal proof that there is a no-contact order or termination of parental rights. The non-custodial parent has the right to know that their child is being seen for services.

I understand that Family Solutions Services 1, Inc. will bill any amount after third party payment to the person who is signing this agreement and/or the policy holder. I understand it is my responsibility to secure payment for any amount owed by the other parent.

I understand that Family Solutions Services 1, Inc. BHIS and therapy staff are Mandatory Child Abuse Reporters and must report to the Department of Human Services if they suspect physical, sexual, or emotional abuse, denial of critical care, or neglect.

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I understand I have the responsibility to be involved with my child's treatment as recommended by my service provider.

INFORMATION ABOUT MEDICARE AND MEDICAID

I understand if I carry Medicaid insurance, I cannot be charged any out-of-pocket expenses for any services at Family Solutions Services 1, Inc. unless Medicaid is not billed per agreement with the client.

INFORMATION AND AGREEMENT REGARDING PAYMENT & INSURANCE

I understand and agree to the following condition of payment for professional services at Family Solutions Services 1, Inc.:

It is the policy of Family Solutions Services 1, Inc. that payment is made at the time of service. We will accept cash, checks or credit cards. You may make payment when checking in if this is convenient or at the end of your visit. Be sure to stop at the front desk to make payment, schedule your next appointment and address any concerns. If it is after hours, you may call to make arrangements for payment during business hours. It is your responsibility to understand your insurance benefits and you agree that financial obligations to Family Solutions Services 1, Inc. for services provided will be taken care of within a reasonable amount of time.

We will be happy to file your insurance claim. We accept most commercial insurances, Medicare and Medicaid. All patients covered by insurance must bring all policy cards with them to their first appointment. You are responsible for the remaining balance or the whole balance if you fail to provide a valid insurance card.

Clients with financial concerns may discuss options with the billing department, their clinician, or the office manager. To qualify for the sliding fee scale, you will need to produce proof of income and family size. For unpaid balances, we do use a collection agency. The guarantor of the account is responsible for any collection fee charge to collect the debt owed.

If you cannot keep your appointment, we ask for a 24 hour advance notice of cancellations. You may be charged a fee for a NO SHOW, $25 for the first, and $50 for subsequent appointments. Your insurance company does not reimburse for no shows so this will be your responsibility to pay. You must make your payment for missed appointments before your next appointment. Parents/Guardians are responsible for payments incurred by their minor children.

INFORMATION ABOUT CONFIDENTIALITY:

According to state and federal laws, any information you provide to any staff member at Family Solutions Services 1, Inc. is confidential and privileged information and cannot be revealed to others without your written consent. This includes spouse, family, friends, courts, attorneys, employers and law enforcement. However, there are exceptions to full confidentiality. You have been given a Privacy Notice that notifies you of specific confidentiality rules and how information about you may be disclosed.

1. All Family Solutions service providers are mandatory reporters of child abuse and dependent adult abuse, and a report to the Department of Human Services will be made if such abuse is suspected.
2. If a Family Solutions Services 1, Inc.'s service provider believes that a client is in danger of harming self or others, the Family Solutions Services, Inc.'s service provider will act to prevent harm form occurring. Those actions may include providing about the client to others.
3. The parent or legal guardian of a minor has the right to information about services that are provided to the minor, with the exception of substance abuse/use information.
4. Limited information about a client who is diagnosed as having a chronic mental illness may be released to a spouse, parent, adult child or adult sibling if the disclosure is necessary to assist in the client's care or treatment.

5. Periodic reports will be made to the court about the status of clients who are court-ordered to receive services at Family Solutions Services 1, Inc.

6. Family Solutions Services 1, Inc. staff must provide information that is required by a court order. On occasion Family Solutions Services 1, Inc. staff consults with other mental health professionals. During those consultations, the client's identity is not revealed, and those consultants are legally bound to maintain confidentiality with respect to those consultations.
7. During accreditation surveys or reviews, representatives of the Iowa State DHS may check client records for compliance with state standards. Those reviewers are required to keep all client information confidential.

APPEAL/GRIEVANCE PROCEDURE:

All clients who receive service from Family Solutions Services 1, Inc. have the right to express their concerns without fear of restraint, interference, coercion, discrimination, reprisal, or retaliatory action. This principal applies to any person taking part in an appeal representation, either as a witness or employee representative. Any client who feels that he/she has been subject to unfair treatment will have a right to appeal.

It shall be the responsibility of Family Solutions Services 1, Inc.'s executive directors to hear promptly and courteously all appeals registered in good faith by clients of services provided by Family Solutions Services 1, Inc., and to clarify misunderstanding and make reasonable adjustments of complaints. All problems will be settled whenever possible at the lowest level. If you feel the issue is not resolved you may follow the appeal process below.

The appeal process is as follows:

1. In the event of a disagreement between a client and Family Solutions Services 1, Inc., the client should first attempt to discuss the issue directly with his/her service provider.
2. In the event the dispute is unable to be resolved, the client or service provider may present the nature of the dispute either verbally or in writing to the Executive Director of Family Solutions Services 1, Inc. within five working days after the client's discussion with his/her service provider.
3. The Executive Director, within five days, shall then notify the service provider and client that the Executive Director is aware of the dispute.
4. Documentation shall be entered into the client record. Any correspondence generated from the dispute shall be filed in the client record and be a permanent part of the record. The Director shall issue a decision within five working days from the initial receipt of the dispute.
5. In the event the Director is unable to resolve the dispute, the Director shall so state in a memo to both parties within a five-day period.
6. In the event the Director is off duty, the grievance shall be held until her return.

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INFORMED CONSENT SIGNATURE

I have read, reviewed and received a copy of the above information. I understand and agree to abide by the above information for all the services that I receive at Family Solutions Services 1, Inc. My signature below attest to my review, understanding, and acceptance of the information outlined in this Informed Consent to Services. I further understand that if I do not sign this consent, treatment will be denied by the providers at Family Solutions Services, Inc.

Signature of Client or Legal Guardian:_____ Date:_____

Witness Signature:_____ Date:_____

This agreement terminates upon termination of services unless otherwise requested in writing by the client or legal guardian.

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THERAPY APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your therapeutic care to Family Solutions Services, Inc. When you schedule an appointment with Family Solutions Services, Inc., we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible and not later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for appointments. Please see our no show/cancellation policy below:

Any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours** of notice will be considered a No Show and charged a **$25.00 fee**.

Any established patient who fails to show or cancels/reschedules and appointment with no 24 hour notice a **second** time will be charged a **$50.00 fee.**

If a third no show or cancellation/reschedule with no 24 hour notice should occur, the patient may potentially be **dismissed** from Family Solutions Services, Inc.

Any new patient who fails to show for their initial visit they may potentially not be rescheduled and a **$50.00** fee will be charged.

The fee is charged to the patient, not the insurance company, and it is **due at the time of the patient's next office visit or you will be sent a bill.**

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office manager, who may be able to waive the No Show fee. You may contact Family Solutions Services, Inc. to inform us of these circumstances. Should it be after regular business hours Monday-Friday, or on a weekend, you may leave a message.

By signing below, we both agree to these terms and conditions and to the above stated fees.

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Client Signature **Date**

_____ _____
Provider/Therapist Signature **Date**

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1. **PURPOSE:** The purpose of this form is to obtain your consent for a telemental health with your BHIS/CMH/THERAPIST from Family Solutions Services, Inc. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or electronic means between a practitioner and a client who are located in two different locations.
2. I understand 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.
3. I understand that 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, and/or limited ability to respond to emergencies.
4. I understand 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. I understand that 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 a higher level of care is required. I understand that my practitioner may need to contact my emergency contact and/or appropriate authorities in case of an emergency.
6. All laws concerning patient access to medical records and copies of medical records apply to telemental health.
7. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session.

You may withdraw your consent at any time.

Verbal consent given to provide telemental health services for:_____
(Client Name)

on Date:_____ Verbal consent given by:_____
(Client/Parent/Guardian)

Signature of Practioner:_____

Signature of Client/Parent/Guardian:_____