1 - Client Information

Today's Date: _____/_____/20_____

Service Location: Avoca Grinnell Red Oak Thera-LINK School:_____

Full Name (Legal): _____ **Full Name (Preferred):** _____ **Suffix:** _____

Email: _____@_____ **Address:** _____

City: _____ **State:** _____ **Zip Code:** _____ **Cell Phone:** _____

Home Phone: _____ **SSN:** _____ **Birthdate:** _____

Sex: Male Female **Gender Identity:** _____ **Marital Status:** _____

Race: _____ **Ethnicity:** _____ **Student Status:** Full-Time Part-Time

School: _____ **Grade:** _____ **Employment Status:** _____

Employer: _____ **Do you have a Psychiatric Advance Directive?** *If yes, please provide a copy.* Yes No

How did you hear about Healthy Homes Family Services? _____

E-mail appointment reminders are sent 1 day prior. **Preferred E-mail:** _____

Text message appointment reminders are sent 1 day prior. **Preferred Cell**: _____

May we leave you phone messages? Yes No

Associated Parties – Please list any individuals directly connected to the client. i.e. Parent, Guardian, Spouse, Family Members, Special Placement, DHS Worker, FSRP Worker. Please use back of paper for additional information. Please sign a separate release of information for your provider to communicate with others.

Name: _____ **Relationship:** _____ **Email:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Cell Phone: _____ **Home Phone:** _____

Name: _____ **Relationship:** _____ **Email:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Cell Phone: _____ **Home Phone:** _____

Emergency Contact

Name: _____ **Relationship:** _____ **Email:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Cell Phone: _____ **Home Phone:** _____

Office Use Only: ☐ Info Entered into Kasa ☐ Sent Shared Client Release Letter(s) ☐ Upload Intake in Kasa ☐ Created Thera-LINK Profile

Updated 07/2019

2 - Consent to Services

Authorization for Treatment: I authorize the therapist(s) and provider(s), their assistants and/or designees in charge of my care to administer treatment as may be necessary or advisable in my diagnosis and treatment at Healthy Homes Family Services, Inc. facility(s). This authorization includes, but is not limited to routine diagnostic procedures, mediation, waiver services, and behavioral health intervention services. I also authorize copies of the medical records to be released to other providers and health care facilities as deemed necessary by any therapist(s) whose care I am under. I am aware that the practice of behavior health is not an exact science and I acknowledge that no guarantees have been made to me as to results of examination and treatment received. I acknowledge that my care is under the direction of my treating professionals and the facility(s) will follow the instructions of my professionals in the provision of said care.

Client Rights: I, the undersigned, have received a separate document informing me of my rights and responsibilities as a client.

Personal Valuables: Facility(s) shall not be liable for my loss of or damage to any personal property.

Assignment of Facility Benefits: I hereby assign all insurance benefits and/or Medicare/Medicaid benefits to the facility(s) and authorize direct payment to the facility(s). This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. This assignment also includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgement of personal injuries caused by a third party. I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.

Assignment of Professional Benefits: I hereby assign all insurance benefits and/or Medicare/Medicaid benefits to all therapist(s) and/or professionals providing services to me and authorize direct payment to professional(s) and therapist(s). This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. This assignment also includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgement of personal injuries caused by a third party. I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.

Authorized Representative: I hereby authorize facility(s) and its agents and representatives to act on my behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for services provided to me by facility(s).

Statement of Responsibility: I understand that I am financially responsible to the facility(s) as the client, parent, guardian, conservator, or insured for all charges not covered by the above assignments. Charges may include medical insurance deductible, co-payment, co-insurance, and out-of-pocket expenses.

Authorization to Release Information to Insurance Company/Third Party Payer: I hereby authorize facility(s) any authorized healthcare provider, including Veterans Administration or governmental hospital, any insurance company, or any person, institution, or organization to release my medical record to any person, corporation, workers' compensation carrier, governmental agency (or representative thereof) which is, or may be, liable under any contract or governmental program to this facility(s), the client, or a family member for all or part of the facility's charge. This facility(s) will endeavor to protect the confidentiality of my medical records. However, this facility(s) shall not be liable by reason of its release of said medical records or any part thereof when responding in good faith to an apparently valid release.

Non-covered Medicare/Medicaid Services: The Medicare and Medicaid Programs have certain coverage plans that exclude mental health. I acknowledge that I am financially responsible for all charges incurred for services that are not paid for my insurance.

- **PLEASE INITIAL: _____ I have received Healthy Homes Family Services' Notice of Privacy Practices.**
- **PLEASE INITIAL: _____ I have received Healthy Homes Family Services' Client Rights and Responsibilities.**
- **PLEASE INITIAL: _____ I have received Healthy Homes Family Services' Medication Information.**
- **PLEASE INITIAL: _____ I have received Healthy Homes Family Services' Psychiatric Advance Directive Education**

The undersigned certifies that he or she has read the foregoing, is the client, parent, guardian, power of attorney, conservator, or is duly authorized by or on behalf of the parent to execute the above and accept its terms.

Client, Parent, or Power of Attorney Signature	Relationship	Date

Responsible Party's Signature (if not same as client/parent)	Insured's Signature

Witness to Signature	Unable to sign (notate reason)

Updated 07/2019

3 – Service Agreement

Name:_____ **Birthdate:** _____

Insurance Coverage, Payment, Services, and Scheduling:

- Client agrees to contact insurance company to verify mental health benefits. It is the client's responsibility to know and understand benefits provided by one's own specific policy.
- Should a financial dispute arise, it is generally the client's responsibility to clarify and resolve the dispute with the insurance company.
- If insurance is billed for services rendered, any deductible, copay, or co-insurance amounts are due at the time of service.
- Client is aware and understands that their provider may not be credentialed with their specific insurance company but is supervised by credentialed providers in supervisor or management roles.
- Services rendered in the school setting will be billed to the insurance provided and the remainder of the balance will be billed to the home address on file.
- Thera-LINK is a secure, online platform used to provide therapy services via online video. Sessions conducted in Thera-LINK are billed to health insurance or directly to the client. The use of Thera-LINK is at the discretion of the therapist.
- Kasa-Solutions is a third-party billing agency that is contracted to submit claims on behalf of Healthy Homes Family Services.
- If insurance is not being billed for services rendered, payment is expected at the time of services.
- Client agrees to provide **24-hour notice to cancel an appointment** or will be subject to no-show charges.
- Client agrees and understands **no-show charges and policy** as follows:
    - 1st no-show = $50, 2nd no-show = $75, 3rd no-show = $100, Medicaid client no-show fee = $10
- A service requested by the client that is not covered by the client's insurance plan may be arranged under a separate written financial agreement with the provider.
- Phone calls are not billable to insurance. Calls over 10 minutes are billed to the client for time spent on the phone at a pro-rated, hourly rate.
- Appointments are typically scheduled via phone or in person with office staff. E-mail appointments are scheduled at the discretion of the provider.
- All phone calls and e-mails will be responded to within 2 business days.
- Fees are subject to change at the discretion of the agency.
- There is a $35 administration charge for returned checks.

Insurance and Payment Information

Please fill out the following insurance information as accurately and completely as possible. Missing insurance information often leads to denied claims and ultimately results in a bill sent to the client for the full amount for services rendered.

Primary Insurance or MCO: _____ **Birthdate:** _____

Policy #: _____ **Group #:** _____ **Effective Date:** _____

Policy Holder/Relationship: _____ **Birthdate:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Employer:** _____

Deductible: _____ **Co-Pay:** _____ **Co-Insurance:** _____

Healthy Homes Family Services

3 – Service Agreement

Secondary Insurance or MCO: _____ **Birthdate:** _____

Policy #: _____ **Group #:** _____ **Effective Date:** _____

Policy Holder/Relationship: _____ **Birthdate:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Employer:** _____

Deductible: _____ **Co-Pay:** _____ **Co-Insurance:** _____

Employee Assistance Program (EAP)

EAP Company: _____ **Number of Approved Sessions:** _____

Session Authorization Dates: _____ **Employer:** _____

☐ I understand that sessions attended after the allotted EAP session limit is reached or after the EAP authorization has expired will be billed to my private insurance or to myself. I am financially responsible for any and all copays, deductibles, co-insurance, or denied claims.

Cash Pay

Clients may choose to pay cash for services. Payment is due at the time of service. Adjustments to the account may be made after services are rendered and is based on the billing code used by the provider. A discount is given when the full session amount is paid at the time of services. The following is a service pricing list, to include the full session amount and the discounted amount per service: 90791: $230 or $138 in full at time of service, 90837: $175 or $123 in full at time of service, 90834: $130 or $78 in full at time of service, 90847: $205 or $81 in full at time of service

☐ **I choose to pay cash for services.**

☐ **I understand that the discount rate only applies when services are paid for in full at time of service.**

I (the client or authorized signing party) certify that I have read, understand, and agree to the foregoing.

_____ _____

Signature of Client or Responsible Party **Date**

_____ _____

Signature of Witness **Date**

Updated 07/2019

Healthy Homes Family Services

4 – Physical and Nutrition Information

Name: _____ **Birthdate:** _____ **Today's Date:** _____

Primary Care Provider: _____ **Clinic Name:** _____

Phone: _____ **Address:** _____

May we share information regarding your treatment with your Primary Care Provider? Yes No (If yes, sign release)

Reason for visit: _____

_____

Do you have any medical or nutritional concerns? Yes No

Date of last complete physical exam: _____ **Explain your overall general health:** _____

Current Medications – Include prescribed, supplements, and vitamins. Use back of paper if needed

Medication Name	Dose	Prescribing Provider

Allergies: _____

Please rate your pain

Have you received medical care or treatment within the past 12 months? Yes No

Please describe any medical treatment you have received in the past 12 months: _____

_____

_____

Healthy Homes Family Services

4 – Physical and Nutrition Information

Nutritional Screening

Do you have any food allergies?	Yes	No
Have you gained or lost 10 or more pounds in the last 3 months?	Yes	No
Has your appetite or food intake decreased or increased?	Yes	No
Do you have dental problems?	Yes	No
Have you exhibited behaviors that may indicate an eating disorder, such as binge eating or inducing vomiting?	Yes	No
Are you being treated for nutritional or eating issues by another provider?	Yes	No

If you answered Yes to any question above, please explain: _____

_____

Physical Information – Have you or a family member ever had the following:

Heart problems?	Yes	No
Lung disease?	Yes	No
Chest, neck, or jaw pain?	Yes	No
Difficulty with physical exercise (breathing, dizziness, pain/discomfort)?	Yes	No
Muscle, joint, or back issues?	Yes	No
Chronic illness?	Yes	No
Cancer?	Yes	No
Diabetes?	Yes	No
High blood pressure or cholesterol?	Yes	No
Smoke?	Yes	No
Drink alcohol?	Yes	No
Used illegal drugs?	Yes	No
Received substance abuse treatment?	Yes	No

If you answered *Yes* to any question above or have other medical information to report, please explain: _____

_____

_____

_____ _____

Client/Parent/Guardian Signature **Date**

_____ _____

Witness Signature **Date**

Updated 03/2019

5a - Authorization to Release Confidential Information – Primary Care Provider

In the age of integrated healthcare, it is important for healthcare providers to remain in contact regarding care and treatment. Please complete this release of information so collaboration can take place with other healthcare providers regarding care and treatment.

Client Name: _____ **Birthdate:** _____ **Today's Date:** _____

☐ Send Information ☐ Receive or Request Information ☐ Send and Receive Information

☐ *Do Not Send or Receive Information*

Primary Care Organization: _____

Provider Name: _____

Address: _____

Phone: _____ **Fax:** _____

Purpose of Release: ☐ Treatment/Continuation of Care ☐ Insurance ☐ Personal ☐ School/Education ☐ Legal Purposes

☐ Other: _____

Released Information: ☐ Acknowledgement of Referral ☐ Social History ☐ Medical History ☐ Progress Report

☐ Program Planning/Coordination ☐ Psychological Testing Results ☐ Psychiatric Evaluation

☐ Education Testing/History ☐ Prior Psychiatric History ☐ Treatment Plan/Diagnosis

☐ **ALL RECORDS ASSOCIATED WITH TREATMENT** ☐ Other: _____

SPECIFIC AUTHORIZATION TO RELEASE INFORMATION PROTECTED BY STATE AND/OR FEDERAL LAW

I specifically authorize the release of date and information regarding:

☐ Substance Abuse (Alcohol and other Drug Assessment and Treatment Information) ☐ HIV Related Information

Client/Guardian Signature: _____ **Date:** _____

I understand the content and nature of the material I am releasing. I understand that I have a right to inspect the information released and that such inspection will occur in a meeting with my therapist or another mental health professional. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original. **A signed authorization will expire within 12 months of the signature date.** Disclosed information is protected by Federal Law (Federal Regulation 42 CFR Part 2). I understand that I may revoke this authorization by providing a written revocation to the recipient named above and Healthy Homes Family Services, INC. I also understand that any information released prior to the revocation may be used for the purpose(s) listed above.

Client Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

5b - Authorization to Release Confidential Information

Client Name: _____ **Birthdate:** _____ **Today's Date:** _____

☐ Send Information ☐ Receive or Request Information ☐ Send and Receive Information

Name/Facility: _____

Address: _____

Phone: _____ **Fax:** _____

Purpose of Release: ☐ Treatment/Continuation of Care ☐ Insurance ☐ Personal ☐ School/Education ☐ Legal Purposes

☐ Other: _____

Released Information: ☐ Acknowledgement of Referral ☐ Social History ☐ Medical History ☐ Progress Report

☐ Program Planning/Coordination ☐ Psychological Testing Results ☐ Psychiatric Evaluation

☐ Education Testing/History ☐ Prior Psychiatric History ☐ Treatment Plan/Diagnosis

☐ **ALL RECORDS ASSOCIATED WITH TREATMENT** ☐ Other: _____

SPECIFIC AUTHORIZATION TO RELEASE INFORMATION PROTECTED BY STATE AND/OR FEDERAL LAW

I specifically authorize the release of date and information regarding:

☐ Substance Abuse (Alcohol and other Drug Assessment and Treatment Information) ☐ HIV Related Information

Client/Guardian Signature: _____ **Date:** _____

I understand the content and nature of the material I am releasing. I understand that I have a right to inspect the information released and that such inspection will occur in a meeting with my therapist or another mental health professional. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original. **A signed authorization will expire within 12 months of the signature date.** Disclosed information is protected by Federal Law (Federal Regulation 42 CFR Part 2). I understand that I may revoke this authorization by providing a written revocation to the recipient named above and Healthy Homes Family Services, INC. I also understand that any information released prior to the revocation may be used for the purpose(s) listed above.

Client Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

5c - Authorization to Release Confidential Information - Iowa Medicaid

Client Name: _____ **Birthdate:** _____ **Today's Date:** _____

☐ Send Information ☐ Receive or Request Information ☐ Send and Receive Information

☐ **Amerigroup Iowa, Inc.:** 4800 Westown Parkway, West Des Moines, IA 50266 *Phone:* (515) 327-7012 *Fax:* (800) 964-3627

☐ **Iowa Total Care:** 1080 Jordan Creek Parkway, Ste 100 South, West Des Moines, IA 50266
Phone: (833) 404-1061 *Fax:* (833) 257-8327

☐ **Iowa Medicaid Enterprise:** PO Box 36450, Des Moines, IA 50315 *Phone:* (800) 338-7909 *Fax:* (515) 725-1155

Purpose of Release: ☐ Treatment/Continuation of Care ☐ Insurance ☐ Personal ☐ School/Education
☐ Legal Purposes ☐ Other: _____

Released Information: ☐ Acknowledgement of Referral ☐ Social History ☐ Medical History ☐ Progress Report
☐ Program Planning/Coordination ☐ Psychological Testing Results ☐ Psychiatric Evaluation
☐ Education Testing/History ☐ Prior Psychiatric History ☐ Treatment Plan/Diagnosis
☐ **ALL RECORDS ASSOCIATED WITH TREATMENT** ☐ Other: _____

SPECIFIC AUTHORIZATION TO RELEASE INFORMATION PROTECTED BY STATE AND/OR FEDERAL LAW

I specifically authorize the release of date and information regarding:

☐ Substance Abuse (Alcohol and other Drug Assessment and Treatment Information) ☐ HIV Related Information

Client/Guardian Signature: _____ **Date:** _____

I understand the content and nature of the material I am releasing. I understand that I have a right to inspect the information released and that such inspection will occur in a meeting with my therapist or another mental health professional. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original. **A signed authorization will expire within 12 months of the signature date.** Disclosed information is protected by Federal Law (Federal Regulation 42 CFR Part 2). I understand that I may revoke this authorization by providing a written revocation to the recipient named above and Healthy Homes Family Services, INC. I also understand that any information released prior to the revocation may be used for the purpose(s) listed above.

Client Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____