Welcome to Plains Area Mental Health Center

Dear New Client:

We thank you for choosing Plains Area Mental Health Center as your mental/behavioral health provider.

Attached is the registration paperwork that you will need to complete and sign where indicated. Please use dark blue or black ink when completing. Please complete the following:

- Client information form
- Symptom checklist
- Release of Information for applicable parties
- Client Cancellation/No Show Policy Acknowledgment
- Informed Consent for services. In some our office locations, you will electronically sign this form with Front Office Administrative Support Staff.
  - Your electronic signature indicates you acknowledge you have received a copy of the Plains Area Mental Health Informed Consent for Services which provides a Description of Services, Informed Consent about those services; Consumer Rights and Responsibilities, Information and agreements regarding payments and insurance; Notice of Privacy Practices: Information about confidentiality and the Center's Appeal/Grievance Procedures for Consumers. *You may keep the copy of the Welcome Letter, Copy of Informed Consent for Services, Notice of Privacy Practices, and Advance Psychiatric Information included in this packet for your records.*

Please return to Plains Area Mental Health front office registration upon completion. We will also need a copy – front & back – of your insurance card(s).

Full fees effective September 29, 2022 are as follows:

Service	**Rate**	**Type**
Psychiatric Medication Check	$65-$175	In Person or Tele-Health
Existing Patient Psychiatric Evaluation	$225	In Person or Tele-Health
New Patient Psychiatric Evaluation	$220-$375	In Person or Tele-Health
Group Therapy Session	$80	In Person or Tele-Health
Individual Therapy Session	$90-160	In Person or Tele-Health
New Patient Therapy Intake	$225	In Person or Tele-Health
DOT Evaluation	$125	In Person
Psychological Evaluation	$225	In Person
Psychological Testing	$250/hr	In Person
Psychological Test Scoring/Report Writing Supported	$250/hr	After In Person
Community Living	$53/hr	In Person

If needed, you may apply for a Fee Reduction Program! You must complete the Fee Reduction application and provide proof of income in order to qualify. Please contact your local PAMHC office location for more information on our Fee Reduction Program/Request for Scholarship.

Client Information Sheet

CLIENT DEMOGRAPHICS

First Name: ______________________ Middle: ________________ Last Name: ____________________________

Preferred Name: ________________________ DOB: _____/_____/______ SSN# ______________ Gender: _____

Race: __________ Preferred Language: _______________________________ Marital Status: ______________

Home Address: ____

City/State/Zip: ____ Primary Phone: ____________________

Secondary Phone: ____________________ Email Address: ___________________________

Employer/School attending: ___________________________________

Referral Source (were you referred by another provider, if so who? :)___________________________________

EMERGENCY CONTACT

Emergency Contact: _______________________________________ Relationship: _______________________

Emergency Contact Phone Number: _____________________________________

PARENT(S)/LEGAL GUARDIAN(S):

Name: _____________________________________DOB: ___/___/___ Relationship: _______________

SSN#: _______________ Phone #____

Address: _________________________________ City/State/Zip_______________________________

Name: _____________________________________DOB: ___/___/___ Relationship: _______________

SSN#:___________________ Phone #____

Address:_________________________________ City/State/Zip________________________________

INSURANCE INFORMATION:

Primary

Policy Holder Name: ________________________ MI: _______ Last Name: ___________________________

DOB: ____/____/______ SSN#: __________________________ Relationship to Client: __________________

Address: ______________________________City/State/Zip____________________________________

Employer: ___________________________________

Insurance Policy Name/Company: ____

Member ID: ____ Group #: ___________

Secondary

Policy Holder Name: ________________________ MI: _______ Last Name: ___________________________

DOB: ____/____/______ SSN#: __________________________ Relationship to Client: __________________

Address: ______________________________ City/State/Zip____________________________________

Employer: ___________________________________

Insurance Policy Name/Company: ____

Member ID: ____ Group #: ___________

CARE COORDINATION

Please list the following	**Release of Information**	
Primary Care Doctor: ____________________________________	Y	N
Primary Pharmacy: _______________________________________	Y	N
Primary Eye Doctor: ______________________________________	Y	N
Primary Dentist: ____	Y	N
Primary Hospital:____	Y	N
If SUD/DOT related, Please list below the following:		
Probation Officer:____	Y	N
Attorney: ____	Y	N
Courthouse you report to: _________________________________	Y	N
DHS:		
DHS Case Worker (if applicable):____________________________	Y	N

Is anyone besides a Legal Parent/Guardian going to bring and/or make appointments for the client?

YES or NO If yes, who? _______________________________ Relationship:____________________

Name:_______________________________DOB:____________Medicaid ID:___________________ Insurance ID:__________________

PAMHC Symptom Checklist

The goal of Plains Area Mental Health Center is to provide the most appropriate services that we can for your current concern(s). With that in mind, we are asking that you complete this informational form. Please complete the form honestly and if you do not wish to go into detail on any topic, please inform the reviewer that you would like to review those written responses later in treatment. This information is confidential and will be maintained as such in accordance with our Privacy Notice provided to you.

Reason For Seeking Treatment/Requirements:

☐ Dept. of Transportation/Driver's License/O.W.I.** ☐ Substance Abuse Evaluation
☐ Mental Health Evaluation ☐ Therapy/Counseling
☐ Dept. Human Services/Child Welfare Case ☐ Diagnosis/Psychological (testing)
☐ Behavioral Health Intervention Services (BHIS) ☐ One-Time Service/Evaluation
☐ Emergent/Urgent/Crisis ☐ Medication Management/Psychiatric
☐ Care Coordination ☐ Other:

Issues with guardianship, visitation or custody: Yes_________ No_________

If yes, Please Explain:____

Please check the symptoms you are experiencing:

☐ Sleeping—not enough	☐ Concentration problems	☐ Thoughts of suicide
☐ Sleeping—too much	☐ Fidgety/hyperactive	☐ Thoughts about harming self
☐ Appetite or eating problems	☐ Disobedient / discipline issues	☐ Thoughts about harming others
☐ Weight loss or gain	☐ Memory problems	☐ Other odd or troubling thoughts
☐ Sadness, tearfulness	☐ Confusion	☐ Hearing voices/seeing things
☐ Anxiety, nervousness	☐ Anger, hurting others	☐ Alcohol or drug problems
☐ Panicky or panic attacks	☐ Loneliness	☐ Sexual abuse victim
☐ Fearfulness or paranoia	☐ Medical / physical issues	☐ Sexual abuse perpetrator
☐ Guilt or shame	☐ Sexual problems	☐ Physical abuse victim
☐ Grief or loss	☐ Legal concerns	☐ Physical abuse perpetrator
☐ Nightmares	☐ Financial concerns	☐ Emotional abuse victim
☐ Not assertive enough	☐ Court or DHS requires	☐ Emotional abuse perpetrator
☐ Loss of pleasure	☐ Work/school conflict or stress	☐ Physical health problems
☐ Loss of interest	☐ Family conflicts	☐ Housing problems
☐ Poor self-esteem/image	☐ Marital conflict or stress	☐ Other (list)
☐ Stress or tension	☐ Other relationship problems	______________________________
☐ Down/depressed/hopeless		______________________________

Please mark any medical condition(s) you currently have:

☐ Alzheimer's Disease	☐ Eating Disorders	☐ Liver Disease
☐ Anemia	☐ Epilepsy	☐ Low Blood Pressure
☐ Arthritis	☐ Fibromyalgia	☐ Lyme Disease
☐ Asthma	☐ Head Trauma	☐ Muscle Strain
☐ Blood Disorders	☐ Headaches/Migraines	☐ Heart Attack
☐ Bowel Disorders/IBS	☐ Hearing Loss	☐ Pancreatic Disease
☐ Cancer	☐ Hepatitis	☐ Pregnancy
☐ Cardiac (heart)Disease	☐ High Blood Pressure	☐ Sickle Cell Disease
☐ Chronic Fatigue	☐ High Cholesterol	☐ Stroke
☐ Chronic Pain	☐ HIV/AIDS	☐ Transplant
☐ COPD	☐ Hyperthyroidism	☐ Weight Change
☐ Dementia	☐ Hypoglycemia	☐ Vision Problems
☐ Dental Conditions	☐ Hypothyroidism	☐ Receiving palliative care
☐ Pre-Diabetes	☐ Kidney Disease	☐ Receiving hospice care
☐ Diabetes Type 1	☐ Learning Disability	☐ Other (list)
☐ Diabetes Type 2		______________________________
		______________________________

Client Cancellation and No-Show Policy

It is the client's responsibility to notify Plains Area Mental Health of a cancellation at least 24 hours (1 day) in advance of the scheduled appointment. Late cancellations are considered no-shows. Appointments cancelled less than 24 hours (after noon 12pm the day before scheduled appointment) will be considered a no show.

1. First No Show: When a client is scheduled for an appointment but has not arrived within 10 minutes of appointment time this is considered a no show, an attempt will be made to contact client during the time of scheduled appointment to touch base. A first No-Show letter will be mailed out to client.

2. Clinical Services 2nd No Show: Clients that do not show for two consecutive service appointments or three appointments within three consecutive months will be placed on the list for our Motivational Interviewing Group called "Strategies for Success." Client will be notified that individualized appointment scheduling privileges have been discontinued in accordance with the "Appointment Cancellation and No Show" policy. This will be done accordingly when repeated no-shows have occurred. Any future appointments that have been scheduled for that service (i.e., therapy) will be cancelled by the Center.

3. Psychiatric 2nd No Show: Client will be placed on Same Day Scheduling for Psychiatric services. For Same Day Scheduling, the client is welcome to call the day they desire to be seen (aligning to providers schedules), if there is an opening an appointment will be scheduled. If not, client will need to call each day to access an appointment time. Once client has successfully attended two (2) same day medication appointments, the client can be advanced scheduled again.

4. After three or more missed scheduled appointments AND failure to comply with follow up recommendation's client may be discharged from services.

NOTE: *Emergencies arise from time to time and a late cancellation cannot be avoided. The Plains Area Mental Health management team will review emergency situations on a case-by-case basis.*

Please arrive 15 minutes prior to your appointment(s) to complete the check-in process. If you arrive after your scheduled appointment time, you may be asked to reschedule.

I have read and understand the Plains Area Mental Health Client Cancellation and No-Show policy:

Client Name: ____

Client /Legal Guardian Signature: _______________________________________ Date:_________________

PLAINS AREA MENTAL HEALTH, INC.
INFORMED CONSENT FOR SERVICES

I request Plains Area Mental Health, Inc. (herein referred to as Plains Area) provide diagnostic, treatment, or other services for: ______________________________
Consumer's Name

DESCRIPTION OF SERVICES

The following is a brief explanation of each service that is provided by Plains Area:

- **Psychotherapy** is a service that assists individuals of all ages who are experiencing problems such as depression, anxiety/fear, difficulty in work/school, marital or family conflict, mood swings, irritability, anger/aggressiveness, difficulty in social/peer relationships, stress, or children at risk. Following an initial assessment, a plan of treatment is developed jointly by the provider and you (and parent/guardian in the case of a minor). The frequency and duration of treatment varies and will depend on your individual needs. Psychotherapy is provided by master's level mental health professionals. Intake sessions will last 45-60 minutes while ongoing therapy sessions will run 20-60 minutes, depending on need.
- **Substance Use Disorder Psychotherapy** is an IDPH licensed service that is incorporated into psychotherapy for individuals who are experiencing problems related to alcohol, prescription medication, and other illegal substances. Psychotherapists providing this co-occurring service are trained and credentialed in this specialty area. Levels of care provided for both adult and adolescent clients include Level I and Level II services.
- **Psychiatric Evaluation** is a service provided by psychiatrists (MD or DO), Psychiatric Physician Assistants, or Nurse Practitioners to determine diagnosis and /or to determine the benefit(s) of medication therapy. Appointments will last 30-60 minutes, depending on need.
- **Medication Management** is provided by psychiatrists (MD or DO), Psychiatric Physician Assistants, or Nurse Practitioners, and Nurses to prescribe and monitor psychotropic (mental health) medication therapy including side effects or adverse reactions, benefits, and interactions that may occur from use of other medications, substances and medical conditions. Appointments will last 10-45 minutes, depending on need.
- **Telehealth** is a method of delivering behavioral health services using interactive telecommunications. It is provided using a combination of live interactive audio and video where the client and the mental health professional are not in the same location. Telehealth provides access and convenience to clients who would otherwise need to travel a greater distance to access behavioral health services.
- **Emergency Services** are provided 24-hours-a-day, seven-days-a-week. Walk-in emergencies are handled during open business hours. After hour emergencies are handled by the Plains Area on-call system.
    - **The following procedures should be followed to access the Emergency Services:** Call any Plains Area office during office hours or the after-hours number (1-888-546-0730) when the offices are closed. The on-call line is staffed by mental health professionals. In the event they are unable to answer your call immediately, please leave a message and they will return your call. If you do not receive a call back and this is a life-threatening emergency, you should call 911.
- **Psychological Testing Services** provides assessment of intellectual, achievement, skills, abilities, personality and mental status of individuals to aid in their treatment and service planning. Psychological testing can be used to help determine disability status, vocational abilities, fitness for work and surgical procedures, as well as general functioning. It is generally a brief service of 1 to 3 visits of varying lengths.
- **The Outreach Services Program** provides assistance to adults who have a serious mental illness to maximize their potential and live as independently as possible. This program provides assistance and support for community integration, crisis prevention and planning, social skill development, adaptive skill development, linkage to other supports and resources, symptom management, family education and support, building natural supports, evening and weekend recreational opportunities. Includes Community Support Service, Home-Based and Day Habilitation services, Supported Community Living Service, and Drop-In Centers.

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- **Consultation and Education** is provided to individuals and professionals throughout the region in regard to the mental health needs of their families, employees, patients, students, and clients. Educational presentations are available to community organizations, schools, businesses, and the general public upon request.
- **Integrated Health Services** is an added benefit for Medicaid eligible persons to receive coordinated holistic care through a team of professionals including an RN, Care Coordinator, Family Support or Peer Support Specialist. The team will work with you, your primary care doctor, your mental health providers, and others who may be providing care to you to ensure coordination and communication. The team will assist you in accessing other services you may need.
- **Residential Crisis Services** provides short term crisis stabilization services to individuals who are 18 years of age or older, meet mental health crisis criteria and are not in need of inpatient mental health treatment. Each individual will be screened by an Emergency Department physician, local physician, or a psychiatric provider to deem that they are medically stable and in a state of mental health crisis.
- **Certified Community Behavioral Health Clinic (CCBHC)** is a federally funded program to increase access to and improve the quality of mental health, substance use disorder, and physical health care by increasing care coordination and integrated treatment, cultural competency, and use of evidenced based treatments. Certain data elements are collected to inform the CCBHC on gaps in service, areas of needed improvement.
- **Crisis Stabilization Community- Based Services (CSCBS)** provides short term crisis stabilization services to individuals within the community following a mental health crisis for youth aged 18 and under or adults aged 18 or older, meets mental health crisis criteria, and are not in need of inpatient mental health treatment. Each individual will be referred for crisis stabilization community- based services through MCAT. Referrals do not need to be medically cleared to be admitted.
- **Assertive Community Treatment** provides comprehensive and effective community treatment and habilitation services to those individuals who are diagnosed with serious mental illness, experience the most intractable symptoms, and consequently, have the most serious problems living independently in the community. Referrals to the program come from a variety of sources.
- **Mobile Crisis** provides on-stie, in-person intervention for individuals experiencing a mental health crisis. Mobile response services provide crisis response in the individual's home or at locations in the community.
- **Medication-Assisted Treatment (MAT)** is the use of medications, in combination with counseling and therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.

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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 difficulties.
- **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 Privacy 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 I have the right to inspect the mental health records pertaining to my treatment under the supervision of my provider or administration at Plains Area. I have a right to a copy of my record and to an electronic copy of my electronic health records.
- **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** that 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 from the last date of service seven years after the last date of service with Plains Area. In the case of minors, records will be kept until the age of 25 or ten years after the last date of service whichever is longer.
- **I understand** that data may be collected that will be used to inform the agency and federal or state funders of outcome performance measures and direction for quality improvement activities.
- **I understand** that if I choose to receive services using telehealth that there are potential risks that include, but may not be limited to, interruptions, unauthorized access, and technical difficulties. I further understand that I have the right and the clinician has the right to end the session at any time if it is felt the videoconferencing connections are not adequate to perform the service. I also understand that that the laws that protect privacy and confidentiality of health information also apply to the health information obtained in the use of telehealth. I understand that I may choose to withdraw my consent to the use of telehealth at any time and opt for other methods of treatment.
- **I understand** that communicating through email, text messaging, and other technology may not be completely secure. I further understand that Plains Area professionals will not engage in therapeutic or emergency/crisis services using email or text messaging. If I have a mental health emergency or crisis I understand that I need to call the Plains Area Office where I am being seen or if after hours I will call the Emergency On-call number outlined above. Plains Area may engage in limited use of email or text messaging to include but not limited to appointment reminders or to communicate additional resources or education material. I may opt out of receiving communications through email and/or text messaging by contacting Plains Area.
- **I understand** if recommended to substance use disorder services or co-occurring, I will be provided a more information on levels of care, hours of operation, information on HIV, and information on medicated assisted treatment.
- **I understand** my provider may request a urine analysis for purpose of confirmation of prescribed medication along with testing for substances for other than prescribed. If I am taking controlled substances or scheduled II medication, I am required to sign a contract with my provider of acknowledgement and responsibilities.

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TREATMENT OF MINOR CHILDREN

- **I understand** that both parents retain a legal right to receive information about their child unless Plains Area 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.
- **I understand** that Plains Area clinical staff do not engage in custody determinations or give opinions pertaining to custody or visitation arrangements.
- **I understand** that Plains Area will bill any amount due after third party payment to the person who is signing this agreement. I understand it is my responsibility to secure payment for any amount owed by the other parent.
- **I understand** that Plains Area clinical 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.
- **I understand** I have the responsibility to be involved with my child's treatment as recommended by my service provider.

CONSUMER RIGHTS

I have read and had explained to me the basic rights of individuals who undergo treatment at Plains Area.
These rights include:

1. All consumers shall receive the same quality of care without regard to race, color, creed, sex, age, sexual orientation, social or economic status, political belief or type of problem. Language barriers, cultural differences, and cognitive deficits are taken into consideration and provisions are made to facilitate meaningful consumer participation in services.
2. Persons with mental illness, mental retardation, and other developmental disabilities have the same fundamental rights as all persons. Rights can be limited only with the informed consent of the consumer, the consumer's guardian or legal authorities within the following guidelines: the limit is based on an identified individual need; skill training is in place to meet the identified need; periodic evaluation of the limit is conducted to determine the continuing need for the limitation.
3. Individuals in need of any service provided by Plains Area have the right to be provided that service with as little delay as possible.
4. Only information essential to an orderly and productive delivery of service shall be required from an individual or family as a condition for service.
5. Consumers will be required to participate only in procedures that are essential to the delivery of care commensurate with their need(s). Consumers shall be informed of the costs of services offered to them.
6. Consumers shall be provided descriptions of the predominant hazards, which may exist in any unusual treatment procedure. Plains Area will not perform any research without a consumer's written, informed consent.
7. Consumers' identities will be protected unless information must be communicated appropriately as outlined in the Privacy Notice provided to me.
8. Individuals admitted into voluntary outpatient, evaluation or emergency care would not, by any routine or administrative action, be enrolled in any greater level of care without a full explanation or opportunity to participate in such decisions.
9. Consumers shall have the right to refuse any service or method of treatment.
10. Consumers shall have the right to be treated without loss of dignity, individuality, privacy or respect. Consumers shall be addressed in a manner that is appropriate to their chronological age.
11. Consumers will be provided opportunity to participate in the formulation of the plan of treatment and services provided to them by Plains Area.
12. Consumers have the right to have an Advanced Psychiatric Directive and the reasonable expectation that Plains Area will follow the Directive where possible. Consumers must inform Plains Area in advance of this Directive.
13. Consumers shall have the right to receive an understandable explanation of their diagnosis and the services provided, including the procedures involved and the expected results and duration of those procedures and services.
14. Consumers have the right to appeal Plains Area actions or decisions pertaining to decisions made regarding

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their care and services. The Appeal / Grievance Procedure must be adhered to, as outlined in the Appeal/Grievance section below.

15. Consumers have the right to a copy of current treatment plan. Each client will be offered a copy of their treatment plan.

CONSUMER RESPONSIBILITIES

1. **I understand that it is my responsibility** to inform my primary medical doctor of any medications prescribed in the course of my treatment at Plains Area.

2. **I understand that it is my responsibility** to inform Plains Area of any medications I am currently taking, past and present medical/health problems or illness, and any unusual changes in my health condition.

3. **I understand that it is my responsibility** to keep my appointments and give at least 24 hours' notice if I am not able to keep my appointment. I further understand that if I have two no-shows I may be subject to same day scheduling and will not be allowed to make appointments ahead of time. I understand exceeding the two no shows and failing to contact the agency, I will be discharged within 14 days of my last no show. I understand if I am unable to comply with my responsibilities for services, it may lead to discharge of services.

4. **I understand that it is my responsibility** to be honest and provide accurate and complete information about myself.

5. **I understand that it is my responsibility** to understand my problems and the services being provided. If I do not understand my problems and the services being provided, I will discuss this with my provider. I understand the success of the service requires my full cooperation.

6. **I understand that is my responsibility** to follow my plan of treatment, as established by me and my service provider, and inform my provider of any changes in my condition or circumstances that may affect my plan of treatment.

7. **I understand that I am responsible** for the results of my decisions including those that may result when I refuse to follow the plan of treatment and /or the instructions to achieve it.

8. **I understand that it is my responsibility** to respect the rights, privacy, and property of staff and other consumers I may come into contact with while receiving services at Plains Area.

9. **I understand that it is my responsibility** to refrain from making unreasonable demands on the time and services of Plains Area personnel.

10. **I understand that it is my responsibility** to follow the Medication Refill Request Procedure or I may not get the prescription renewed/refilled prior to running out of the medication.

11. **I understand that it is my responsibility** to understand my insurance benefits and agree that financial obligations to Plains Area for services provided will be taken care of quickly. I further understand that payment is due at the time of the service. If I am unable to meet my financial obligations to Plains Area, I can ask for a fee consultation.

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INFORMATION AND AGREEMENTS REGARDING PAYMENT & INSURANCE

I understand and agree to the following conditions of payment for professional services at Plains Area:

1. It is my responsibility to contact or respond to my insurance carrier for any restrictions or requirements. If I fail to do so, I will be responsible for the full fee.
2. I have the right to restrict information disclosed to a health plan. The full fee will be charged to those who have insurance coverage but choose not to file. I will be responsible for paying the full fee at the time of the service.
3. To release information necessary to process claims to a third-party payer. This may include name, age, sex, address, insurance number, consumer number, diagnosis, dates of service, length of service, provider name, type of treatment rendered, and my treatment plan and progress notes, if I choose to have the services billed to my health plan.
4. That if I carry group insurance through my employer, my employer's benefit department may be provided this information.
5. That a psychiatric diagnosis is often required to secure third party reimbursement.
6. That my third-party payer(s) will reimburse Plains Area directly for services rendered and billed.
7. It is my responsibility to complete the scholarship process if I request a fee reduction. I agree to pay the established percentage determined by Plains Area Mental Health.
8. That payment and co-payment is due at time service is provided, unless payment plan has been established.
9. If, in the judgment of the staff of Plains Area, my income information has been reported fraudulently, or if my account becomes delinquent, I understand that the staff of Plains Area has the right to release my name and account information to a private collection agency. I further understand that if I am turned over to collections the full fee for each service will be reinstated and collected upon.
10. That if I fail to make payments under the terms of this agreement, a fee conference with Plains Area staff may be required before further professional services will be provided to the above-named consumer.
11. I will submit a current insurance card and notify staff at Plains Area of any changes in my insurance. I realize I will be charged full fee until current information is provided.
12. It is my responsibility to notify insurance card holder, if other than myself, that their insurance or the insurance card holder will be billed for payment of these services.
13. That if services are supported by third-party payers, those services may be subject to audit by authorized representatives of those payers for purposes of verifying the fact of service and I consent to reviews of services rendered for such purposes. I further understand that such audits will not involve sharing information other than that authorized by state and federal laws as outlined in the Privacy Notice provided to me relating to disclosure of mental health information.
14. That if a Plains Area service provider is subpoenaed or ordered to appear in court by my attorney or the court in relation to the subpoena, the current rate established per hour for all time away from the office will be charged. Providers are not paid for their testimony but are compensated for their time away from their practice at Plains Area. Sliding scale fees do not apply to these charges. I further understand that a fee will be charged to me or my attorney for copying, mailing, or faxing any records in relation to a court order or subpoena. A fee will be charged for any reports/summaries/letters that are produced in relation to a court order or subpoena.
15. A fee may be charged for any reports requested for non-treatment activities including but not limited to Workman's Comp, Disability Determination, and fitness for duty determinations.

INFORMATION ABOUT MEDICARE AND MEDICAID

- I understand Medicare or Medicaid Insurance will not reimburse both a therapy and a psychiatric service provided on the same day.
- I understand if I carry Medicaid insurance, I cannot not be charged any out of pocket expenses for any service at Plains Area.

Financial Arrangements
For your convenience, we offer the following methods of payment. Please check which you prefer.

____Cash
____Personal Check
____Credit Card

Any outstanding balance may be charged to my credit card ____Visa ____MasterCard ____Discover ____American Express

I understand that I will be asked for this credit card information at the time I present for services.

INFORMATION ABOUT CONFIDENTIALITY

According to state and federal laws, any information you provide to any staff member at Plains Area 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. The following are general 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 Plains Area service providers are mandatory reporters of child abuse and dependent adult abuse, and a report to the Department of Human Services (DHS) will be made if such abuse is suspected.
2. If a Plains Area service provider believes that a consumer is in danger of harming self or others, the Plains Area service provider will act to prevent harm from occurring. Those actions may include providing information about the consumer 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, in most cases. Exceptions include cases where releasing information to a parent or legal guardian may cause harm to the minor child and/or it is in the best interest of the child not to release information.
4. Limited information about a consumer 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 consumer's care or treatment, unless the consumer specifically restricts disclosure to a spouse or family member.
5. Periodic reports will be made to the court about the status of consumers who are court-ordered to receive services at Plains Area.
6. Plains Area staff members must provide information that is required by a court order.
7. On occasion, Plains Area providers consult with other mental health professionals. During those consultations, the consumer's identity is not revealed, and those consultants are legally bound to maintain confidentiality with respect to those consultations.
8. During accreditation surveys or reviews, representatives of the Iowa State DHS may check consumer records for compliance with state standards. Those reviewers are required to keep all consumer information confidential.
9. The confidentiality of substance use disorder patient records and information is protected by HIPAA and the regulations on confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, which implement federal statutory provisions, 42 U.S.C. 290dd-3 applicable to alcohol abuse patient records, and 42 U.S.C. 290ee-3 applicable to drug abuse patient records. The confidentiality of problem gambling patient records and information is protected by HIPAA, Iowa Code Chapter 228 and Iowa Code Section 22.7(35).

APPEAL/GRIEVANCE PROCEDURE

All consumers who receive services from Plains Area have the right to express their concerns without fear of restraint, interference, coercion, discrimination, reprisal, or retaliatory action. This principle also applies to any person taking part in an appeal representation, either as a witness or employee representative. Any consumer who feels that he/she has been subject to unfair treatment will have the right to an appeal.

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It shall be the responsibility of Plains Area authorities to hear promptly and courteously all appeals registered in good faith by consumers of services provided by Plains Area, and to clarify misunderstandings 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 consumer and Plains Area, the consumer should first attempt to discuss the issue directly with his or her service provider.
2. In the event the dispute is unable to be resolved, the consumer or service provider may present the nature of the dispute either verbally or in writing to the Executive Director of Plains Area within **five (5)** working days after the consumer's discussion with his or her service provider.
3. The Executive Director, within **five (5)** working days, shall then notify the service provider and consumer that the Executive Director is aware of the dispute.
4. Documentation shall be entered into the consumer record. Any correspondence generated from the dispute shall be filed in the consumer record and be a permanent part of the record. The Director shall issue a decision within **five (5)** 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 memo form to both parties within the five- day period as stated above.
6. In the event the Director is off duty, the grievance shall be held until the Director's return.
7. The grieving party may then elect to present the dispute to the President of the Board of Directors.
8. If the consumer is presenting the complaint, the consumer must sign a release of information allowing Plains Area's clinical staff to discuss the case so that confidentiality is not breached, and the Board Member can understand the issue. If the consumer refuses to sign, the Executive Director's decision will be considered final. The President has **fifteen (15)** working days to respond to the complainant with a decision that shall be in writing.
9. In the event the release is signed, and the President of the Board is in receipt of the dispute, he or she may elect to resolve the decision (as above) or appoint a subcommittee of Board Members to review the dispute. A meeting must take place in **fifteen (15)** working days and decisions must be issued in **five (5)** working days from the date of the hearing in writing with a copy to the consumer and to Plains Area.
10. If the dispute is decided upon by either the President of the Board or a subcommittee of the Board, but is unsatisfactory to either party, the Full Board shall make a ruling on the matter at a regularly scheduled meeting in the form of a majority vote and the decision shall be considered final at that juncture.
11. Board members should inform any consumer of the grievance procedure in the event that a consumer accesses the Board directly, prior to following the grievance procedure. Plains Area staff will educate the consumer about his or her rights as it pertains to the grievance.
12. If the Board member wishes to discuss the case with staff of Plains Area, then, the Board Member (and Plains Area staff, as appropriate) shall have the consumer sign a release before any discussion takes place between a Plains Area staff and a member of the Board. The latter is included to protect the consumer's right to confidentiality. The purpose of including this provision is to avoid a full grievance if possible and attempt informal resolution of any complaint or problem brought forth by a consumer of Plains Area.

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 Plains Area. My signature below and my initials on each page attest to my review, understanding, and acceptance of the information outlined in this Consent to Services.

Signature of Consumer, Custodial: ____________________________ **Date: _______________** **________________________**
Parent or Legal Representative **Signature of Witness**

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Psychiatric Advance Directives

1. **What is a Psychiatric Advance Directive (PAD)?**
   A Psychiatric Advance Directive (PAD) is a legal document allowing a person to direct their healthcare in the event that they become unable to make or communicate healthcare decisions, including mental healthcare.

2. **What are some of the benefits of having a PAD?**
   There are multiple benefits for having a PAD, such as giving additional legal support for your right to choose your own treatment. PADs also provide you with an opportunity to discuss planning and recovery with family, friends, and providers, gives providers who may not know you well information that will help them provide you with better care, allows you to give approval in advance for who can receive/release your medical information, and can put in place legal arrangements for the care of your children, finances, and pets at a time of crisis.

3. **Can I write a legally binding psychiatric advance directive (PAD) in the state of Iowa?**
   Yes, by appointing an agent. Iowa's Durable Power of Attorney for Health Care statute allows you to appoint an agent (called an "Attorney in fact") to make healthcare decisions for you if you become incompetent to make those decisions yourself. "Health care" may include mental health care. A recommended form for this purpose is called a Durable Power of Attorney. The form is not mandatory but is recommended.

4. **Before following my PAD, would my mental health care providers need a court to determine I am not competent to make a certain decision?**
   No. The statute does not specify any particular procedure by which your PAD goes into effect. In practice, your PAD will be followed whenever your providers consider that you are unable to understand or communicate treatment decisions yourself.

5. **Does the statute say anything about when my mental health providers may decline to follow my PAD?**
   Yes. Your provider could decline to follow the Attorney in fact's instructions in an emergency. An "emergency" includes a situation in which a person is considered a danger to him/herself or others.

If you would like more information or have questions please let your provider know.

**Information above obtained from the National Resources Center on Psychiatric Advance Directives: http://www.nrc-pad.org/states/iowa-faq and SAMHSA's webinar: Recovery to Practice – Psychiatric Advance Directives, Siebert and Verna, 2016.*

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.
Please review it carefully.

If you have any questions about this Privacy Notice or want more information, please contact our Privacy Officer at Plains Area Mental Health Inc., 712-546-4624, or in writing at PO Box 70, Le Mars, IA 51031.

Protected Health Information: While receiving care from Plains Area Mental Health Inc., information regarding your medical history, treatment, and payment for your 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 health care or payment for health care. This information is Protected Health Information or 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:

- Provide you with a notice of our legal duties and Plains Area's policies regarding the use and disclosure of your Protected Information;
- Maintain the confidentiality of your Protected Information in accordance with state and federal law;
- Abide by the terms of this notice;
- 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 your Protected Information may be used and disclosed: Generally, your Protected Information will not be disclosed without prior written authorization. However, we may disclose your Protected Information without your consent in the following situations:

You waive your right to confidentiality of mental health records when you assert your mental or emotional condition as a claim or defense.

Treatment Purposes: Mental Health and/or Substance Use Disorder Information may be disclosed for the purpose of providing additional treatment if you have made a written request. Additionally, we may disclose mental health information to other providers of professional services who may be involved in your care. *Examples: We may provide your primary physician a list of medications that have been prescribed to you by Plains Area Mental Health Inc.'s psychiatrist so that your doctor can best treat your medical problems. We may also have contact with your pharmacist in order to get your prescriptions filled correctly. This may also include sharing information with other professionals that are on your treatment team such as a case manager.* 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. We may also contact you to provide information about treatment alternatives or related services that may be of benefit to you.

Certified Community Behavioral Health Clinic: The statute directs the care provided by CCBHCs be "patient-centered." It is expected CCBHCs will offer care that is person-centered and family-centered in accordance with The term "State" is defined in the statute (PAMA § 233(e)(4)) as having "the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.). The requirements of section 2402(a) of the Affordable Care Act (ACA), trauma-informed, and recovery-oriented, and that the integration of physical and behavioral health care will serve the "whole person" rather than simply one disconnected aspect of the individual. The criteria are infused with these expectations and states are encouraged to certify clinics providing care consistent with these principles.

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.

Emergencies: Mental health and Substance Use Disorder information may be disclosed at any time to another facility, physician, or mental health professional in cases of a medical emergency.

Payment and Operations: Plains Area Mental Health contracts with a Clearinghouse for billing and payment operations. Pursuant to an authorization from you to provide a third party payer information for payment purposes we may

release the minimum necessary information that is required for billing through the Clearinghouse. The Clearinghouse must abide by confidentiality and use and disclosure laws as set out in this Notice and any other applicable law and as specified in the Business Associate Agreement. We may disclose information to other Business Associates for Healthcare Operation purposes including our Auditor, Legal Counsel, Medical Director, or any Business Associate that performs services on our behalf. Where possible the information will be de-identified or minimum necessary information will be disclosed. All Business Associates are bound to 42 CFR Part 2 for substance use protected information and must abide by confidentiality and use and disclosure laws as set out in this Notice and any other applicable law as specified by the Business Associate Agreement.

Collections: Information necessary to collect payment on an unsettled account. You will receive special notice prior to us disclosing information to collection agencies.

Research and Health Oversight: While Plains Area Mental Health, Inc. does not engage in research on a regular basis, research projects may be allowed. The policies and procedures concerning research must be adhered to. Mental health information may be disclosed for conducting scientific research and data research, management audits, or program evaluations of Plains Area Mental Health Center. In most cases we will remove any information that can identify you and, persons conducting audits and evaluations are also held to keeping your Protected Information confidential.

Specific authorization by law:
When otherwise specifically required by other states or the federal government by laws that specifically relate to the protection of human health and safety.
When specifically authorized by provisions relating to hospitalization of persons with mental illness.
When specifically authorized by provisions relating to government support of individuals with mental illness.
<u>Child or Dependent Adult Abuse</u>: Plains Area Mental Health 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.
<u>Court Order</u>: Court orders may authorize disclosures.
<u>Commitment</u>: Disclosure may be made to initiate or complete civil commitment proceedings.

Confidentiality of Alcohol and Drug Abuse Records:
Confidentiality of Alcohol and Drug Abuse records maintained by Plains Area Mental Health is protected by Federal law and regulations 42 CFR Part 2. We may not identify that you are a patient or disclose any information identifying you as an alcohol or drug abuser to anyone outside of the agency unless:

- You consent in writing
- The disclosure is required by a court order
- The disclosure is made to medical personal in a medical emergency or to qualified personal for research, audit or program evaluation.

Federal law and regulation does not protect information about:

- A crime committed by you either at Plains Area Mental Health, against any employer of Plains Area Mental Health or about any threat to commit such a crime.
- Any information concerning suspected child abuse or neglect from being reported under state law.

Family members: We may disclose information to family members if you are diagnosed as having a chronic mental illness. The information is limited to a summary of your diagnosis and your prognosis, a list of your medications and your history of the last six months of compliance in taking these medications, and your treatment plan. The family member must be directly involved in your care or monitoring your treatment and this must be verified by the treating physician, mental health professional or someone other than the family member involved in your care. **However, if you are not incapacitated you have the right to agree or object to disclosures to family members.**

Workers Compensation: We may release PHI to comply with laws relating to workers compensation or other similar programs.

Social Security Administration: We may release PHI for eligibility and benefit determinations.

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.

Law enforcement: We may release your PHI to law enforcement, as required by State and Federal law, 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 would 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.

Coroner, Medical Examiners, Funeral Homes: PHI may be released to a coroner or medical examiner in order to identify a deceased person, determine the cause of death, or other duties authorized by law. Protected Information may be released to funeral directors to carry out their duties.

Specialized Government Functions:
- Military and veteran's activities.
- National security and intelligence activities.
- Protective service of the President and others.
- Medical suitability determinations for the Department of State Officials.
- Correctional institutions and law enforcement custodial situations.
- Provisions of public benefits.

Public Health Activities:
- Preventing or controlling disease, injury, or disability.
- Reporting births or deaths.
- Reporting reactions to medications or problems with products.
- Notifying individuals exposed to disease who may be at risk for contracting or spreading the disease.

Your Rights. Federal and state laws grant you certain rights with respect to your Protected Health Information. Specifically you have the right to:
- Receive notice of our policies and procedures used to protect your Protected Information.
- Request that certain uses and disclosures of your PHI be restricted. However, we have the right to refuse your request in certain instances. The request needs to be in writing using a form provided by Plains Area Mental Health, Inc.
- 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 using a form provided by Plains Area Mental Health, Inc.
- Request that your information be amended. We can only amend the information that has been produced by an employee of Plains Area Mental Health, Inc. and may be denied in certain instances. A request for amendment can be done by requesting and completing a form provided by Plains Area Mental Health, Inc.
- Obtain an accounting of certain disclosures by us of your protected information since April 14, 2003. An accounting can be requested by completing a form provided by Plains Area Mental Health, Inc.
- Revoke any prior authorizations for use or disclosure except to the extent the action has already been taken. Revocations can be done by requesting and completing a form provided by Plains Area Mental Health, Inc.
- Request that any communications to you are done by an alternative means or at alternative locations such as a different mailing address or phone number.
- Request an Electronic Copy of Electronic Medical Records.
- Ask that certain uses and disclosures of your PHI be restricted including release to your health plan if the disclosure is for payment or health care operations and the cost of the health care item or service has been 100 % paid by you and not your health plan.
- Receive notice of any unauthorized release of your unsecured PHI.

For More Information or to Contact Us:

For more information, or to receive a copy of this notice please contact the Privacy Officer. Any complaints can be rep reported to the Privacy Officer at Plains Area Mental Health, Inc. You can also report any complaints to the U.S. Secretary of the Department of Health and Human Services. Plains Area Mental Health is obligated by law to refrain from any intimidating or retaliatory acts against any individual for filing a complaint or assisting in the investigation of a complaint.

Contact:
Privacy Officer
PO Box 70 or 712-546-4624
Le Mars, IA 51031

Effective Date:

This notice becomes effective on July 22, 2020. Please note we reserve the right to revise this notice at any time. A current notice of our privacy practices may be obtained

CONSENT TO RELEASE INFORMATION

Plains Area Mental Health Center
180 10th St. SE. Suite 201
P.O. Box 70 Le Mars, Iowa 51031
Phone: 712-546-4624 Fax: 712-546-9395

Client's Legal Name: ______________________________DOB: ______________

By signing this form, I am allowing Plains Area Mental Health Center to RELEASE ☒ or OBTAIN ☒ written and oral information by telephone, fax, electronic data exchange or mail concerning the above named client with the following individual or agency:

PCP: ____ (____)______________
Name of Person and or/ Institution Phone Number

______________________ ______________________ ______________________(____)______________
Address City State Zip Code Fax Number

Check the Information to be disclosed:

- ☐ Psychiatric Evaluation
- ☐ Initial Assessment (CDE)
- ☐ Psychological Evaluation
- ☐ DOT/SUD Evaluation
- ☐ Psychiatric Notes
- ☐ Other: (Please Specify) ______________________________
- ☐ Laboratory Results
- ☐ Billing Information
- ☐ Treatment Plan/ Diagnosis
- ☐ Treatment Summary
- ☐ Discharge Summary
- ☐ Clinical Notes
- ☐ Medication List
- ☐ Social History
- ☐ Appointment Dates
- ☐ All of the above

Please indicate the reason for release:

☒ Continuity of Care ☐ Rehab/Disability ☐ Legal ☐ Insurance ☐ Transferring Care
☐ Other: (Please Specify) ______________

This authorization is voluntary. I understand that I may revoke this consent at any time except to the extent that action has been taking in reliance on it. If I choose to revoke this consent, I must send written notification to: Medical Records, Plains Area Mental Health Center. If I revoke this consent, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Medical Records at the above address. Confidentiality of the information is protected by Federal Law (42-CFR-Part 2) and the code of Iowa Chapter 228. 42 CFR Part 2 prohibits unauthorized disclosure of these records. Part 2 re-disclosure is prohibited, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Part 2 (42 CFR § 2.32).

I understand that Plains Area Mental Health Center may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization, except that a) Plains Area Mental Health Center may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for such research, and b) Plains Area Mental Health Center may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on the provision of authorization for that third party.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

______Substance Abuse ______Mental Health ______HIV-related Information ______Genetic Tests/Info

If I do not revoke consent, this release will expire no more than one year from the date below, or on date specified here:________________

______________________________________ ______________
Client Signature Date

______________________________________ ______________
Parent/Legal Guardian/Representative Signature Relationship to Client Date

______________________________________ ______________
Signature of PAMHC Staff Witness Date

Only clients 18 years of age or older, or legal representative, can authorize release of mental health information.
Only clients, regardless of age, can authorize release of substance abuse information.

CONSENT TO RELEASE INFORMATION

Plains Area Mental Health Center
180 10th St. SE. Suite 201
P.O. Box 70 Le Mars, Iowa 51031
Phone: 712-546-4624 Fax: 712-546-9395

Client's Legal Name: ________________________ DOB: ______________

By signing this form, I am allowing Plains Area Mental Health Center to RELEASE ☒ or OBTAIN ☒ written and oral information by telephone, fax, electronic data exchange or mail concerning the above named client with the following individual or agency:

PHARMACY: ________________________ (____)______________
Name of Person and or/ Institution Phone Number

______________ ______________ ______________(____)______________
Address City State Zip Code Fax Number

Check the Information to be disclosed:

- ☐ Psychiatric Evaluation
- ☐ Initial Assessment (CDE)
- ☐ Psychological Evaluation
- ☐ DOT/SUD Evaluation
- ☐ Psychiatric Notes
- ☐ Laboratory Results
- ☐ Billing Information
- ☐ Treatment Plan/ Diagnosis
- ☐ Treatment Summary
- ☐ Discharge Summary
- ☐ Clinical Notes
- ☐ Medication List
- ☐ Social History
- ☐ Appointment Dates
- ☐ All of the above
- ☐ Other: (Please Specify) ______________________________

Please indicate the reason for release:

☒ Continuity of Care ☐ Rehab/Disability ☐ Legal ☐ Insurance ☐ Transferring Care
☐ Other: (Please Specify) ______________

This authorization is voluntary. I understand that I may revoke this consent at any time except to the extent that action has been taking in reliance on it. If I choose to revoke this consent, I must send written notification to: Medical Records, Plains Area Mental Health Center. If I revoke this consent, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Medical Records at the above address. Confidentiality of the information is protected by Federal Law (42-CFR-Part 2) and the code of Iowa Chapter 228. 42 CFR Part 2 prohibits unauthorized disclosure of these records. Part 2 re-disclosure is prohibited, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Part 2 (42 CFR § 2.32).

I understand that Plains Area Mental Health Center may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization, except that a) Plains Area Mental Health Center may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for such research, and b) Plains Area Mental Health Center may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on the provision of authorization for that third party.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

______Substance Abuse ______Mental Health ______HIV-related Information ______Genetic Tests/Info

If I do not revoke consent, this release will expire no more than one year from the date below, or on date specified here:______________

______________________________ ______________
Client Signature Date

______________________________ ______________
Parent/Legal Guardian/Representative Signature Relationship to Client Date

______________________________ ______________
Signature of PAMHC Staff Witness Date

Only clients 18 years of age or older, or legal representative, can authorize release of mental health information.
Only clients, regardless of age, can authorize release of substance abuse information.

CONSENT TO RELEASE INFORMATION

Plains Area Mental Health Center
180 10th St. SE. Suite 201
P.O. Box 70 Le Mars, Iowa 51031
Phone: 712-546-4624 Fax: 712-546-9395

Client's Legal Name: ______________________________DOB: ______________

By signing this form, I am allowing Plains Area Mental Health Center to RELEASE ☒ or OBTAIN ☒ written and oral information by telephone, fax, electronic data exchange or mail concerning the above named client with the following individual or agency:

VISION: ______________________________ (____)______________
Name of Person and or/ Institution Phone Number

______________ ______________ ______________(____)______________
Address City State Zip Code Fax Number

Check the Information to be disclosed:

- ☐ Psychiatric Evaluation
- ☐ Initial Assessment (CDE)
- ☐ Psychological Evaluation
- ☐ DOT/SUD Evaluation
- ☐ Psychiatric Notes
- ☐ Other: (Please Specify) ______________________________
- ☐ Laboratory Results
- ☐ Billing Information
- ☐ Treatment Plan/ Diagnosis
- ☐ Treatment Summary
- ☐ Discharge Summary
- ☐ Clinical Notes
- ☐ Medication List
- ☐ Social History
- ☐ Appointment Dates
- ☐ All of the above

Please indicate the reason for release:

☒ Continuity of Care ☐ Rehab/Disability ☐ Legal ☐ Insurance ☐ Transferring Care
☐ Other: (Please Specify) ______________

This authorization is voluntary. I understand that I may revoke this consent at any time except to the extent that action has been taking in reliance on it. If I choose to revoke this consent, I must send written notification to: Medical Records, Plains Area Mental Health Center. If I revoke this consent, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Medical Records at the above address. Confidentiality of the information is protected by Federal Law (42-CFR-Part 2) and the code of Iowa Chapter 228. 42 CFR Part 2 prohibits unauthorized disclosure of these records. Part 2 re-disclosure is prohibited, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Part 2 (42 CFR § 2.32).

I understand that Plains Area Mental Health Center may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization, except that a) Plains Area Mental Health Center may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for such research, and b) Plains Area Mental Health Center may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on the provision of authorization for that third party.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

______Substance Abuse ______Mental Health ______HIV-related Information ______Genetic Tests/Info

If I do not revoke consent, this release will expire no more than one year from the date below, or on date specified here:__________________

______________________________ ______________
Client Signature Date

______________________________ ______________
Parent/Legal Guardian/Representative Signature Relationship to Client Date

______________________________ ______________
Signature of PAMHC Staff Witness Date

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Only clients, regardless of age, can authorize release of substance abuse information.

CONSENT TO RELEASE INFORMATION

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180 10th St. SE. Suite 201
P.O. Box 70 Le Mars, Iowa 51031
Phone: 712-546-4624 Fax: 712-546-9395

Client's Legal Name: ______________________________DOB: ______________

By signing this form, I am allowing Plains Area Mental Health Center to RELEASE ☒ or OBTAIN ☒ written and oral information by telephone, fax, electronic data exchange or mail concerning the above named client with the following individual or agency:

DENTIST: ______________________________ (____)______________
Name of Person and or/ Institution Phone Number

______________ ______________ ______________(____)______________
Address City State Zip Code Fax Number

Check the Information to be disclosed:

- ☐ Psychiatric Evaluation
- ☐ Initial Assessment (CDE)
- ☐ Psychological Evaluation
- ☐ DOT/SUD Evaluation
- ☐ Psychiatric Notes
- ☐ Laboratory Results
- ☐ Billing Information
- ☐ Treatment Plan/ Diagnosis
- ☐ Treatment Summary
- ☐ Discharge Summary
- ☐ Clinical Notes
- ☐ Medication List
- ☐ Social History
- ☐ Appointment Dates
- ☐ All of the above
- ☐ Other: (Please Specify) ______________________________

Please indicate the reason for release:

☒ Continuity of Care ☐ Rehab/Disability ☐ Legal ☐ Insurance ☐ Transferring Care
☐ Other: (Please Specify) ______________

This authorization is voluntary. I understand that I may revoke this consent at any time except to the extent that action has been taking in reliance on it. If I choose to revoke this consent, I must send written notification to: Medical Records, Plains Area Mental Health Center. If I revoke this consent, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Medical Records at the above address. Confidentiality of the information is protected by Federal Law (42-CFR-Part 2) and the code of Iowa Chapter 228. 42 CFR Part 2 prohibits unauthorized disclosure of these records. Part 2 re-disclosure is prohibited, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Part 2 (42 CFR § 2.32).

I understand that Plains Area Mental Health Center may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization, except that a) Plains Area Mental Health Center may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for such research, and b) Plains Area Mental Health Center may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on the provision of authorization for that third party.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

______Substance Abuse ______Mental Health ______HIV-related Information ______Genetic Tests/Info

If I do not revoke consent, this release will expire no more than one year from the date below, or on date specified here:______________

______________________________ ______________
Client Signature Date

______________________________ ______________
Parent/Legal Guardian/Representative Signature Relationship to Client Date

______________________________ ______________
Signature of PAMHC Staff Witness Date

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Only clients, regardless of age, can authorize release of substance abuse information.

CONSENT TO RELEASE INFORMATION

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180 10th St. SE. Suite 201
P.O. Box 70 Le Mars, Iowa 51031
Phone: 712-546-4624 Fax: 712-546-9395

Client's Legal Name: ____DOB: ___________________

By signing this form, I am allowing Plains Area Mental Health Center to RELEASE ☒ or OBTAIN ☒ written and oral information by telephone, fax, electronic data exchange or mail concerning the above named client with the following individual or agency:

HOSPITAL:____ (_____)____________________
Name of Person and or/ Institution Phone Number

________________________________ __________________________ ________________________(_____)________________
Address City State Zip Code Fax Number

Check the Information to be disclosed:

- ☐ Psychiatric Evaluation
- ☐ Initial Assessment (CDE)
- ☐ Psychological Evaluation
- ☐ DOT/SUD Evaluation
- ☐ Psychiatric Notes
- ☐ Other: (Please Specify) ____
- ☐ Laboratory Results
- ☐ Billing Information
- ☐ Treatment Plan/ Diagnosis
- ☐ Treatment Summary
- ☐ Discharge Summary
- ☐ Clinical Notes
- ☐ Medication List
- ☐ Social History
- ☐ Appointment Dates
- ☐ All of the above

Please indicate the reason for release:

- ☒ Continuity of Care
- ☐ Rehab/Disability
- ☐ Legal
- ☐ Insurance
- ☐ Transferring Care
- ☐ Other: (Please Specify) ____________________

This authorization is voluntary. I understand that I may revoke this consent at any time except to the extent that action has been taking in reliance on it. If I choose to revoke this consent, I must send written notification to: Medical Records, Plains Area Mental Health Center. If I revoke this consent, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Medical Records at the above address. Confidentiality of the information is protected by Federal Law (42-CFR-Part 2) and the code of Iowa Chapter 228. 42 CFR Part 2 prohibits unauthorized disclosure of these records. Part 2 re-disclosure is prohibited, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Part 2 (42 CFR § 2.32).

I understand that Plains Area Mental Health Center may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization, except that a) Plains Area Mental Health Center may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for such research, and b) Plains Area Mental Health Center may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on the provision of authorization for that third party.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

______Substance Abuse ______Mental Health ______HIV-related Information ______Genetic Tests/Info

If I do not revoke consent, this release will expire no more than one year from the date below, or on date specified here:______________________

____ ________________________
Client Signature Date

____ ________________________
Parent/Legal Guardian/Representative Signature Relationship to Client Date

____ ________________________
Signature of PAMHC Staff Witness Date

Only clients 18 years of age or older, or legal representative, can authorize release of mental health information.
Only clients, regardless of age, can authorize release of substance abuse information.

MAIN OFFICE:
LE MARS
180 10th St. SE, Suite 201
P.O. Box 70 • Le Mars, Iowa 51031-0070
712-546-4624 • 1-800-325-1192
FAX 712-546-9395
www.plainsareamentalhealth.org

AUTHORIZATION FOR RELEASE AND/OR EXCHANGE OF BEHAVIORAL HEALTH INFORMATION
FINANCIAL AND PAYMENT

TO:____
Agency/Third Party Payee

EXPIRATION DATE: I understand that this authorization is effective until the earlier of (i) the termination of all services to Patient,or (ii) if the following is completed:_______________(date on which this authorization expires).

____
Street Address

PHONE NUMBER:___________________________________

____
City, State, Zip Code

FAX NUMBER:_____________________________________

REGARDING: CLIENT NAME: ____ DATE OF BIRTH: ________________________

AUTHORIZE: __Plains Area Mental Health Center________

TO DISCLOSE: Any such information from my medical record as may be necessary for the completion of claims for reimbursement to my insurance company, preferred provider organization, health maintenance organization, utilization review organization or agency. I understand I am authorizing disclosure which includes mental health, and substance use disorder records which are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that the disclosures may include: diagnosis or procedures performed and at the request of the insurance company, preferred provider organization, health maintenance organization, utilization review organization or agency, my complete record may be subject to review.

I am also providing disclosure permission to release any necessary information to Hawkeye Adjustment Services, Sioux City, IA for the purpose of collection if I fail to comply with my payment agreement. Information to be disclosed to the collection agency includes demographic information and outstanding balance. Attempts to collect unpaid insurance deductible or co-pays will be made prior to disclosure to the collection agency.

FAXED information accepted as original.

I understand that that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it, request to revoke authorization must be made in writing as described in Plains Area Mental Health Center's Notice of Privacy Practices. I further understand that I might be denied services if I refuse to consent to a disclosure for the purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I assign all insurance benefits due me to PLAINS AREA MENTAL HEALTH.

Signature of Patient:____ **Date:**_________________

Signature of Parent/Guardian:_____________________________________ **Date:** ________________

Signature of Plains Area Mental Health Staff: ______________________________ **Date:** ________________

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Confidentiality of mental health information is protected by federal and state law, i.e. Chapter 228 of the Iowa Code and federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Prt. 2, and cannot be further disclosed without the written consent to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any substance use disorder patient. Unauthorized disclosure may result in civil damages and criminal penalties.