

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.
- **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.
- **The Senior Care Program** offers comprehensive care for elderly who are experiencing emotional, behavioral, or psychiatric problems of acute or chronic durations, including those that are complicated by medical or neurological problems. Our psychiatric staff works with family members, nursing home staff, and medical personnel to develop comprehensive treatment planning and routine follow-up at nursing home facilities.
- **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, and Supported Community Living Service.
- **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.
- **Trauma-Sensitive Yoga (TSY)** is an [empirically validated](#), adjunctive clinical treatment for complex trauma or chronic, treatment-resistant PTSD. Developed at the Trauma Center in Brookline, Massachusetts, TSY has foundations in both Trauma Theory and Hatha Yoga practice with an emphasis on body-based yoga forms and breathing practices.

## 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 seven years after the last date of service with Plains Area (a Brief Service or Intake and Discharge Summary and this Consent Form will be kept perpetually). In the case of minors, records will be kept until the age of 25 or seven years after the last date of service which ever is longer.

**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 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.

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

## CONSUMER RESPONSIBILITIES

**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.

**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.

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

**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.

**I understand that it 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.

**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.

**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.

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

**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.

**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.

## 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.

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.

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 CPC process if I request a sliding fee. I agree to pay the established percentage determined by the CPC of my county of legal settlement.
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.
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.

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.

<b>Signature:</b>	<b>Date:</b>
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## 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.

## 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.

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.

<b>Signature of Consumer, Custodial:</b> _____ <b>Parent or Legal Representative</b>	<b>Date:</b> _____	_____ <b>Signature of Witness</b>
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