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
- Release of Information for applicable parties
- Please Review the Informed Consent for Services Forms, 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; information about confidentiality and the Center's Appeal/Grievance Procedures for Consumers. You may keep the copy 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 Support Services	$180/Per Month	In Person
Peer Support Services	$120/hr	In Person or Tele-health

If needed, you may apply for Financial Assistance (Fee Reduction & SafetyNet Funding). You must complete the application and provide proof of income in order to qualify. Please contact your local Plains Area Office for more information on our Financial Assistance Program.

CLIENT DEMOGRAPHICS *Please use legal information

First Name: _____Middle Initial: _____

Last Name: _____ Gender: ☐ Male ☐ Female

DOB: _____/_____/_____ Preferred Name: _____

Marital Status: _____ Preferred Language: _____

SSN: _____ Race: _____ Ethnicity: _____

Military Status: _____ Guardianship Status: No Yes

Preferred Contact Method: _____

Living Arrangement: _____ Living Arrangement Name: _____

Physical Address: _____ PO Box _____

City/State/Zip: _____ County: _____

Primary Phone: _____ Portal Phone (must be cell): _____

Portal Email Address: _____

Non-Portal Email Address: _____

Referral Source (Were you referred to us by another provider, if so, who?):_____

Reason for seeking treatment:

☐ Therapy/ Counseling ☐ Medication Management/ Psychiatric

☐ Dept. of Transportation/ Driver's License/ O.W.I** ☐Substance Abuse Evaluation

☐ Court Order ☐ Legal

☐ Dept. of HHS/Child Protective Case

Issues with guardianship, visitation or custody: ☐ YES ☐ NO

EMERGENCY CONTACT

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone Number: _____

Parent(s) (if minor child) or Legal guardian:

Name: _____ DOB: ___/_____/_____ Relationship: _____

SSN #: _____ Phone #: _____

Address: _____

City/State/Zip: _____

Name: _____ DOB: _____ Relationship: _____

SSN #: _____ Phone: _____

Address: _____ City/State/Zip: _____

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

If yes, who? _____ Relationship: _____

Employer/School Attending: _____

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: _____
Address: _____ City/State/Zip: _____
Employer: _____
Insurance Policy Name/Company: _____
Member ID: _____ Group: _____

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: _____
Client's Name

DESCRIPTION OF SERVICES
The following is a brief explanation of each service that is provided by Plains:

- **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. Therapy sessions are available for: individuals, groups, family, couples, etc. and are available for children, adolescents and adults.

- **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. This service may be delivered via telemedicine or in person. This service is available for children, adolescents or adults.

- **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 the use of other medications, substances and medical conditions. Appointments will last 10-45 minutes, depending on need. This service may be delivered via telemedicine or in person. This service is available for children, adolescents or adults.

- **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 on-call system.

    - **The following procedures should be followed to access the Emergency Services:** Call any Plains 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

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functioning. It is generally a brief service of 1 to 3 visits of varying lengths.

- **Community Support Services** 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.

- **Drop in Centers-** The Clubhouse (located in Carroll, IA) and The Meeting Place (located in Le Mars, IA) are safe havens for recreational and social activities geared towards those with a diagnosed persistent mental illness. You don't have to be involved with Plains Center to utilize our Drop-In Centers. A variety of activities are available including crafts, billiards, computers, Internet access, television and areas for group activities. In addition to unstructured socialization and recreation, there are numerous structured activities scheduled throughout the month, such as birthday celebrations, movies, skill-building/problem-solving groups, peer support, art therapy, guest speakers, games, business and planning meetings, crafts, holiday parties and community outings.

- **Consultation and Education** is provided to individuals and professionals throughout the service area specific 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.

- **Crisis Stabilization Residential 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 (ACT)** 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 Assessment Team (MCAT)** 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-client" 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. 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. This may include a report to appropriate law enforcement staff.
- **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. 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, I may be subject to certain risks, including but not limited to technical difficulties, interruptions, and potential unauthorized access. I acknowledge that both I and my clinician have the right to end a session if the videoconferencing connection is inadequate. I am aware that the same laws protecting the privacy and confidentiality of my health information apply to Telehealth services, and that neither I nor the provider may record sessions without written consent. I understand I am responsible for maintaining my own privacy (e.g., using a secure device in a private space), and that Telehealth may not be appropriate for all conditions. My provider will inform me if in-person care is recommended. I have the right to decline or withdraw from Telehealth services at any time without impacting my access to future care, services, or program benefits.
- **I understand** that communicating through email, text messaging, and other technology may not be completely secure. I further understand that Plains 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 Office where I am being seen or if after hours, I will call the Emergency On-call number outlined above. Plains 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.
- **I understand** that recording devices of all types are prohibited on the premises of all Plains offices. No recording of private therapy or consulting sessions is allowed in any form, which includes phone recordings, unless all parties are consenting.
- **I understand** that I cannot bring any weapons into any Plains location, even with a permit to carry.

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- **I understand** no illegal drugs or alcohol will be brought into any Plains location.
- **I understand** if recommended to substance use disorder services or co-occurring, I will be provided more information on levels of care, hours of operation, information on HIV, and information on medicated assisted treatment (MAT).
- **I understand** my provider may request a urine analysis for the purpose of confirmation of prescribed medication along with testing for substances 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.

CLIENT RIGHTS

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

- All clients 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 client participation in services.

- Persons with mental illness, intellectual disability, and other developmental disabilities have the same fundamental rights as all persons. Rights can be limited only with the informed consent of the client, the client'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.

- Individuals in need of any service provided by Plains have the right to be provided with that service with as little delay as possible.

- Only information essential to an orderly and productive delivery of service shall be required from an individual or family as a condition for service.

- Clients will be required to participate only in procedures that are essential to the delivery of care commensurate with their need(s). Clients shall be informed of the costs of services offered to them.

- Clients shall be provided with descriptions of the predominant hazards which may exist in any unusual treatment procedure. Plains will not perform any research without a client's written, informed consent.

- Clients' identities will be protected unless information must be communicated appropriately as outlined in the Privacy Notice provided to me.

- 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.

- Clients shall have the right to refuse any service or method of treatment.

- Clients shall have the right to be treated without loss of dignity, individuality, privacy or respect.

- Clients shall be addressed in a manner that is appropriate to their chronological age.

- Clients will be provided opportunity to participate in the formulation of the plan of treatment and services provided to them by Plains. Clients have the right to a copy of current treatment plan. Each client will be offered a copy of their treatment plan.

- Clients have the right to have an Advanced Psychiatric Directive and the reasonable expectation that Plains will

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follow the directive where possible. Clients must inform Plains in advance of this directive.

- Clients 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.

- Clients have the right to appeal Plains 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.

CLIENT 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.

- **I understand that it is my responsibility** to inform Plains that I am the guardian for the client who is requesting services and to provide Plains with guardianship paperwork that proves I am guardian before services can be received.

- **I understand that it is my responsibility** to attend all scheduled appointments and to provide at least 24 hours' notice if I need to cancel. Cancellations made with less than 24 hours' notice will be considered a no-show. I further understand that after two no-shows, I may be subject to one or both of the following: (1) same-day scheduling for psychiatric appointments and/or (2) completion of the Strategies for Success group before continuing therapy services. During this time, I will not be permitted to schedule appointments in advance. I also understand that three or more missed appointments, combined with failure to follow through on recommended care, may result in discharge from services.

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

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

- **I understand that it is my responsibility** to follow the NO WEAPONS policy. Plains does not allow weapons of any kind on any of our premises and I agree to not carry or bring a weapon of any kind on any Plains premises.

- **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. In general, Plains does not authorize medication refills without a visit with the prescriber.

- **I understand that it is my responsibility** to understand my insurance benefits and agree that financial obligations to

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Plains 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, 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 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 clinical staff do not engage in custody determinations or give opinions pertaining to custody or visitation arrangements.

- **I understand** that Plains 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** Plains clinical staff are Mandatory Child Abuse Reporters and must report to the Department of Health & 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.

- **I understand** that Plains Inc. requires that a parent or legal guardian provide informed consent for the treatment of any individual under the age of 18.

- **I understand** a parent or guardian must be present at the time of the initial appointment to review and sign all required documentation.

- **I understand** for all mental health services (excluding substance use disorder treatment), the parent or legal guardian will be involved in the treatment process, including participation in planning, progress updates, and coordination of care as appropriate.

- **I understand** a parent or guardian must be present at the time of the EVERY psychiatric or medication check appointment.

INFORMATION AND AGREEMENTS REGARDING PAYMENT & INSURANCE

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

- 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.

- 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.

- To release information necessary to process claims to a third-party payer. This may include name, age, sex, address, insurance number, client 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.

- If I carry group insurance through my employer, my employer's benefit department may be provided with this information.

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- A psychiatric diagnosis is often required to secure third party reimbursement.

- That my third-party payer(s) will reimburse Plains directly for services rendered and billed.
- 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.

- That payment and co-payment is due at the time service is provided, unless payment plan has been established.

- If, in the judgment of the staff of Plains, my income information has been reported fraudulently, or if my account becomes delinquent, I understand that the staff of Plains 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.

- That if I fail to make payments under the terms of this agreement, a fee conference with Plains staff may be required before further professional services will be provided to the above-named consumer.

- I will submit a current insurance card and notify staff at Plains of any changes in my insurance. I realize I will be charged a full fee until current information is provided.

- It is my responsibility to notify the insurance card holder, if other than myself, that their insurance or the insurance card holder will be billed for payment of these services.

- 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.

- That if a Plains 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. 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.

- 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 be charged any out-of-pocket expenses for any service at Plains.

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INFORMATION ABOUT CONFIDENTIALITY

According to state and federal laws, any information you provide to any staff member at Plains 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.

- All Plains service providers are mandatory reporters of child abuse and dependent adult abuse, and a report to the Health and Human Service (HHS) will be made if such abuse is suspected.

- If a Plains service provider believes that a client is in danger of harming self or others, the Plains service provider will act to prevent harm from occurring. Those actions may include providing information about the consumer to others.

- 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.

- Limited information about a client who is diagnosed as having a chronic mental illness may be released to a spouse, parent, adult child or adult sibling if the disclosure is necessary to assist in the client's care or treatment, unless the client specifically restricts disclosure to a spouse or family member or if protected 42 CFR Part 2 information.

- Periodic reports will be made to the court about the status of clients who are court-ordered to receive services at Plains.

- Plains staff members must provide information that is required by a court order.

- On occasion, Plains providers consult with other mental health professionals. During those consultations, the client's identity is not revealed, and those consultants are legally bound to maintain confidentiality with respect to those consultations.

- During accreditation surveys or reviews, representatives of the Iowa Health and Human Service (HHS) may check consumer records for compliance with state standards. Those reviewers are required to keep all consumer information confidential.

- The confidentiality of substance use disorder client 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).

- The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) is a law that protects the privacy and security of patient health information anywhere in the United States. In addition, there are other federal and state laws that protect “sensitive health information,” including information relating to HIV/AIDS; behavioral or mental health; developmental disabilities; treatment for substance (alcohol and/or drugs) use disorder; adult or child abuse or neglect; and genetic testing and counseling.

APPEAL/GRIEVANCE PROCEDURE

All clients who receive services from Plains 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

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representation, either as a witness or employee representative. Any client 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 authorities to hear promptly and courteously all appeals registered in good faith by clients of services provided by Plains, 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, the client 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 client or service provider may present the nature of the dispute either verbally or in writing to the Executive Director of Plains within **five (5)** working days after the client's discussion with his or her service provider.

3. The Executive Director, within **five (5)**working days, shall then notify the service provider and client that the Executive Director is aware of the dispute.

4. Documentation shall be entered into the client record. Any correspondence generated from the dispute shall be filed in the clients 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 (5)** 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 client is presenting the complaint, the client must sign a release of information allowing Plains' clinical staff to discuss the case so that confidentiality is not breached, and the Board Member can understand the issue. If the client 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 client and to Plains.

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 client of the grievance procedure in the event that a consumer accesses the Board directly, prior to following the grievance procedure. Plains staff will educate the client 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, then, the Board Member (and Plains staff, as appropriate) shall have the client sign a release before any discussion takes place between a Plains staff and a member of the Board. The latter is included to protect the client's right to confidentiality.
    The purpose of including this provision is to avoid a full grievance if possible and attempt informal resolution of any

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complaint or problem brought forth by a client of Plains.

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. My signature below attest to my review, understanding, and acceptance of the information outlined in this Consent to Services.

_____

Client Signature **Date**

_____

Parent/Legal Guardian Signature (if applicable) **Date**

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PLAINS AREA
Mental Health Center
Helping People Cope with Everyday Living

NOTICE OF PRIVACY PRACTICES

This notice describes how your protected health information (PHI), including substance use disorder (SUD) records, may be used and disclosed and your rights under federal law, including HIPAA and 42 CFR Part 2.

Protected Health Information (PHI) is information that:

- Identifies you, and
- Relates to your past, present, or future physical or mental health, treatment, or payment for services

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 this Privacy Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Maintain the privacy of your health information which is protected information according to HIPAA, 42 CFR Part 2, and other state and federal requirements
- Abide by the terms of this notice;
- Notify you if a breach occurs that may have compromised the privacy or security of your information

Your Rights: Federal and state laws grant you certain rights with respect to your Protected Health Information.

Specifically you have the right to:

- Request and obtain a paper copy of this notice
- Request communications of your health information by alternative means or at alternative locations
- Request to inspect and obtain a copy of your health record; however, if there are grounds for denial after review by your service provider, you will be provided with a an explanation of the decision to deny access.
- Request a restriction on certain uses and disclosures of your information; however, Plains Area Mental Health, Inc is not required to agree to a requested restriction.
- Request an amendment of your protected health information. 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.
- Receive Breach Notification, you will be notified if a breach occurs involving your PHI, including substance use disorder records.
- Revoke your authorization to use or disclose health information except to the extent that: 1) action has already been taken 2) Authorization was obtained as a condition of obtaining health insurance coverage

How your Protected Information may be used and disclosed: We may use and disclose your PHI for treatment, payment, and healthcare operations (TPO) as permitted by law. Certain disclosures, particularly involving SUD records, require your written consent unless otherwise allowed by law. Information disclosed for treatment, payment, and health care operations may be redisclosed in accordance with HIPAA regulations. However, federal law continues to protect substance use disorder records from unauthorized use or disclosure.

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.

Examples of Disclosures for Treatment, Payment, and Health Operations:

We limit uses and disclosures of your information to the minimum necessary to accomplish the intended purpose when required by law.

Treatment Purposes: We may use and disclose your PHI to provide, coordinate, or manage your care. This may include communication with doctors, therapists, pharmacies, case managers, and other providers involved in your care. *Example: 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.*

Payment and Health Care Operations: We may use and disclose your PHI to bill and receive payment for services. This includes sharing information with insurance companies, Medicaid, and billing services. For SUD records, disclosures for payment and operations may occur with your written consent for TPO. We may use and disclose your PHI for operations such as:

- Quality improvement
- Staff training
- Licensing and accreditation

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

Business associates/qualified service organizations: There are some services provided in our organization through contracts with business associates or qualified services organizations. When these services are contracted, we may disclose your health information to our business associate or qualified service organization so they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate or qualified service organization to appropriately safeguard your information.

Other Uses and Disclosures
We may also disclose your information when required or permitted by law, including:

- Medical emergencies
- Public health and safety reporting
- Abuse or neglect reporting
- Court orders or legal proceedings
- Law enforcement purposes
- Workers' compensation and government programs

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.

Research and Health Oversight: While Plains Area Mental Health, Inc. does not engage in research on a regular basis, research projects may be allowed. 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.

Public health: As required by law, we may disclose your health information to public health or legal authorities responsible for preventing or controlling disease, injury, or disability.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Child Custody: 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.

Family members: We may release your health information to family members and those you have authorized. Unless you object, we may disclose health information to family member(s) or legal representative(s) who are involved in your care or involved in payment of your care. If you are unable to agree or object to such a disclosure, our health professionals, using their best judgment, may disclose information if it is determined to be in your best interest as permitted by confidentiality laws, Substance use disorder information will not be disclosed to family members without your consent unless permitted by law (HIPAA and 42 CFR Part 2).

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Court Proceedings: Records, or testimony relaying the content of such records, shall not be used or disclosed in any civil, administrative, criminal, or legislative proceedings against you unless based on your specific written consent or a court order. Records shall only be used or disclosed based on a court order after notice and an opportunity to hear is provided to you (the client) and/or the holder of the record, where required by 42 USC§290dd-2 and 42 CFR Part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other similar legal mandate compelling disclosure before the record is used or disclosed. If you were mandated to treatment through the criminal legal system (including drug court, probation, or parole) and you sign a consent authorizing disclosures to elements of the criminal legal system such as the court, probation officers, parole officers, prosecutors, or other law enforcement, your right to revoke consent may be more limited and should be clearly explained on the consent you sign

For More Information or to Contact Us: For more information, or to receive a copy of this notice please contact the Privacy Officer. You may file a complaint regarding violations of your privacy rights, including protections related to SUD confidentiality under 42 CFR Part 2 to the Privacy Officer at Plains Area Mental Health, Inc. or U.S. Department of Health and Human Services, Office for Civil Rights. You will not be penalized or retaliated against for filing a complaint.

Contact:
Privacy Officer
PO Box 70 or 712-546-4624 Le Mars, IA 51031
Effective Date: 02/16/2026
Please note that we reserve the right to revise this Notice at any time. A current copy of our Notice of Privacy Practices is available upon request at any time.

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.*

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 [x] or OBTAIN [x] written and oral information by telephone, fax, electronic data exchange or mail concerning the above named client with the following individual or agency:

_____ (____)_____
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:

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
- [ ] 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:

- [x] Continuity of Care
- [ ] Rehab/Disability
- [ ] Legal
- [ ] Insurance
- [ ] Transferring Care
- [ ] Other: (Please Specify) _____

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_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian/Representative Signature Relationship to Client Date

_____ _____
Signature of PAMHC Staff Witness Date

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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 [X] or OBTAIN [X] 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:

- [X] Continuity of Care
- [ ] Rehab/Disability
- [ ] Legal
- [ ] Insurance
- [ ] Transferring Care
- [ ] Other: (Please Specify) _____

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Client Signature Date

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_____ _____
Signature of PAMHC Staff Witness Date

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Client's Legal Name: _____ DOB: _____

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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
- [ ] 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:

- [X] Continuity of Care
- [ ] Rehab/Disability
- [ ] Legal
- [ ] Insurance
- [ ] Transferring Care
- [ ] Other: (Please Specify) _____

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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

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