



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.

DESCRIPTION OF SERVICES

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

- **Crisis Services:** Our Crisis services can be accessed 24-hours-a-day, seven-days-a-week. We provide immediate help when an individual is experiencing a mental health crisis, offering rapid crisis screening, assessment, and stabilization. The Mobile Crisis Team can be deployed when necessary to provide a face-to-face crisis screening/intervention. Additionally, more intensive Crisis Services are available when needed, offering in person, daily sessions with a mental health professional, and connection to medication, counseling, and peer support services as well as linkage to ongoing services within the community. Crisis Line: 1-888-546-0730
- **Psychiatric Services:** Psychiatric Services are provided by Psychiatrists, Physicians Assistants, and/or Nurse Practitioners. Comprehensive outpatient psychiatric care is provided to children and adults. The Psychiatrist/PA/ARNP diagnose and treat psychiatric disorders. Psychiatric services are completed for the purpose of assessing symptoms, needs, abilities, disabilities, and history, diagnosing illness, and determining treatment and follow-up service needs. Ongoing treatment is provided through medication management in order to monitor medication effects and side effects.
- **Outpatient Mental Health Services:** Outpatient Therapy services focus on alleviating specific mental health challenges, enhancing overall functioning, and preventing development of more serious or more disruptive challenges for the individual and for those involved in their care. Outpatient therapy services are available for: individuals (children, adolescents, and adults), groups, family, couples, etc. All therapists are licensed or eligible to be licensed in their discipline. Based on a comprehensive assessment and social history, the therapist and individual(s) develop a mutually agreed upon plan for treatment to facilitate goal achievement. The therapy process is individualized and based on the resources, abilities, and limitations of the individual(s) receiving their service. The frequency and duration of treatment varies and will depend on your individual needs. In addition to individual therapy, outpatient services are also provided in family and/or group modalities.
- **Outpatient Substance Use Disorder Services:** 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. SUD psychotherapy services focus on alleviating specific substance abuse/ dependency problems, enhancing overall functioning and preventing development of more services or disruptive problems for the individual and their families. Therapists 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. Plains Area Mental Health also provides DOT evaluations for individuals who have received an OWI/DUI charge.
- **Psychological Testing Services:** Psychological testing services provide 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.
- **Community Services:** Community Services provide assistance to individuals who have a serious mental illness to maximize their potential and live as independently as possible. These programs provide 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, and building natural supports. Services include Community Support Services, Home-Based and Day Habilitation services, Peer Support services, and Peer Wellness Centers.

- **Peer Wellness 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 other Plains Center services to utilize our Centers. A variety of activities are available including crafts, games, computer and Internet access, television, and group activities. In addition to unstructured socialization and recreation, there are numerous structured activities scheduled throughout the month, such as movies, skill-building/problem-solving groups, art and crafts, guest speakers, games, 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.
- **Turning Point - Crisis Stabilization Residential Services:** Turning Point 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. Turning Point is a 8 bed facility offering short-term supervised care for up to 5 days along with daily therapy and skill building.
- **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.
- **Medication-Assisted Treatment (MAT):** 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.

Safeguarding the Rights of Individuals Served Rights and Responsibilities

Plains Area Mental Health recognizes that its primary responsibility is to promote and protect the mental well-being of the individuals it serves. Employees are committed to providing services that respect and support each individual's autonomy, privacy, dignity, self-esteem, and active participation in treatment. Care is delivered with consideration for language barriers, cultural differences, and cognitive limitations, and appropriate accommodations are made to ensure each individual can meaningfully participate in their care and treatment.

Individual Rights include:

- The right to be treated with respect and dignity, regardless of health status, sex, race, color, religion, national origin, age, marital status, sexual orientation, arrest or conviction record.
- The right to receive services based on their individual needs, circumstances, preferences, and treatment goals.
- The right to receive quality services and to have the quality and appropriateness of their care monitored and assured.
- The right to consistent enforcement of program rules and expectations.

- The right to consent or decline services.
- The right to refuse any service, treatment, or medication, unless mandated by law or court order. Consequences of refusal will be discussed with the individual and may include discharge from services.
- The right to receive services in a setting where no force, threats, or pressure are used, and where autonomy, respect, and self-determination are protected.
- The right to have their views considered in the making of decisions which affect them.
- The right to have those who are legally responsible for their welfare be fully informed about the nature of services/actions to be provided and their outcome in order that they may have choices regarding their participation and/or their children's participation.
- The right to be informed about the purpose of the services they are receiving.
- The right to be informed of the benefits, risks, side effects, and alternatives to services.
- The right to speak with Crisis Staff, over the phone, regardless of age or other demographic without guardian consent; however, consent to treat by client or parent/ guardian of a minor is required for mobile crisis calls.
- The right for a minor, over the age of 12, to consent to Substance Use treatment without parent/guardian consent.
- The right to 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 consent.
- The right to receive services without non-clinically determined delays.
- The right to be served in the least restrictive setting.
- The right to express opinions, lodge complaints, and express grievances about the services received and to appeal agency actions, including alleged civil rights violations, verbally or by completing the Individual Appeal Form without risk of interference or retaliation.
- The right to have access to their client records, and to have their records protected from an invasion of privacy. To have information held confidential unless consent is given in written form by signing a release, a court order is issued to Plains Area Mental Health, disclosure is made to medical personnel in a medical emergency, or qualified person for research, audit, or program evaluation.
- The right to have an Advanced Psychiatric Directive and the reasonable expectation that Plains Area Mental Health will follow the directive where possible. Clients must inform Plains of this directive.

INDIVIDUAL RESPONSIBILITIES

Individual responsibilities include:

- Individuals will inform their primary medical provider of any medications prescribed as part of their treatment at Plains Area Mental Health.
- Individuals will inform Plains Area Mental Health if they are the legal guardian of an individual requesting services and provide documentation verifying guardianship before services are initiated.
- Individuals will attend all scheduled appointments and provide at least 24 hours' notice if they need to cancel. Appointments canceled with less than 24 hours' notice will be considered a no-show. After two no-shows, individuals 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, advance scheduling of appointments may not be available. Three or more missed appointments, combined with failure to follow recommended treatment, may result in discharge from services.
- Individuals will provide honest, accurate, and complete information about their health, including current medications, past and present medical or behavioral health conditions, and any significant changes in their health status.

- Individuals will ask questions if they do not understand their diagnosis, treatment recommendations, or the services being provided and will actively participate in their care to support successful treatment outcomes.
- Individuals will participate in developing and following their treatment plan in collaboration with their provider and will inform their provider of any changes in their condition or circumstances that may affect their treatment.
- Individuals will accept responsibility for the outcomes of their healthcare decisions, including decisions to decline recommended treatment or not follow the agreed-upon treatment plan.
- Individuals will respect the rights, privacy, dignity, and property of staff and other individuals receiving services at Plains Area Mental Health.
- Individuals shall be mindful and respectful of other clients accessing services as well as Plains staff: no use of profanity or vulgarity in public areas, no physical violence or threats of physical violence or intimidation, and no vandalizing or destroying Plains Area Mental Health property.
- Individuals will comply with the No Weapons Policy. Weapons of any kind are prohibited on all Plains Area Mental Health property. In addition, no drugs or alcohol are permitted on Plains Area Mental Health property.
- Individuals will check with pharmacy regarding refills before contacting Plains Area Mental Health.
- Individuals will understand their insurance coverage and benefits and will fulfill any financial responsibilities for services received, including applicable copayments, deductibles, coinsurance, and charges not covered by insurance.
- Individuals will promptly notify Plains Area Mental Health of any changes to their insurance coverage, address, telephone number, or other information necessary to support continuity of care and accurate billing.

TREATMENT OF MINOR CHILDREN

- I understand that both parents retain the legal right to receive information regarding their child's treatment unless Plains is provided with legal documentation establishing a no-contact order or termination of parental rights. The non-custodial parent has the right to be informed that their child is receiving services.
- I understand that Plains clinical staff do not make custody determinations or provide opinions regarding custody, visitation, or parenting-time arrangements.
- I understand that Plains will bill the individual signing this agreement for any balance remaining after third-party insurance or other payment. I am responsible for securing payment from the other parent for any portion of the balance that parent has agreed to pay.
- I understand that Plains clinical staff are Mandatory Child Abuse Reporters and are required to report suspected physical, sexual, or emotional abuse, denial of critical care, or neglect to the Department of Health & Human Services.
- I understand that I am responsible for participating in my child's treatment as recommended by the treating service provider.
- I understand that Plains Area Mental Health requires informed consent from a parent or legal guardian before providing treatment to an individual under the age of 18.
- I understand that a parent or legal guardian must be present at the initial appointment to review and sign all required documentation.
- I understand that, for all mental health services, excluding substance use disorder treatment, a parent or legal guardian will be involved in the treatment process as appropriate, including treatment planning, receiving progress updates, and coordinating care.
- I understand that a parent or legal guardian must be present at every psychiatric or medication-management 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.
- 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.
- 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.
- 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.

Psychiatric Advance Directives

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.

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.

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.

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.

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 on Psychiatric Advance Directives obtained from the National Resources Center on Psychiatric Advance Directives: <http://www.nrcpad.org/states/iowafaq> and SAMHSA's webinar: Recovery to Practice – Psychiatric Advance Directives, Siebert and Verna, 2016.

Individual Appeals Process

Clients have the right to express concerns, file complaints or grievances, and appeal decisions regarding their care or services without fear of retaliation, discrimination, coercion, interference, or other adverse action. This protection also applies to individuals who participate in an appeal on behalf of a client.

Plains will review concerns promptly and respectfully, make reasonable efforts to resolve complaints, and address issues at the lowest appropriate level whenever possible. If a concern is not resolved, the client may follow the formal appeal process outlined below.

The appeal process is as follows:

- When an individual verbally presents a complaint or appeal to an employee of Plains Area Mental Health:
 - The employee will suggest the individual first speak directly with the employee involved with the concern to resolve the matter
 - If the individual is uncomfortable addressing the staff person directly, the individual will be directed to talk to the employee's supervisor or the Vice President of the Department.
- If the individual is dissatisfied with the results of #2, or wishes to pursue the matter further, they will be given an Individual Appeal Form.
 - If they need assistance with completing the form, the CEO, or whom the CEO designates, will assist with doing so
 - The CEO, or whom the CEO designates, will write all pertinent information or allow the individual to write their concerns
- Within 10 days the CEO, or whom the CEO designates, shall investigate the complaint and respond in writing to the individual
- If dissatisfied with the recommendations, the individual will be informed he/she may submit a written complaint or request to the Executive Committee of the Board of Directors
 - The Executive Committee will review the complaint, ensure the appeals process was followed, and make their recommendations to the Board of Directors at the next scheduled meeting of the full Board for decision.
 - A response from the Board President will be written and delivered to the individual within 45 days of receipt of the written complaint/appeal.
 - The decision of the Board of Directors shall be final.
- If you believe that your civil rights have been violated, you may also choose to file a complaint with the Office of Civil Rights at the link below:
 - <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

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 we are unable to agree to a requested restriction
- Notify you if a breach occurs that may have compromised the privacy or security of your information
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our policies, terms, and conditions and to make the new provision effective for all protected health information we maintain at our sole discretion. Should our information practices change, we will post notice of this along with the revised policy in our reception areas and will supply you with the revised policy upon request. We will not use or disclose your health information without your authorization, except as described in this notice.

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 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 complet-

ing 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 health-care operations (TPO) as permitted by law. Certain disclosures, particularly involving SUD records, require your written consent (federal law 42 CFR Part 2) unless otherwise allowed by law. Information disclosed to covered entities or business associates for treatment, payment, and health care operations may be re-disclosed in accordance with HIPAA regulations except for civil, criminal, or legislative proceedings.

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 confidentiality 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

CCBHC: Plains Area Mental Health is part of The Certified Community Behavioral Health Clinic project (CCBHC), funded by the Substance Abuse and Mental Health Services Administration, this is a model that provides a number of integrated services to improve access to quality mental health and substance abuse treatment. De-identified information regarding your service utilization may be reported to federal monitors to assess and improve community behavioral health outcomes, protected under standard federal privacy rules. Your participation in this specialized program is completely voluntary. You may revoke your participation in writing at any point. Choosing not to participate or withdrawing later will not affect your right to standard care at this facility.

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: 09/16/2026

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.

**Plains Area Mental Health
Consent to Treat and Payment of Services**

Client Name: _____ Date of Birth: _____

Fee Rates, Financial Assistance, and Insurance: For the services I receive at Plains Area Mental Health, I understand and agree that I will be billed the current full fee rate. If I have insurance, my insurance company will be billed full fee. The Board of Directors has approved a sliding fee scale based upon my gross income, should I choose to apply for financial assistance through fee reduction or SafetyNet, I will be charged at the current full fee rate (100%) until the financial assistance application has approved or denied. Payment is expected at the time services are rendered. I understand that fees not paid after 90 days may be sent to collections if no alternative payment agreement has been made.

I understand that if services are supported by third party, these services may be subject to audit by authorized representatives of those payers for verification purposes. I authorize payment of health benefits otherwise payable to me, directly to Plains Area Mental Health, and I consent to reviews of services rendered for such purposes. Plains Area Mental Health has agreed to bill third party payers, such as insurance, upon being provided current and accurate billing information. This Signature on File is valid for all third-party payers, such as insurance, involved in collecting monies for services rendered. I agree to provide Plains Area Mental Health with accurate and current insurance information. I also understand that Plains Area Mental Health cannot guarantee (insurance) third party payment.

Quality of Service: Members of Plains Area Mental Health governing board and the State of Iowa have established standards of quality for services provided by Plains Area Mental Health. It is their intent that the staff of Plains Area Mental Health be fully trained and competent health professionals. Because behavioral health treatment/services is a cooperative effort between my service provider and me, I will work with my service provider to resolve my difficulties. If I feel the staff is not providing the type or quality of services needed, I will first talk to the staff person involved. The staff member will try to resolve my concern and explain the process for further action if I am not satisfied. If I feel unable to discuss the matter with the staff person, I have the right to contact the staff's supervisor or the Chief Compliance Officer, who will then fully investigate.

Crisis Services: Crisis services provide a focused assessment and rapid stabilization of acute symptoms of mental illness or emotional distress and are available and accessible to individuals on a 24-hour basis by calling 1-888-546-0730. Additionally, the 988 Suicide & Crisis Lifeline is available 24/7 for individuals facing mental health struggles, emotional distress, alcohol or drug use concerns, or just need someone to talk to. 988 can be anonymous, if desired.

Permission to Provide Behavioral Health Services

I understand that by signing below I am consenting for Plains Area Mental Health to provide diagnostic and treatment services, or both

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, as outlined in the Privacy Notice provided to me.

- **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.
- **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 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 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. 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. Emails and texts should not be used if you need to speak with someone immediately due to a mental health crisis. In those events, you can always call 1-888-546-0730 or 988 which is available 24 hours a day, 7 days a week. Plains will treat Electronic Communication with the same degree of privacy and confidentiality of written medical records. I may opt out of receiving communications through email and/or text messaging by contacting Plains.
- **I understand** Plains may use secure, HIPAA-compliant technology, including artificial intelligence tools, to assist with documentation and care coordination. No clinical decisions will be made from the use of artificial intelligence.
- **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.
- **I understand** that I cannot bring any weapons into any Plains location, even with a permit to carry.
- **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.
- **I understand** that assistance is available if I have difficulty reading or understanding these materials and that I may ask questions or request clarification at any time. I may contact the Plains Area Mental Health Center Privacy Officer with questions or concerns regarding my privacy rights or the Notice of Privacy Practices.

By signing below, I acknowledge that I have completed the registration process and understand that my treatment will begin when I meet with my behavioral health service provider.

Client/Legal Representative Signature: _____ Date: _____

Client/Legal Representative Printed Name: _____

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.

Name: _____

Health Questionnaire:

DOB: _____

PAST/PRESENT MEDICAL HISTORY (select all that apply).

- | | |
|---|--|
| ☐ Asthma | ☐ Kidney Disease |
| ☐ Cancer | ☐ Lipid Disorder (High Cholesterol) |
| ☐ Cardiovascular Disease (heart disease) | ☐ Liver Disease |
| ☐ Chronic Pain | ☐ Memory Disorders (Alzheimer's/dementia) |
| ☐ CNS Degenerative Disease | ☐ Currently Pregnant |
| ☐ Diabetes | ☐ COPD |
| ☐ Eating Disorder | ☐ Seizure Disorder |
| ☐ Gastrointestinal Disorders | ☐ Thyroid Disease |
| ☐ Hepatitis | ☐ Tuberculosis |
| ☐ History of Head Injury | ☐ Other not listed condition _____ |
| ☐ HIV/AIDS | ☐ No Medical Conditions |
| ☐ Currently receiving Hospice Care | |
| ☐ Hypertension | |

PREVENTATIVE CARE/SCREENINGS (check any that you have completed and the approximate date if known).

- | | |
|--|--|
| ☐ Blood Sugar or A1C Blood Test _____ | ☐ Vision Exam _____ |
| ☐ Cholesterol or Lipid Blood Test _____ | ☐ Bone Density Screening _____ |
| ☐ Abdominal Aortic Aneurysm Screening _____ | ☐ Colonoscopy _____ |
| ☐ Pap Smear/Cervical Cancer Screening _____ | ☐ Screening for Sexually Transmitted Infections _____ |
| ☐ Mammogram _____ | ☐ HIV Testing _____ |
| ☐ Genetic Testing for Cancer _____ | ☐ Screening for Viral Hepatitis _____ |
| ☐ Skin Cancer Screening _____ | ☐ TB Test (tuberculosis) _____ |
| ☐ Dental Exam _____ | |

Have you seen a medical provider in the last 12 months? ☐ Yes | ☐ No

If yes, indicate name of clinic _____

Have you seen a mental health provider in the last 12 months ☐ Yes | ☐ No

If yes, indicate name of clinic _____

Have you been hospitalized or used an emergency room in the past 12 months? ☐ Yes | ☐ No

If yes, indicate name of hospital _____

MEDICATIONS: List all prescribed and over-the-counter medications include the DRUG NAME, DOSE & DIRECTIONS, REASON FOR TAKING.

What PHARMACY did you last fill medications at? _____

ALLERGIES/ DRUG REACTIONS: LIST ANY FOOD OR ENVIRONMENTAL ALLERGIES AND PAST DRUG/ MEDICINE REACTIONS.

HEALTH HABITS AND PERSONAL SAFETY. Select any that apply to you.

- ☐ Current Tobacco Use
- ☐ Sexually active with multiple partners
- ☐ Current use of street drugs with a needle/IV

What is your current height _____ and weight _____



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:

Insurance:

Name of Person and or/ Institution

(_____) _____

Phone Number

Address

City

State

Zip Code

(_____) _____

Fax Number

Check the Information to be disclosed:

- | | | |
|---|--|--|
| ☐ Psychiatric Evaluation | ☐ Laboratory Results | ☐ Clinical Notes |
| ☐ Initial Assessment (CDE) | ☐ Billing Information | ☐ Medication List |
| ☐ Psychological Evaluation | ☐ Treatment Plan/ Diagnosis | ☐ Social History |
| ☐ DOT/SUD Evaluation | ☐ Treatment Summary | ☐ Appointment Dates |
| ☐ Psychiatric Notes | ☐ Discharge Summary | ☐ All of the above |
| ☒ Other: (Please Specify) <u>any pertinent information necessary for payment/ Insurance claims/ billing including Mental Health and SUD</u> | | |

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 (HIPAA, 42 CFR § 2, and 45 CFR § 164) and the code of Iowa Chapter 228. 42 CFR Part 2 prohibits unauthorized use or disclosure of these records. Part 2 redisclosure is prohibited, unless further disclosure is expressly permitted with the client's written consent, except as permitted by 42 CFR Part 2, HIPAA, and applicable state laws. I understand that If HIPAA covered entities and business associates receive these records for treatment, payment, and health care operations purposes, the records may be redisclosed in accordance with HIPAA, except for uses or disclosures for civil, criminal, administrative, or legislative proceedings against me.

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 one year from the date signed below, or on date/event 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
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) _____

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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 one year from the date signed below, or on date/event 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 | ☐ Laboratory Results | ☐ Clinical Notes |
| ☐ Initial Assessment (CDE) | ☐ Billing Information | ☐ Medication List |
| ☐ Psychological Evaluation | ☐ Treatment Plan/ Diagnosis | ☐ Social History |
| ☐ DOT/SUD Evaluation | ☐ Treatment Summary | ☐ Appointment Dates |
| ☐ Psychiatric Notes | ☐ Discharge Summary | ☐ 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) _____

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_____ Substance Abuse _____ Mental Health _____ HIV-related Information _____ Genetic Tests/Info

If I do not revoke consent, this release will expire one year from the date signed below, or on date/event 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

Plains Area Mental Health Center

180 10th St. SE. Suite 201

P.O. Box 70 Le Mars, Iowa 51031

Phone: 712-546-4624

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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 | ☐ Laboratory Results | ☐ Clinical Notes |
| ☐ Initial Assessment (CDE) | ☐ Billing Information | ☐ Medication List |
| ☐ Psychological Evaluation | ☐ Treatment Plan/ Diagnosis | ☐ Social History |
| ☐ DOT/SUD Evaluation | ☐ Treatment Summary | ☐ Appointment Dates |
| ☐ Psychiatric Notes | ☐ Discharge Summary | ☐ 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) _____

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If I do not revoke consent, this release will expire one year from the date signed below, or on date/event 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.