COUNSELING ASSOCIATES OF CENTRAL IOWA, PC

CHILD/ADOLESCENT CLIENT INFORMATION FORM

Today's Date:_____

Full Name: First_____ **MI**_____ **Last**_____ **Nickname:**_____

Date of Birth:____/____/____ **Sex: Male**___ **Female**___ **Transg**___ **Gender:**___ **Gender Pronoun(s):**_____

Address:_____ **Apartment/Unit #:**_____

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

Email:_____ **OK to Email? Yes**___ **No**___ **Referred By:**_____

Cell #: Patient:_____ **Father:**_____ **Mother:**_____ **Guardian:**_____

School:_____ **Grade:**_____ **Has a 504 Plan** _____ **or an IEP**____

PLEASE CHECK THE PRIMARY REASON(S) YOU ARE SEEKING COUNSELING NOW:

	Abuse/Trauma		Depression		Life Transitions
	Adjustment Difficulties		Dyslexia, Learning Differences		Relationship Issues
	ADD/ADHD Distracted/Hyperactivity		Executive Functioning		Parenting Skills/Coaching
	Anger/Frustration		Emotional Regulation		Personal Development
	Anxiety/Fear		Grief/Loss		Other
	Behavioral Issues		Gender/Sexual Identity/Concerns		Other

Primary Medical Provider:_____ **Contact Number:**_____
Psychiatrist:_____ **Contact Number:**_____
Medications:_____ **Allergies:**_____
Health Needs/Concerns:_____
Current Diagnosis:_____ **Date of Last Dr. Visit:**_____
Previous Therapist:_____ **Date of Last Therapy:**_____

Parent/Guardian #1:

Name:_____ **DOB:**____/____/____ **Marital/Legal Status:**_____
Relationship to Client:_____ **Employer:**_____ **Occupation:**_____
Home Address:_____
City:_____ **State:**_____ **Zip:**_____
Cell #:_____ **Home #:**_____ **Work #:**_____
Email:_____

Parent/Guardian #2:

Name:_____ **DOB:**____/____/____ **Marital/Legal Status:**_____
Relationship to Client:_____ **Employer:**_____ **Occupation:**_____
Home Address:_____
City:_____ **State:**_____ **Zip:**_____
Cell #:_____ **Home #:**_____ **Work #:**_____
Email:_____

Please List Other Persons residing with Client:

Name:_____ **Age:**_____ **Relationship to Client:**_____
Name:_____ **Age:**_____ **Relationship to Client:**_____
Name:_____ **Age:**_____ **Relationship to Client:**_____

COUNSELING ASSOCIATES OF CENTRAL IOWA, PC

INFORMED TREATMENT CONSENT ~ NOTICE OF PRIVACY PRACTICES

This form documents that I/we, _____, (the "parent/guardian(s)") give my/our consent and agreement to Counseling Associates of Central Iowa, PC (the "therapist") to provide psychotherapeutic treatment to our child, _____ (the "child") and to include us, the parent/guardian(s), as necessary as adjuncts in the child's treatment.

While the parent/guardian(s) can expect benefits from this treatment for the child, they fully understand that no specific outcome can be guaranteed. The parent/guardian(s) understand that they are free to discontinue treatment of the child at any time, but it would be best to discuss with the therapist any plans to end therapy before doing so.

The parent/guardian(s) have fully discussed with the therapist what is involved in psychotherapy and understand and agree to the policies about scheduling, fees and missed appointments. The discussion about therapy has included the therapist's evaluation and diagnostic formulation of the child's problems, the method of treatment, goals and length of treatment, and information about recordkeeping. The parent/guardian(s) have been informed about and understand the extent of treatment, its foreseeable benefits and risks, and possible alternative methods of treatment. The parent/guardian(s) understand that therapy can sometimes cause upsetting feelings to emerge and the child's problems may worsen temporarily before improving.

Emergency Procedure:

The parent/guardian(s) understand that the therapist is not always available outside of business hours and cannot provide immediate emergency service. If an emergency arises, parent/guardian(s) understand they are to call 911 or report to the nearest hospital emergency room. Once contact with emergency services has been made, then please try to contact the therapist.

Notice of Privacy Practices:

The parent/guardian(s) have access to a copy of this form and a HIPAA Notice of Privacy Practices in the Counseling Associates of Central Iowa, PC office. A copy can be provided to the parent/guardian(s). The parent/guardian(s) understand that information about psychotherapy is kept confidential by the therapist and not revealed to others, besides the parent/guardian(s), unless a parent authorizes such release. There are a few exceptions as noted in the HIPAA Notice of Privacy Practices. Details about certain exceptions are as follows:

1. The therapist is required by law to report to the proper authorities any suspected child abuse or neglect.
2. If a child tells the therapist that he or she intends to harm another person, the therapist must try to protect the endangered person by telling the police, the person, the school and/or other health care providers. Similarly, if a child threatens to harm him or herself or a child's life or health is in any immediate danger, the therapist will try to protect the child as necessary by telling the parent/guardian(s), police and/or other health care providers who may be able to assist in protecting the child.
3. If a child is involved in certain court proceedings, the therapist may be required by law to reveal information about the child's treatment. These situations include child custody disputes, cases where a child's psychological condition is an issue, lawsuits or formal complaints against the therapist, civil commitment hearings, and court-ordered treatment.
4. If the child's health insurance or managed care plan will be paying the therapist directly, confidentiality will be waived if the therapist is required to give them information about the child's treatment.
5. The therapist may consult with other healthcare professionals about the child's treatment but in doing so, will not reveal the child's name or other information that would identify the child unless specific consent to do so is obtained from a parent/guardian(s). Further, when the therapist is away or unavailable, another therapist might answer calls and will need to have access to information about the child's treatment.
6. If an account with the therapist becomes overdue and responsible parties do not work out a payment plan, the therapist will have to reveal a limited amount of information about a client's treatment in taking legal measures to be paid. This would include the child's and parent/guardian(s)' names, Social Security number, address, dates and type of treatment and the amount due.

In the situations described above, the therapist will try to discuss with a parent/guardian(s) before any confidential information is revealed and will reveal only the least amount of information that is necessary.

Appropriate safeguards will be used by Counseling Associates of Central Iowa, PC and their business associates to prevent unauthorized use or disclosure of Protected Health Information (PHI) as required by HIPAA.

COUNSELING ASSOCIATES OF CENTRAL IOWA, PC

The parent/guardian(s), as legal guardians of the child, have rights to general information about what takes place in the child's therapy, information about the child's progress in therapy, information about any dangers the child might present to self or others, and upon request, to obtain copies of the child's treatment record (with certain qualifications and exceptions). The parent/guardian(s) understand that it is usually best not to ask for specific information about what was said in therapy sessions because this might break the trust between the child and the therapist, especially for children over the age of 12.

The parent/guardian(s) agree that in the event of custody, visitation or if the child is contested in a legal proceeding, each of the parent/guardian(s) and their attorneys will not require the therapist to testify at any of the proceedings because to do so would hurt the child's treatment. The therapist's role is a therapeutic and not evaluative one so other forensic professional would be better able and more appropriate to conduct any necessary evaluation. Because of these limitations, the therapist also will not be able to give any opinion regarding custody, visitation or any other legal issues. If such a proceeding does occur, the parent/guardian(s) agree that the therapist's role will be limited to providing to a mental health professional appointed to perform such an evaluation and/or to the attorneys, law guardian, if any, and the judge involved in the legal proceeding written information regarding, and/or the record of, the child's treatment; the therapist will provide these either as required by law or upon the authorization of either parent/guardian(s).

The therapist has explained to the parent/guardian(s) that children with two parent/guardian(s) have the best chance to benefit from therapy if both parent/guardian(s) are involved and cooperate with each other and the therapist. If both of a child's parent/guardian(s) are consenting to therapy:

- Each of us agrees that he or she will not end the child's therapy without the agreement of the other parent, and that if we disagree about the child's continuing in therapy, we will try to come to an agreement, by counseling if necessary, before ending the child's therapy.
- We each agree to cooperate with the therapist's treatment plan for the child and understand that without cooperation, the therapist may not be able to act in the child's best interests and may have to end therapy.
- We agree that each of us has and shall continue to have the right to information about the child's treatment and to the treatment records of the therapist regarding the child and agree that the therapist may release information or records to either of us without any additional authorization of the other.

If the parent/guardian(s) and child are participating in a managed care plan, the parent/guardian(s) have discussed with the therapist their financial responsibility for copayments, coinsurance and deductibles and the plan's limits on the number of therapy sessions. A diagnosis is required to submit the claim to an insurance company. If the parent/guardian(s) are not participating in a managed care program, they understand that they are fully financially responsible for treatment including any portion of the fees not reimbursed by the health insurance. The therapist has also discussed options for continuation of treatment when managed care or health insurance benefits end.

The parent/guardian(s) understand that they have a right to ask the therapist about the therapist's training and qualifications and about where to file complaints about the therapist's professional conduct.

Consent for Treatment:

By signing below the parent/guardian(s) are indicating that they have read and understood this agreement, that they give consent to the therapist's evaluation/treatment to be administered to _____ (client/child under age of 18), and that they have the proper legal status to give consent with or without their presence to therapy for the child.

By signing below, parent/guardian(s) consent to the use of a diagnosis in insurance or managed care billing and to the release of information as necessary to complete the billing process if they choose to utilize insurance benefits.

Signature:_____ Date:_____
(Parent/Guardian)

Signature:_____
(Parent/Guardian)

Signature:_____
(CHILD OVER THE AGE OF 12)

Witness:_____ Date:_____

PRIVACY OF INFORMATION SHARED IN THERAPY: FOR ADOLESCENTS-YOUR RIGHTS AND OUR POLICIES

What to expect:
The purpose of meeting with a therapist is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a therapist about these problems. Or you may be here because your parent, guardian, doctor or teacher had concerns about you. When we meet, we will discuss these problems. Your therapist will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking to your therapist about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their therapist. Privacy, also called confidentiality, is an important and necessary part of good therapy.

As a rule, your therapist will keep the information you share confidential, unless you give written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with your therapist in a therapy session. In some situations, your therapist is required by law or by the guidelines of their profession to disclose information whether they have your permission. Some of these situations are listed below.

Confidentiality cannot be maintained when:

- You tell your therapist you plan to cause serious harm or death to yourself and your therapist believes you have the intent and ability to carry out this threat in the very near future. Your therapist must take steps to inform parent/guardian(s) of what you have said and how serious this threat is. Your therapist must make sure that you are protected from harming yourself.

- You tell your therapist you plan to cause serious harm or death to someone else who can be identified, and they believe you have the intent and ability to carry out this threat in the very near future. In this situation, your therapist must inform your parent/guardian(s) and the person who you intend to harm.

- You are doing things that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, your therapist will need to use their professional judgment to decide whether a parent or guardian should be informed.

- You tell your therapist you are being abused-physically, sexually or emotionally or that you have been abused in the past. In this situation, your therapist is required by law to report the abuse to the Iowa Department of Human Services (DHS).

- You are involved in a court case and a request is made for information about your therapy. If this happens, your therapist will not disclose information without your written agreement *unless* the court requires them to do so. Your therapist will do all they can within the law to protect your confidentiality and if they are required to disclose information to the court, they will inform you.

Communicating with your parent(s) or guardian(s):
Except for situations such as those mentioned above, your therapist will not tell your parent/guardian(s) specific things you share in private therapy sessions. This includes activities and behavior that your parent/guardian(s) would not approve of, or would be upset by, but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then your therapist will need to use professional judgment to decide whether you are in serious and immediate danger of being harmed. If your therapist feels that you are in such danger, they will communicate this information to your parent or guardian.

Example: If you disclose that you have tried alcohol at a few parties, your therapist would keep this information confidential. If you disclose that you are drinking and driving or that you are a passenger in a car with a driver who is drunk, your therapist would not keep this information confidential from your parent/guardian(s). If you disclose, or if your therapist believes based on things you've said, that you are addicted to alcohol, they would not keep this information confidential.

Example: If you disclose that you are having protected sex with a boyfriend or girlfriend, your therapist would keep this information confidential. If you tell your therapist that, on several occasions, you have engaged in unprotected sex with people you do not know or in unsafe situations, they will not keep this information confidential. You can always ask questions about the types of information that would be disclosed. You can ask in the form of "hypothetical situations," in other words: "If someone told you that they were doing _____, would you tell their parents?"

Even if your therapist has agreed to keep information confidential from your parent/guardian(s), they may believe that it is important for them to know what is going on in your life. In these situations, they will encourage you to tell your parent/guardian(s) and will help you find the best way to tell them. Also, when meeting with your parent/guardian(s), your therapist may describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

You should also know that, by law in Iowa, your parent/guardian(s) has the right to see any written records kept about your sessions. It is extremely rare that a parent/guardian(s) would ever request to look at these records.

Communicating with other adults:
School: Your therapist will not share any information with your school unless they have your permission and permission from your parent/guardian(s). Sometimes your therapist may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for your therapist to give suggestions to your teacher or counselor at school. If your therapist wants to contact your school or if someone at your school wants to contact your therapist, it will be discussed with you and you will be asked for your written permission. A very unlikely situation might come up in which your therapist does not have your permission, but your parent or guardian believes that it is very important to share certain information with someone at your school. In this situation, your therapist will use their professional judgment to decide whether to share any information.

Doctors: Sometimes your doctor and therapist may need to work together; for example, if you need to take medication in addition to seeing a counselor or therapist. Your therapist will get your written permission and permission from your parent/guardian(s) in advance to share information with your doctor. The only time they will share information with your doctor without your permission is if you are doing something that puts you at risk for serious and immediate physical/medical/mental harm.

* * * * *

Adolescent Consent Form & Parent Agreement to Respect Privacy

Adolescent Therapy Client:
Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time.

Minor's Signature:_____ Date:_____

* * * * *

Parent/Guardian(s):
Check boxes and sign below indicating your agreement to respect your adolescent's privacy:

☐ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress and/or may be asked to participate in therapy sessions as needed.

☐ Although I know I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my adolescent's treatment.

☐ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may be made in confidential consultation.

Parent Signature:_____ Date:_____

Parent Signature:_____ Date:_____

Therapist Signature:_____ Date:_____

PAYMENT, INSURANCE & CANCELLATION POLICY

Please check the box next to each paragraph indicating that you have read and understand our policy regarding payment for services.

☐ **INSURANCE COVERAGE**

It is your responsibility to verify current coverage with your insurance provider. Any changes to your insurance policy or coverage must be reported before services are rendered. If for any reason your insurance company does not pay, you are responsible for paying the expense for the service you received. It is your responsibility to know which services are covered by your insurance company. Please be advised that some or all services provided may be "non-covered" services and may not be considered reasonable and necessary under your medical insurance. You are responsible to pay your copayment, coinsurance and/or deductible at the time of service (if applicable). It is your responsibility to contact your insurance company if you need an explanation of benefits.

☐ **CANCELLATIONS OR MISSED APPOINTMENTS AND LATENESS**

Missed and cancelled sessions pose some issues for both you and your therapist. The work of psychotherapy is sometimes challenging, and you may find it easier to avoid coming in for treatment. It is always better to speak about this intentionally with your therapist. We hold your scheduled appointment specifically for you. Your therapist sees a limited number of clients so that you get the focus and attention you deserve. Counseling Associates of Central Iowa, PC may charge you $50 or the amount of our current self-pay fee for appointments that are missed and cancelled less than 24 hours.

If you are running late for your appointment, please phone the office as soon as you can to let us know. If you are late for your session, it will still end at the regular time so your therapist can stay on schedule.

☐ **BILLING AND CONSEQUENCES OF NON-PAYMENT**

For all returned checks, there will be a surcharge of $30.00. If a client's third-party benefits or payments ends and/or if the client is more than 90-days delinquent on payments owed, Counseling Associates of Central Iowa, PC will determine on a case-by-case basis its responsibility to provide services until appropriate referrals are made, and if termination or withdrawal of service is probable due to non-payment, the provider works with the person or family to identify other service options.

☐ **RATES FOR THERAPY/COUNSELING SERVICES**

Current rate for individual therapy services not billed to insurance is $110.00. Current rate for couples' counseling is $125.00 and is not billed to insurance. If paying by insurance, Counseling Associates of Central Iowa, PC has negotiated terms with the insurance companies regarding reimbursement levels.

By signing below, I acknowledge that all bills will be sent to me directly (or the person listed on the payment information form) and payment of all charges not covered by insurance will be solely my responsibility.

Signature of Client or Authorized Person: _____ Date: _____

Signature of Witness: _____ Date: _____

COUNSELING ASSOCIATES OF CENTRAL IOWA, PC

PAYMENT AND INSURANCE FORM

- **Private Pay: I agree to pay by cash, check or credit card after each session.**

- **Private Insurance: I agree to pay my copayment, coinsurance and/or deductible by cash, check or credit card at the time of each session.** *I authorize my insurance benefits to be paid directly to Counseling Associates of Central Iowa, PC. I hereby authorize the release of any medical or other information necessary to process this claim. If my coverage is under a group contract held by an employer, an association, a trust fund, a union, or similar entity, this authorization also permits disclosure to them for the purposes of utilization, review or audit.*

Primary Insurance Company:_____

If Card On Phone, Please Complete: Insurance ID #:_____ **Group #:**_____

Name of Person Who Holds This Insurance:_____ **Date of Birth:**_____

Relationship to Insured: Self___ **Spouse**___ **Child**___ **Other**___ **Insured Employer/School:**_____

Secondary Insurance:_____ **Insurance ID Number:**_____

Name of Person Who Holds This Insurance:_____ **Date of Birth:**_____

Relationship to Insured: Self___ **Spouse**___ **Child**___ **Other**___ **Insured Employer/School:**_____

If Card On Phone, Please Complete: Insurance ID #:_____ **Group #:**_____

Insurance Claims/Authorization: If you are interested in using your health insurance for out-of-network benefits, please check with your insurance company about your mental health benefits and pre-approval requirements. For out-of-network reimbursement, you will pay for therapy services upfront and then your therapist will provide you with a form/receipt of therapy service to submit to your insurance carrier.

Payment: Payment is due at the time services are rendered. Cash, check or credit card is expected at time of service. Checks can be made payable to Counseling Associates of Central Iowa, PC. It is the obligation of the client to make payment for services. Payment and insurance follow-up are the responsibility of the insurance contract holder.

Cancellation Policy: Missed and cancelled sessions pose some issues for both you and your therapist. The work of psychotherapy is sometimes challenging, and you may find it easier to avoid coming in for treatment. It is always better to speak about this intentionally with your therapist. We hold your scheduled appointment specifically for you. Your therapist sees a limited number of clients so that you get the focus and attention you deserve. Counseling Associates of Central Iowa, PC may charge you $50 or the amount of our current self-pay fee for appointments that are missed and cancelled less than 24 hours.

Balances: We do not permit clients to carry a balance of more than two sessions and if you are unable to pay this balance, we will discuss whether it makes sense to pause your care or develop another strategy so that you can avoid incurring additional debt. Please let the office staff know if any problem arises during the course of therapy regarding your ability to make timely payments.

I verify that I have read and understood the above statements on Claims Authorization, Payments, and the Cancellation Policy.

Signature of Client or Authorized Person:_____ Date:_____

Signature of Witness:_____ Date:_____

COUNSELING ASSOCIATES OF CENTRAL IOWA, PC

PRIMARY CARE PHYSICIAN CONSENT FORM

Consent to Release Confidential Information: Communication between behavioral health providers and your primary care physicians is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary. I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event, this consent shall expire twelve (12) months from the date of signature unless another date is specified.

I, _____, give permission to COUNSELING ASSOCIATES OF CENTRAL IOWA, PC
Client/Guardian Name *Behavioral Health Provider*
and my Primary Care Physician _____ to share information
Primary Care Physician (PCP)
about my diagnosis and/or treatment related to substance abuse, mental health, and/or medical history, NOT including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care.

_____ _____
Client/Guardian/Authorized Representative *Date*

_____ _____
Witness *Date*

PCP Address: _____

City: _____ State: _____ Zip: _____

Phone (Include area code): _____ Fax (Include area code): _____

Refusal to Release Confidential Information:

I, _____, **DO NOT** give permission to COUNSELING ASSOCIATES OF CENTRAL IOWA, PC
Client/Guardian Name *Behavioral Health Provider*

and my Primary Care Physician _____ to share information about my diagnosis and/or
Primary Care Physician (PCP)
treatment related to substance abuse, mental health, or medical history, including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care. I also understand that my refusal to share information does not affect my insurance coverage.

_____ _____
Client/Guardian/Authorized Representative *Date*

_____ _____
Witness *Date*

I, _____, **DO NOT** have a Primary Care Physician at this time.
Client/Guardian Name

_____ _____
Client/Guardian/Authorized Representative *Date*

_____ _____
Witness *Date*

This consent form expires 12 months from the date of signing and can be canceled at any time.

COUNSELING ASSOCIATES OF CENTRAL IOWA, PC

RECEIPT/ACKNOWLEDGMENT: NOTICE OF PRIVACY PRACTICES CLIENT RIGHTS & RESPONSIBILITIES

"I can obtain a copy of the Counseling Associates of Central Iowa, PC Notice of Privacy Practices and HIPAA Statement which summarizes the ways my identifiable health information may be used and disclosed by this provider and states my rights with respect to my medical information. I understand they have the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that the most current copies are available to me in the waiting room at Counseling Associates of Central Iowa, PC."

Signature of Client or Guardian/Representative Date

Guardian/Representative, Relationship to Client

Signature of Witness Date

AUTHORIZATION FOR ELECTRONIC COMMUNICATIONS

Please check the box indicating your request for electronic communications:

☐ I do not want to receive text messages from Counseling Associates of Central Iowa, PC.

☐ I hereby request that Counseling Associates of Central Iowa, PC communicate with me via text message. I understand that this means Counseling Associates of Central Iowa, PC will transmit my scheduled appointments to me via text message.

I understand there are risks inherent in the electronic transmission of information via text message and such communications may be lost, delayed, intercepted, corrupted, altered, incomplete or fail to be delivered which may result in a breach of my confidentiality. Electronic transmissions are not guaranteed to be secure or error-free and may be vulnerable to unauthorized third parties. Counseling Associates of Central Iowa, PC will not have any responsibility or liability with respect to claims or loss arising from or connection with the electronic communications to me. Counseling Associates of Central Iowa, PC will not be responsible for any fees my cell phone company may charge me.

I agree that Counseling Associates of Central Iowa, PC will communicate with me electronically until I revoke this authorization by submitting written notice to Counseling Associates of Central Iowa, PC.

I understand that if I do not receive a text message to remind me of my appointment, my appointment is still scheduled, and I am responsible to attend or give 24-hour notice to cancel the appointment.

After being provided notice of the risks inherent in the use of electronic communications, I authorize Counseling Associates of Central Iowa, PC to communicate with me electronically via text message.

Cell Phone Number: _____

Client Printed Name: _____

Client or Legal Guardian Signature: _____ Date: _____

Witness: _____

COUNSELING ASSOCIATES OF CENTRAL IOWA, PC

MANDATORY REPORTER POLICY

It is your therapist's duty, as a mandatory reporter, to immediately report any suspected child abuse and any suspected dependent adult abuse to the Department of Human Services (DHS). Your therapist will report suspected abuse orally to the DHS followed by a written report within 48 hours after such oral report. They will also make an oral report to an appropriate law enforcement agency if immediate protection of the child or adult is advisable.

Types of Abuse:

- Physical Abuse
- Mental Injury
- Sexual Abuse
- Denial of Critical Care
- Child Prostitution
- Presence of Illegal Drugs in The Body
- Manufacture or Possession of Dangerous Substances in The Presence of The Child
- Bestiality in The Presence of a Minor
- Cohabitation with A Registered Sex Offender

Your records cannot be released to any other individual without your written consent. However, certain information may be released without your authorization under the following circumstance:

- When Juvenile Court is involved, records may be shared with Juvenile Court Officers.
- Information about a child may be shared with the child's Guardian Ad Litem.
- Information may be shared in the event of a legitimate subpoena for court appearance.
- In the event of a medical emergency.
- When the receipt of information suggests that child or dependent adult abuse or neglect has occurred.
- Auditors may review your records to evaluate treatment effectiveness.

Counseling Associates of Central Iowa, PC is legally obligated to report any such information to DHS when there exists a danger to the child, dependent adult, or others.

These policies have been explained to me in my own language.

Signature:_____ Date Signed:_____

Patient 18 Years and Older

Signature:_____

Parent/Guardian For Patients Under 18 Years

Patient Printed Name:_____

Witness:_____ Date Signed:_____

COUNSELING ASSOCIATES
OF CENTRAL IOWA, PC

Phone: (515) 255-2224
Fax: (515) 255-2228
4401 Westown Parkway, Suite 280
West Des Moines, IA 50266
www.caciowa.com

CREDIT CARD AGREEMENT

Patient Name:_____

I authorize Counseling Associates of Central Iowa, PC (CACI) to charge my credit/debit card for balances due at CACI whether they are or are not covered by my insurance company, including no-show and late cancellation fees. It is my responsibility to know my insurance benefits and provide CACI with any insurance updates in a timely manner.

This authorization will be terminated when I stop receiving services and all services have been paid in full and any overpayments refunded to me. This authorization will be void when this credit card expires; a new form will be completed with my new credit card information.

_____ _____
Patient or Guardian Signature Date

____MasterCard ____Visa ____Discover ____American Express

Name on Card:_____

Card #:_____

Expiration Date:_____ Security Code:_____

Your credit card information is securely protected in our HIPAA compliant practice management system with a secure network server. Receipts for any payments can be obtained by calling our office.