COUNSELING ASSOCIATES OF CENTRAL IOWA, PC

ADULT CLIENT INFORMATION FORM

Today's Date:_____

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**___

Cell #:_____ **Home #:**_____ **Work #:** _____

Marital Status: Married___ **Single**___ **Divorced**___ **Domestic Partner**___ **Widow/er**___ **Other**_____

Employer:_____ **Fulltime**___ **Part-time**___ **Retired**___ **Disabled**___

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:**_____

Emergency Contact:_____ **Relationship to Client:** _____
Address: _____
City:_____ **State:**_____ **Zip:** _____
Cell #:_____ **Home #:**_____ **Work #:** _____
Email:_____

Referral Source to Counseling Associates of Central Iowa, PC: _____

COUNSELING ASSOCIATES OF CENTRAL IOWA, PC

INFORMED CONSENT TO TREATMENT/NOTICE OF PRIVACY/CLIENT RIGHTS & RESPONSIBILITIES

This form documents that I, _____, give my consent to Counseling Associates of Central Iowa, PC, (the "therapist") to provide psychotherapeutic treatment to me.

CLIENT RIGHTS & RESPONSIBILITIES: While I expect benefits from this treatment, I fully understand that no specific outcome can be guaranteed. I understand that I am free to discontinue treatment at any time but that it would be best to discuss with the psychotherapist any plans to end therapy before doing so. Our discussion about therapy has included the therapist's evaluation and diagnostic formulation of my problems, the method of treatment, goals and length of treatment, and information about recordkeeping. I have been informed about and understand the extent of treatment, its foreseeable benefits and risks, and possible alternative methods of treatment. I understand that therapy can sometimes cause upsetting feelings to emerge and may feel worse temporarily before feeling better. I have the right to considerate, safe, and respectful care without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. I understand that I have a right to ask the therapist about the therapist's training and qualifications and where to file complaints about the therapist's professional conduct.

I have fully discussed with the therapist what is involved in psychotherapy and understand and agree to the policies about scheduling, fees and missed appointments. I understand that I am fully financially responsible for treatment which, if I have health insurance, includes any portion of the psychotherapist's fees that are not reimbursed by my insurance.

In the event of a medical, behavioral or mental health emergency, I will call 911 or go the nearest hospital emergency room. I understand that the psychotherapist cannot provide immediate emergency services. It is my responsibility to take care of myself until such a time that I can talk to my therapist. If I am not able to keep myself safe, I will go to the nearest emergency room and ask to speak to the psychiatrist or psychologist on call.

NOTICE OF PRIVACY: I have received a HIPAA Notice of Privacy Practices from the therapist which is available in the Counseling Associates of Central Iowa, PC office. I understand that information about psychotherapy is almost always kept confidential by the therapist and not revealed to others unless I give my consent. There are a few exceptions as noted in the HIPAA Notice of Privacy Practices. Some exceptions include, but are not limited to:

1. Mandatory Reporting of child/dependent adult abuse or neglect to the proper authorities.
2. Emergency circumstances for the purposes of treating a medical or mental condition which poses a threat to the safety and health of any individual or the public and requires immediate intervention.
3. Judicial and Administrative Proceedings: If I am involved in certain court proceedings, the psychotherapist may be required by law to reveal information about my treatment.
4. Payment Purposes: If my health insurance or managed care plan will be reimbursing me or paying the psychotherapist directly, they will require that I waive confidentiality and the psychotherapist will give them information about my treatment.
5. Treatment Purposes: The psychotherapist may consult with other psychotherapists about my treatment but in doing so will not reveal my name or other information that would identify me unless specific consent to do so is obtained. Further, when the psychotherapist is away or unavailable, another psychotherapist might answer calls and so will need to have access to information about my treatment.

In the situations described above, I understand that the therapist will try to discuss the situation with me or notify me before any confidential information is revealed and will reveal only the least amount of information that is necessary.

By signing below, I 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 I choose to utilize insurance benefits. By signing below, I am indicating that I have read and understood this form and give my consent to treatment.

X_____ _____

Signature of Client or Authorized Person Date Signed

X_____ _____

Signature of Witness Date Signed

AUTHORIZE EMERGENCY CONTACT FORM

I volunteer to provide the below contact information and authorize Counseling Associates of Central Iowa, PC to contact any listed individual on my behalf in the event of an emergency. (Provide at least one contact)

1. **EMERGENCY CONTACT NAME:** _____
   Relationship to Client: _____ Address same as Client: ___Yes ___No
   Address: _____ City: _____ State: ____ Zip: _____
   Phone (Include area code): _____

2. **EMERGENCY CONTACT NAME:** _____
   Relationship to Client: _____ Address same as Client: ___Yes ___No
   Address: _____ City: _____ State: ____ Zip: _____
   Phone (Include area code): _____

☐ **I choose not to furnish any emergency contact information to Counseling Associates of Central Iowa, PC.**

Client or Legal Guardian Signature _____ **Date Signed** _____

AUTHORIZATION TO RELEASE INFORMATION TO PHARMACY

☐ **If receiving prescription medications from Counseling Associates of Central Iowa, PC providers, I authorize to release pertinent information regarding prescription of medications to my pharmacy.**

Pharmacy: _____ **Address:** _____

Pharmacy Phone Number: _____

Client or Legal Guardian Signature _____ **Date Signed** _____

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: _____

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 Company:_____ **Insurance ID #:**_____ **Group #:**_____

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:_____

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.

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: _____

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.