To better help us serve you or your child today, please answer the following questions:

Name:____Birthdate:_____________________

1. Are you or your child currently being treated for a psychiatric diagnosis? YES NO
2. Do you or your child currently take psychiatric medication? YES NO
3. Are you or your child currently experiencing suicidal or homicidal thoughts? YES NO
4. Do you want to see someone about medication today? YES NO
5. Do you want to see someone today? YES NO

   If yes: Therapy ☐ Psychiatry ☐

   What is the reason to be seen today? ____
   ____
   ____
   ____

***To see someone today it can take anywhere from 45-90 minutes

*WE DO NOT TAKE OUT OF STATE MEDICAID

****If you have out of state Medicaid for primary or secondary insurance, we cannot see you.**

**ALL FORMS NEED TO BE SIGNED BY LEGAL GUARDIAN

SIOUXLAND MENTAL HEALTH CENTER NEW CLIENT INFORMATION

Adult / Child

Date: ________________ Account # ___________

Patient's Information:

Name: ____

Gender: M F Date of Birth: ______________ SSN: _______________________________

Race:______________ Preferred language: ________________________________

Address: ____

City: _________________________________ State: __________ Zip Code: ______________

Primary Phone #: ______________________________ Home ____ Cell ____ Work _____

Is it okay to leave a voice mail message? Yes No

Secondary Phone #: __________________________ Home ____ Cell ____ Work _____

Is it okay to leave a voice mail message? Yes No

Email Address: ____

Type of Insurance: Primary: _______________________ Secondary:____________________

Military Status: Active Member____Veteran____NA____

Branch(es): Army____Navy____Air Force____ Coast Guard____Marine Corps____

NOTICE: WE <u>CANNOT</u> SEE YOU IF YOU HAVE <u>OUT OF STATE MEDICAID</u> FOR A <u>PRIMARY</u> OR <u>SECONDARY INSURANCE</u>.

Referred by: ____

Do you have any family members seeing somebody here? Yes No

If yes, who are they seeing? Doctor? _______________________Therapist? ______________

Emergency contact: _________________________________ Phone #: __________________

Patient's relationship to emergency contact: ____

If under 18 or has a legal guardian (NEED PROOF), fill out guardian's information: ONLY LEGAL GUARDIAN CAN SIGN PAPERWORK: NO STEP-PARENTS, FAMILY MEMEBERS, OR FACILITIES.

Guardian's name(s): ____

Guardian's DOB: _____________________ Guardian's SSN: ________________________

Guardian's Address if different than above:_______________________________

Guardian's Primary Phone #: _______________________ Home ____ Cell ____ Work_____

Is it okay to leave a voice mail message? Yes No

Guardians Email Address:____

Please list additional Parents/Guardians and the relationship to the child:

Name: _______________________ Relationship: ________________ PH: ______________

Employee initials: _____________

*Over the last **2 weeks**, how often have you or your child been bothered by any of the following problems?*

0= Not at all: 1= Several days; 2= More than half the days; 3= Nearly every day

1. Little interest or pleasure in doing things 0 ☐ ☐1 ☐2 ☐3
2. Feeling down, depressed, or hopeless 0 ☐ ☐1 ☐2 ☐3
3. Feeling nervous, anxious or on edge 0 ☐ ☐1 ☐2 ☐3
4. Not being able to stop or control worrying 0 ☐ ☐1 ☐2 ☐3

*Over the past **1 month**, have you or your child experienced the following?* Have you wished you were dead or wished you could go to sleep and not wake up?

☐ Yes ☐ No

Have you had any thoughts of killing yourself?

☐ Yes ☐ No

Have you had any thoughts of wanting to harm others?

☐ Yes ☐ No

Over the past ***3 months*** have you or your child experienced the following?

Have you made a suicide attempt?

☐ Yes ☐ No

Have you done anything to harm yourself?

☐ Yes ☐ No

Do you feel you are able to keep yourself/your child safe after leaving here today? Yes No If ☐ ☐ No, please describe safety concerns:

Who referred you here today:

☐ Self ☐ Medical Staff ☐ Another Agency ☐ School Staff ☐ Other ___________

What services do you need today:

☐ Crisis Intervention ☐ Intake for Services ☐ Other ___________

Are you willing to participate in any of the following services?

☐ Therapy (Individual, Family, Group, Marital)

☐ Medication Management/Psychiatry

☐ Integrated Home Health

☐ Community Support

CLIENT'S INFORMED CONSENT

I have voluntary chosen to receive treatment services by Siouxland Mental Health Center. I understand that I may terminate services at any time.

I understand that psychotherapy is cooperative effort between me and my provider and I will work with my provider in a cooperative manner to resolve my issues.

I understand that during the course of my treatment material may be discussed with me that may be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that records and information collected about me will remain confidential and will only be released with a signed consent form in accordance with state laws regarding confidentiality. I understand that if I choose to have another person in with me during my appointment, they are privileged to the information that is disclosed during that appointment.

I understand that my records may be released in accordance with state and local laws in case in which a danger to self or others exists.

I understand that all the individuals participating in treatment are expected to conduct themselves in an appropriate and respectful manner. I understand that any aggressive, violent, or threatening behavior or violation of confidentiality may be the basis for exclusion from some or all services at Siouxland Mental Health Center.

I understand that I may be contacted by Siouxland Mental Health during my treatment to ensure continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment. I have read and understand the basic rights of individuals as seen at Siouxland Mental Health. These rights include:

1. The right to be informed of the various steps and activities involved in receiving services.
2. The right to confidentiality under federal and state laws relating to the receipt of services.
3. The right to humane care and protection from harm abuse or neglect.
4. The right to make an informed decision on whether to accept or refuse treatment.
5. The right to contact and consult with counsel at my expense.
6. The right to select practitioners of my choice at my expense.

I understand that my provider, insurance representative, and primary care physician may exchange any and all information pertaining to my services, including retrieval of my medication history, to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes.

I understand that I can revoke my consent at any time, except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after discharge of treatment.

Client Acknowledgement and Consent to Privacy Notice

I have received an orientation to the Center, which has explained the policies and procedures, and I consent to Siouxland Mental Health Center privacy notice, a copy of which has also been made available to me. By signing below, I acknowledge I have read and understand the above information.

___________________________________ _____________________________________

Print name of client Signature of client/guardian

Date: __________

INSURANCE: WE CANNOT SEE YOU IF YOU HAVE OUT OF STATE MEDICAID FOR A PRIMARY OR SECONDARY INSURANCE.

Primary Insurance:

Name of insurance company: ______________________________

Cardholder's Name: ______________ Patients relationship to cardholder: ______________

Gender of the cardholder: ___________ Cardholder's date of birth: ______________

Certificate (ID) #: ______________________ Group #: ______________________

Cardholder's social security #______________Place of employment: ______________

WE CANNOT SEE YOU IF YOU HAVE OUT OF STATE MEDICAID FOR A PRIMARY OR SECONDARY INSURANCE.

Secondary Insurance:

Name of insurance company: ______________________________

Cardholder's Name: ______________ Patients relationship to cardholder: ______________

Gender of the cardholder: ___________ Cardholder's date of birth: ______________

Certificate (ID) #: ______________________ Group #: ______________________

Cardholder's social security #______________Place of employment: ______________

You are required to provide Siouxland Mental Health Center with any changes to your insurance coverage as they occur. If this is not provided, you will be financially responsible for the services that were provided to you. In the event your insurance company pays you directly, you are responsible to reimburse Siouxland Mental Health Center for the amount that your insurance company pays you. All payments made to Siouxland Mental Health Center must be by cash, debit/credit card or check.

I understand that this will become a part of my service record; information accumulated in the record may be confidentially reviewed by the accrediting agency for Siouxland Mental Health Center. *I authorize Siouxland Mental Health Center to file an insurance claim and receive the payment for services rendered on my behalf.* Some insurance coverage requires copayment and/or a deductible portion, which is due at the time of service.

______________________ ______________________

Print name of client Signature of client/guardian

Date: ___________

No-Call No-Show Policy as of April 09, 2018

New patients (new psych evaluations and new therapy). All new clients will be scheduled for a therapy intake through Same Day Access (SDA). If a new client does not come to their scheduled therapy intake through SDA, it will not be counted as a No Call/No Show and they will be able to reschedule this appointment. If a new client comes to their intake appointment, and would like to have medication management, they will then be scheduled for a psychiatric evaluation. If the client no calls/no shows to the psychiatric evaluation, they will need to attend Pathways before being able to reschedule their psychiatric evaluation. If a new client comes to the Psychiatric Urgent Care and needs to follow up with psychiatry, they will be scheduled for a psychiatric evaluation. If the client No Calls/No Shows to this evaluation, they will then need to schedule an intake and come to the intake appointment before being able to reschedule the psychiatric evaluation.

Established patients (psych and therapy): If an established client no calls/no shows to 2 appointments (psychiatry, therapy, or both in a revolving year, they will lose their privileges to schedule further appointments. Any existing appointments that have been scheduled will also be cancelled at this time. Siouxland Mental Health Center Client Policies. If an established client loses their scheduling privileges, they will need to attend Pathways to regain scheduling privileges. Once the client has attended Pathways, their revolving year starts over. If a client prefers to be seen by their provider before they are able to attend Pathways, they have the option to walk in and wait in the lobby until a provider has an opening in their schedule. SMHC will make every effort to have the client be seen, however there is no guarantee that the client will be seen that day.

It is the policy of Siouxland Mental Health Center that if you miss a schedule psychiatric or therapy appointment, you run the risk of being charged. If it is an initial intake appointment with a therapist or a psychiatric evaluation that is missed without canceling in 24 hours in advance, the charge will be $50.00. If it is a medication check or a therapy appointment that is missed without canceling 24 hours in advance the charge will be $25.00. The patient will be responsible for paying this fee.

If you cannot make your appointment, please give us at least a 24 hour notice and with that notice, this will not be considered a no-call no-show appointment.

______________________________ ______________________________

Print name of client Signature of client/guardian

Date: ___________

CONSUMER RIGHTS AND RESPONSIBILITIES

Consumer Rights Policy. The policy of Siouxland Mental Health Center is that all consumers will receive treatment subject to the following protection:

1. Each consumer has the right to participate in the development of his/her treatment/service plan.
2. Services are made available to all Woodbury County residents on an equal basis.
3. Each consumer has the right to assume that all treatment information will be held in confidence and will not be released to anyone unless one of the following situations exists:
    a. Written request is made by a consumer to released portion of file information.
    b. That a court order requires submission of certain file materials.
    c. That, in the opinion of the professional staff members of center, a life-threatening situation exists.
4. Each consumer of the Center has the right to be fully informed about any risks that might be entailed in the treatment or as the result of research studies.
5. Each consumer of the Center has the right to expect treatment with dignity and respect and without unnecessary invasion of privacy.
6. Each consumer has the right to refuse treatment.
7. Each consumer has the right to treatment with as little delay as possible.
8. Only information that is needed to assist the center's professional staff and their treatment process will be obtained from a consumer/guardian.
9. Each consumer has the right to be treated in the least restrictive setting possible.
10. Each consumer has the right to express his/her opinion concerning the services delivered at the center.
11. Consumers of Siouxland Mental Health Center, and their guardians, have the right to appeal any policy, procedure, or action of Siouxland Mental Health Center in order to adequately protect the consumer's rights.
12. I have voluntarily chosen to receive treatment services by Siouxland Mental Health Center. I understand that I may terminate services at any time.

Procedure:

a. First, the consumer/guardian should attempt resolution with their primary staff.
b. If the issue is not resolved within fourteen days, written statements from the consumer/guardian and the staff person will be submitted to the staff person's immediate supervisor.
c. If the issue is still not resolved, letters from the consumer/guardian, staff, and supervisor and to the Chief Executive Officer will be sent to the Chairperson of the Board of Directors for review by the Executive Committee of the Board. The Executive Committee will review the appeal at the next regularly scheduled Executive Committee meeting. The Chair of the Board of Directors will respond to all parties, in writing, within 30 days of the Executive Committee Meeting.

Consumer Responsibilities: I understand that in addition to having the rights listed above, I also agree to abide by the following responsibilities. I understand that failure to do so can result in my discharge from services.

1. I will take my medication as prescribed by the doctor to be the best of my ability.
2. I will attend all scheduled appointments with my providers. If I cannot attend, I will call 24 hours in advance to cancel.
3. I will attempt to fulfill the goals I have set my service plan to the best of my ability or, notify my provider if I feel the goal is no longer appropriate.
4. I will treat my worker respectfully in the same manner that I would like to be treated.
5. I will refrain from abusing drugs and alcohol to the best of my ability.
6. I will contact my provider on a regular basis.
7. I understand that it will be necessary for me to sign documents in order to continue to receive services with Siouxland Mental Health Center.

______________________________ ______________________________

Print name of client Signature of client/guardian

Date: __________

PSYCHIATRIC ADVANCE DIRECTIVE NOTIFICATION FORM

Do you have a Psychiatric Advance Directive Form or a Durable Power of Attorney for Medical Care Form?

Yes No

If yes, do you wish to provide a copy to Siouxland Mental Health?

Yes No

Copy provided to intake person?

Yes No

PRIMARY CARE PHYSICIAN FORM

NAME OF PHYSICIAN: ___________________________________

_______I want you to contact my Primary Care Physician

_______I do not want my Primary Care Physician contacted

_______I do not have a Primary Care Physician

______________________________ ______________________________

Print name of client Signature of client/guardian

Date: ___________

Siouxland Mental Health Center
Informed Consent for Telehealth Services

Client Name: ______________________________ **Date of Birth**:___________________________

Telehealth is the delivery of behavioral health services using interactive audio and visual electronic systems between a provider and a client that are not in the same physical location.

As with any medical or behavioral health treatment, there are certain potential benefits and risks to receiving telehealth services.

The potential benefits of receiving telehealth services are:

- Reduced wait time to receive behavioral healthcare
- Avoiding the need to travel to a psychiatrist or therapist office

The potential risks of receiving telehealth services are:

- Telehealth sessions will not be exactly the same and may not be as complete as a face-to-face service.
- There could be some technical problems (video quality, internet connection) that may affect the virtual care session and may affect the decision making capability of the provider.
- The provider may not be able to provide medical treatment using interactive electronic equipment nor provide for, or arrange for emergency care that you may require.
- A lack of access to all the information that might be available in a face-to-face visit, but not in a telehealth visit may result in errors in judgement.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- SMHC utilized software that meets the recommended standards to protect the privacy and security of the telehealth session, however SMHC cannot guarantee total protection against hacking or tapping into the telehealth session by outsiders. The risk of this happening is small, but it does exist.

Alternatives to the use of telehealth services:

- Traditional face-to-face sessions

Client's Rights and responsibilities when receiving telehealth services:

1. I have the right to withhold or withdraw consent for telehealth services at any time, including during a telehealth session without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The laws that protect the confidentiality of my medical information also apply to telehealth services.
3. The potential benefits and risks of receiving telehealth services have been explained to me and I understand the potential risks and benefits.
4. I have had the chance to ask any questions and have received clarification regarding telehealth services.
5. I understand that telehealth services may not be as complete as face-to-face services. I also understand that there are potential risks and benefits associated with any form of behavioral health services and that despite my efforts and the efforts of my provider, my condition may not improve and in some cases may get worse.
6. I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured.
7. I understand that my telehealth session will not be recorded by my provider.
8. I understand that it is the policy of SMHC that I am not able to record any sessions, whether they are face-to-face or telehealth.
9. I understand that if it is known that I am or have recorded a session, my appointment will be cancelled and my eligibility to receive telehealth services may be suspended, based on provider discretion.
10. I understand that I have a right to access my medical information and copies of medical records in accordance with the Health Insurance Portability and Accountability Act of 1996.
11. I understand that in order to maintain confidentiality I must ensure that I am in a private setting during my telehealth session. If I am unable to ensure that I am in a private setting, I understand that my telehealth session will be cancelled.
12. I understand that my provider will ensure that they are in a private setting when conducting my telehealth session.
13. I understand that to participate in my telehealth session, I cannot be actively driving.
14. I understand that I must physically be in the state of Iowa during my telehealth session.

15. I understand that I and my provider must have our cameras turned on during my telehealth session.
16. I understand that if my appointment cannot be conducted or completed, I run the risk of the appointment being counted as a no call/no show per provider discretion.
17. I understand that I, not my provider, am responsible for the configuration of any electronic equipment used for telehealth services on my electronic device.
18. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
19. I understand that my provider determines whether or not the condition being diagnosed and/or treated is appropriate for a telehealth encounter.

I hereby consent to engaging in telehealth services with Siouxland Mental Health Center as part of my behavioral healthcare. I understand that telehealth services includes the practice of healthcare delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio and video data communications. I have read and understand the information provided above regarding telehealth services.

______________________________________ ______________________________

Signature of Client/Client Representative **Date**

____

Relationship to client (if applicable)

Reviewed by: ______________________________________

Staff Signature

Siouxland Mental Health Center
Email Authorization

Client Name: ________________________________ DOB: __________________

Siouxland Mental Health Center offers its clients the ability to communicate with certain members of their care team via email. Both the client and Siouxland Mental Health Center must enter into an agreement for this.

Privacy and Security of E-mail

Siouxland Mental Health Center cannot and does not guarantee the privacy or security of any messages being sent via email. There is the potential that these messages can be intercepted and read by others when sent through the internet. If this is of concern to you, you should not communicate with Siouxland Mental Health Center via email.

Additionally, you should be aware of and understand that if you use email provided by your employer, any message sent or received on your employer's system may be viewed by your employer.

This document along with Siouxland Mental Health Center's "Notice of Privacy Practices" constitutes a notice of privacy practices for email use.

Keeping Records of E-mail

E-mail communications will be documented in an electronic note maintained in your medical record chart.

Authorization to Use E-mail

I have been informed and understand the risks and procedures involved with using email. I agree to the terms listed on this form and hereby voluntarily request, consent to, and authorize the use of e-mail as one form of communication with Siouxland Mental Health Center.

You will be given a copy of this signed form to keep for your records.

____ ____________

Signature of Client or Representative **Date**

____

Relationship to Client (if applicable)

Reviewed by: ______________________________________

Staff Signature

Siouxland Mental Health Center
Text Messaging Authorization

Client Name: ____________________________________ DOB: ___________________

Siouxland Mental Health Center offers its clients the ability to communicate with certain members of their care team via text message. Both the client and Siouxland Mental Health Center must enter into an agreement for this.

Privacy and Security of text messaging

Siouxland Mental Health Center cannot and does not guarantee the privacy or security of any messages being sent via text message. There is the potential that these messages can be intercepted and read by others. If this is of concern to you, you should not communicate with Siouxland Mental Health Center via text messaging.

Additionally, you should be aware of and understand that if you use any phone provided by your employer, any text message sent or received on your employer's system may be viewed by your employer.

This document along with Siouxland Mental Health Center's "Notice of Privacy Practices" constitutes a notice of privacy practices for text messaging use.

Keeping Records of text messaging

Text message communications will be documented in an electronic note maintained in your medical record chart.

Authorization to Use Text Messaging

I have been informed and understand the risks and procedures involved with using text messaging. I agree to the terms listed on this form and hereby voluntarily request, consent to, and authorize the use of text messaging as one form of communication with Siouxland Mental Health Center.

You will be given a copy of this signed form to keep for your records.

____ ______________
Signature of Client or Representative **Date**

____
Relationship to Client (if applicable)

Reviewed by: ____________________________________
Staff Signature

Patient Name: ___________________________ DOB: ___________________________

I have given Siouxland Mental Health Center permission to bill my insurance for services offered**. I understand that if my insurance does not cover a provided service, I am responsible to pay the remaining bill to Siouxland Mental Health Center.** The prices for services is listed below:

Service	**Price**
New Patient Therapy Intake (In Person or Telehealth)	$110-$150
Annual Therapy Intake (In Person or Telehealth)	$110.00
Individual Therapy Session (In Person or Telehealth)	$60-$165
Group Therapy Session (In Person or Telehealth)	$67.00
Family Therapy Session (In Person or Telehealth)	$110.00
New Patient Psychiatric Evaluation (In Person or Telehealth)	$180-353
Existing Patient Psychitric Evaluation (In Person or Telehealth)	$150.00
Psychiatric Medication Check (In Person or Telehealth)	$67-$173
Nurse Visit	$15.00
Injection Fee	$25.00

By signing this form, I acknowledge that I have seen the price list for services offered that could be billed to my insurance.

___________________________________ ___________________________________

Printed Name of Client **Signature of client/guardian**

____

Date