Client Name:_____
MR#_____
WCBS worker_____
Date of referral:_____
Date of Admission:_____

Woodward Community Based Services
Referral Form

☐BCLIAISON ☐PEER SUPPORT ☐FAMILY PEER SUPPORT ☐SUBSTANCE ABUSE ☐CBI ☐ART
☐ BHIS ☐SAL ☐THERAPY ☐REENTRY ☐O.S.O.T. ☐ TRACKING& MONITORING

Name:_____DOB:_____ Age: _____ Gender:_____ Race:_____ Title XIX:_____

SS#:_____ Religion:_____Preferred Language/Communication:_____ School/Employer:_____

Current placement/residence:_____Address:_____

Client phone number/contact number: _____Email:_____

Guardian(s)_____ Phone ( )_____Address:_____

Guardian Religion:_____ Preferred Language:_____Email:_____

Mother:_____ Phone( )_____Address:_____

Father:_____ Phone( )_____Address:_____

Emergency Contact:_____ Phone( )_____Relationship to Client:_____

Referral Source:_____ Phone ( )_____Agency_____
Funding Source?: _____ Private Pay?:_____ Sliding Fee Scale?:_____

Medical Conditions: _____ Impairments (If Any):_____ Allergies_____
Medications (Include Usage and Duration):_____
Primary Care Physician:_____ Diagnosis:_____

Supplemental Services: (Please include services for all siblings as well as client, examples: IEP, therapy, med management, etc.)

_____

_____

Behaviors

Behavior of Concern	How Often Behavior Occurs	Severity of Behaviors 1 (lowest) to 5 (highest)	Triggers	Coping Mechnaisms

Treatment History (If there is no history please write none)

Provider-Agency	Type of Service	Dates of Service

Approved Contacts

First & Last Name	Relationship	Approved By

Unapproved Contacts/Unsafe Contacts? _____

_____

Are there any environmental safety/security concerns in the home for the WCBS worker?_____
☐Adequate lighting? ☐Loose Animals ☐Loitering outside home entrance ☐Weapons ☐Substances

Client Name:_____
MR#_____
WCBS worker_____
Date of referral: _____
Date of Admission: _____

Woodward Community Based Services
Referral Form

Insurance Information

Please provide a copy of your insurance card(s) prior to your appointment by sending it to wcbs@sequelyouthservices.com or bring a copy with you for your intake.

Primary Insurance Coverage: _____ Phone Number: _____
Name of Insured: _____ Insured DOB: ____/____/_____
Relationship to Insured: _____ Insured Employer: _____
Policy #: _____ Group #: _____
Effective Date: ____/____/_____

Secondary Insurance Coverage: _____ Phone Number: _____
Name of Insured: _____ Insured DOB: ____/____/_____
Relationship to Insured: _____ Insured Employer: _____
Policy #: _____ Group #: _____
Effective Date: ____/____/_____

In signing this form, I acknowledge that I have disclosed ALL insurance information to Woodward Community Based Services. I also acknowledge that I may be billed for unpaid services that occur as a result of not disclosing insurance information.

Signature: _____ Date: _____

Notes:

Woodward Community Based Services
Insurance Benefit/Patient Demographics

Requesting Admin: _____
Provider name if existing: _____
☐New Client ☐Existing Client
☐MH ☐SA ☐ FGC ☐PSS ☐HAB ☐BHIS ☐Other

Client:
Last Name: _____ First Name: _____ DOB: ____/____/_____
SS#: _____
Address: _____ City/State/Zip: _____
Home #: _____ Cell: _____

Primary Policy Holder:
☐Same as Client (Skip to Insurance Section)
Last Name: _____ First Name: _____ DOB: ____/____/_____
SS#: _____
Address: _____ City/State/Zip: _____
Home #: _____ Cell #: _____

Insurance:
Please make a copy of the Insurance Cards, Front and Back & email to wcbsbilling@sequelyouthservices.com

Insurance Company: _____ Group #: _____
ID #: _____ Phone #: _____
Benefit Year (Mark One): _____ Calendar _____ Other: _____
Deductible: **Individual $**_____ **Family $** _____ N/A ____ **Met $**_____
Coinsurance: _____ Y _____ N Co-Pay: $_____
Visit Limit:
☐____# Per Benefit Year ☐ Auth after _____ Visit ☐No Limit
Initial Authorization #: _____ Validation Dates: ____/____/____ to ____/____/____
Visits _____
Authorizing Entity: _____ Phone: _____ Fax: _____

Secondary Insurance:
Please make a copy of the Insurance Cards, Front and Back & email to wcbsbilling@sequelyouthservices.com

Insurance Company: _____ Group #: _____
ID #: _____ Phone #: _____
Benefit Year (Mark One): _____ Calendar _____ Other: _____
Deductible: **Individual $**_____ **Family $** _____ N/A ____ **Met $**_____
Coinsurance: _____ Y _____ N Co-Pay: $_____

Notes/Exclusions: _____
_____

☐LMHC, LISW, LMSW, OR MD Only ☐Not Allowed

Woodward Community Based Services

Informed Consent for Therapy Services – Adult

COUNSELOR-CLIENT SERVICE AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

COUNSELING SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in therapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Therapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Therapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS

Appointments will ordinarily be 40-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice. If you miss a session without canceling, or cancel with less than 24 hour notice, my policy is to collect the amount of your co-payment [unless we

both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES

You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check or cash; I am not able to process credit card charges as payment. Any checks returned to my office are subject to an additional fee of up to $50 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

INSURANCE

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, my billing service and I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-IV. There is a copy in my office and I will be glad to let you see it to

learn more about your diagnosis, if applicable.). Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by check or cash. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount, that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my provider contract.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are

fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

CONTACTING ME

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) go to your Local Hospital Emergency Room, or 2) call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice. You can also contact Joint Commission at 1-800-994-6610 or email at complaint@jointcommission. Joint Comissions's fax number is 630-792-5632.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You 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. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

Informed Consent to Treatment.

By placing my initials next to the following statements, I am voluntarily consenting to mental health services provided by WCBS. My initials also represent that I acknowledged my rights as a client.

_____ I have chosen to receive mental health treatment services and understand I may terminate these services at any time.

_____ I understand there is no assurance that I will feel better. Because these services are a cooperative effort between me and my counselor, I will work with my counselor in a cooperative manner to resolve my difficulties.

_____ I understand that during the course of my treatment, material may be discussed that will be upsetting in nature and this may be necessary to resolve my problems.

_____ I understand that records and information collected about me will be held or released in accordance with federal and state laws regarding confidentiality of such records and information.

_____ I understand that state and local laws require that my therapist report all cases of suspected abuse or neglect of minors or vulnerable adults.

_____ I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others.

_____ I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

_____ I understand that I may be contacted by my health plan to ensure continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment.

CONSENT TO THERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

_____

Date _____

Description of Personal Representative's Authority:_____

NOTICE OF PRIVACY PRACTICES

"THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."

A. Introduction:

As part of your health care, Woodward Community Based Services originates and maintains numerous medical, billing, and other related records which contain information identifying you and describing your health history, symptoms, test results, diagnosis, treatment, and any plans for future care. This notice describes how this information may be used and disclosed by the Facility, as well as your rights and the Facility's duties with respect to such information.

B. Your Health Information Rights:

Although all records relating to the treatment you receive at the Facility are the property of the Facility, you have the following rights with respect to your health information:

- The right to request restrictions on certain uses and disclosures of your health information as provided by 45 C.F.R. 164.522. The Facility is not required to agree to any requested restriction.
- The right to obtain a copy of this Notice upon request.
- The right to inspect and obtain a copy of your health information as provided in 45 C.F.R. 164.524.
- The right to amend your health information as provided in 45 C.F.R. 164.526.
- The right to obtain an accounting of disclosures of your health information as provided in 45 C.F.R. 164.528. A Request for Accounting of Disclosures of Health Information must be made on the Facility's form. Copies of these forms are available at the Facility.
- The right to receive confidential communications of your health information as provided in 45 C.F.R. 164.522(b), as applicable.
- The right to receive notifications of breaches of unsecured PHI as provided in 45 C.F.R. 164.520(b)(1)(v)(A)).

You may exercise any of these rights by contacting the Facility representative listed below.

C. Facility Responsibilities:

The Facility is required by law to maintain the privacy of your health information and to provide you with a notice as to the Facility's legal duties and privacy practices with respect to your health information. The Facility is also required to abide by the terms of this Notice, as it may be revised from time to time.

The Facility reserves the right to change the terms of this Notice and to make any revisions to the Notice effective for all your health information that the Facility maintains. Should the Facility change the terms of this Notice it will either hand-deliver or mail you a revised notice as well as post the revised notice in an area accessible to residents.

D. **For More Information or to Report a Problem:**

If you have questions or would like additional information, you may contact

___Darian Baker_____ at _____515-274-9607_____

If you believe your privacy rights have been violated, you can file a complaint with

___Darian Baker _____ at ____515-274-9607_____

or with the Secretary of the Department of Health and Human Services without fear of retaliation for filing a complaint. All complaints must be in writing.

E. **Use and Disclosure of Your Health Information.**

As a general rule, the Facility may use or disclose your health information in the following ways:

Treatment: The Facility will use your health information in the provision and coordination of your healthcare. We may disclose all or any portion of your health information to other health care providers who have a legitimate need for such information in your care and continued treatment. The Facility also may disclose your health information to people outside the Facility who may be involved in your medical care after you leave the Facility, such as family members, clergy, and others used to provide services that are part of your care.

Family/Friends: In certain situations, the Facility may release health information about you to a friend or family member who is involved in your medical care, or to someone who helps pay for your care

Payment: The Facility may release health information about you for the purposes of determining coverage, billing, claims management, medical data processing, and reimbursement. Your health information may be released to an insurance company, third party payer or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record which are necessary for payment of your account. For example, a bill sent to a third party payer may include information that identifies you, your diagnosis, and the services and supplies provided to you. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Routine Healthcare Operations: The Facility may use and disclose your health information during routine healthcare operations, including, but not limited to, quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities of the Facility.

Facility Directory: In certain situations, the Facility may use your name and location in the Facility for directory purposes. This information may be provided to people who ask for you by name.

Business Associates: The Facility may disclose certain health information about you to business associates. A business associate is an individual or entity under contract with the Facility to perform or assist the Facility in a function or activity which necessitates the use or disclosure of health information. Examples of business associates, include, but are not limited to, consultants, accountants, lawyers, medical transcriptionist and third-party billing companies. The Facility requires the business associate to protect the confidentiality of your health information.

Marketing: The Facility may disclose certain contact information to a third party to provide marketing materials and information to you.

Regulatory Agencies: The Facility may disclose your health information to a health oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and other health oversight agencies to monitor the healthcare system, government programs, and compliance with civil rights.

Law Enforcement/Litigation: The Facility may disclose your health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

Public Health: As required by law, the Facility may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Victims of Abuse: The Facility may disclose your health information to government authorities, such as social services authorities or protective agencies, if the Facility reasonably believes that you are a victim of abuse, neglect, or domestic violence.

Workers Compensation: The Facility may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Required by Law: The Facility will disclose medical information about you when required to do so by law.

Coroners, Medical Examiners, Funeral Directors: In the event of your death, the Facility may release your health information to a coroner or medical examiner. This may be necessary,

for example, to determine a cause of death. The Facility may also release your health information to funeral directors as necessary to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, the Facility may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Research: The Facility may disclose your health information to researchers when their research has been approved by an institutional review board that has reviewed the research purpose and established protocols to ensure the privacy of your health information. Before disclosing any of your health information we will verify that the researchers have obtained your consent to participate in the study.

Appointment Reminders/Treatment Alternatives: The Facility may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): The Facility may disclose to the FDA health information relative to adverse events with respect to food supplements, products, and product defects, or post- marketing surveillance information to enable product recalls, repairs, or replacement.

Avert Threat to Health or Safety: The Facility may disclose your health information if the Facility in good faith believes that disclosure is necessary to prevent serious harm to an individual or the public.

Government Functions: When appropriate, the Facility may disclose health information to serve certain governmental functions. The entities who may receive this information include, but are not limited to the military, intelligence agencies, and correctional institutions.

Fundraising: The Facility may contact you as part of our fundraising efforts.

Other Uses: Any other uses or disclosures of your health information will be made only with your written authorization. You may revoke an authorization, in writing, at any time except to the extent that the Facility has relied on your authorization.

F. The following uses and disclosures require authorization from you:

- Most uses and disclosures of psychotherapy notes (where applicable).
- Uses and disclosures of PHI for marketing purposes; and
- Uses and disclosures that constitute the sale of PHI.

G. **Confidentiality of Substance Abuse Treatment Records.**

Federal regulations (42 C.F.R. Part 2) provide special protection for the confidentiality of

certain alcohol and drug abuse treatment records. To the extent that the Facility maintains any records or other health information about you that is protected from disclosure by these regulations, the Facility will only disclose such information as permitted by these regulations.

H. **Mental Health Care Treatment Records.**

State law and/or regulations may provide special protection for mental health care treatment records. To the extent that the Facility maintains any records or other health information about you that is protected from disclosure by such state law and/or regulations, the Facility will only disclose such information as permitted by state law and/or regulations.

I. **Effective Date:**

The effective date of this notice is _____.
(Date)

I acknowledge that I have been provided a copy of the Facility's "Notice of Information Practices" which provides a description of the manner in which the Facility may use and disclose my protected health information. If I have any questions, I know that I have the right to contact Sequel and ask the Privacy Officer about my concerns.

_____ _____
Signature of Client Date

_____
Client's name (please print)

_____ _____
Signature of Parent or Guardian Date

_____ _____
Signature of Witness /Therapist /Counselor Date