DEMOGRAHIC INFORMATION:

Client's Full Name: ____ DOB: ____/_____/____
Address: ____________________________________ City:___________________ State:____ Zip:____________
Phone: _________________ Email: ___________________________ Social Security #: ____________________
Preferred contact method: ☐Phone ☐Email ☐ Either Ok to Text? ☐ Yes ☐ No
Gender: ☐Female ☐Male ☐Trans ☐ Other Marital/Legal Status: ☐Single ☐Married ☐Divorced ☐Partnered
Employer: ______________________________________Occupation:____

PLEASE LIST OTHER PERSONS RESIDING WITH THE CLIENT:

Name:_________________________________ Age:_______ Relationship to Client: _________________________
Name:_________________________________ Age:_______ Relationship to Client: _________________________
Name:_________________________________ Age:_______ Relationship to Client: _________________________

PLEASE CHECK THE PRIMARY REASONS YOU ARE SEEKING COUNSELING NOW:

______ Abuse/Trauma
______ Adjustment Difficulties
______ Anger/Temper
_______ Anxiety
_______ Behavioral Difficulties
_______ Body Issues/Awareness
_______ Depression
_______ Drug/Alcohol Use
_______ Family Concerns
_______ Grief and Loss
_______ Gender/Sexual Identity Issues
_______ Marital/Relationship Issues
_______ Pain Management
_______ Personal Development
_______ Pre-marriage Counseling
_______ Sexual Concerns
_______ Other

Highest education level: ____ High School/GED ______ Vocational Business/Tech _____ Some College
____ College Degree ______ Master's Degree _____ Doctoral Degree

Are religious/spiritual issues an important part of your life? _______ Yes ________ No
Religious Preference: _______Protestant _______ Catholic _______ Jewish _______ Buddhist
Other: __________

Have you ever been seen for therapy services in the past? ☐ Yes ☐ No By?: ____________________ Date Last Seen: _________	Reason for ending services: ___________________________ ___________________________ ___________________________	Involved with a psychiatrist currently?	☐ Yes ☐ No
Any health needs or concerns to be aware of?		Current Diagnosis:	
How were you referred to me?		Name of psychiatrist:	
List Current medications (if any):		Date of last visit:	

EMERGENCY CONTACT INFORMATION:

☐ **I volunteer to provide the below contact information and authorize Central Iowa Therapy Solutions, LLC 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): ___________________________

Client or Legal Guardian Signature __________________________ **Date Signed** __________________________________

DECLINE TO PROVIDE EMERGENCY CONTACT INFORMATION:

☐ **I choose not to furnish any emergency contact information to Central Iowa Therapy Solutions, LLC at this time.**

Client or Legal Guardian Signature __________________________ **Date Signed** ____________________________

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.

PROTECTED HEALTH INFORMATION: In the course of treatment, information regarding your care may be created and/or received. Information which can be used to identify you and which relates to your past, present of future physical or mental condition, receipt of care or payment for care is considered protected information and is protected by federal and state law.
Federal law imposes certain obligations and duties upon providers of services with respect to your protected information. Specifically, I am required to:

- Provide you with notice of my legal duties and policies regarding the use and disclosure of your protected information;
- Maintain the confidentiality of your protected information in accordance with state and federal law;
- Honor your requested restrictions regarding the use and disclosure of your protected information, unless under the law we are authorized to release your protected information without your authorization.
- Allow you to inspect and copy your protected information;
- Act on your request to amend protected information, although I am not required to amend the protected information, within sixty (60) days and notify you of any delay which would require me to extend the deadline by the permitted thirty (30) day extension;
- Accommodate reasonable requests to communicate protected information by alternative means or methods;
- Notify you of any breach in your protected health information with sixty (60) days of discovery; and
- Abide by the terms of this notice.

HOW YOUR PROTECTED INFORMATION MAY BE USED AND DISCLOSED
Generally, your protected information may be used and disclosed only with your express written authorization. This written authorization includes to whom the information may be disclosed, what information may be disclosed, and for what purpose. You may revoke this authorization at any time, although any information released prior to the revocation may be used as stated on the consent.
There are some exceptions to this general rule. The following explains how Central Iowa Therapy Solutions, LLC will use or disclose your protected information without your authorization:

- **Treatment Purposes:** Central Iowa Therapy Solutions, LLC may use or disclose your protected information for treatment purposes to doctors, nurses, hospitals, for instance, in order to facilitate your treatment.
- **Payment Purposes:** Your protected information may be used or disclosed to your insurance company, for instance, for payment purposes as it may be necessary to disclose this information so that I may properly receive payment for treatment and services provided.
- **Health Care Operations:** Your protected information may be used or disclosed for health care operations. For example, record review related to quality assurance and improvement activities or third party system related to scheduling/billing operations.
- **Compliance and Quality Assurance:** I may release your protected information to another individual or entity covered by the HIPPA privacy regulations that has a relationship with you for fraud and abuse detection or compliance purposes, quality assessment and improvement activities, or review, evaluation or training of professionals or students.
- **Oversight Activities:** Your protected information may be used or disclosed to an oversight agency for activities authorized by law. Examples of oversight activities include audits, investigations, and inspections. In most cases, the oversight activity will be for the purpose of overseeing services and agency compliance with certain laws and regulations.
- **Judicial and Administrative Proceedings:** If you are involved in a lawsuit or other administrative proceeding, I may release your protected information in response to a court or administrative order. I may also release protected information pursuant to a subpoena or discovery request, but only if efforts have been made by the requestor to provide you with notice of the request and you have failed to object or the objection was resolved in favor of disclosure, or in the alternative, the requestor has obtained a protective order protecting the requested information.
- **Law Enforcement:** I may release your protected information to law enforcement officials when required or permitted by federal or state law to do so.
- **Emergency Circumstances:** Protected information may be disclosed to personnel who have a need for information about a client, such as for the purpose of treating a medical or mental condition which poses an immediate threat to the health and safety of any individual or the public and which requires immediate intervention.

- **Individuals Involved in Your Care:** I may give out your protected information to a friend or family member who is helping with your care or with payment for your care. However, prior to sharing your protected information in this instance I will first attempt to obtain your verbal or written consent. An example of when obtaining such consent would not be feasible would be if you are involved in a serious accident and unavailable to give your consent and it is necessary for me to speak with your emergency contact or other responsible party.
- **Mandatory Reporting of Child Abuse/Dependent Adult Abuse:** I am a mandatory reporter of child abuse and dependent adult abuse. In the event that there is reason to suspect that child abuse or dependent adult abuse has occurred, your protected information may be disclosed as required by law.
- **As Authorized by Law:** I will disclose your protected information for reasons not described above when required by law to do so.
- **More Stringent Laws:** Some of your protected information may be subject to other laws and regulations and are afforded greater protection than what is outlined in this Notice. For instance, HIV/AIDS, substance abuse, and mental health information is often given more protection. In the event your protected information is afforded greater protection under federal or state law, I will comply with the applicable law.

YOUR RIGHTS

Federal law grants you certain rights with respect to your protected information. Specifically, you have the right to:

- Receive notice of Central Iowa Therapy Solutions, LLC. policies and procedures used to protect your protected information;
- Request that certain uses and disclosures of your protected information be restricted, provided, however, if I release the information without your consent or authorization, I have the right to refuse your request;
- Access to your protected information be amended, although I am not required to grant your request;
- Obtain an accounting of certain disclosures of your protected information for the past six (6) years;
- Revoke any prior authorizations for use or disclosure of protected information, except to the extent that action has already been taken; and
- Request that communications of your protected information are done by alternative means or at alternative locations.

IMPORTANT CONTACT INFORMATION

This notice has been provided to you as a summary of how Central Iowa Therapy Solutions, LLC. will use your protected information and what your rights with respect to your protected information are. If you have any questions or would like more information regarding your protected information, please contact me directly. If you believe your privacy rights have been violated, please speak with me directly about this. You may also file a complaint with the Secretary of Health and Human Services. There will be no retaliation for the filing of a complaint.

This Document to be left with the client

RECEIPT OF PROVIDER'S PRIVACY PRACTICES AND CLIENT'S RIGHTS

I, ____________________________ acknowledge that I have received a copy of the Notice of Privacy Practices and Client Rights which summarizes the ways my identifiable health information may be used and disclosed by this provider, and it also states my rights with respect to my medical information. I understand this provider has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event this provider revises its information practices, a revised Notice of Privacy Practices will be posted at Central Iowa Therapy Solutions, LLC. and that I may obtain a current form at any time from Jill Lehmann-Bauer, LISW / Central Iowa Therapy Solutions, LLC.

____ ____________________
Printed Name of Client/Parent/Legal Guardian Date Signed

____
Signature of Client/Parent/Legal Guardian

____
Relationship to Client (if different from client)

____ ____________________
Witness Date Signed

CLIENT RIGHTS AND RESPONSIBILITIES

Clients Have the Right To:

- Be treated with dignity and respect.
- Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Express and practice religious and spiritual beliefs.
- Have their treatment and other member information kept confidential. Only where permitted by law may records be released without the member's permission.
- To request to view their records and to request that the record be amended or corrected if it is determined appropriate by the provider.
- Obtain a second opinion when appropriate.
- A clear working contract in which business items, such as times of sessions, payment plans/fees, absences, access, emergency procedures, and third-party reimbursement procedures are discussed.
- Know about their treatment choices, regardless of cost or coverage by their benefit plan.
- Share in developing their plan of care.
- Receive a clear explanation of their condition and treatment options.
- Give input on the Members' Rights and Responsibilities policy.
- To speak to the provider about a grievance without retaliation.
- To be informed and given the opportunity to complete a written consent prior to being recorded, photographed, or filed.
- Know of their rights and responsibilities in the treatment process.
- Have provider decisions about their care made on the basis of treatment needs.
- Receive information about Provider's qualifications.
- Ask their provider about their work history and training.
- Decline participation or withdraw from services at any time.

Clients Have the Responsibility To:

- Treat the provider with dignity and respect.
- Give the provider information that they need so the provider can deliver quality care.
- Ask questions about care. This is to help understand the services.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider as soon they know they need to cancel visits.
- Let their provider know when the treatment plan is not working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.
- Let their provider know if they decide to withdraw from the program.
- Make agreed upon payments in a timely manner, if applicable.

This Document to be left with the client

Emergency Procedure

In the event the client has a medical emergency please contact 911. In the event the client has a behavioral or mental health emergency please also contact 911. Jill Lehmann-Bauer of Central Iowa Therapy Solutions, LLC is typically not available outside of business hours. Once 911 has been contacted, then please make an effort to contact Jill Lehmann-Bauer.

Other Resources for Emergencies:

Iowa – 2-1-1 phone number: 211
Child Abuse Hotline: 1-800-362-2178
Suicide Prevention Hotline and Veterans Crisis Hotline: 1-800-273-8255

Hours of Operation:

Jill Lehmann-Bauer, LISW is open from 11am-6pm, Monday, Wednesday, Thursday and limited hours on Sundays. Hours for Central Iowa Therapy Solutions, LLC / Jill Lehmann-Bauer may vary depending on need and preference.

Termination of Services

The following actions can result in the termination of services: failure to comply with Client Responsibilities, failure to respond to the attempts to contact by Central Iowa Therapy Solutions, LLC, harassment or abusive behavior of any nature (verbal, physical, sexual) towards Jill Lehmann-Bauer or others in the office complex, safety concerns with Jill Lehmann-Bauer, no longer insured and/or eligible and unable to pay out of pocket, completion of services, and/or voluntary termination.

Grievance Procedure

Enrollees, participants or their designees are encouraged to speak to Jill Lehmann-Bauer of Central Iowa Therapy Solutions LLC regarding any concerns and/or grievances. This may be done either orally or in writing. Grievances in writing can be sent to 12951 University Avenue, Suite #3, Clive, Iowa 50325

CONSENT FOR TREATMENT / ACKNOWLEDGEMENT OF RECEIPT OF CLIENT RIGHTS

I have read the above itemized statement, I have asked any questions I have about this consent, and I understand it. I consent to the use of a diagnosis in insurance or managed care billing, and to the release of information and other information necessary to complete the billing process if I choose to utilize my insurance benefits. I acknowledge that I have received a copy of the Notice of Privacy Practices which summarizes the ways my identified health information may be used and disclosed by this provider and states my rights with respect to my medical information. I understand this provider has the right to revise these information practices, a revised Notice of Privacy Practices will be posted online at www.iatherapysolutions.com and that I may obtain a current form at any time.

I consent to treatment with Central Iowa Therapy Solutions. I recognize this therapist provides therapeutic services to individuals and couples. I understand that Central Iowa Therapy Solution, LLC does not provide emergency services. I understand that a variety of topics may be covered throughout the course of treatment. I understand that Central Iowa Therapy Solutions will strive to create an environment of open and non-judgmental communication where all clients feel safe, comfortable, and heard by the therapist and/or family member(s).

I have read and understand the above information regarding Consent for Treatment and Receipt of Client Rights, Hours of Operation, Financial Policy, Central Iowa Therapy Solutions', LLC Grievance Procedures, and Termination of Services and Emergency Procedures provided to me in an additional document.

____ ____________________

Printed Name of Client/Parent/Legal Guardian Date Signed

____

Signature of Client/Parent/Legal Guardian

____

Relationship to Client (if different from client)

____ ____________________

Witness Date Signed

Client's Full Name: ___________________________ DOB: ___/___/___

MANDATORY REPORTER POLICY

It is my duty, as a mandatory reporter, to immediately report any suspected child abuse to the Department of Human Services and any suspected dependent abuse to DHS. This provider shall report suspected abuse orally to the DHS, followed by a written report within 48 hours after such oral report. This provider shall also make an oral report to an appropriate law enforcement agency if the provider believes that immediate protection of the child or adult is advisable.

Types of Abuse

1. Physical Abuse
2. Mental Injury
3. Sexual Abuse
4. Denial of Critical Care
5. Child Prostitution
6. Presence Of Illegal Drugs In The Body
7. Manufacture Or Possession Of Dangerous Substances In The Presence Of The Child
8. Bestiality In The Presence Of A Minor
9. 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 legal 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 also be shared in the event of a legitimate subpoena for court appearance, in the event of a medical emergency, or when the receipt of information suggests that child abuse or neglect has occurred. Central Iowa Therapy Solutions, LLC / Jill Lehmann-Bauer is legally obligated to report any such information to DHS under circumstances in which there exists a danger to the child or others. Auditors may also review your records to evaluate treatment effectiveness.

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

____ ____________________
Printed Name of Client/Parent/Legal Guardian Date Signed

____
Signature of Client/Parent/Legal Guardian

____
Relationship to Client (if different from client)

____ ____________________
Witness Date Signed

Client's Full Name: ___________________________ DOB: ___/___/___

PRIMARY CARE PHYSICIAN – COMMUNICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

CHOOSE ONE:

☐ **Please do not contact my primary care physician unless it is necessary for my physical and/or emotional safety.**

☐ **I, the identified client or legal representative, request that Central Iowa Therapy Solutions, LLC / Jill Lehmann-Bauer communicate with my Primary Care Physician (please note, this is not required for treatment and only if you expressly request this formal communication and provide the complete physician contact information):**

RELEASE TO, SECURE FROM, or EXCHANGE WITH:
Physician Name: ____
Address: ____
Phone: ____

Information from the records of ____ the following information:
(Client name)

☐ Diagnosis Assessment ☐ Termination/Treatment Summary ☐ Evaluation/Testing Results
☐ Substance Abuse Treatment ☐ Mental Health Treatment* ☐ Other (specify) ____________________
☐ Medications ☐ HIV/AIDS information

The purpose for this disclosure is to facilitate effective treatment service coordination. A photocopy or exact reproduction of this form for release of information shall have the same effect as the original. This authorization will automatically expire one year from the date of signature unless a shorter period is specified (specific number of days/months or date): ______________________

☐ I understand that I may revoke this authorization at any time, except to the extent that information has already been released as authorized by giving written notice to Central Iowa Therapy Solutions, LLC.
☐ I understand that I have the right to review the disclosed information by contacting Central Iowa Therapy Solutions, LLC.
☐ Once this authorization has expired or has been revoked, it can be renewed only by proper execution of another authorization. I acknowledge that information to be released may include material that is protected by state and/or federal law, including applicable mental health, alcohol/drug abuse, HIV/AIDS information, or all of these.
☐ My signature authorizes release of only the information specified above.
☐ I understand that information authorized by this consent cannot be released to anyone than those listed above unless I give written permission.
☐ I understand I may request a photocopy of this signed document

____ _______________________
Printed Name of Client/Parent/Legal Guardian Date Signed

____
Signature of Client/Parent/Legal Guardian

____
Relationship to Client (if different from client)

____ _______________________
Witness Date Signed

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Client's Full Name: ___________________________ DOB: ___/___/___

CENTRAL IOWA THERAPY SOLUTIONS, LLC FINANCIAL POLICY

Thank you for choosing Central Iowa Therapy Solutions, LLC as your mental health care provider. I am committed to providing you with excellent treatment in an efficient and effective manner. Please check the box next to each paragraph indicating that you have read and understand our policy regarding payment for services.

My current rates for therapy services are $215.00 for a diagnostic assessment, $160.00 per clinical hour (53 minutes) for both individual and couples session. If paying by insurance, I will bill at these rates and have negotiated terms with the insurance company regarding reimbursement levels.

☐ **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 to Central Iowa Therapy Solutions, LLC before services are rendered.
- Central Iowa Therapy Solutions will bill your insurance company for all services provided to you; however, if for any reason your insurance company does not pay, you are responsible for paying the out-of-pocket 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 of the 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 co-payment, co-insurance 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.

☐ **CHARGES FOR CANCELLATIONS OR MISSED APPOINTMENTS**

- There will be no charge if you call and cancel your appointment during the previous business day prior to your scheduled appointment. Clients who cancel during the same day of the appointment may incur a fee of $75.00. Clients who do not come in for a scheduled appointment and no phone contact has been made prior to the time of the appointment may incur a charge of $100. If cancelations and/or no shows exceed two in a three month period, this therapist will review services with the client to determine if services will continue.

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

- Statements will reflect all charges and payments received by the last billing day of the previous month. My interest charges are calculated at the rate of 18% annually, upon unpaid balances over sixty days. For all returned checks, there will be a surcharge of 5% of the amount of the face value or $20, whichever is greater. If a client's third-party benefits or payments ends and/or if the client is more than 90-days delinquent on payments owed, Central Iowa Therapy Solutions, LLC 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.

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, Parent or Legal Guardian Date Signed

______________________________________ ______________________

Witness Date Signed

Client's Full Name: ___________________________ DOB: ___/___/___

PAYMENT / INSURANCE INFORMATION

How will you be paying for your services? (Check all that apply)

☐ **I WILL PAY OUT OF POCKET**

☐ I agree to pay by cash or check after each session

☐ **PRIVATE INSURANCE**

☐ I agree to pay my copayment by cash or check after each session

Name of Insurance Company: ____

Identification # on card: ____

Full Name of Insured: ____

DOB of Insured: ____

SS# of Insured: ____

Employer of Insured: ____

Payment for treatment is due at the time of service unless other arrangements are made. Payments can be made in the form of cash, check, or credit card. Copayments are due at the end of each session to Jill Lehmann-Bauer. I authorize Central Iowa Therapy Solutions to release all information necessary to secure payment. I assign all medical benefits to which I am entitled to Central Iowa Therapy Solutions, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand and agree to the financial policy as stated on the preceding page.

____ ________________________

Printed Name of Client/Parent/Legal Guardian Date Signed

____

Signature of Client/Parent/Legal Guardian

____

Relationship to Client (if different from client)

____ ________________________

Witness Date Signed