

Grinstead & Associates

Real Solutions to Fit your Needs

Missed appointment policy –

If you miss 3 appointments without calling/cancelling you will be terminated from our office. Your signature below acknowledges that you are aware of this office policy

Patient or guardian signature

Date

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Due to a policy required by insurance companies our office must keep a **release or denial** for your current medical doctor in your file. Please sign the attached release if you like us to be able to speak to or send a summary to your medical doctor. If you choose not to sign it please "X" across the sheet, write decline and sign the bottom left side and date.

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RECORD RELEASE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO INCLUDE SUPER CONFIDENTIAL PHI

I, _____, (Name of Patient making Request), hereby request a copy of my health records and authorize **Grinstead & Associates**, (hereafter collectively referred to as "this Healthcare Facility") to use and disclose a copy of my health records to _____

I prefer my records be sent in the following format, but understand that by law, the records can be sent in any electronic format similar if the format I desire is not available. I know this Healthcare Facility will supply these records within **30 days** of this request and will contact me should there be any reason they need to extend this time frame. I understand, by law this Healthcare Facility can request an extension for more time but, can only request an extension, once for an additional 30 days. The format which I prefer to have my electronic records sent is.

- Email a word document to (email address): _____
- Fax a copy to (fax number): _____
- Send a hard copy to (address): _____
- I will pick up a copy on or after (date): _____
- Phone calls
- Appointments (verify or make) Payments (call and check balance and pay)

I specifically authorize this Healthcare Facility to use and disclose verbally, by mail, fax or unencrypted email, the following types of **super-confidential information** as stated in the NOPP (initial where appropriate):

- HIV records (including HIV test results) and sexually transmissible diseases
- Alcohol and substance abuse diagnosis and treatment records
- Psychotherapy records summary

The undersigned does hereby release, hold harmless and agree to indemnify this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given an opportunity to ask questions; that I have received a copy of the signed authorization; that I may inspect a copy of my protected health information to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

By Patient: _____ Date: _____

Print Name

Sign Name

or

Patient's Representative: _____ Date: _____

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Demographics Yearly Update

Please complete the following information

Client Name _____ Birthdate _____

Address _____

City _____ State _____ Zip _____

Billing Address (if different from above): _____

Phone - Home _____ Work _____ Cell _____

Emergency Contact _____

Name	Relationship	Phone number
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Is there any concerns about our office contacting you by phone or mail? YES NO

Please explain _____

Policy Holder Name _____ Birthdate _____

Address (if different from client) _____

Medical Insurance Co _____ Employer _____

EAP/ Mental Health Company (if different from above) _____

Insurance ID Number (SSN if private pay or EAP) _____

Is there secondary insurance? _____

Relationship to client _____

PLEASE COMPLETE IF CLIENT IS A MINOR

Father's name _____ SSN _____

Father's Address _____ Phone Number _____

Employer _____ Date of Birth _____ Work Phone _____

Mother's name _____ SSN _____

Mother's Address _____ Phone Number _____

Employer _____ Date of Birth _____ Work Phone _____

BY SIGNING BELOW, I AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO PROCESS MY INSURANCE/ EAP/ MANAGED CARE/ DDS CLAIM AND I ACKNOWLEDGE FINANCIAL RESPONSIBILITY FOR THIS ACCOUNT

Client Signature _____ Date _____

Authorized Signature for a Minor _____ Date _____

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APPOINTMENTS

The therapy session will be 45-55-minute session (one appointment hour). **Once an appointment hour is scheduled, you will be expected to pay for a late cancellation unless you provide 24 hours advance notice of cancellation [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***

You will be responsible for \$50 for the first missed appointment and \$105 for any subsequent missed appointments. If this is a continuing pattern, your care may be discontinued in our clinic and we would provide you with referrals to other mental health clinics.

If patient is a Medicaid patient by state law we cannot charge for missed appointments. If a Medicaid patient no shows for an appointment they will be eligible to be discharged from therapy services and a referral will be provided to other mental health professionals.

We make every effort to make reminder calls, texts, or email if you give us permission and provide the valid information. However, reminder calls are a **courtesy**. We are not responsible in the event that you do not receive your reminder call, text, or email for any reason. Not receiving a reminder call regarding an appointment **does not** absolve your responsibility in terms of our missed appointment / no show policy.

The patient is responsible for contacting the office with any changes in phone numbers, addresses, insurance information, and legal issues pertaining to minor children.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE RECEIVED THIS AGREEMENT AND READ THIS AGREEMENT AND ARE CONSENTING TO TREATMENT WITH GRINSTEAD & ASSOCIATES. IT ALSO INDICATES THAT YOU AGREE TO THE TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

We require any one 14 and older to sign this agreement. For all minors, 18 and younger, a parent/guardian must also sign.

Signature of Patient

Date

If Minor Signature of Parent/Guardian

Date

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INFORMED CONSENT/WAIVER FOR NON-COVERED, NON-THERAPY, OR UNUSUAL SERVICES

We would like you to know that not all services we provide are covered by insurance, and we would like you to be aware of our policies regarding these services. We will do our best to remind you if we receive a request to provide any services of this nature. We will not release any information without proper signed releases of information from all parties involved in therapy. We may also request that you sign a separate consent for certain specific services.

Some specific examples of non-covered services include but *are not* limited to:

- Preparation for any services requested in regard to litigation
- Testimony in court and time spent waiting to testify or present requested information.
- Deposition for any litigation
- Reports in regard to any litigation
- Any services in response or regard to litigation
- Any fees associated with protecting your medical record including but not limited to:
 - Filing a motion to quash a subpoena
 - Letters (to attorney, school, law enforcement, DHS and others)
 - Reports (conciliation, school, etc.)
 - Meeting with attorneys and others
 - Associated travel for any non-covered services
 - School staffings, meetings with teachers and other school personnel, etc.
 - Conciliation
 - Specific phone consultations that do not include therapy
 - Requested medical records, summaries, reports, etc.
- Time blocked out for anything on this list (even if it is cancelled within 24 hours)**

SERVICES IN REGARD TO LITIGATION: WE REQUIRE PREPAYMENT IN FULL FOR ANY SERVICES IN REGARD TO LITIGATION. FEES FOR THESE SERVICES ARE \$200.00 PER HOUR. When possible, we will provide you with an estimate regarding costs for these services.

I understand that I will be billed for the therapist's time and I acknowledge responsibility for paying for these services in full.

Signature of client or guardian

Date signed

Print client name: _____

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ADDENDUM TO CONSENT FOR COUPLES OR FAMILY OR GROUP THERAPY

When there is more than one person in the room with the healthcare professional there is a "limit of confidentiality." Anyone in the room could choose to speak about the session to outsiders. Although all parties should treat information shared as confidential, it is equally important that all parties involved know that confidentiality is limited.

Parents, by signing below, you are consenting to being quoted or discussed in your children's psychotherapy notes, intake or history.

Further, if any one of the parties requests copies of the chart it will require the signature of all parties that signed the original "informed consent" before any information will be released.

To maintain and protect the therapeutic process, I ask that you sign below. By signing you are also agreeing to not ask for records of these group/couple/family sessions to be released for any legal/litigation purposes.

Print name

Signature

Date

Print name

Signature

Date

Print name

Signature

Date

Print name

Signature

Date

_____declined to sign this addendum on this date: _____

_____ Therapist initials

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

Please **print** name of Patient

Please **sign** for Patient / Guardian of Patient

Legal Representative / Guardian

Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

First Name Only Proper Sir Name Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- Cell Phone Confirmation Email Confirmation
 Home Phone Confirmation **Any of the Above**
 Work Phone Confirmation

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- Cell Phone Confirmation Email Confirmation
 Home Phone Confirmation **Any of the Above**
 Work Phone Confirmation

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

Signature of Privacy Officer

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MINOR CHILD CHECKLIST

DATE: _____

CHILD'S NAME: _____ APPT. DATE: _____

PARENT'S NAME(S): _____

If your child is adopted we will need adoption paperwork to verify custody

ARE YOU AND THE OTHER PARENT MARRIED SEPARATED DIVORCED

(IF MARRIED AND COMING TOGETHER, YOU CAN SKIP THE REST OF THIS CHECKLIST)

If divorced, we will need a copy of the decree at or before the 2nd session

What are the custody arrangements? JOINT CUSTODY PRIMARY CUSTODY

OTHER _____

Who will be attending the appointments? _____

We always encourage both parents to be involved in therapy for a child. Will you notify the other parent? YES NO _____

Is there litigation pending at this time? YES NO

If yes understand that the therapist is not agreeing to be an expert witness or to testify at any deposition, court proceeding, or in any other way.

If there is joint custody or any type of shared custody, it is our understanding that each parent has the ability to give their consent for medical treatment of a child unless the court has specified in the order that the consent of both parents is required. Each parent can know about all appointments and treatment of the child. If either parent calls our office to inquire about appointments or treatment, we are obligated to release that information. We will always encourage both parents to be involved in the treatment of a child. We will not take sides or be involved in any pending litigation. The therapists are not inclined to abandon the patient by a quick and clinically unwarranted termination of treatment because one of the parents is upset.

CO-PAYMENTS - Our office is not responsible for collecting co-payments from anyone but the person who brings the child to appointments. You are responsible for payment for services rendered to you or your minor child(ren).

CUSTODY AND VISITATION ISSUES – The therapist cannot make any recommendations about custody or visitation. If custody and visitation are a concern, the therapist may speak with you about a referral to another therapist for a formal custody evaluation, a mediator, or guardian ad litem. It is assumed that both parents want to work towards the best interest of their child(ren), which includes maintaining a safe, therapeutic environment with the therapist.

BEHAVIOR/CONDUCT – At times, parents who are involved in divorce or custody disputes have difficulty maintaining an appropriate decorum in the waiting room or therapist office. Out of concern for your child(ren), other patients in our clinic and clinic staff, parents are asked to behave respectfully to one another. If they do not behave in a civil manner they may be required to attend sessions separately or services may be terminated. This also applies to appropriate behavior towards office staff.

RELEASE OF INFORMATION – If information from the child(ren)'s record is requested, any person who has attended a therapy session with the child must sign a release or the information cannot be released.

Pursuant Iowa Code for the best interest of the child receiving counseling treatment, therapy notes will be considered privileged and will not be released due to harm for therapist/client relationship. At any time, you may request a therapist discuss or review your entire chart with you. That request must be made in writing and be approved by the Clinical Director of Grinstead & Associates. A fee will be charged of \$150.00.

If you request to meet with the therapist and the child(ren) is not present the child(ren)'s insurance cannot be billed. The parent attending the session can fill out new patient paperwork and their insurance can be billed, or the session can be paid out of pocket for the current session price.

I have read the above paragraphs and understand them. By signing below, I agree to the above.

Date _____ Name _____

Date _____ Name _____

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Name _____

Date of Birth _____

Childhood Developmental History (Please complete if client is 18 years old or younger)

1). Please list any allergic reactions to things the client may have:

2). List any significant injuries while growing up?

3). List any **past or present** serious health diseases? (chicken pox, whooping cough, pneumonia, etc..)

4). List any **past or present** chronic health problems (asthma, ear infections, etc.)

5). List any hospitalizations and briefly explain the reason why?

6). Were developmental milestones met appropriately? Yes No (If No then identify what delays occurred): _____

7). What type of social interaction does your child engage in?

- Normal Isolates self Very Shy Alienates Self Dominates others
 Inappropriate Sex play Associates with acting out peers Other _____

8). Does your child have any intellectual / academic disabilities?

- Normal Intelligence High Intelligence Learning Problems Underachieving
 Authority conflicts Attention conflicts mild retardation Moderate retardation
 Severe Retardation Other _____

9). Does or has your child exhibited any of the following emotional/behavioral problems? (Please check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Repeats words of other | <input type="checkbox"/> distrustful |
| <input type="checkbox"/> Drug use | <input type="checkbox"/> Not trustworthy | <input type="checkbox"/> extreme worrier |
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> hostile/angry mood | <input type="checkbox"/> self-injurious acts |
| <input type="checkbox"/> Chronic Lying | <input type="checkbox"/> indecisive | <input type="checkbox"/> impulsive |
| <input type="checkbox"/> Stealing | <input type="checkbox"/> immature | <input type="checkbox"/> easily distracted |
| <input type="checkbox"/> Violent temper | <input type="checkbox"/> bizarre behavior | <input type="checkbox"/> poor concentration |
| <input type="checkbox"/> Fire-setting | <input type="checkbox"/> self-injurious threats | <input type="checkbox"/> often sad |
| <input type="checkbox"/> Hyperactive | <input type="checkbox"/> frequently tearful | <input type="checkbox"/> breaks things in anger |
| <input type="checkbox"/> Animal cruelty | <input type="checkbox"/> lack of attachment | <input type="checkbox"/> Assaults others |
| <input type="checkbox"/> Disobedient | | |
| <input type="checkbox"/> Other _____ | | |