Healthy Care Solutions, LLC

NEW CLIENT INTAKE PACKET

Client Name: _____ ☐ Male ☐ Female

Address: _____

City: _____State: _____ ZIP: _____

Primary Phone: _____ Secondary Phone: _____

Email address: _____

Date of Birth: _____ SS#: _____

Parent/Guardian Name: _____ Phone: _____

Primary Source of Income: ☐ Employment ☐ Social Security ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Race / Ethnic Origin: _____ Referred By:_____

Work/School: _____ Phone #: _____

Primary Care Physician: _____ Phone: _____

Allergies: _____ Special Medical Needs: _____

Emergency Contact Name(s): _____ Phone: _____

Relationship: _____ Secondary Phone: _____

INSURANCE INFORMATION:

☐Medicaid #: _____ ☐Medicare #: _____

☐Other Primary Insurance Name: _____

Policy #: _____ Group Number: _____

Policy Holder Name:_____ Policy Holder Date of Birth: _____

☐Additional Primary Insurance Name: _____

Policy #: _____ Group Number:_____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Please mark the services you are interested in: (Refer to attached sheet OR ask your counselor for info.

☐ Counseling ☐ Family Support ☐ Peer Support ☐ Case Management

☐CBRS (aka PSR) ☐ Psychological Testing ☐ Group: (indicate group name): _____

☐Other: _____

Healthy Care Solutions, LLC

2019

CONSENT FOR MENTAL HEALTH SERVICES

Welcome to Healthy Care Solutions, LLC. We offer a variety of behavioral and mental health services including: Comprehensive Diagnostic Assessments, Psychotherapy-Counseling, Community Based Rehabilitative Services (formerly PSR), Targeted Case Management, Certified Peer Support Specialist, Certified Family Support Partners, Drug & Alcohol Assessments, Psychological Testing

This document/agreement contains important information about these services, your rights, confidentiality, Healthy Care Solutions policy and procedures, and the Health Insurance Portability and Accountability Act (HIPAA). Please take the time to read this document. Ask your provider any questions you may have and sign the document.

MENTAL HEALTH SERVICES

Psychotherapy- Individual, Family Therapy, Couples Counseling, Group Therapy, Play Therapy, Art Therapy, Equine Assisted Intervention.

Strengths- Based Focused, Evidence Based Procedures, Brainspotting, EMDR (Eye Movement Desensitization and Reprocessing) and PE (Progressive Exposure) to address symptoms of PTSD, Play Therapy, DBT, Motivational Enhancement, EFP Equine Assisted Psychotherapy, Art Therapy, Group Therapy, Family psychoeducation and more. For questions please speak with your intake counselor.

Psychological Testing

Cognitive/ IQ testing, ADHD, Autism, Behavioral Medicine, Disability & Competency, and Vocational testing. Additional tests are available depending on what is referred, required and requested. Please ask for a consultation with our Psychologist after discussing these options with your intake counselor should you desire these services to determine the best options available for you.

Community Based Rehabilitative Services

CBRS provides in-home and community interventions & support to people experiencing severe mental illness. CBRS workers help people maintain mental stability by helping their client achieve measurable goals related to daily living. CBRS promotes increased independence in thinking and behavior leading to the eventual ability for clients to move beyond the need for CBRS.

Targeted Case Management

Targeted Case Management helps people access local, state, and federal services. Some of these services include SSI, SSDI, food stamps, housing, energy assistance, transportation, and making medical appointments.

Certified Peer Support Specialists

No Judgment, Shared Experiences, You make your goals!

A Certified Peer Support Specialist (PSS) uses their lived experience to engage, educate, advocate, guide, and support clients with a serious and persistent mental illness to role model recovery. A Peer Support Specialist will assist a client in developing their own “recovery plan” to promote their personal hopes, wellness, and recovery to successful living in the community.

Certified Family Support Partner

Parent-To-Parent, Caregiver-To-Caregiver, Partner-To-Partner

Family support comes from someone who has lived the experience of raising a child that has had a behavioral health challenge. All family members are affected when a child in the household is living with a challenge. Getting into the right programs and developing the resiliency needed for recovery can be overwhelming. Family Support Partners are here to help with this process.

PARTICIPANT’S RIGHTS

1. **Procedure:** The agency will provide the following rights for participants:

   Humane care and treatment, Not be put in isolation, Be free of mechanical restraints, unless necessary for the safety of that person or for the safety of others, Be free of mental and physical abuse, Voice grievances and recommend changes in policies or services being offered, Practice his/her own religion, Wear his/her own clothing and to retain and use personal possessions, Be informed of his/her medical

and habilitative condition, of services available at the agency and the charges for the services, Reasonable access to all records concerning your services. *Healthy Care Solutions may take up to 15 days to process any records requests. Requests must be submitted in writing.* Refuse services at any time, exercise all civil rights, unless limited by prior court order.

2. **Additional Participant Rights**. The agency will also ensure the following rights for each participant:
   Privacy and confidentiality, receive a response from the agency to any request made within a reasonable time frame, Refuse to perform services for the agency. If the participant is hired to perform services for the agency the wage paid must be consistent with state and federal law, All other rights established by law, Be protected from harm.

RISKS AND BENEFITS

There are some risks as well as benefits with the mental health services offered at Healthy Care Solutions. Some of the risks include but are not limited to: worsening of symptoms, interacting with others in the community inherently affects limits to confidentiality, and therapy can be a difficult experience at times; please be open-minded in the expectations or activities in therapy. Some of the benefits may include, but not limited to: decreases of symptoms, improved relationships and increased understanding of self-care. We are committed in supporting you to maximize the benefits to you as you receive services. You must remember that you are part of a team and we are all striving for the same goal.

RISK OF USING E-MAIL

Provider offers patients the opportunity to communicate by e-mail and text. Transmitting patient information by e-mail and text, however, has a number of risks that patients should consider before using these forms of communication.

CONDITIONS FOR THE USE OF E-MAIL AND TEXT

Provider will use reasonable means to protect the security and confidentiality of e-mail and text information sent and received. However, because of the risks, Provider cannot guarantee the security and confidentiality of e-mail and text communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of e-mail and/or text for patient information.

_____Initial: I understand the above stated risks and benefits and have been given appropriate opportunities to have my questions answered.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The federal government has passed the HIPAA law which provides new privacy protection guidelines for medical records and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. Healthy Care Solutions must provide you with a copy a Notice of Privacy Practices regarding these provisions. The notice explains in depth the HIPAA policy and its application.

LIMITS TO CONFIDENTIALITY

Idaho law protects the communication between a patient and a mental health provider. Every effort will be made to keep your evaluation and treatment strictly confidential. We only release information about your treatment to others if you sign a written authorization form. Listed below are situations in which no authorization is required.

1. Clinical information concerning your case may be shared among various providers within Healthy Care Solutions; this facilitates much needed communication between the supervisor and the provider. All employees are aware of Idaho laws, ethical guidelines and Healthy Care Solution's policies and procedures regarding your privacy rights and their responsibility to protect them. Agency files are also available to program site visitors such as the Department of Health and Welfare (DHW)/Center for Medicare/ Medicaid Services (CMS).

2. It is required by law that the agency reports any reasonable concern regarding abuse or neglect of a child, elderly person, or disabled person with the appropriate agency such as the Department of Health and Welfare. The agency may be required to take protective actions when a client communicates an explicit threat of serious physical harm to a clearly identifiable victim or victims; and has the ability and apparent intent to carry out the threat. The protective actions may be notifying the police, the potential victim, and/or seeking hospitalization for the client. We will also take protective actions if we believe that there is an imminent or even, in our judgment high risk that a participant will physically harm himself or herself.
3. If you are involved in, or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order the agency to disclose information. The agency may be required to provide information about court ordered evaluations or treatments. *Healthy Care Solutions does not provide records for legal purposes unless subpoenaed by the Court.*
4. The agency is required to provide information requested by a legal guardian or legal steward of a minor child, including a non-custodial parent.
5. If a client files a complaint or lawsuit against the agency or a professional staff in our agency, the agency may disclose relevant information regarding the client in order to defend itself.
6. If a client chooses to engage in mental health services in a community setting, there may be certain breaches to confidentiality, from which Healthy Care Solutions is released from liability.
7. Information may be shared with your insurance company for reimbursement purposes and claim processing.

If any of the situations above were to arise, the clinic would make every effort to fully discuss it with you before taking action, and would limit disclosure to only that which is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions you have with us now or when they arise.

It has been explained to me that the agency respects my privacy and shall maintain confidentiality. At times, discussion and exchange of documentation between providing agencies must occur. I shall sign a Request/Release of Information that shall allow for this exchange. I also authorize the agency to share documentation generated from other agencies to my care providers that shall help facilitate plan development and service delivery.

CRISIS POLICY

If you have a life-threatening crisis, please call 911.

If you have a non-life threatening crisis during our normal business hours (Monday-Thursday 8-5, Friday 8-12) you can call our office at 208-529-1660

After Hours Number: 208-557-9874; your call will be routed to the appropriate party.

CONFLICT OF INTEREST

Conflicts of interest may be considered opportunities for inappropriate personal gain during the pursuit of official duties. The gains might be financial, but may include other forms of benefit such as power or advantage. They may also cover conflicts of commitment -- the choices individuals make about their professional priorities, especially the allocation of their time to the different institutions and organizations they serve as professionals. Employees may encounter conflicts of commitment when outside professional activities take priority over other AGENCY/CLIENT-related responsibilities.

Activities that may generate Conflicts of Interest include:

Referrals

Referring participants to service providers is an area where concerns about Conflict of Interest traditionally have focused, given the opportunities that exist for an employee to benefit inappropriately from official activities. Healthy Care Solutions' procedures are designed to protect employees from the appearance of taking unfair advantages or making inappropriate gains through their control of referrals to service

providers. The procedures also protect Healthy Care Solutions' and insure that individuals responsible for referring participants are not in a Conflict of Interest and abusing their position.

Social Media

As a mental health agency we are bound by the National Association of Social Workers Code of Ethics, which is a guide designed to ensure safety and protection to all clients and employees. Secondary relationships between employees and clients violate personal boundaries and threaten confidentiality to both parties. That being said, Healthy Care Solutions employees are NOT permitted to connect with any client on any form of social media (ie, Facebook, Twitter).

_____ Initial: I understand the above stated conflicts and limitations to confidentiality and have been given appropriate opportunities to have my questions answered.

Our Promise to You:

Give first consideration to the objectives, policies and procedures of Healthy Care Solutions. Strive to obtain the maximum ultimate benefit for the participant in meeting his/her needs. Cooperate with service providers in the promotion and development of sound business methods and service provision procedures. Demand honesty in service representation. Decline personal gifts, gratuities, goods, and services, which might in any way influence the referral of participants. Grant all service providers equal consideration, regard each service on its own merits, and foster and promote fair ethical and legal practices. Accord a prompt and courteous reception insofar as conditions permit to all who call on legitimate service delivery missions.

PAYMENT OF SERVICES

It has been explained to me that Medicare/Medicaid and any private insurance is a Payer for services. I agree to inform the agency if I procure additional insurance coverage for services or if I become in-eligible for any insurance providing services. I acknowledge that the agency is required to first seek payment from other sources as required by rule, regulation, or statute. I assume full responsibility for any/all copays, premiums, and non-reimbursed services per my insurance plan and contract with Healthy Care Solutions, LLC.

ASSIGNMENT OF BENEFITS

I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to Healthy Care Solutions, LLC.

FINANCIAL RESPONSIBILITY

I understand that any deductibles not met, co-pays, out of network costs and non-covered services will be my responsibility and due at time of service, unless other payment arrangements have been made. After a third and final written notice, and 1 telephone attempt to notify you of a past due balance of 90 days or more, your account will be sent to collections and assess an additional 30% fee. If you receive a check from your insurance company, it should be forwarded to our agency and applied to your balance. Any bounced checks will accrue an additional $25 to your balance.

NO SHOW-CANCELLATION POLICY

Healthy Care Solutions, LLC requests at least 24 hours of notice to cancel an appointment. I understand that when applicable with my insurance, I will be charged a **$25 no call/no show fee.** Exception to the no-show fee: It is the policy of Healthy Care Solutions to prevent the spread of communicable diseases. Both staff and clients that are suspected of an illness will be asked to cancel their appointments.

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TITLE VI OF THE 1964 CIVIL RIGHTS ACT

Healthy Care Solutions, LLC

Policy: Healthy Care Solutions adheres to Title VI, 42 U.S.C. § 2000d et seq., which was enacted as part of the landmark Civil Rights Act of 1964. It prohibits discrimination on the basis of race, color, age, religion and national origin in programs and activities receiving federal financial assistance.

As President John F. Kennedy said in 1963: Simple justice requires that public funds, to which all taxpayers of all races [colors, and national origins] contribute, not be spent in any fashion which encourages, entrenches, subsidizes or results in racial [color or national origin] discrimination.

Procedure: If a recipient of services from Healthy Care Solutions is found to have discriminated and voluntary compliance cannot be achieved, the matter may be referred to the Department of Justice for appropriate legal action. Aggrieved individuals may file administrative complaints with the federal agency that provides assistance to a recipient through Healthy Care Solutions, or the individuals may file suit for appropriate relief in federal court. Title VI itself prohibits intentional discrimination. Additionally, Healthy Care Solutions strictly prohibits practices that have the effect of discrimination on the basis of race, color, age, religion or national origin.

COMPLAINTS, GRIEVANCES AND APPEALS

In accordance with the Participant Rights Statement, participants and their families as well as, Medicaid, advocates are offered the opportunity report complaint and/or grievances. The complaint, grievance and appeal policy and procedure must be posted in every room of the office in all relevant languages so as to be easily understood. Complaints and/or grievances may be filed as a result of problems with training, service delivery, supervision, funding, planning, service barriers, staff, etc. The agency has a rigorous, internal process for assuring quality services and resolving problems in a prompt manner. Please refer to the Problem Resolution policy and procedure for additional information. All grievances will be solved verbally as quickly as possible when appropriate. If a formal written grievance is filed, the right to file a grievance is outlined as follows: A grievance is made by calling the Administrator**, Michelle Havens at 208-529-1660 ;** or by filling out a grievance report.

Complaint/Grievance reports are to be handled with the utmost confidentiality. The report is to remain amongst the Management team and the people directly involved in any corrective actions. The content or context of the report may be used as training material as decided by Management.

INFORMED CONSENT

By signing below you acknowledge that you have read this agreement and agree to its terms. These matters have been explained to you and you fully and freely give consent to receive mental health services through this agency.

☐ **CHOICE OF PROVIDER**: I verify that I have been informed of my rights to choose any provider for myself.

Name of Client:_____ Date: _____

Signature of client/Guardian: _____

Signature of Witness:_____

Healthy Care Solutions, LLC

2019

Healthy Care Solutions, LLC

HIPAA 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.

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is the information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by treatment staff or office staff and others outside our office that are involved in your care and treatment for the purpose of providing mental health treatment services to you, to pay your treatment bills, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or mange you mental health care and any related services pertaining to your care. This includes the coordination or management of your health care with a third party, for example, your protected health information to diagnose or treat you. Your protected health information may also be disclosed to your physician who referred you to our services to effectively manage your case.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining authorization for services may require that your relevant protected health information be disclosed to the health plan to obtain approval for therapy services.

Research Purposes: Your protected health information may be used to determine the efficacy of your treatment. Your information will only be referred to as a patient number. All data and information will be kept confidential.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities, training of staff, etc. These activities include, but are not limited to, quality assessment activities, employee review activities, training of clinical and/or CBRS staff, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, when calling to inform you of appointments or any other health information regarding you care.

We may use or disclose your protected health information in the following situations without your authorization. These situations include as required by law: public health issues as required by law, communicable diseases, health oversight; abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; coroner; funeral directors and uses and disclosures. Under the law, we must take disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that Medically-Based Fitness has taken an action in reliance on the use or disclosure indicated in the authorization.

2. **Your Right:** Following is a statement of your rights with respect to your protected health information.
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
You have the right to request to receive confidential communications from use by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.
You may have the right to have your therapist or CBRS Specialist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you to any changes. You then have the right to object or withdraw as provided in this notice. A complete copy of all HIPAA regulations is available in our office, and upon request we will provide you with a copy.

3. **Complaints**
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.
This notice is effective as of **August 9, 2011.**
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA compliance officer in person or by phone at (208)529-1660.

Signature below is only an acknowledgement that you have received this Notice of our Privacy Practices.

Name of Client:_____ Date: _____

Signature of client/Guardian: _____

Signature of Witness: _____

Healthy Care Solutions, LLC

Release of Information Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 CFR. Parts 160 and 164) **

1. Authorization

I (Patient Name)_____DOB: _____

authorize (third party/provider)_____

☐ to use the protected health information described below FROM Healthy Care Solutions, LLC.

☐ disclose the protected health information described below to Healthy Care Solutions, LLC.

☐ to **use & disclose** the protected health information described below to/from Healthy Care Solutions, LLC.

2. Effective Period

This authorization for release of information covers the period of healthcare from ***either***:

☐ _____ to _____

☐ All past, present, and future periods.

☐ **ONLY** the following: _____

3. Extent of Authorization

☐ I authorize the release of my **COMPLETE** health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

☐ I authorize the release of my complete health record with the **EXCEPTION** of the following information:

- ☐ Mental Health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _Discharge__ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative Patient's name if not self-Relationship Date