Healthy Care Solutions

New Client Intake Packet

Name (First,M,Last):____

**** Please use spelling as shown on insurance card. ****

Parent/Guardian Name: ___________________________ ☐ **Not Applicable** **Phone:** ______________

Date of Birth: ___________________________ ☐ **Male** ☐ **Female** ☐ **Other** ______________

Cell Phone: _______________________ **Secondary Phone:** ______________________________

Initials _________ If you consent to receive messages for appointment reminders or billing purposes.

Mailing Address: ________________________ **City:** _______________ **State:** ___ **ZIP:** _______

Email address: ____

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: _____________________________

****Please be prepared to provide photo ID & Insurance Card at your first visit.***

☐ **Medicaid #:**______________________________ ☐ **Not Applicable**

Primary Insurance

Name: _____________________________ **Policy Holder:** ____________________________

ID #: ______________________________ **Policy Holder DOB (if not self)**_______________

Group #____________________________ **Policy Holder Relationship:** __________________

Start Date: _________________________ **Customer Service #:**_______________________

Secondary Insurance

Name: _____________________________ **Policy Holder:** ____________________________

ID #: ______________________________ **Policy Holder DOB:** _______________________

Group #____________________________ **Policy Holder Relationship:** __________________

Start Date: _________________________ **Customer Service #:**_______________________

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, The Child and Adolescent Needs and Strengths (CANS) Assessment, Psychotherapy-Counseling, Community Based Rehabilitative Services (formerly PSR), Targeted Case Management, Targeted Care Coordination, Certified Peer Support, Certified Youth Support, Certified Family Support Partners, Drug & Alcohol Assessments, and 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 ☒ *Mark what services you are here for:*

☐ **Psychotherapy- Individual, Family, Group, Play Therapy, Couples Counseling,**
Modalities include: 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, Art Therapy, Group Therapy, Family psychoeducation and more.

☐ **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.

☒ **If you have Medicaid please indicate whether you are interested in any of the following services:**

☐ **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.

YES Program
The Youth Empowerment Services Program refers to services and supports available under the Idaho Behavioral Health Plan, and/or accessed via the 1915(i) State Plan option. The Youth Empowerment Services Program provides children with serious emotional disturbance (SED) access to Medicaid services and supports.

Targeted Care Coordination (TCC) includes the coordination and facilitation of the interdisciplinary Child and Family Team (CFT) meetings to develop an outcome-focused, strengths-based, Person-Centered Service Plan (PCSP) that includes both formal and informal services and support.

CANS Assessments (Child and Adolescent Needs and Strengths Assessment)

☐ **Certified Peer Support Specialists**
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. Now available for youth!

☐ **Certified Family Support 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.

Healthy Care Solutions

PARTICIPANT'S RIGHTS

- To be treated fairly, with dignity and with respect for your right to privacy.
- To receive all health care services in a caring, non-judgmental way.
- To receive your information in a manner that meets your needs. This includes accommodating any communication barriers, disabilities, or cultural needs.
- To take part in all health care decisions, including treatment and recovery planning. You also have the right to refuse treatment.
- To understand any treatment you agree to receive. This is called informed consent.
- To choose someone to help you with care choices.
- To get a second opinion from a provider at no cost to you.
- To make a complaint about the care you are receiving. Complaints can be made about your insurance provider, your treatment provider, or anything else about your treatment experience.
- To choose your providers from your insurance network. This includes not being required to use the same provider for multiple services or not being denied treatment if multiple services are not obtained from the same provider or agency.
- To see your own behavioral health treatment records. This is based on federal and Idaho laws and rules. You have the right to restrict who can view those records based on those laws and rules. You also have the right to request your records be amended or corrected according to federal and Idaho laws and rules.
- *Healthy Care Solutions may take up to 15 days to process any records requests. Requests must be submitted in writing.*
- To not be restrained or secluded as described in federal and state rules on the use of constraints and seclusion.

PARTICIPANT'S RESPONSIBILITIES

- You are responsible for providing your insurance company and its providers with information needed to provide quality care. This may include past behavioral health or medical history that could affect your treatment.
- You are responsible for learning about your health problems to the best of your ability.
- You are responsible for working with your provider to create treatment and recovery goals that are meaningful to you.
- You are responsible for letting your providers know if your treatment and recovery plans need to be updated to meet your changing needs.
- You are responsible for keeping, changing, or cancelling appointments with reasonable notice.

NO SHOW-CANCELLATION POLICY

Healthy Care Solutions, LLC requests at least 24 hours of notice to cancel an appointment unless the staff member or you (the client) are ill. 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. **If you miss 3 appointments with your provider (not related to illness), you may be taken off of the schedule. When applicable with your insurance company, we reserve the right to charge you a $25 no call, no-show fee.**

RISKS AND BENEFITS

There are some risks as well as benefits with receiving mental health services. 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. **By receiving services from our agency, you are releasing Healthy Care Solutions and our Associates/Contractors from all liability related to personal injury or illnesses accrued as a result of treatment activities.**

Healthy Care Solutions

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. 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.

PRIVACY POLICY

We are required by law to maintain the privacy of and provide individuals with a notice of our legal duties and privacy practices with respect to protected health information. If you have any objections or questions related to this policy, please ask to speak with our HIPAA compliance officer in person or by phone at (208)529-1660.

CONDITIONS FOR THE USE OF E-MAIL AND TEXT

Providers may 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. The 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, providers 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 the provider's intentional misconduct. Thus, the patients must consent to the use of e-mail and/or text for patient information.

Healthy Care Solutions

TELEHEALTH

I understand that I have the right to withdraw consent for telehealth services at any time without disrupting my services. I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to: disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies. I understand that we could encounter technical difficulties and may have to end or restart the session. Whether or not we are able to secure a connection, I will provide alternate contact and location information for myself. I understand that there will be no recording of any of the online sessions by either party. All information disclosed or written during a telehealth session are confidential and protected under privacy laws. I understand that if I am experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

VIDEO TAPE CONSENT (For those that will be working with an intern)

Videotaping is used for the purpose of training and supervision of counseling interns. This will allow the intern to consult with his or her assigned supervisor and enhance the effectiveness and quality of treatment
You will be informed prior to each session that is videotaped. You can request that the tape recorder or video recorder be turned off at any time and may request that the tape or any portion be erased. You may terminate this permission to tape at any time.

CONFLICTS OF INTEREST

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).

Referrals
We have a responsibility to decline personal gifts, gratuities, goods, and services, which might in any way influence the referral of participants.

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: 208-450-5308; your call will be routed to the appropriate party.

Healthy Care Solutions

PAYMENT OF SERVICES

Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. If you are without insurance, you may opt to see an Intern **(based on availability)** or apply for our sliding scale program.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your medical claim will be forwarded to your **secondary insurance** (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not. **In the event that your insurance company sends payment to you, the patient, it should be forwarded to our office to be applied to your balance.**

PATIENT PORTION/BALANCE: You are responsible for payment of deductibles, co-payments, co-insurance, and other fees at the time services are rendered. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductible from patients can be considered fraud. Any returned checks will accrue an additional $25 to your balance.

COLLECTIONS: You will be sent three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After a third and last notice, your account will be forwarded to our collection agency. If your account is sent to a collections agency, a **30% FEE** will be added to your account. You bear complete financial responsibility for any fee(s) incurred. Payment arrangements can be made on a case by case basis.

ASSIGNMENT OF BENEFITS: I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Healthy Care Solutions, LLC** all insurance benefits, payable to me for services rendered. 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.
NON-COVERED SERVICES: I assume full responsibility for any/all remaining balance that my insurance does not cover.

INSUFFICIENT PROOF OF COVERAGE: I understand that if I have arrived at my appointment without sufficient proof of insurance (discrepancy in insurance coverage/invalid insurance card) that ultimately, I am responsible for services rendered at this time and choose to receive them willingly. If I provide sufficient proof of being insured within in a timely manner (within 5 Business Days), I understand that I may be reimbursed for payment of today's services after my claim has been processed and paid for by the insurance. If I do not provide proof of insurance within a timely manner, I understand that I will be responsible for today's visit in full.

THIRD PARTY AGREEMENT: I understand that if I am over 18 years of age, and if another party (ie. parents, church, business, Etc.) agrees to be financially responsible for services rendered, that I must provide written documentation of our financial agreement in the form of a letter. The letter must contain the payer's contact information (Name, Phone Number, Address, Ward, Stake) as well as the specific payment arrangements.
I hereby authorize the release all information necessary to secure payment of benefits.

COMPLAINTS, GRIEVANCES AND APPEALS

Healthy Care Solutions

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: 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.

In Accordance with the method of informing participants of their rights described in the Medicaid Provider Agreement, the Company provides participants and their family's information pertaining to protection and advocacy services.

Regional Mental Health Offices
OPTUM IDAHO
Member Services
1-855-202-0973

Adult Protection Services
935 Lincoln Rd
Idaho Falls, ID 83402
(208) 522-5391

Idaho Legal Aid
482 Constitution Way #101
Idaho Falls, ID 83402
(208) 524-3660

Disability Rights Offices
845 West Center St., C107
Pocatello, ID 83204-4237
(208) 336-5396 Fax (208) 232-0938
Email: info@disabilityrightsidaho.org

Child Protection Services
150 Shoup Ave.
Idaho Falls, ID 83402
24-hour emergency: (208) 528-5900

Health & Human Services
HIPAA Violations
2201 6th Ave.
Seattle, WA 9312

Complaints & Grievances
Michelle Havens
Healthy Care Solutions
(208) 529-1660

Licensing
IBOL.IDAHO.GOV

Qualis Health (Medicare)
P O Box 33400
Seattle, WA 98133
800-949-7536

TITLE VI OF THE 1964 CIVIL RIGHTS ACT

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.

INFORMED CONSENT

Healthy Care Solutions

- I agree to the terms and freely give consent to receive mental health services through this agency.
- I verify that the information I have provided above is accurate to the best of my knowledge.
- I understand the above stated electronic communication & telehealth polices.
- I understand and consent to be videotaped, if I should choose to meet with an intern.
- I have been given appropriate opportunities to have my questions answered.
- I authorize the Release of My Information to my insurance carrier.
- I authorize the use of my signature on all insurance submissions.
- I acknowledge that I have had the opportunity to receive and understand the Financial Policy of Healthy Care Solutions, LLC and agree to the policy.
- I understand the above stated conflicts and limitations to confidentiality and have been given appropriate opportunities to have my questions answered.
- I acknowledge that I have the right to request a copy of the privacy policy.
- I understand the above stated rights and responsibilities, risks, and benefits, and have been given appropriate opportunities to have my questions answered.

- By signing I verify that I have read, understood, and received an explanation of the information listed above, and that I may request a copy for myself.

X Client/Guardian Signature:____Date:_________________

Healthy Care Solutions

Authorization for Disclosure Of Mental Health Treatment Information

I,______________________________[Name of Patient/Client], whose Date of Birth is___________

Authorize to disclose to and/or obtain from: **Healthy Care Solutions, LLC & Associates**

____the following information:
[Insert Name of Person/Organization that records may be shared with]

Description of Information to be Disclosed

Unless specified below, this Authorization covers the release of your COMPLETE record (Excluding Psychotherapy Notes).

If you want to limit what information is released, please specify here:
____

Purpose

This information may be used or disclosed in connection with mental health treatment, payment, or healthcareoperations.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Healthy Care Solutions. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires: *Upon Discharge from Services*
or as otherwise indicated:____

Conditions

I further understand that Healthy Care Solutions will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: *Medicaid requires us to notify your Primary Care Doctor that you are engaged in services. We will request a copy of your yearly wellness exam, which must be current (within the past year).*

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information may no longer be protected by federal or state law. I request a copy of this authorization for my records.

If you are signing on behalf of the client, Please print your name and relationship here:

____

X Client/Guardian Signature:____Date:________________

Healthy Care Solutions

Depression Screener

Client Name: ___________________________________ DOB: __________Date:___________

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

Little interest or pleasure in doing things.

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed or hopeless.

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Trouble falling or staying asleep or sleeping too much.

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling tired or having little energy.

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Poor appetite or overeating.

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling bad about yourself — or that you are a failure or have let yourself or your family down.

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Trouble concentrating on things, such as reading the newspaper or watching television.

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Thoughts that you would be better off dead, or of hurting yourself in some way.

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day