For office use only:___Adult___Child

CCA Client Information Sheet

Date:_____

Name of Client:_____ Gender: M_____ F_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____Cell Phone:_____ Work Phone:_____

DOB:_____ SSN:_____ Email:_____

Age:_____ Employer or School:_____ Grade Level:_____

Emergency Contact Name and Phone:_____

Marital Status:_____ Spouse Name:_____ Spouse DOB:_____ Spouse Age:_____

Spouse Employer:_____ Spouse Cell/Work Phone:_____ Spouse SSN:_____

Parent Information (if client is 17 years old and under or Adults covered under parent Insurance)

Mother's Name:_____ DOB:_____ Age:_____ SSN:_____

Address (if different from above):_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Employer:_____ Email:_____

Father's Name:_____ DOB:_____ Age:_____ SSN:_____

Address (if different from above):_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Employer:_____ Email:_____

Children/Siblings:

Name:_____ Age:_____ DOB_____ Name:_____ Age:_____ DOB_____

Name:_____ Age:_____ DOB_____ Name:_____ Age:_____ DOB_____

Name:_____ Age:_____ DOB_____ Name:_____ Age:_____ DOB_____

Insurance Information

Primary Insurance Company:_____ Secondary Insurance Company:_____

Policy Holder Name:_____ Policy Holder Name:_____

Patient ID #:_____ Patient ID #:_____

Claims Address:_____ Claims Address:_____

Policy Holder DOB:_____ Relation to Patient:_____ Policy Holder DOB:_____ Relation to Patient:_____

Employer Group:_____ Copayment:_____ Employer Group:_____ Copayment:_____

(Initial Please) I do_____ I do not_____ want my family physician contacted by this office regarding my or my child's treatment here. If so, you must complete the following information. (All physician fields below must be completed.)

Physician Name:_____ Address: _____City_____ State:_____ Zip:_____

Telephone:_____ Fax:_____

Compass Clinical Associates, PLLC
2500 82nd Place
Urbandale, Iowa 50322

Informed Consent for Treatment

I _____, agree and consent to participate in behavioral health services offered and provided by the staff of Compass Clinical Associates, PLLC, a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the staff member is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient.

I understand that staff is available by phone during normal business hours. Staff is also available after hours by our **"After Hours Phone Contact System"**. It is understood that our staff uses an on-call rotation of qualified clinical staff that may or may not be my current clinician.

If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have the legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature_____Date_____

Relationship to Patient (if applicable):_____

Compass Clinical Associates, PLLC
Client Rights and Responsibilities Statement

Statement of Patient's Rights

- The Client has the right to be treated with dignity and respect.
- The Client has the right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- The Client has the right to have their treatment and other member information kept private.
- Only in an emergency, or if required by law, can records be released without member permission.
- The Client has the right to information from staff/providers in a language they can understand.
- The Client has the right to an easy to understand explanation of their condition and treatment.
- The Client has the right to know all about their treatment choices. This would mean no matter of cost or if they are covered or not.
- The Client has the right to get information about services and role in the treatment process.
- The Client has the right to information about providers.
- The Client has the right to know the clinical guidelines used in providing and/or managing their care.
- The Client has the right to provide input on policies and procedures.
- The Client has the right to know about the complaint, grievance and appeal process.
- The Client has the right to know about State and Federal laws that relate to their rights and responsibilities.
- The Client has the right to know of their rights and responsibilities in the treatment plan.
- The Client has the right to share in the formation of their plan of care.

Statement of Client's Responsibilities:

- The Client has the responsibility to give providers information they need. This is so they can deliver the best possible care.
- The Client has the responsibility to let their provider know when the treatment plan no longer works for them.
- The Client has the responsibility to follow their medication plan. They must tell their provider about medical changes, including medications given to them by other providers.
- The Client has the responsibility to treat those giving them care with dignity and respect.
- The Client should not take actions that could harm the lives of employees, providers, or other Client's.
- The Client has the responsibility to keep their appointments. The Client should call their providers as soon as possible if they need to cancel visits.
- The Client has the responsibility to ask their providers questions about their care. This is so they can understand their care and their role in that care.
- The Client has the responsibility to let their provider know about problems with paying fees.
- The Client has the responsibility to follow the plans and instructions for their care. The care is to be agreed upon by the member and provider.

Client Signature _____Date_____

NOTICE OF PRIVACY PRACTICES, HIPAA STATEMENT

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms or our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment:

We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment:

We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations:

We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization:

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice

To Your Family and Friends:

We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care:

We may use or disclose health information to notify, or assist in the notification of (including identifying or location) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services:

We will not use your health information for marketing communications without your written authorization.

Required by Law:

We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect:

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security:

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders:

We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

PATIENT RIGHTS

Access:

You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information
listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting:
You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction:
You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication:
You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment:
You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice:
If you receive this Notice on our Web sites or by electronic mail (e-mail), you are entitled to receive this Notice in written form

Contact Officer:
Bruce Buchanan, ACSW, LISW, BCD, Compass Clinical Associates, PLLC
Telephone (515) 412-5112
Address: 2500 82nd Place – Urbandale, Iowa – 50322

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
"You may refuse to Sign this Acknowledgement."

I, _____ have received and/or read a copy of Compass Clinical Associates, PLLC notice of Privacy Practices.

Please Print Name_____

Signature_____

Date_____

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
___ Individual refused to sign
___ Communications barriers prohibited obtaining the acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement
___ Other (please specify)

_____

Compass Clinical Associates, PLLC

2500 82nd Place Urbandale,
Iowa 50322
515-412-5112
FAX - 515-412-5123

MEDICAL FORMS AND LETTERS POLICY
Effective 10/1/2017

It is the goal of the clinicians and staff to accommodate paperwork requests in an accurate and timely manner. Please allow **3-5 business days** for completion of any medical form or letter request. The completion time may be extended if the clinician is out of the office when the request is made. No request will be completed for same-day pick-up.

Please see below for additional guidelines:

1. Release of Information (ROI) **must be completed** for the intended party prior to the release of mental health information which may be included in the letter or form. Mental health/substance abuse must be initialed on the ROI.

2. Forms and letters will be completed for those accounts in good standing. Outstanding balances must be paid prior to paperwork being released.

3. Most paperwork will require a current examination prior to being completed and clinicians may deny completion at their discretion until seen.

4. The charge for review and completion of medical forms is **$20.00** and letters is **$15.00**. The fee will be billed to the patient account and should be paid in a timely manner.

Signature_____ Date_____

Relationship to patient (if applicable)_____

Compass Clinical Associates P.L.L.C.
IMPORTANT FINANCIAL INFORMATION
Please Read Carefully

Authorization for Services

Our clinicians participate with various HMO's, PPO's and other managed-care organizations. Some of these plans require preauthorization before the first visit. I understand it is my responsibility to obtain this authorization. Mental health benefits may differ from medical benefits so it is essential that I have researched my mental health benefits prior to my visit. If I have not done this prior to my visit and/or treatment is not a payable benefit, I will be responsible for the full payment at the time of service. Further, if my insurance carrier determines that the services I receive are not medically necessary, I will be responsible for full payment of the bill.

Payment at the Time of Service

I understand this office's policies regarding payment for services. I will make payment in full at the time of each visit unless other arrangements have been made in advance. Insurance will be filed by the office at no charge and I will make any deductible, co-payments, or non-covered service payments at the time of service. If I must be billed there may be a $10.00 service fee**.** The parent/guardian signing Compass Clinical Associate's intake documentation is considered the responsible party for payment. **All self-pay contracts will be paid at the time of service**.

Canceled or Missed Appointments

I understand that when scheduling an appointment, I am reserving professional time in advance. It is my responsibility to keep scheduled appointments. If unable to keep an appointment, I agree to provide a minimum of 24-hour notice during business hours. I acknowledge that a pattern of missed appointments constitutes grounds for unilateral termination of services. I will pay a minimum of $75.00 for all missed appointments and appointments canceled without 24-hour notice. I acknowledge that my insurance plan will not cover these fees.

Telephone Consultation

I will pay for all telephone consultations requested in lieu of a scheduled appointment or to discuss non-urgent medication or clinical concerns (minimum of $25). I understand I will not be charged for calls the clinician requested of me for updates. I acknowledge that my insurance plan will not cover these charges.

Prescription Refills

The expectation is that I will obtain prescriptions at the time of my appointment. I will pay for each prescription called into a pharmacy and/or those written in lieu of obtaining the prescriptions at the time of my appointment (minimum $15). I acknowledge that my insurance will not cover these charges.

Requests for Records

I agree to pay for any copies of records sent to other facilities, providers, or insurance companies regarding my care (minimum $35). I also agree to pay for any reports or letters requested by or sent to a third party.

Court-Related Work

If my clinician is called upon to appear in court, testify in court, or prepare reports for the court related to services received, I agree to pay for all such services.

I have received a copy of this document and assign any insurance benefits to be payable to Compass Clinical Associates P.L.L.C.

Signature_____**Date**_____

(legal guardian if under 18 years)

Compass Clinical Associates, PLLC

Consent to the Use and Disclosure of Health Information for the Purposes of Treatment, Payment, or Healthcare Operations

I understand that as part of my care, **Compass Clinical Associates, PLLC (CCA)** will originate and maintain paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment, including communication between providers in the practice.
A source of information for applying my diagnosis and procedure information to my bill,
A means by which a third-party-payer can verify that services billed were actually provided, and
A tool for routine health care operations such as quality assurance.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent,
The right to request restrictions as to how my health information may be used or disclosed.

I understand that Compass Clinical Associates, PLLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Compass Clinical Associates, PLLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.5220 of the Code of Federal Regulations. Should Compass Clinical Associates, PLLC change their notice, they will send a copy of any revised notice to the address I've provided (U.S. Mail or, if I agree, Email).

I wish to have the following restrictions to the use or disclosure of my health information:

I, _____, understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my or my dependent's protected health information. I consent to the disclosure to my insurance carrier for the purpose of payment. A photocopy of this authorization will be valid as the original.

I fully understand and [ ] accept [ ] decline the terms of this consent (check one).

_____ _____
Signature of Patient or Authorized Patient Representative Date

_____
Relation to Patient

Authorization for Reminder Calls /Electronic Communication

As a convenience to me, I hereby request that **Compass Clinical Associates, PLLC** communicate with me regarding my treatment by **Compass Clinical Associates, PLLC** via electronic communications for any purpose including, but not limited to appointment reminders and therapeutic services via phone/video. I understand that this means **Compass Clinical Associates, PLLC** and/or my treating provider will transmit my protected health information such as information about my appointments and electronic billing statements.

I understand there are risks inherent in the electronic transmission of information by email, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization may or may not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, **Compass Clinical Associates, PLLC** shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by **Compass Clinical Associates, PLLC** to me.

Electronic Billing Statements:

After being provided notice of the risks inherent in the use of electronic communications, I hereby: Accept_____ **(Please initial)** / Decline:_____ **(Please Initial)** to authorize **Compass Clinical Associates, PLLC** to communicate electronically with me, at this e-mail: _____.

Reminder Calls:

After being provided notice of the risks inherent in the use of electronic communications, I hereby: Accept_____ **(Please initial)** / Decline:_____ **(Please Initial)** to authorize **Compass Clinical Associates, PLLC** to communicate with me by using this telephone #_____.

This will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications from **Compass Clinical Associates, PLLC**, I may revoke this authorization by providing written notice to **Compass Clinical Associates, PLLC** to **buchanan@ccaiowa.com** or fax at 1-515-412-5123.

I further expressly authorize **Compass Clinical Associates, PLLC** to provide therapeutic services to me via the electronic platform of their choosing (e.g., Skype, telephone, etc.). I agree to share all requested contact information and account contact information (e.g., contact number, username, etc.) for any such platform in a timely manner so as to not delay the provision of therapeutic services as recommended by my provider(s).

I agree that **Compass Clinical Associates, PLLC** may communicate with me electronically unless and until I revoke this authorization by submitting notice to **Compass Clinical Associates, PLLC** in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

I hereby authorize the transmission and receipt of my protected health information and/or therapeutic services electronically as described above.

_____
Patient Name

_____ _____ _____
Signature of Patient/Guardian Relationship Date

Therapy Authorization for Electronic Communication

I hereby authorize **Compass Clinical Associates, PLLC** and any individual provider I may see within the agency to communicate with me regarding my treatment by **Compass Clinical Associates, PLLC** via electronic communications for any purpose including, but not limited to appointment reminders and therapeutic services via phone/video. I understand that this means **Compass Clinical Associates, PLLC** and/or my treating providers will transmit my protected health information such as information about my appointments and other individually identifiable information about my treatment to me via electronic communications.

I understand there are risks inherent in the electronic transmission of information by phone or video, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization may or may not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, **Compass Clinical Associates, PLLC** shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by **Compass Clinical Associates, PLLC** to me.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize **Compass Clinical Associates, PLLC** to communicate electronically with me, I hereby expressly authorize **Compass Clinical Associates, PLLC** to communicate electronically with me, at this e-mail_____ or text using this #_____, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications from **Compass Clinical Associates, PLLC**, I may revoke this authorization by providing written notice to **Compass Clinical Associates, PLLC** to **buchanan@ccaiowa.com** or fax at 1-515-412-5123.

I further expressly authorize **Compass Clinical Associates, PLC** to provide therapeutic services to me via the electronic platform of their choosing (e.g., Skype, telephone, etc.). I agree to share all requested contact information and account contact information (e.g., contact number, username, etc.) for any such platform in a timely manner so as to not delay the provision of therapeutic services as recommended by my provider(s).

I agree that **Compass Clinical Associates, PLLC** may communicate with me electronically unless and until I revoke this authorization by submitting notice to **Compass Clinical Associates, PLLC** in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

I hereby authorize the transmission and receipt of my protected health information and/or therapeutic services electronically as described above.

_____

Patient Name

_____ _____ _____

Signature of Patient/Guardian Relationship Date

Compass Clinical Associates, PLLC
2500 82nd Place
Urbandale, Iowa 50322
515-412-5112
FAX - 515-412-5123

Acknowledgement of Mental Health/ Substance Abuse
Electronic Medical Records Storage

Patient's Name_____

The undersigned understands and consents to the following:

All documents, clinical records, and billing information relevant to the party identified are stored in the electronic record systems of

Compass Clinical Associates, P.L.L.C.
Everest Institute, L.L.C.

I acknowledge that this information may include material that is protected by state and/or federal law applicable to either mental health or substance abuse or both.

_____
Signature of Patient or Patient's Authorized Representative

_____
If authorized Representative. Relationship to Patient

Date_____