Name DOB

Clear Mind Therapy LLC
35 Main Place Suite 100
Council Bluffs, IA 51503

Explanation of Private Pay Rates and Session Times

Clear Mind Therapy LLC has private pay rates for individuals or families who do not have insurance or have insurance and mental health services are not covered in their policy. Rates and session times are explained below:

90791 Initial Assessment: 85.00

90834/90837 Individual Therapy (45-60 minutes): 65.00

90832 Individual Therapy (16-37 minutes): 45.00

90847 Family Therapy (30-45 minutes): 70.00

The above times are the same as the times used by insurance companies for qualification to be reimbursed at their set rates for the corresponding code. Insurance companies identify the codes by a specific time, but they allow for variances in minutes (over and under) in case clients are late or need to leave early. For example, the 90834 is a identified as a 45 minute session, but they allow anywhere from 38-52 minutes to be a valid, billable session. The 90837 is identified as a 60 minute session but they allow from 53 minutes to 60 minutes for it to be a valid, billable session. Clear Mind Therapy is combining the 90834 and 90837 for private pay sessions into one session for simplicity sake. The 90832 is identified as a 30 minute session but can be 16 to 37 minutes to qualify as a valid, billable code. The 90791 does not have a time limit set by insurance companies, neither does the 90847 family session. Clear Mind Therapy will allow for 30-45 minutes for family session, this is a typical time spent in family session for most family sessions billed to insurance companies. Clear Mind Therapy LLC will not bill extra if family sessions go past the defined time.

All private pay sessions are expected to be paid at the time service is rendered.

I hereby acknowledge that I have received a copy of this document and agree to the rates explained above.

_____ _____

Signature of Patient or Legal Guardian: Date:

_____ _____

Witness: Date:

Name DOB

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Council Bluffs, IA 51503

CLIENT BILL OF RIGHTS

You have the right to:

- Receive respectful treatment that will be helpful, promote dignity and self-respect.
- Receive services without discrimination against race, color, religion, creed, ethnicity, gender, sexual orientation, economic status, handicap or disability.
- Have a safe environment, free from sexual, physical, and emotional abuse.
- Report unethical and illegal behavior by a therapist. Receive services that are free from any restraint or form of punishment.
- Request and received information about the therapist's professional capabilities, including licensure, education, training, experience, membership in professional associations, specialized areas of practice, and limitations on practice.
- Have written information, before entering therapy, about fees, method of payment, insurance reimbursement, number of sessions, substitutions (in cases of vacations and emergencies), and cancellation policies.
- Refuse to answer any questions or disclose any information you choose not to reveal.
- Refuse treatment or services, unless the treatment or services is court ordered, required by law or Board of Mental Health
- To emergency support
- To examine the most recent facility survey conducted by the Dept of Human Services(DHS) and access to the DHS telephone number to file a complaint (if applicable).
- Know if there are supervisors, consultants, students, or others with whom your therapist will discuss your case.
- To be informed, in advance, about any changes in treatment that may affect the client's wellbeing.
- Request that the therapist inform you of your progress.

Clear Mind Therapy LLC retains the right to deny services to any or all of the following reasons: the level of care referred is inappropriate; there is a conflict of interest or potential for a conflict of interest, etc. In the event that any of the aforementioned occurs Clear Mind Therapy LLC will make every effort to provide the referral source and/or the client other resources/providers in the community.

Client Responsibilities

Clear Mind Therapy LLC expects clients to:

- Be considerate and respectful of the rights of fellow clients and staff.
- Be considerate and respectful of the property of fellow clients, staff, and Clear Mind Therapy LLC.
- Adhere to confidentiality with regard to other clients.
- Be cooperative and actively take part in identifying and resolving problems.
- Adhere to Clear Mind Therapy LLC smoking policy and drug free environment.
- Meet the financial obligations incurred for treatment services.

_____Date_____
Client's Signature

_____Date_____
Parent/Guardian Signature

_____Date_____
Witness Signature

Name DOB

Clear Mind Therapy LLC
35 Main Place Suite 100
Council Bluffs, IA 51503

Consent for Assessment and Treatment

I, the undersigned, ***DO*** authorize and request Clear Mind Therapy LLC to perform an LPHA Behavioral Health Clinical Assessment for the purpose of obtaining private pay, or pro bono approval for the below named individual to receive therapy services.

Client Name: _____ Program Affiliation: Assessment and Therapy

I, _____, (name of client/parent/guardian for client) understand that involvement in the above program is expected; I will work on the identified goals or participate as expected and/or discussed with me (or in the case that this is signed for a minor child/impaired adult, will assist my son/daughter/ward/etc. in working on the identified goals or encourage participation in the aforementioned program).
If you (or your son/daughter/ward/etc.) are not able to attend a session according to the program's expectations, it is important to reschedule at least 24 hours in advance. You could be responsible for any session fees that may result in the failure to notify of an absence. In addition, I (or on behalf of my son/daughter/ward/etc.) agree to adhere to the following (when applicable):

- I understand that more than three consecutive no shows (cancellations without a call in advance) could result in a reassignment of the case and/or termination of services (if applicable).
- Follow through is expected when referrals are made for any adjunctive treatment that may be deemed important to supplement the current level of service provision. For example, following through on treatment reviews/recommendations as determined by the funding source or treatment team, psychiatric services for medication evaluations, lab tests to determine the appropriate medication levels, psychological testing as requested, etc.
- If I (or your son/daughter/ward/etc.) refuse to follow the recommendations of my (or your son/daughter/ward/etc.) treating professionals, I acknowledge that my (or your son/daughter/ward/etc.) involvement with Clear Mind Therapy LLC, services could be placed at risk and my result in termination of services.
- I agree to the following emergency protocol that was explained to me (or your son/daughter/ward/etc) in the rights and responsibilities handout and/or discussed with me by my (or your son/daughter/ward/etc) treatment professional.

_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Witness Date

Name DOB

Clear Mind Therapy LLC
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Council Bluffs, IA 51503

INFORMED CONSENT STATEMENT

The attached Informed Consent form for treatment has been made available to me and all 12 items have been fully explained to me. I understand my rights as a client of Clear Mind Therapy LLC and have been given a copy of the informed consent statement. I also understand that, if at any time, I wish to review or re-evaluate the Informed Consent Statement, the Clear Mind Therapy LLC therapist will be available for this discussion.

RECEIPT OF MENTAL HEALTH ADVANCE DIRECTIVE INFORMATION SHEET

I have received the Mental Health Advance Directive Information Sheet and my mental health provider has explained the intent and purpose of an Advance Directive. In addition, my mental health provider has explained that an example of a Mental Health Advance Directive form is available should I request one.

_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Witness Signature Date

Name DOB

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MEDICATION CONSENT FORM

_____ (Psychiatrist/Physician/Med Manager) has educated me regarding the medication that has been prescribed for me. I have been educated regarding the possible side effects of this medication, possible drug and/or food interactions that could occur, and the possible effects of this medication if the person taking it becomes pregnant. I have also been informed of the reason this medication has been prescribed.

If the person for whom the medication has been prescribed is under the age of eighteen (18) or is unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or am legally authorized to initiate and consent to treatment on behalf of this person.

Client Name: _____

Client Guardian/Legal Representative: _____

Witness Signature: _____

Date: _____

- It is recommended that women who are or may become pregnant, or are breastfeeding, discuss this with their doctor before taking any medication.
- It is recommended that clients be educated on reporting all sides effects they experience, including but not limited to, which side effects to report immediately to a health care provider.
- It is recommended that any provider prescribing medication obtain a thorough client history, including but not limited to:
    - What medication, included prescribed and over-the-counter medications, the client is or has been taking.
    - What food and/or drug allergies the client has.
    - What medical conditions the client has.

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<u>Medication Log</u>

Name of Medication	Date Changed	Daily Dosage/ Duration of Use	Authorizing Physician	Reason for Discontinuation

Name DOB

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Council Bluffs, IA 51503

Notice Of Privacy Practices

This notice describes how medical/mental health/other identifying information may be used to disclosed and how you can get access to this information.

This Notice of Privacy Practices describes how Clear Mind Therapy LLC may use and disclose your protected health information (PHI). It also describes your rights to access and control your PHI. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical, mental health or any other condition and related health care services. Clear Mind Therapy LLC is required to abide by the terms of this Notice of Privacy Practices.

Notice of Privacy Practices-a written notice in compliance with the requirements of Health Insurance Portability and Accountability Act (HIPAA), and Health Information Technology for Economic and Clinic Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009, made available from Clear Mind Therapy LLC to an individual or the individual's personal representative at the first delivery of service, or at the individual's next visit following a revision to the Notice, that describes the uses and disclosures of protected health information that may be made by Clear Mind Therapy LLC and the individual's rights and Clear Mind Therapy LLC legal duties with respect to protected health information.

Clear Mind Therapy LLC responsibilities with this Privacy Notice

Clear Mind Therapy LLC agrees by the terms of its' Privacy Notice currently in effect. Clear Mind Therapy LLC reserves the right to make changes to the privacy notice and will post any changes in advance of their effective date. Changes made by Clear Mind Therapy LLC will be reflected in a privacy notice that will be available to you.

I have received an orientation to Clear Mind Therapy LLC which has explained the policies and procedures. I consent to Clear Mind Therapy LLC privacy notice, a copy of which has also been made available to me.

_____ _____

Client Signature Date

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Witness Date

Name DOB

Clear Mind Therapy LLC
35 Main Place Suite 100
Council Bluffs, IA 51503
Phone: 712-256-9902 Fax: 712-256-9903

PHYSICIAN NOTICE OF PATIENT BEING SEEN

Date: _____

Dear: _____

This is a courtesy note to notify you that your patient, _____is now being seen for therapy services by _____.

If you have any questions or require further information, please have the patient sign the appropriate authorizations. Thank you for partnering with our agency in this matter.

Sincerely,

Name DOB

Clear Mind Therapy LLC
35 Main Place Suite 100
Council Bluffs, IA 51503
Phone: 712-256-9902 Fax: 712-256-9903

PSYCHIATRIC/MENTAL HEALTH NOTICE OF PATIENT BEING SEEN

Date: _____

Dear: _____

This is a courtesy note to notify you that your patient, _____, is now being seen for therapy services by _____.

If you have any questions or require further information, please have the patient sign the appropriate authorizations. Thank you for partnering with our agency in this matter.

Sincerely,