

Name

DOB

Insurance

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

**AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE CARRIERS**

Name of Patient: \_\_\_\_\_

The undersigned hereby authorizes Clear Mind Therapy LLC to release information to my insurance carrier:

\_\_\_\_\_

Furthermore, I SPECIFICALLY AUTHORIZE disclosure and re-disclosure of this confidential information to the entities referenced above.

Furthermore, I SPECIFICALLY AUTHORIZE the provider to use this form as approval authorizing payment of medical benefits to the undersigned as outlined on HCFA-1500 blocks 12 & 13.

I understand that I have a right to inspect the disclosed information at any time.

This authorization is in effect for the duration of my treatment following the date that it is signed.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written revocation to the health care provider or record keeper.

A photo copy or exact reproduction of this signed authorization shall have the same force and effect as the original.

I hereby authorize the release as indicated above.

I hereby acknowledge that I have received a copy of this document.

\_\_\_\_\_  
Signature of Patient or Legal Guardian:

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Witness:

\_\_\_\_\_  
Date:

Name

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**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.

\_\_\_\_\_  
**Client’s Signature** **Date**

\_\_\_\_\_  
**Parent/Guardian Signature** **Date**

\_\_\_\_\_  
**Witness Signature** **Date**

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**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 insurance, 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

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**INFORMED CONSENT STATEMENT**

I have received the Informed Consent form for treatment 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

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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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**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

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**Acknowledgement of Private Insurance Payment Expectations**

Clear Mind Therapy LLC will submit payment to your private party insurance in a timely manner. It is the expectation of Clear Mind Therapy LLC that all consumers bring their ID card to their first session in order for a copy to be made for our records. If you have more than one insurance policy it is your responsibility to inform your counselor and provide both cards at the session and indicate which is primary. If any changes are made regarding your insurance carrier throughout your course of treatment (i.e., coverage is dropped, coverage is changed to a new company), it is your responsibility to inform Clear Mind Therapy LLC immediately of these changes. If you do not inform Clear Mind Therapy LLC of carrier changes and submitted charges are denied, it will be your responsibility to pay the unpaid amount.

All co-pays are due at time of service. All co-insurances and deductibles will be billed to you directly after Clear Mind Therapy LLC has submitted your billing and received/denied payment from your insurance carrier. It is the expectation of Clear Mind Therapy LLC that payment is made within 14 days of receiving this notice. Clear Mind Therapy LLC has the right to place services on hold or refer you to another agency if your outstanding co-insurance balance reaches \$100 or your outstanding deductible balance reaches \$250.

Clear Mind Therapy LLC will do everything we can to work with you in regards to setting up a payment system for your outstanding balance, if necessary, by contacting staff at the office number. Clear Mind Therapy LLC encourages all consumers to be aware of their co-pays, co-insurances, or deductibles prior to scheduling your first appointment by calling your insurance company.

I, \_\_\_\_\_ have reviewed and acknowledged the expectations regarding billing my private insurance company and my responsibility regarding any outstanding billing.

\_\_\_\_\_  
Client/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



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**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

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**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,