# Client Information

Date: _____

_____ _____
Primary Client Name (Last, First, Middle) Marital Status

_____ _____
Street Address Telephone

_____ _____
City and State Zip Code

_____ - _____ - _____ _____ _____
Social Security Number Date of Birth Age

**Complete this section for clients under age of 18**

Parent/Guardian Name: _____

_____ _____
Address Phone Number

Employer Name: _____ Employer Phone: _____
(Provide school information if client is a juvenile)

Employer Address: _____

Who Referred You to Us: _____
Organization Name, Caseworker, Phone

Court /Children's Division Involvement: [] Yes [] No Other Agency [] Yes [] No
If your answer is yes, please provide the following information:

Jurisdiction: _____ Other Agency: _____
Deputy Juvenile Officer (DJO) Name & Number: _____
Caseworker Name & Number: _____

Whom should we contact in case of a medical emergency (Name, Address & Phone Number):
_____

_____

# Consent for Treatment and Confidentiality Policy

## Consent for Treatment

I have chosen to receive professional therapy services from SMART Ideas Consulting Firm, LLC for myself and/or a member of my family. My choice is voluntary, and I understand that I can terminate therapy at any time by informing my clinician.

_____ _____

Signature of Client/Legal Guardian Date

## Confidentiality Policy

All therapeutic communications, records, and contacts with professional and support staff will be held in strict confidence. However, in certain circumstances in accordance with state law, information may be released if:

- The client signs a written "Release of Information" form giving us permission to share information.
- The client elects to use insurance, managed care organizations or other third-party payers.
- The client expresses serious intent to harm themselves or someone else
- There is evidence or reasonable suspicion of abuse against a child, dependent adult or elderly adult
- When a subpoena or other court order is received directing the disclosure of information.

When the client elects to use an insurance carrier or other third-party payers, we cannot maintain complete confidentiality. In most cases, confidentiality is not respected by managed care plans. Clients who elect to use insurance and managed care programs agree that SMART Ideas Consulting Firm LLC, shall not be held liable for any disclosures and or consequences of disclosure of confidential records and information demanded by insurance companies or managed care programs that may be released to other parties. Discretion regarding content and the nature of the disclosure will be used in submitting information to managed care programs or insurance companies responsible for the payment of therapeutic fees.

_____ _____

Signature of Client/Legal Guardian Date

# Insurance Information and Financial Agreement

SMART Ideas Consulting Firm, LLC will bill your insurance (or other funder) and collect payments as reimbursement for the services that you receive. Please share insurance information below to help with this process.

Primary Insurance Information (Funding Source)

_____ _____ _____
Insurance Carrier Name of Insured DOB

_____ _____
Address of Insured (if different from above) Phone

Group Number: _____ ID Number: _____

Secondary Insurance Information (Funding Source)

_____ _____ _____
Insurance Carrier Name of Insured DOB

_____ _____
Address of Insured (if different from above) Phone

Group Number: _____ ID Number: _____

**Please provide employment information of primary and secondary insurance holders below:**

Company Name, Address and Phone: _____
_____

I hereby authorize SMART Ideas Consulting Firm, LLC to process insurance claims on my behalf and collect funds directly from my insurance company (or other funder) to render payment for services received.

I am responsible for co-payments, deductibles or any remaining balance that the insurance company does not pay.
All co-payments and deductible payments are due at the time of services, before the session begins.
SMART Ideas Consulting Firm LLC accepts cash, checks, debit & credit cards. I understand that there is a $40.00 charge for returned checks. Outstanding balances that are not paid in a timely manner will be sent to a collection agency and can impact your credit.

Notice will be given to you when your clinician must reschedule your session for any reason.
If for any reason, you are unable to keep your scheduled appointment time, please notify the office 24 hours in advance. Failure to do so will result in a fee of **$35** charged to your account that must be paid prior to your next appointment (this fee is **not** applicable if disallowed by your insurance company).

I hereby acknowledge that I have read the statements above and that I agree and consent to these guidelines.

_____ _____
Client Name (Printed) Date

_____
Signature of Client/Legal Guardian

# Authorization to Release Information

Client(s) Name: _____ DOB: _____

Social Security Number(s): _____

I hereby authorize SMART Ideas Consulting Firm, LLC to (Check Appropriate Selection(s) Below)

Obtain Information From: []

Release Information To: []

_____ _____
Name of Organization Address

_____ _____
Name of Contact Person Phone Number(s)

_____ _____
Email Address Fax Number

## Nature of Request:

The following documents/information from the records pertaining to services received

Date(s) of Service: _____

The records are required for the specific purpose of: to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

The documents to be released are described or listed as:

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____ Psychotherapy Notes*

Other:_____

I have read and understand the nature of this release. I understand that my authorization will remain effective from the date of my signature and that this consent will expire 90 days after the termination of treatment. For reimbursement purposes this authorization shall remain in effect until full reimbursement for services has been received.

I understand that this information will only be used for the purposes described above and that the information will be handled confidentially and in compliance with all applicable federal and state laws. I understand that I may revoke the authorization at any time by written and dated communication.

_____ _____
Client Signature/Legal Guardian Date

# 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 THIS NOTICE CAREFULLY.

**Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.**

**We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.**

### HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

**For Treatment**. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

**For Payment.** We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

**For Health Care Operations.** We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

**Required by Law.** Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

**Without Authorization.** Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As licensed clinicians in the state of Missouri and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

**Child Abuse or Neglect.** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

**Judicial and Administrative Proceedings.** We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

**Deceased Patients.** We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

**Medical Emergencies.** We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

**Family Involvement in Care.** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

**Health Oversight.** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

**Law Enforcement.** We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

**Specialized Government Functions.** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

**Public Health.** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

**Public Safety.** We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

**Research.** PHI may only be disclosed after a special approval process or with your authorization.

**Fundraising.** We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

**Verbal Permission.** We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

**With Authorization**. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or

disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

## YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at info@smartideasconsultingfirm.com

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

### *COMPLAINTS*

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at info@smartideasconsultingfirm.com or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint. The effective date of this Notice is January 1st, 2016**

## Notice of Privacy Practices

## Receipt and Acknowledgment of Notice

**Client Name: _____**

**DOB: _____**

**Last Four of SSN: _____**

**Parent/Guardian Name: _____**

I hereby acknowledge that I have received and have been given an opportunity to read a copy of SMART Ideas Consulting Firm's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact LaDonna Turner at info@smartideasconsultingfirm.com or 314-326-3004.

_____

***Signature of Patient/Client*** ***Date***

_____

***Signature or Parent, Guardian or Personal Representative **** ***Date***

_____

* *If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*

_____

❑ ***Patient/Client Refuses to Acknowledge Receipt:*** ***Date***

_____

***Signature of Staff Member*** ***Date***