Royster PLLC

(712)-225-5344 Phone
204 W. Maple St. Cherokee, IA 51012
(712)-225-5346 Fax

PATIENT'S INFORMED CONSENT

I have chosen to receive treatment services from Royster and Royster Counseling, PLLC. My choice has been voluntary and I understand that I may terminate therapy at any time.

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between my counselor and me, I will work with my counselor in a cooperative manner to resolve my difficulties.
I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.
I understand that confidentiality of records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information.
I understand that state and local laws require that my counselor report all cases in which there exists a danger to self or others.
I understand that there may be other circumstances in which the law requires my counselor to disclose confidential information.
I understand that it is my responsibility to inform my primary medical doctor of any medications prescribed in the course of my treatment with Royster and Royster Counseling, PLLC.
I understand that it is my responsibility to inform Royster and Royster Counseling, PLLC of any medications that I am taking.

I have read and had explained to me the basic rights of individuals who undergo treatment with Royster and Royster Counseling, PLLC.

These rights include:

- **The right** to be informed of the various steps and activities involved in receiving services.
- **The right** to confidentiality under federal and state laws relating to the receipt of services.
- **The right** to make an informed decision whether to accept or refuse treatment.
- **The right** to contact and consult with counsel and select practitioners of my choice and at my expense.

I understand that my counselor may disclose any and all records pertaining to my treatment if necessary for claims processing, care management, coordination of treatment, quality assurance, or utilization of the facility if and to the extent necessary to facilitate the provisions of administrative and professional services.
I also understand that I have the right to inspect the mental health records pertaining to my treatment under the supervision of my counselor.

_____**(Please initial)** I understand my records will be kept for a period of seven years after the last date of service with Royster and Royster Counseling, PLLC. The intake and discharge summary will be kept perpetually. In the case of minors records, they will be kept until the age of 25 or seven years after the last date of service, which ever is longer.

I have read and understand the above.

Client Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Royster PLLC

(712)-225-5344 Phone | 204 W. Maple St. Cherokee, IA 51012 | (712)-225-5346 Fax

FEE AGREEMENT **Client:**

I AGREE TO THE FOLLOWING CONDITIONS OF PAYMENT FOR PROFESSIONAL SERVICES.

1. To pay Royster & Royster, PLLC, the charges per service for the above named client. I am not required to use my health insurance benefits. I realize that if I chose to not use my health insurance benefits that I will pay full fee for services rendered. It is my responsibility to contact my insurance carrier for any restrictions or requirements. If I fail to do so, I will be responsible for the full fee.
2. If I choose to use my health insurance benefits, the following rates will apply: intake/initial session $200 (75 minutes) ~ clinical hour $140 (50 minutes) ~ clinical half-hour $90 (25 minutes).
3. If I choose to not use my health insurance, the following rates will apply unless a cash plan is selected: intake/initial session $200 (1.5 clinical hours) ~ clinical hour $140 (50 minutes) ~ clinical half-hour $90 (25 minutes).
4. For sexual offender evaluation purposes Royster & Royster, PLLC will not accept health insurance benefits. The charge for a sexual offender evaluation will be assigned at $200 an hour. This includes time spent researching case history, interviews, contact, driving, testimony, etc.
5. That payment is due at the time the services in rendered.
6. I understand that there will be a $25.00 charge if the above named client for whom I am financially responsible, fails to keep an appointment (without 8 hours of notice).
7. If in the judgment of Royster & Royster, PLLC, my account becomes delinquent, I understand that Royster and Royster Counseling, PLLC, has the right to release my name and account information to a private collection agency.
8. I understand that if I fail to make payments under the terms of this agreement, a conference with Royster & Royster, PLLC, may be required prior to further professional services continuing.
9. I will submit a current insurance card and notify Royster & Royster, PLLC, of any changes in my insurance. I realize that I will be charged full-fee until current insurance information is provided.
10. I realize that if services are supported by 3rd party payers, those services may be subject to audit by authorized representatives of those payers for purposes of verifying services and I consent to review of services rendered for such purposes. I further understand that audits will not involve sharing information other than that is authorized in Chapter 228 of the Iowa Code relating to disclosure of mental health information.

I have read the above, regarding fees. I understand this and agree to be responsible for charges.

Signature of Person Responsible for Payment:_____

Signature Witnessed By:_____

Date:_____

(712)-225-5344
Phone

204 W. Maple St
Cherokee, IA 51012

(712)-225-5346
Fax

Client & Insurance Information

Client Information:

Full Legal Name: _____
(First) (Middle) (Last)

Date of Birth: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Marital Status/Legal Status: _____

Spouse's Name (if Applicable): _____

Name of Guardian and relationship (if applicable): _____

Employer or School Name: _____

Employer or School's telephone number: _____

Emergency Contacts: _____

Policy Holder's Information:

Full Legal Name: _____
(First) (Middle) (Last)

Date of Birth: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Employer or School Name and number: _____

Relationship to client: Self Spouse Parent Child Other

Insurance Information:

Name of Insurance: _____

Policy Identification Number: _____

Group Number: _____

Supplemental Insurance: _____

Policy Identification Number: _____

Group Number: _____

Signature: _____ Date: _____
(Client, Guardian, or Authorized Individual)

(712)-225-5344
Phone

204 W. Maple St.
Cherokee, IA 51012

(712)-225-5346
Fax

AUTHORIZATION TO TREAT A MINOR CHILD

I request that Royster and Royster Counseling, PLLC perform diagnosis or treatment services or both for:

_____ _____ _____
Minor's first name Initial Last

Minor's Date of Birth:_____

PARENT/GUARDIAN SIGNATURE:_____

DATE:_____

STAFF/WITNESS SIGNATURE:_____

(712)-225-5344 Phone
204 W. Maple St. Cherokee, IA 51012
(712)-225-5346 Fax

AUTHORIZATION OF RELEASE AND/OR EXCHANGED OF MENTAL HEALTH INFORMATION

From Primary Address: Royster and Royster, PLLC
Tele: 712.225.5344
Fax: 712.225.5346
204 W Maple St
Cherokee, IA 51012

Secondary Address: Royster and Royster, PLLC
Tele: 712.295.7601
Fax: 712.295.7600
4509 20th Ave
Peterson, IA 51047

TO: Midwest Christian Services (Agency/Individual) EXPIRATION DATE: _____

4509 20th Ave (Street Address) PHONE NUMBER: 712.295.7601

Peterson, IA 51047 (City, State, and ZIP Code) FAX NUMBER: 712.295/7600

REGARDING CLIENT NAME(S) _____ DOB: _____

YES/NO

___ ___ Psychological Assessment
___ ___ Pertinent History
___ ___ Discharge or Closing Summary
___ ___ Psychiatric Evaluation
___ ___ Pertinent Medical Information
___ ___ Prognosis or Response to Treatment

Information that is disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule.
I understand that I may revoke this Authorization at any time by giving written notification. ____(Initial)

Other: _____

The purpose of the disclosure of the above information is: ☐ Coordination of services **OR**

Other (specifically list) _____

I specifically authorize the release of information relating to (Client must initial/check appropriate items).

___ Mental Health Information
___ Substance Abuse (alcohol/drug abuse)
___ HIV Information

_____ _____ _____
Signature of Client or Representative | Printed Name | Date

If signed by a representative, explain authority to sign: _____

_____ _____
Signature of Therapist | Date

Confidentiality of mental health information is protected by federal and state law, ie Chapter 228 of the Iowa Code and federal regulations governing confidentiality of alcohol and drug abuse client records, 42 CFR Prt 2, and cannot be disclosed without my written consent. Unauthorized disclosure may result in civil damages and criminal penalties Last updated 8/08

(712)-225-5344
Phone

204 W. Maple St.
Cherokee, IA 51012

(712)-225-5346
Fax

AUTHORIZATION OF RELEASE AND/OR EXCHANGED OF MENTAL HEALTH INFORMATION

From Primary Address: Royster and Royster, PLLC
Tele: 712.225.5344
Fax: 712.225.5346
204 W Maple St
Cherokee, IA 51012

Secondary Address: Royster and Royster, PLLC
Tele: 712.295.7601
Fax: 712.295.7600
4509 20th Ave
Peterson, IA 51047

TO: Dr. Veit Medical Office EXPIRATION DATE: _____
Agency/Individual

212 East Bow Drive PHONE NUMBER: 712.225.6431
Street Address

Cherokee, IA 51012 FAX NUMBER: 712.225.3572
City, State, and ZIP Code

REGARDING CLIENT NAME(S) _____ DOB: _____

YES/NO

___ ___ Psychological Assessment
___ ___ Pertinent History
___ ___ Discharge or Closing Summary
___ ___ Psychiatric Evaluation
___ ___ Pertinent Medical Information
___ ___ Prognosis or Response to Treatment

Information that is disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule.
I understand that I may revoke this Authorization at any time by giving written notification. ____(Initial)

Other: _____

The purpose of the disclosure of the above information is: ☐ Coordination of services **OR**

Other (specifically list) _____

I specifically authorize the release of information relating to (Client must initial/check appropriate items).

___ Mental Health Information
___ Substance Abuse (alcohol/drug abuse)
___ HIV Information

_____ _____ _____
Signature of Client or Representative | Printed Name | Date

If signed by a representative, explain authority to sign: _____

_____ _____
Signature of Therapist | Date

Confidentiality of mental health information is protected by federal and state law, ie Chapter 228 of the Iowa Code and federal regulations governing confidentiality of alcohol and drug abuse client records, 42 CFR Prt 2, and cannot be disclosed without my written consent. Unauthorized disclosure may result in civil damages and criminal penalties Last updated 8/08

(712)-225-5344 Phone
204 W. Maple St. Cherokee, IA 51012
(712)-225-5346 Fax

AUTHORIZATION OF RELEASE AND/OR EXCHANGED OF MENTAL HEALTH INFORMATION

From Primary Address: Royster and Royster, PLLC
Tele: 712.225.5344 204 W Maple St
Fax: 712.225.5346 Cherokee, IA 51012

Secondary Address: Royster and Royster, PLLC
Tele: 712.295.7601 4509 20th Ave
Fax: 712.295.7600 Peterson, IA 51047

TO: Dawn Howley, Spencer Psychiatric and Counseling EXPIRATION DATE:_____
Agency/Individual

2016 Hwy Blvd South Office PHONE NUMBER: 712.580.3882
Street Address

Spencer, IA 51301 FAX NUMBER: 712.580.3932
City, State, and ZIP Code

REGARDING CLIENT NAME(S)_____ DOB:_____

YES/NO

___ ___ Psychological Assessment
___ ___ Pertinent History
___ ___ Discharge or Closing Summary
___ ___ Psychiatric Evaluation
___ ___ Pertinent Medical Information
___ ___ Prognosis or Response to Treatment

Information that is disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule.
I understand that I may revoke this Authorization at any time by giving written notification. ____(Initial)

Other:_____

The purpose of the disclosure of the above information is: ☐ Coordination of services **OR**

Other (specifically list)_____

I specifically authorize the release of information relating to (Client must initial/check appropriate items).

___ Mental Health Information
___ Substance Abuse (alcohol/drug abuse)
___ HIV Information

_____ _____ _____
Signature of Client or Representative Printed Name Date

If signed by a representative, explain authority to sign: _____

_____ _____
Signature of Therapist Date

Confidentiality of mental health information is protected by federal and state law, ie Chapter 228 of the Iowa Code and federal regulations governing confidentiality of alcohol and drug abuse client records, 42 CFR Prt 2, and cannot be disclosed without my written consent. Unauthorized disclosure may result in civil damages and criminal penalties Last updated 8/08

(712)-225-5344
Phone

204 W. Maple St.
Cherokee, IA 51012

(712)-225-5346
Fax

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF
PRIVACY PRACTICES

Royster and Royster Counseling, PLLC reserve the right to modify the privacy practice outlined in the notice.

I have been offered/received a copy of the Notice of Privacy Practices for Royster and Royster Counseling, PLLC.

_____
Name of Patient (Please Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult unable to sign this form)

_____
Relationship of Patient Representative to Patient

Royster PLLC

(712)-225-5344 Phone | 204 W. Maple St. Cherokee, IA 51012 | (712)-225-5346 Fax

NOTICE OF PRIVACY PRACTICE

This document being supplied to you represents our compliance with the Health and Insurance Portability and Accountability Act (HIPPA) passed by congress and enacted into law in August, 1996. This notice describes how medical/mental health information about you may be disclosed, and how you can get access to this information, should you choose. If you have any questions or concerns regarding the information in this notice please feel free to speak with the Privacy Officer, Matthew Royster, LMHC. Please review this information carefully.

WHO WILL FOLLOW THESE PRACTICES:

This notice describes the privacy practices of every employee of the practice who is authorized to enter or see information in your chart.

OUR PLEDGE REGARDING MENTAL HEALTH INFORMATION:

This practice will protect the privacy of the records of our clients. We understand the information about you and your health is personal. We are committed to protecting your medical/mental health information. We are required by law:

* to make sure that your medical information is kept private

* to give you this notice of our legal duties and privacy practices with respect to medical/mental health information about you

* to follow the terms of this privacy practice

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

For each category of uses or disclosures of your medical/mental health information, we will explain what we mean and try to give some examples to every use or disclosure in a category will be listed.

For Treatment: We may use medical/mental health information about you to provide you with treatment or services. If you sign release(s) to your medical provider(s), other mental health professionals, or Department of Human Service workers we may disclose information pertinent to your care to your doctor(s) or other individuals who are involved in taking care of you.

For Payment: We may use and disclose treatment information about you so that the treatment and services you receive may be billed and payment collected from your insurance company, or third party

Payer: We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose treatment information about you for office operations. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care. For example, we may use file information to review the quality of patient care and to evaluate the performance of our staff in caring for you.

Appointment Reminders: We may use and disclose information to contact you as a reminder that you have an appointment. You will be asked if you have any preferences in regard to where and when you are contacted.

Health-related benefits and services: We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals involved in Your Care or Payment for Your Care: If you sign a release of information, we may disclose information about you to a friend or family member who is involved in your medical care. If you are a minor child, we may disclose treatment information to your parents that we feel is in your best interest for them to know.

Research: Under certain rare circumstances, we may use and disclose medical information about you for research purposes. We will always ask you your specific written permission if the researcher will have access to your name, address or other information that reveals who are or will be involved in your care.

As Required By Law: We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and the safety of the public or another person. Any disclosure; however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

Worker’s Compensation: We will ask you to sign a release so that we may use and release information about you for worker’s compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health Risk: We may use and disclose mental health information about you to public authorities as required by law:

* report births or deaths

* report reactions to medications or problems with medications

* notify the appropriate government authority if we believe a client has been the victim of abuse, neglect, or domestic violence

* notify the appropriate government authority if we believe a client has been the perpetrator of abuse, neglect, or domestic violence

Health Oversight Activities: We may use and disclose information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may use and disclose information about you in response to a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request, or other process by someone else involved in the dispute, but only if efforts have been made to tell you about the request.

Law Enforcement: We may use and disclose medical information if required to do so by a law enforcement official:

*in response to a court order, subpoena, warrant, summons or similar process

*to identify or locate a suspect, fugitive, material witness, or missing person

*about the victim of a crime if, under the limited circumstances, we are unable to obtain person's agreement

*in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime

Coroners, Medical Examiners and Funeral Directors: We may use and disclose information to a coroner or medical examiner. This may be necessary, for example to identify a deceased person or determine the cause of death.

National Security and Intelligence Activities: We may use and disclose information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:

You have the following rights regarding medical information we maintain about you:

Right to Copy: You have the right to a copy of any information in your chart. To obtain a copy of any information, please obtain a request from the office. If you request a copy of the information, we charge a fee for the costs of copying of 5 cents per page and actual cost of mailing. We will provide the records within 10 business days. We may deny your request to a copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend: If you feel that the information we have about you is incorrect or incomplete, you have the right to request an amendment; however, by law, we cannot alter the original information. To request an amendment, please obtain a request form from the Privacy Officer, Matthew Royster. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

*was not created by us, unless the person or entity that created the information is no longer available to make the amendment

*is not part of the mental health information kept by the office

*is not part of the information which would be permitted to inspect and copy

*is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosure”

This is a list of the disclosures we made of information about you. To request this list of accounting disclosures, please obtain a request from the Privacy Officer, Matthew Royster. Your request must state a time period that may not be longer than six years and may not include dates before 5/23/11. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any cost is incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the disclosure of the information in your chart. For example, you could ask that we not disclose the information about past abuse that you experienced to a particular family member. We are not required to agree to your request. If we do agree, we will comply with your request, unless the information is needed to provide you emergency medical treatment.

To request a restriction, please obtain a request form from the Privacy Officer, Matthew Royster. In your request, you must tell us [1] what information you want to limit; and [2] to whom you want the limits to apply; for example, disclosures to your spouse.

Right to Request Confidential Communication: You may request to receive Protected Health Information by alternative means of communication or at alternative locations. To request confidential communications, please obtain a request form from the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you another copy of this notice at any time.

Right to Designate A Personal Representative: You have the right to designate a Personal Representative who can act on your behalf in regard to your records. This person can make all decisions that you can make only in so far as to handling of your records, not your mental health care. Please obtain a request form from the Privacy Officer, Matthew Royster to designate a personal representative for mental health information. This designation will remain in effect until you change or revoke it in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for information we already have about you as well as any information we receive in the future. We will post a current notice in the office. The notice will contain the effective date on the first page in the upper left-hand corner.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, please contact the Privacy Officer, Matthew Royster or the practice manager, Valorie Royster at 712-225-5344. All Complaints must be submitted in writing on a special form available from the practice. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of mental information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By no means of this Notice intended to supersede or waive your rights under the state laws of Iowa.