Acknowledgement of Receipt of Notice of Privacy Practices

Midwest Christian Services 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 Midwest Christian Services.

_____

Name of Client (Please Print or Type)

_____

Signature of Client

_____

Date

_____

Signature of Client Representative
(Required if the client is a minor or an adult unable to sign this form)

_____

Relationship of Client Representative to Client

Building Better Lives

MIDWEST CHRISTIAN SERVICES

Authorization to Release Professional Information

1) All blanks are to be filled out.
2) Signing this is not required as a condition for treatment.
3) You fully understand the limitations of this release

I also authorize Midwest Christian Services (4509 20th Ave., Peterson, IA) to release and receive professional information to/from: **AEA** in regards to services rendered to:

Name: _____

Date of Birth: _____

For the purpose of: Continuity of care

Specific information to be released electronically via telephone, verbally, or written report will consist of (check appropriate lines):

___X___ Social History	___X___ Group Therapy
___X___ Treatment Plan	_____ Family Therapy Summary
___X___ Progress Report	___X___ Discharge Summary /
___X___ Individual Therapy Summary	Recommendations
___X___ Medical	

_____ Other (specify) _____

I understand I have the right to see this information at any time. I can revoke my consent by writing to both the person giving and receiving the information. But any information already released may be used as stated on this consent. This release is valid for a period of NINTY (90) DAYS past the date of discharge. This consent is not automatically renewable. It expires automatically at the end of the period specified unless revoked sooner. I have read this release form, or it has been read to me if requested, and I understand its contents.

Witness: _____ Signature: _____

Date: _____ Relationship: _____

Address: _____

Date: _____

Authorization to Release Professional Information

1) All blanks are to be filled out.
2) Signing this is not required as a condition for treatment.
3) You fully understand the limitations of this release

I also authorize Midwest Christian Services (4509 20th Ave., Peterson, IA) to release and receive professional information to/from: **Lisa Lindeman DDS** in regards to services rendered to:

Name: _____

Date of Birth: _____

For the purpose of: Continuity of care

Specific information to be released electronically via telephone, verbally, or written report will consist of (check appropriate lines):

_____ Social History
_____ Treatment Plan
_____ Progress Report
_____ Individual Therapy Summary
__X__ Medical
_____ Other (specify) _____
_____ Group Therapy
_____ Family Therapy Summary
_____ Discharge Summary / Recommendations

I understand I have the right to see this information at any time. I can revoke my consent by writing to both the person giving and receiving the information. But any information already released may be used as stated on this consent. This release is valid for a period of NINTY (90) DAYS past the date of discharge. This consent is not automatically renewable. It expires automatically at the end of the period specified unless revoked sooner. I have read this release form, or it has been read to me if requested, and I understand its contents.

Witness: _____
Date: _____
Signature: _____
Relationship: _____
Address: _____
Date: _____

Building Better Lives

MIDWEST CHRISTIAN SERVICES

Authorization to Release Professional Information

1) All blanks are to be filled out.
2) Signing this is not required as a condition for treatment.
3) You fully understand the limitations of this release

I also authorize Midwest Christian Services (4509 20th Ave., Peterson, IA) to release and receive professional information to/from: **Royster & Royster PLLC** in regards to services rendered to:

Name: _____

Date of Birth: _____

For the purpose of: Continuity of care

Specific information to be released electronically via telephone, verbally, or written report will consist of (check appropriate lines):

___X___ Social History	___X___ Group Therapy
___X___ Treatment Plan	___X___ Family Therapy Summary
___X___ Progress Report	___X___ Discharge Summary /
___X___ Individual Therapy Summary	Recommendations
___X___ Medical	

_____ Other (specify) _____

I understand I have the right to see this information at any time. I can revoke my consent by writing to both the person giving and receiving the information. But any information already released may be used as stated on this consent. This release is valid for a period of NINTY (90) DAYS past the date of discharge. This consent is not automatically renewable. It expires automatically at the end of the period specified unless revoked sooner. I have read this release form, or it has been read to me if requested, and I understand its contents.

Witness: _____ Signature: _____

Date: _____ Relationship: _____

Address: _____

Date: _____

Building Better Lives

MIDWEST CHRISTIAN SERVICES

Authorization to Release Professional Information

1) All blanks are to be filled out.
2) Signing this is not required as a condition for treatment.
3) You fully understand the limitations of this release

I also authorize Midwest Christian Services (4509 20th Ave., Peterson, IA) to release and receive professional information to/from: **Sioux Central Community Schools** in regards to services rendered to:

Name: _____

Date of Birth: _____

For the purpose of: Continuity of care

Specific information to be released electronically via telephone, verbally, or written report will consist of (check appropriate lines):

___X___ Social History	___X___ Group Therapy
___X___ Treatment Plan	_____ Family Therapy Summary
___X___ Progress Report	___X___ Discharge Summary /
___X___ Individual Therapy Summary	Recommendations
___X___ Medical	

_____ Other (specify) _____

I understand I have the right to see this information at any time. I can revoke my consent by writing to both the person giving and receiving the information. But any information already released may be used as stated on this consent. This release is valid for a period of NINTY (90) DAYS past the date of discharge. This consent is not automatically renewable. It expires automatically at the end of the period specified unless revoked sooner. I have read this release form, or it has been read to me if requested, and I understand its contents.

Witness: _____ Signature: _____

Date: _____ Relationship: _____

Address: _____

Date: _____

Building Better Lives

MIDWEST CHRISTIAN SERVICES

Authorization to Release Professional Information

1) All blanks are to be filled out.
2) Signing this is not required as a condition for treatment.
3) You fully understand the limitations of this release

I also authorize Midwest Christian Services (4509 20th Ave., Peterson, IA) to release and receive professional information to/from: **Northwest Vision** in regards to services rendered to:

Name: _____

Date of Birth: _____

For the purpose of: Continuity of care

Specific information to be released electronically via telephone, verbally, or written report will consist of (check appropriate lines):

_____Social History
_____Treatment Plan
_____Progress Report
_____Individual Therapy Summary
___X___ Medical
_____Other (specify) _____
_____Group Therapy
_____Family Therapy Summary
_____Discharge Summary / Recommendations

I understand I have the right to see this information at any time. I can revoke my consent by writing to both the person giving and receiving the information. But any information already released may be used as stated on this consent. This release is valid for a period of NINTY (90) DAYS past the date of discharge. This consent is not automatically renewable. It expires automatically at the end of the period specified unless revoked sooner. I have read this release form, or it has been read to me if requested, and I understand its contents.

Witness: _____
Date: _____
Signature: _____
Relationship: _____
Address: _____
Date: _____

Building Better Lives

MIDWEST CHRISTIAN SERVICES

Bill of Rights

1. **The Right** to impartial access to treatment, regardless of race, religion, sex, ethnicity, age, or handicap.
2. **The Right** to personal dignity shall be recognized and respected in the provision of all care and treatment including; freedom from abuse, neglect, invasion of boundaries or financial or other exploitation.
3. **The Right** to confidentiality and personal privacy.
4. **The Right** to access client records.
5. **The Right** to refuse to participate in any research project without compromising access to services.
6. **The Right** to the extent of the law, to refuse specific medications or treatment procedures.
7. **The Right** to initiate a complaint or grievance procedure, and the appropriate means of requesting a hearing or review of the complaint.
8. **The Right** to request the opinion of a consultant at the client's expense or to request an in-house review of the individual's treatment plan.
9. **The Right** to call and be called by family members. When limitations of visitation or other communications are indicated, they shall be determined with the participation of you, your family, your lawyer, your guardian, and the referring worker. You have the right to place two ten-minute calls at MCS expense, per week.
10. **The Right** to send and receive, without staff reading or censoring the mail. Staff may require the resident to open mail in front of them to check for contraband.
11. **The Right** to not have food withheld as a consequence.
12. **The Right** to process grievances without the threat of retaliation or humiliation.

I have read and had the opportunity to have explained to me the client bill of rights.

_____ _____

Client Signature Date

_____ _____

Guardian Signature Date

Authorization to Release Professional Information

1) All blanks are to be filled out.
2) Signing this is not required as a condition for treatment.
3) You fully understand the limitations of this release

I also authorize Midwest Christian Services (4509 20th Ave., Peterson, IA) to release and receive professional information to/from: **CRMC** in regards to services rendered to:

Name: _____

Date of Birth: _____

For the purpose of: Continuity of care

Specific information to be released electronically via telephone, verbally, or written report will consist of (check appropriate lines):

_____ Social History
_____ Treatment Plan
_____ Progress Report
_____ Individual Therapy Summary
__X__ Medical
_____ Other (specify) _____
_____ Group Therapy
_____ Family Therapy Summary
_____ Discharge Summary / Recommendations

I understand I have the right to see this information at any time. I can revoke my consent by writing to both the person giving and receiving the information. But any information already released may be used as stated on this consent. This release is valid for a period of NINTY (90) DAYS past the date of discharge. This consent is not automatically renewable. It expires automatically at the end of the period specified unless revoked sooner. I have read this release form, or it has been read to me if requested, and I understand its contents.

Witness: _____
Date: _____
Signature: _____
Relationship: _____
Address: _____
Date: _____

Emergency Medical Care Release Form

I hereby give my consent to any emergency medical, surgical, or dental care that may be necessary for the welfare of _____

(Child's Name)

I also give my consent to administer necessary anesthetics during these procedures. I also give consent for authorized medical personnel to give any vaccinations which are necessary.

_____

Parent/Legal Guardian

_____

Date

_____

Witness

_____

Date

If you have medical insurance please complete the following:

Name of Insurance Company _____
Policy Number _____
Address of Insurance Company _____

Building Better Lives

MIDWEST CHRISTIAN SERVICES

Extra-Curricular Activities Contract

The following guidelines must be followed by residents in order to participate and continue participating in extra-curricular activities.

1) MCS staff must know at least 2 weeks before the first practice of the resident's intention to participate in any extra-curricular activities.
2) The residents must be on Level II status. Any behavior that would result in loss of privileges for more than one week will cause the resident to be moved from the activity.
3) Residents are expected to meet the grade standard established by the school. Eligibility will be based on 9 weeks and mid-term grades.
4) MCS will contact the school personnel involved with the activity. The resident is accountable to the school personnel and MCS staff for their actions.
5) The resident's behavior and attitude at MCS is important. When extra-curricular activities become more important than participating in the MCS program, adjustments to participation in activities will be made.
6) Permission to walk around town or to be anywhere other than with the activity peers under school personnel supervision must be obtained from MCS staff. If this is not followed it will be considered a violation of rules. The consequences will be 2 day suspension from the activity. If these rules are violated 3 times, it will result in immediate suspension from activities.
7) The resident must call MCS staff on duty immediately after practices or Activities.
8) The resident must make direct trips to a designated place to phone staff. There will be no taking walks to utilize other communication sources.

I understand the terms of this agreement for _____

(Child's Name)

to participate in extra-curricular activities.

_____

Parent/Legal Guardian

_____

Date

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Authorization to Release Professional Information

1) All blanks are to be filled out.
2) Signing this is not required as a condition for treatment.
3) You fully understand the limitations of this release

I also authorize Midwest Christian Services (4509 20th Ave., Peterson, IA) to release and receive professional information to/from: **A & M Psychiatric Services** in regards to services rendered to:

Name: _____

Date of Birth: _____

For the purpose of: Continuity of care

Specific information to be released electronically via telephone, verbally, or written report will consist of (check appropriate lines):

X	Social History	X	Group Therapy
X	Treatment Plan	X	Family Therapy Summary
X	Progress Report	X	Discharge Summary /
X	Individual Therapy Summary		Recommendations
X	Medical		
	Other (specify) _____		

I understand I have the right to see this information at any time. I can revoke my consent by writing to both the person giving and receiving the information. But any information already released may be used as stated on this consent. This release is valid for a period of NINTY (90) DAYS past the date of discharge. This consent is not automatically renewable. It expires automatically at the end of the period specified unless revoked sooner. I have read this release form, or it has been read to me if requested, and I understand its contents.

Witness: _____ Signature: _____

Date: _____ Relationship: _____

Address: _____

Date: _____

Building Better Lives

MIDWEST CHRISTIAN SERVICES

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, concerns regarding the information in this notice please feel free to speak with the Privacy Officer, Deanna Scott, Executive Director. 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 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 YO:

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

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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.

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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, Deanna Scott. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is

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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, Deanna Scott. Your request must state a time period that may not be longer than six years. 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, Deanna Scott. In your request, you must tell us [1] what information you want to limit; [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 Privacy Officer, Deanna Scott. 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, Deanna Scott to designate a personal representative for mental health information. This designation will remain in effect until you change or revoke it in writing.

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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 Midwest Christian Service or with the Secretary of the Department of Health and Human Services. To file a complaint with Midwest Christian Service, please contact the Privacy Officer, Deanna Scott or the Quality Improvement Specialist at 712-295-7601. All complaints must be submitted in writing on a special form available from Midwest Christian Service. 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 provide to you.

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

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Patient's Informed Consent

I understand that Midwest Christian Services 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 record will be kept for a period of seven years after the last date of service with Midwest Christian Services. The intake and discharge summary will be kept perpetually. In the case of minor's records, they will be kept until the age of 25 or seven years after the last date of service, whichever is longer.

I have read and understand the above.

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Building Better Lives

MIDWEST CHRISTIAN SERVICES

Permission to Participate in Work Program
Addendum to Case Permanency Plan

I hereby give permission for _____

(Child's Name)

To participate in the Midwest Christian Services work program. I realize this may include some work on the facility's farm. All work will be done under adult staff supervision.

_____

Parent / Legal Guardian

_____

Date

Personal Property Contract

I understand that Midwest Christian Services does not assume responsibility for the personal belongings of my child _____.

(Child's Name)

I understand that belongings of my child that will not be used during the placement should be sent home. I understand that for protection, Midwest Christian Services will provide the following services:

1) Marking of clothing for identification and sorting purposes.
2) Storage of items not sent home, as follows:
    a. Child's money is recorded and kept in office safe.
    b. Storage of valuables in office safe.

_____

Parent / Legal Guardian

_____

Date

Promotion Consent Form

Midwest Christian Services is a non-profit organization, and much of its income is donated by concerned individuals and groups. MCS feels that promotion is a vital part of the existence of the agency. Promotion also includes recognition of clients where recognition is due, such as community projects, awards, and honors. Promotion may include one or all of the following situations. Please initial all that you would be willing to allow MCS to use a picture and/or first name and last initial of your child in the promotion and recognition of the client and facility. In most cases a first name will be all that will be used, but in the case where we have two or more children with the same first name, it will be necessary to use the last initial.

I hereby give my consent to Midwest Christian Services to use the name and/or picture

of _____ as indicated by my initials below in the promotion
(Child's Name)

and recognition of the clients and facility.

1. MCS Newsletter: _____ Picture _____ First name and last initial
2. Christian Seminars and Churches: _____ Picture _____ First name and last initial
3. Local Newspaper: _____ Picture _____ First name and last initial

_____
Parent/Guardian

_____
Date

_____
Witness

_____
Date

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Building Better Lives

MIDWEST CHRISTIAN SERVICES

Statement of Religious Policy

The religious policies of Midwest Christian Services have been read and explained to me in regards to _____.
(Child's Name)

_____ _____
Parent/Legal Guardian Date

Use sections below if applicable:

1) I request arrangements, within reason, be made for _____
(Child's Name)

to attend church services at: _____
(Name of Church)

_____ _____
Parent/Legal Guardian Date

2) Our beliefs make attendance of any church service unacceptable, therefore, I request that alternate activities be provided for _____
(Child's Name)

_____ _____
Parent/Legal Guardian Date

3) I cannot conscientiously have my child _____
(Child's Name)

Participate in the prayer and devotions practices and ask to have my child excused from these practices.

_____ _____
Parent/Legal Guardian Date

Building Better Lives

MIDWEST CHRISTIAN SERVICES

Student Transcript Release

Name of Student: _____

Name of Current School Attending: _____

Address: _____

_____

_____

To Whom It May Concern:

Please release a transcript of the scholastic records and standardized test scores along with all immunization records to:

Sioux Central Community School District
4440 Hwy 71
Sioux Rapids, IA 50585

_____
Parent/Legal Guardian

_____
Date

Transportation

As the Parent / Legal Guardian(s) of _____, I (we) authorize the staff of Midwest Christian Services to transport our child to and from all necessary appointments or activities, which my child is involved in, during the course of his treatment at Midwest Christian Services.

_____

Parent/Legal Guardian

_____

Date