Matthew Royster, MA, LMHC, SOTP-II, TF-CBT
Licensed Mental Health Counselor

Phone
(712)-295-7601

Email
matthew@roystercounseling.com

Address
4509 20th Ave.
Peterson, Iowa 51047

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

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.

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PATIENT INFORMED CONSENT

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:_________________

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FEE AGREEMENT

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 rates assigned by the individual insurance company will be applied.
3. If I choose to not use my health insurance, the following rates will apply: intake/initial session $150 (60 minutes) ~ clinical hour $100 (50 minutes) ~ clinical half-hour $75 (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.
5. For testimony purposes, Court Ordered or Not Royster and Royster, PLLC will not accept health insurance benefits. The charge for testimony will be assigned at $200 an hour. This includes time spent researching case history, interviews, contact, driving, testimony, etc.
6. A retainer payment for Sexual Offender Evaluation or testimony is due BEFORE the time the services are rendered. An itemized invoice will be delivered electronically 24 Hours in advance of scheduled services. The reminder will be forwarded after services rendered. Testimony or Evaluation WILL BE WITHHELD if retainer payment is not satisfied.
7. I understand that there will be a ($100.00 for therapy) charge if the above named client for whom I am financially responsible, fails to keep an appointment (without 8 hours of notice).
8. 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.
9. 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.
10. 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.
11. 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.

Client Name: ____
Signature of Parent:____

Signature Witnessed By:____
Date:____

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CLIENT AND INSURANCE INFORMATION

Client 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: ____________________________

Title 19 #/Magellan ID: ____

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 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)

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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:____

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ANIMAL-ASSISTANCE WAIVER

I understand that participation in the Animal-Assisted Therapeutic Intervention Program with Royster and Royster, PLLC includes an element of risk. These risks may include without limitation, risks of illness, falls, scratches, bites, nips, and injury through contact. These behaviors will be corrected through training, but she is ultimately a canine and 100% predictability is uncertain.

I understand that participation is voluntary and that each person expressly agrees to hold Midwest Christian Services and/or Royster and Royster, PLLC and their employees harmless from any liability whatsoever resulting from injuries or damages sustained as a result of participation in animal assisted therapy even though such liability may arise out of negligence or carelessness on the part of the person named in this Waiver and Release.

I, and attending family members herby expressly waives, releases and discharges Midwest Christian Services and Royster and Royster, PLLC and their employees, from any claims, demands, injuries, damages or causes of actions that are in any way related to participation in animal assisted therapy, even though such liability may arise out of negligence or carelessness on the part of the persons names in this Waiver and Release.

It is fully understood that regardless of the extensive training received by the animal, a dog always possesses the ability to bite.

I hereby agree to indemnify and hold harmless Midwest Christian Services and/or Royster and Royster, PLLC and their employees from any and all claims, or claims by any member of my family or any other person while on the grounds, or the surrounding area thereto.

Client Name: ______________________________

Signature: ____________________________________ Date:__________________________

Parent or Legal Guardian

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AUTHORIZATION OF RELEASE AND/OR EXCHANGED OF MENTAL HEALTH INFORMATION

From Primary Address:	Royster and Royster, PLLC	Secondary Address:	Royster and Royster, PLLC
Tele: 712.225.5344	204 W Maple St	Tele: 712.295.7601	4509 20th Ave
Fax: 712.225.5346	Cherokee, IA 51012	Fax: 712.295.7600	Peterson, IA 51047

TO: CRMC ________________________ EXPIRATION DATE: ____________________
Agency/Individual

300 Sioux Valley Dr. ________________ PHONE NUMBER: 712.225.5101 ______________
Street Address

Cherokee, IA 51012 ________________ FAX NUMBER: ____________________
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

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Fax: 712.225.5346	Cherokee, IA 51012	Fax: 712.295.7600	Peterson, IA 51047

TO: JCO/DHS Services ________________ EXPIRATION DATE: __________________________
Agency/Individual

Cedar Loop. STE 120 __________________ PHONE NUMBER: 712.225-2669
Street Address

Cherokee, IA 51012 ____________________ FAX NUMBER: ______________________
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

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____ 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

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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: Midwest Christian Services ________ EXPIRATION DATE: ____________
Agency/Individual

4509 20th Street ________ PHONE NUMBER: 712.295.7601 ________
Street Address

Peterson, IA 51012 ________ FAX NUMBER: 712.295.7600 ________
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

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____ HIV Information

______________________ ______________________ ____________
Signature of Client or Representative Printed Name Date

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Signature of Therapist Date

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

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Tele: 712.295.7601 4509 20th Ave
Fax: 712.295.7600 Peterson, IA 51047

TO: A and M Psychiatric Services EXPIRATION DATE:________________________
Agency/Individual

4904 M Ave PHONE NUMBER: 712.229.7771
Street Address

Meriden, IA 51037 Email: ampsychiatricservices@gmail.com
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

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Fax: 712.225.5346	Cherokee, IA 51012	Fax: 712.295.7600	Peterson, IA 51047

TO: Prairie Lakes Area Education Agency ________________ EXPIRATION DATE: ________________________
Agency/Individual

500 NE 6th St. ________________ PHONE NUMBER: 712.335-3588
Street Address

Pocahantas, IA 51012 ________________ FAX NUMBER: ______________________
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

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Signature of Client or Representative	Printed Name	Date

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______________________________	______________________________
Signature of Therapist	Date

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

TO: Sioux Central Community Schools ____________ EXPIRATION DATE: ____________
Agency/Individual

4440 Us Highway 71 ____________ PHONE NUMBER: 712.283-2571
Street Address

Sioux Rapids, IA 51012 ____________ FAX NUMBER: ____________
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

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___ HIV Information

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Agreement for Family Therapy Policy

Your voluntary signature affirms that you have read, understand, and agree to the non-negotiable policies of Royster and Royster, PLLC providing family therapy and telehealth services. Your signature affirms that you are in agreement that Family Therapy services provided by Royster and Royster, PLLC are not court ordered entitlements; but rather voluntary services that you agree to partake. Royster and Royster, PLLC and the family reserve the right to terminate Family Therapy Services at any time, specifically, if the service becomes of non-untherapeutic benefit for Identified Primary Client.

Identified Primary Client Name: ____________________________

______________________________ ______________

Parent/Guardian Signature Date