Electronic Communication Agreement

Electronic communications, including but not limited to, emails and text messages (hereinafter "Electronic Communications"), provide an opportunity to communicate with the healthcare providers at Seasons Center for Behavioral Health ("Seasons Center").

The following is intended as an agreement between Seasons Center and _____.
PRINT NAME

General Considerations

- As your healthcare provider, Seasons Center will treat Electronic Communications with the same degree of privacy and confidentiality as written medical records. Seasons Center has taken reasonable steps with internal information technology systems and program policies to protect the security and privacy of your personal identifying and health information in accordance with the security guidelines required by the Health Information Protection and Accountability Act of 1996, as amended ("HIPAA").
- Communicating electronically with Seasons Center has benefits, including but not limited to more prompt access to your healthcare provider and reminders of upcoming appointments. However, communicating electronically also has its risks, including but not limited to the below:
    - Standard email services, including, but not limited to, Yahoo, Hotmail, and Gmail, are not secure. This means that the email, including any individually identifiable health information and other sensitive or confidential information that may be contained in such email are not encrypted and could be misdirected, disclosed to, read or intercepted by, unauthorized third parties.
    - Text messaging services are not secure. This means that the text message, including any individually identifiable health information and other sensitive or confidential information that may be contained in a text message are not encrypted and could be misdirected, disclosed to, read or intercepted by, unauthorized third parties.

I have read and understood the above description of the risks and responsibilities associated with Electronic Communications with Seasons Center. I acknowledge that commonly used Electronic Communications are not secure.

Please check one of the three below statements:

A. ☐ Having been informed of the risks associated with Electronic Communications, I consent to, accept the risk in and still desire to communicate with Seasons Center via Electronic Communications. I understand that I can withdraw this consent authorizing Seasons Center to communicate with me via Electronic Communications at any time by written notification to Seasons Center. I agree to notify Seasons Center and complete a new Electronic Communications Agreement when my cell phone number or email address changes.

My email address is bspooner@midwestchristianservices.com_____.

My cell phone number is No text messages.

B. ☐ Having been informed of the risks associated with Electronic Communications, I consent to, accept the risk in and still desire to communicate with Seasons Center via Electronic Communications *only with respect to appointment reminders*. I understand that I can withdraw this consent authorizing Seasons Center to communicate with me via Electronic Communications at any time by written notification to Seasons Center. I agree to notify Seasons Center and complete a new Electronic Communications Agreement when my cell phone number or email address changes.

My email address is bspooner@midwestchristianservices.com.

My cell phone number is No text Messages.

C. ☐ Having been informed of the risks associated with Electronic Communications, I do *not* consent to, accept the risk in and desire to communicate with Seasons Center via Electronic Communications. I understand that I can change my mind and provide a consent authorizing Seasons Center to communicate with me via Electronic Communications at a later time by written notification to Seasons Center

To the extent that I have checked Box A or B, I release and hold harmless Seasons Center, its provider(s) and their staff, employees, affiliates, agents, officers, and principals from any and all expenses, claims, actions, liabilities, attorney fees, damages, losses of any kind that I may have resulting from Electronic Communications between Seasons Center and me and/or the minor identified based on this authorization given to Seasons Center to communicate with me via Electronic Communications.

_____
Patient Name (printed)

_____ _____
Patient Signature (Parent signature if Patient is a minor) Date

Welcome to Seasons Center for Behavioral Health Center

September 3, 2014

Dear _____

Congratulations on taking the first step toward better mental health. We thank you for choosing Seasons Center as your behavioral health provider.

Attached are intake papers that you need to complete and sign where indicated. Please ***return to Seasons Center as soon as possible. Please include a copy – front & back – of your insurance card(s).***

Please return by using one of the following:
Mail to: Seasons Center, 201 E 11th St., Spencer, IA 51301 Attn: Intake Specialists
Email to: intake@seasonscenter.org
Fax to: 712-264-3173

If you would like help in filling out your paper work, please give us a call at 1-800-242-5101 ext. 1105 and we can assist you over-the-phone or schedule an appointment with you at one of our other locations.

Full fees effective July 1, 2013 are as follows (A full list of all fees is available upon request):

	Doctor/Therapist
Psychiatric Evaluation	**$300**
Medication Management	**$55 - $185**
Therapy Evaluation	**$220**
Therapy Session	**$75 - $170**
Substance Abuse Evaluation	**$150**
DOT Substance Abuse Evaluation	**$125**
Substance Abuse Therapy Session	**$40 - $100**
Intensive Outpatient Program (Daily Rate)	**$150**
Substance Abuse Group (2 hr)	**$64**

- **Consent to Treat and Payment of Services**: Please review and sign and date where indicated. If you are the parent or guardian of the client, please sign where applicable and date.
- **Description of Services**: This form is for you to keep. It explains the various services Seasons Center offers.
- **HIPAA Acknowledgment**: Please review, then sign and date where indicated. Substance abuse patients please be advised that your records are further covered by Federal Standards 42-CFR-Part 2.
- **Rights of Individuals Served**: Please review and keep for your records.
- **Notice of Privacy Practices:** Please review this form and keep for your records.
- **Authorizations:** Please complete where indicated and sign.

Please consider not bringing other children to your child's appointments. It is important the doctor have as few interruptions as possible to accurately access and treat your child

Name: Case#: Medicaid # DOB

I have been informed and given a copy of the Seasons Center for Behavioral Health Center Privacy Notice. I have been told that if I have trouble reading or understanding the Seasons Center notice, I may request assistance. I understand that if I have questions or concerns, I should contact the Seasons Center Privacy officer.

I acknowledge I have been provided with descriptions of services provided by Seasons Center. I have also been offered copies of any and all parts of the registration process. By completing these forms, I understand I have completed the registration process and my treatment will begin when I meet with my mental health service provider.

Signature Obtained	Accepts Copy	Declines Copy	Forms
☑YES ☐NO ☐N/A	☐	☐	Consent to Treat & Payment
☑YES ☐NO ☐N/A	☐	☐	Description of Services
☐YES ☐NO ☑N/A	☐	☐	Consumer Rights
☑YES ☐NO ☐N/A	☐	☐	HIPAA Acknowledgement:
☐YES ☐NO ☑N/A	☐	☐	Notice of Privacy Practices
☑YES ☐NO ☐N/A	☐	☐	Authorizations

Client/Legal Representative Date

Staff Member Date

6-1-10

Seasons Center for Behavioral Health
Consent to Treat and Payment of Services

Fee Rates, County funding, and Insurance: For the services I receive at Seasons, I understand and agree that I will be billed the current full fee rate. If I have insurance, my insurance company will be billed full fee. Should I choose to make application to the county for a subsidy of my fee, I will be charged at the current full fee rate (100%) until the county has approved or denied funding for mental health services at Seasons. The Board of Directors has approved a sliding fee scale for county funding based upon my gross income. Should the county deny funding, I understand that I am responsible for all charges for my services. **Payment is expected at the time services are rendered.** I understand that fees not paid after 90 days will be sent to collections if no alternative payment agreement has been made.

I understand that if services are supported by third party and/or county, these services may be subject to audit by authorized representatives of those payers for verification purposes. I authorize payment of health benefits otherwise payable to me, directly to Seasons Center, and I consent to reviews of services rendered for such purposes. Seasons has agreed to bill third party payers upon being provided current and accurate billing information. This Signature on File is valid for all third party payers involved in collecting monies for services rendered. **I agree to provide Seasons Center with accurate and current insurance information.** I also understand that Seasons cannot guarantee third party payment.

Quality of Service: Members of Seasons' governing board and the State of Iowa have established standards of quality for services provided at Seasons. It is their intent that the staff of Seasons be fully trained and competent mental health professionals. I understand that there is no assurance that I will feel better. Because therapy is a cooperative effort between my clinician and me, I will work with my clinician in a cooperative manner to resolve my difficulties. If I feel the staff is not providing the type or quality of services needed, I will first talk to the staff person involved. The staff member will try to resolve my concern and explain the process for further action if I am not satisfied. If I feel unable to discuss the matter with the staff person, I have the right to contact the staff's supervisor or the consumer concerns department at 712-262-2922 or 1-800-242-5101, who will then fully investigate.

Emergency Services: Emergency services are crisis services that provide a focused assessment and rapid stabilization of acute symptoms of mental illness or emotional distress, and are available and accessible to consumers on a 24-hour basis by calling **1-800-242-5101 or 712-262-2922.**

Appointments: Due to the demand for services and the nature of treatment **please give 24-hour notice of cancellation. Seasons will charge clients $26.00 unless we are notified of an appointment cancellation.**

Seasons Center for Behavioral Health
Consent to Treat and Payment of Services

Permission to Provide Mental Health Services:

Seasons will provide diagnostic and treatment services, or both, upon your written consent to do so. Please sign indicating that you are requesting services.

I request that Seasons perform either diagnostic or treatment services, or both, for _____

Date of Birth _____ Account # _____ Medicaid # _____

Individual's Signature _____ Date _____

Parent/Guardian _____ Date _____

Staff Member _____

Signature on file for third party payers _____

Approved 01/18/06
Revised 10/28/09

SEASONS CENTER FOR BEHAVIORAL HEALTH
DESCRIPTION OF SERVICES

PSYCHIATRIC SERVICES

The Psychiatric Department consists of Psychiatrists, Physicians Assistants, Nurse Practitioners, and Registered Nurses. Comprehensive outpatient psychiatric care is provided to children and adults. The psychiatrist/ARNP/PA diagnose and treat psychiatric disorders. Psychiatric evaluations are completed for the purpose of assessing symptoms, needs, abilities, disabilities, and history; diagnosing illness, and determining treatment and follow-up service needs. Ongoing treatment is provided through medication management in order to monitor medication effects and side effects. A psychiatrist is available to provide services for inpatient management of adults. 24-hour on-call services are available through the Triage Services and/or the after-hour emergency on-call system. Consultation is available to other community physicians regarding inpatient and outpatient treatment, as needed.

OUTPATIENT MENTAL HEALTH SERVICES

Outpatient therapy services focus on alleviating specific mental health problems, enhancing overall functioning, and preventing development of more serious or more disruptive problems for the individual and for those involved in their care. At a minimum, Seasons Center therapists are educated at a Masters level in psychology, social work, counseling, and/or marriage and family counseling. All therapists are licensed or eligible to be licensed in their discipline. Based on the assessment and social history, the therapist and individual(s) develop a mutually agreed upon plan for treatment. Therapists use a variety of interventions to facilitate goal achievement. The therapy process is individualized and based upon the resources, abilities, and limitations of the individual(s) receiving the service. In addition to individual therapy, outpatient services are also provided in family and/or group therapy modalities.

OUTPATIENT SUBSTANCE ABUSE SERVICES

Outpatient services focus on alleviating specific substance abuse/dependency problems, enhancing overall functioning and preventing development of more services or disruptive problems for the individual and their families. At a minimum, Seasons Center Substance abuse/dependency therapists are educated at a Bachelors level in psychology, social work or other related field. Master level therapists are strongly sought and bachelor level therapists strongly encouraged to seek out a graduate level education. All therapists are certified or eligible for certification through the Iowa Board of Substance Abuse Certification. Therapists are also encouraged to seek out advanced certification as well as licensure in a counseling related field after meeting eligibility requirements. Based on the assessment and social history the therapist and individual(s) develop a mutually agreed upon plan for treatment. Seasons outpatient substance abuse programming incorporates three distinct levels of care provided by the Addiction Society Addiction Medicine (ASAM) criteria. These levels of care include Intensive Outpatient (IOP), Extended Outpatient (EOP) and Continuing Care (CC.) Therapists use a variety of interventions to facilitate goal achievement no matter the level of care provided. The therapy process is individualized and based upon the resources, abilities, and limitations of the individual(s) receiving the service. In addition to individual therapy, outpatient services are also provided in family and/or group therapy modalities.

COMMUNITY BASED SERVICES

Seasons offers numerous options to encompass clients in their homes and community that are designed to assist them to meet any challenges stemming from emotional health.

- **Supported Community Living** (SCL) provides services and support to individuals where they live, learn, work and socialize in a community setting.
- **Community Support Services** (CSS) address disabilities that may negatively affect the individual's integration and/or stability in their community.
- **Habilitation Services** are individualized services for individuals with Chronic Mental Illness.
- **Elderly Waiver or Senior Living Trust** services are designed to support the individual, over the age of 60, addressing mental and functional disabilities that negatively affect stability in functioning.

Seasons Center for Behavioral Health
Safeguarding the Rights of Individuals Served

Seasons Center for Behavioral Health holds that its primary obligation is to enhance and safeguard the mental well being of individuals served. Seasons' employees shall provide services in ways that respect and enhance the individual's sense of autonomy, privacy, dignity, self-esteem and involvement in the treatment. Employees take language barriers, cultural differences and cognitive deficits into consideration and make provisions to facilitate meaningful individual participation.

Individual Rights Include:

- The right to be treated with respect and dignity.
- The right to receive care based on their individual situations/needs.
- The right to have the quality of their care assured.
- The right to consent or decline services.
- The right to have their views considered in the making of decisions which affect them.
- The right to have those who are legally responsible for their welfare be fully informed about the nature of services/actions to be provided and their outcome in order that they may have choices regarding their participation and/or their children's participation.
- The right to be informed about the purpose of services they are receiving.
- The right, if over the age of 7, to be informed about and make choices regarding their participation in research as well as the right to have their parents/guardians review and approve it.
- The right to receive services without non-clinically determined delays.
- The right to be served in the least restrictive setting.
- The right to express opinions about services received.
- The right to have patient records protected from an invasion of privacy. To have information held confidential unless consent is given in written form by signing a release, a court order is issued to Seasons, disclosure is made to medical personal in a medical emergency, or qualified person for research, audit or program evaluation.
- The right to appeal agency actions.

Individual Responsibilities Include:

- Individuals will actively participate in the establishment of treatment goals.
- Individuals will keep scheduled appointments and notify the Center regarding any necessary changes in scheduled appointments.
- Individuals will inform their primary clinician of any changes in medication and will take medication as prescribed.
- Individuals will follow through with suggestions, recommendations, or homework assignments between sessions.
- Individuals will check with pharmacy regarding refills before contacting the Center.
- Individuals will respect the privacy and confidentiality of other patients.

Seasons Center for Behavioral Health does not conduct any experimental treatment procedures; does not conduct any procedure that carries an intrinsic risk such as convulsive therapy, psychosurgery, or aversive conditioning; and does not conduct education demonstrating programs involving audio visual equipment or one-way mirrors.

Anyone who believes that Center actions are not in accord with this policy should contact the Director.

Kim Scorza, MSW, LMSW
Executive Director

Seasons Center for Behavioral Health

HIPAA Acknowledgment

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. As stated in our notice, the terms of the notice may change. If we change our notice, you may obtain a revised copy by contacting the Privacy Officer at Seasons Center for Behavioral Health, 201 E. 11th St., Spencer, IA 51301.

By signing this form, you acknowledge that you have received a copy of our Notice of Privacy Practices (dated April 14, 2003), Individual Rights & Responsibilities form, and a Description of Services form.

Individual Appeals Process

Seasons provides and informs all individuals served (and their guardians) of their right to appeal the application of policies, procedures, or any staff action that affects them.

1. All individuals served are informed of Seasons' appeals process during the intake process. They receive a printed copy of Individual Rights and Responsibilities, which includes the appeals process.
2. When an individual verbally presents a complaint or appeal to an employee of Seasons Center:
   A. The employee will suggest that the individual speak first directly with the employee involved with the concern to resolve the matter.
   B. If the individual is uncomfortable addressing the staff person directly, the individual will be directed to talk to the employee's supervisor or the Executive Director.
3. If the individual is dissatisfied with the results of #2, or wishes to pursue the matter further, they will be given an Individual Appeal form.
   A. If they need assistance with filling out the form, the Executive Director, or whom the Executive Director designates, will assist them with doing so.
   B. The Executive Director, or whom the Executive Director designates, will write down all pertinent information or allow them to write their concerns.
4. Within ten (10) days, the Executive Director, or whom the Executive Director designates, shall investigate the complaint and respond in writing to the individual.

5. If dissatisfied with the recommendations, the individual will be informed that they may submit their written complaint or request to the Executive Committee of the Board of Directors.

A. The Executive Committee will review the complaint, ensure that the appeals process was followed, and make their recommendations to the Board of Directors at the next scheduled meeting of the full Board for decision.
B. A response from the Board President will be written and delivered to the individual within 45 days of receipt of the written complaint/appeal.
C. The decision of the Board of Directors shall be final.

My signature below indicates I have received a copy of this form stating the individual appeals process (dated February 24, 2006).

Individual's Name:

Date of Birth: Account #: Medicaid #:

Signature of Individual or Individual's Representative: _____

Date _____

Approved 01/18/06
Revised 06/01/2010

SEASONS CENTER FOR COMMUNITY MENTAL HEALTH (SEASONS)

Notice of Privacy Practices – Effective Date: April 14, 2003

This notice is distributed to each Seasons client at time of intake and is on our website: www.seasonscenter.org.

This notice describes:

- How medical information about you may be used
- How you can get access to your medical information

Please review it carefully.

Each time you visit Seasons a record of your visit is made. Typically, this record contains your symptoms, diagnoses, treatment, and a plan for future care or treatment. Understanding what is in your record and how your health information is used helps you to ensure its accuracy. It also helps you to better understand who, what, when, where, and why others may access your health information, and it helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of Seasons, the information belongs to you.

You have the right to:

- Request and obtain a paper copy of this notice
- Request communications of your health information by alternative means or at alternative locations
- Request to inspect and obtain a copy of your health record; however, if there are grounds for denial after review by your service provider, you will be provided with an explanation of the decision to deny access.
- Request a restriction on certain uses and disclosures of your information; however, Seasons is not required to agree to a requested restriction.
- Request an amendment of your protected health information. We may deny your request for the following reasons:
    1. It is not in writing or does not include a reason
    2. The information was not created by us
    3. The information is not part of the information maintained to make care decisions
    4. The information is not part of the information you are permitted to inspect
    5. The information is accurate and complete as is
- Revoke your authorization to use or disclose health information except to the extent that:
    1. Action has already been taken
    2. Authorization was obtained as a condition of obtaining health insurance coverage
- Obtaining an accounting of disclosures of your health information not pertaining to payment, treatment or health care operation or your authorization released after April 14, 2003

To take any of the above actions, contract our Privacy Officer at 201 E 11th St., Spencer, IA 51301.

OUR RESPONSIBILITIES:

Seasons is required by law to:

- Maintain the privacy of your health information which is protected information.
- Provide you with this Privacy Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post notice of this along with the revised policy in our reception areas and will supply you with the revised policy upon request to our Privacy Officer. We will not use or disclose your health information without your authorization, except as described in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have questions and would like additional information, you may contact Seasons at 712-262-2922 or 800-242-5101. If you believe your privacy rights have been violated, you can file a written complaint with the Seasons Privacy Officer at 201 E 11th St., Spencer, IA 51301. There is no retaliation for filing a complaint.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS
We may release your private health information (PHI) in the following circumstances:

- **Treatment:**
  For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will then record the actions they took and their observations.
- **Payment:** A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

- **Regular health operations:** Members of the medical staff, quality assurance, or members of a qualify improvement team may use information in your health record to assess the care and outcomes in your case and others like it. this information will then be used in an effort to continually improve the qualify and effectiveness of the healthcare and service we provide.
- We may release your health information to family members and those you have authorized
  Unless you object, we may disclose health information to family members or legal representative who are involved in your care or involved in payment of your care; however, it is our policy to obtain your authorization for all releases of information whenever possible. If you are unable to agree or object to such a disclosure, our health professionals, using their best judgment, may disclose information if it is determined to be in your best interest.
- **Workers compensation:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- **Public health:** As required by law, we may disclose your health information to public health or legal authorities responsible for preventing or controlling disease, injury, or disability.
- **Correctional institution:** Should you be an inmate of a correctional institution, we may disclose to the institution or agents there of health information necessary for your health and the health and safety of other individuals.
- **Business associates:** There are some services provided in our organization through contacts with business associates. Examples include certain medical laboratory for tests, pharmacies, accounting firm, and computer support. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
- **Research:** We may disclose information to researchers when an institutional review board that has reviewed the research proposal, and established protocols to ensure the privacy of your health information has approved their research.
- **Food and Drug Administration (FDA):** We may disclose to the FDA health information related to adverse affects of medication or post marketing surveillance information to enable product recalls.
- *Notification:* We may contact you to provide appointment reminders, information about treatment alternatives, other health-related benefits, and/or services that may be of interest to you.
- **Law enforcement:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.
- **Emergency:** If you have given indication through your words or actions that you are a danger to yourself or someone else, or that there has been incident of child or adult abuse, we are mandated by law or obligated to report this to the appropriate authorities such as the police or DHS.
- **The Federal Department of Health and Human Services (DHHS):** Under the privacy standards, we must disclose your health information to DHS as necessary for them to determine our compliance with those standards.

AUTHORIZATION- SEASONS CENTER FOR BEHAVIORAL HEALTH

CONSENT FOR THE RELEASE
OF CONFIDENTIAL INFORMATION
Medicaid

I, _____, authorize communication between Magellan Behavioral
(Name of Patient)
Care of Iowa (MBC), and Seasons Center for Behavioral Health
(Name of program making disclosure)

to authorize the following information pertinent to my treatment episode:

assessment and evaluation
proposed treatment plan of care
diagnosis
progress notes related to preauthorization or concurrent review
continuing care plan
other psychosocial information relating to preauthorization or concurrent review
follow-up contact
other(specify)_____

The purpose of the disclosure authorized herein is to support care management and reimbursement, satisfaction surveying and quality improvement through IMSACP (Iowa Managed Substance Abuse Care Plan).

I also authorize MBC to redisclose the information listed above to the Department of Human Services, Division of Medical Services for the purpose of evaluating and auditing MBC or for conducting appeals of reimbursement determinations. I also authorize MBC to verbally redisclose case management information to Department of Human Services, County office for the purpose of case coordination.

I understand that my records are protected under the Federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2 and can not be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires when there has been a resolution of all outstanding claims or one year form discharge, whichever is later.

_____ _____
Signature of patient Date

_____
Signature of parent, guardian or authorized representative when required

_____ _____
Printed Patient Name ID

Prohibition of Redisclosure of Information concerning Patient in Alcohol or Drug Abuse Treatment: This notice accompanies a disclosure of information concerning a patient in alcohol/drug abuse treatment, made to you with the consent of such patient. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as other wise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any drug or alcohol abuse patient.

SEASONS CENTER FOR BEHAVIORAL HEALTH

Authorization to Release Information
to Insurance Company

I authorize **SEASONS CENTER FOR BEHAVIORAL HEALTH** to release such information from my medical record as may be necessary for the completion of the SEASON CENTER FOR BEHAVIORAL HEALTH or my physician's claims for reimbursement to my insurance company, preferred provider organization, health maintenance organization, utilization review organization or agency.

I understand that the disclosure may include diagnosis or procedures performed and that, at the request of my insurance company, preferred provider organization, health maintenance organization, utilization review organization, or agency, my complete medical record may be subject to review. In addition, I understand that copies of my medical record may be obtained by my insurance company, preferred provider organization, health maintenance organization, utilization review organization, or agency.

I also authorize SEASON CENTER FOR BEHAVIORAL HEALTH to release such medical information from my record as may be required to permit each physician who provides care to me during the course of this stay or service to complete their office records.

This authorization includes mental health, alcohol and drug abuse records protected by state and federal legislation.

I understand that my records are protected under the Federal regulations governing confidentiality of alcohol and drug abuse records, 42 CFR Part 2 and can not be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires when there has been a resolution of all outstanding claims or one year from discharge, whichever is later.

Assignment of Benefits:

In consideration of the services received or to be received for these services, I assign all insurance benefits due me to SEASONS CENTER FOR BEHAVIORAL HEALTH.

_____ _____

Patient or authorized representative Date

_____

Relationship

_____

Guarantor/Insured Certificate Holder

_____ _____

Patient Printed Name Date

Medicaid #

CONSENT TO RELEASE OF INFORMATION Northwest
Iowa Mental Health Center (Seasons Center)
201 E 11th St, Spencer, IA 51301
Phone: (800) 242-5101 Fax: (712) 262-3826

Patient's Legal Name _____ Birth Date _____ Medicaid # _____

By signing this form, I am allowing Seasons Center to ✔ release or ✔ obtain written and oral information by telephone, fax, electronic data exchange or mail concerning the above named patient with the following individual or agency:

Midwest Christian Services
Name of Person and/or Institution

4509 20th Avenue	Peterson	IA	51047	(712) 295-7601	(____)_____
Address	City	State	Zip	Phone #	Fax #

Check the information to be disclosed:

✔ Psychiatric Evaluation	✔ Laboratory Results	☐ Medical Records
✔ Med/Progress Notes	✔ Billing Info	✔ Annual Review
✔ Psychological Testing/Assessments	✔ Appointment Dates/Info	✔ Initial Assessments
✔ Educational/Vocational Records	✔ Discharge Summary	✔ Progress Summary
✔ Service Plan/ICP/Treatment Plan	✔ Social History	☐ All of the above
☐ Other: Please Specify		

Please indicate the reason for release:

✔ Continuity of Care ☐ Rehab/Disability ☐ Legal ☐ Insurance ☐ Transferring Care
✔ Other: (Please Specify) Residential Treatment

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send written notification to: Medical Records, Seasons Center, 201 E 11th St., Spencer, IA 51301. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Medical Records at the above address.

Confidentiality of the information is protected by Federal Law (42-CFR-Part 2) and the code of Iowa Chapter 228. Further disclosure is prohibited without specific consent from whom it pertains. General authorization is not sufficient for this purpose.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

_____Substance Abuse _____Mental Health _____HIV-related information _____Genetic tests/info

This agreement will expire one year from the date of signature, or on date specified: _____

_____ _____
Patient Signature Date

_____ _____ _____
Legal Guardian Signature Date Relationship

_____ _____
Witness Signature Date

Only clients 18 years of age or older, or legal representative, can authorize release of mental health information.
Only clients, regardless of age, can authorize release of substance abuse information.

Office Use Only:

Please send records: _____ Date records/request was sent and by whom:_____
Please request records: _____ Description of records sent:_____

CONSENT TO RELEASE OF INFORMATION Northwest
Iowa Mental Health Center (Seasons Center)
201 E 11th St, Spencer, IA 51301
Phone: (800) 242-5101 Fax: (712) 262-3826

Patient's Legal Name _____ Birth Date _____ Medicaid # _____

By signing this form, I am allowing Seasons Center to ✔ release or ✔ obtain written and oral information by telephone, fax, electronic data exchange or mail concerning the above named patient with the following individual or agency:

Primary Care Doctor: Mercy Medical Clinics
Name of Person and/or Institution

_____ (___) _____ (____) _____
Address City State Zip Phone # Fax #

Check the information to be disclosed:

✔ Psychiatric Evaluation	✔ Laboratory Results	✔ Medical Records
✔ Med/Progress Notes	✔ Billing Info	✔ Annual Review
✔ Psychological Testing/Assessments	✔ Appointment Dates/Info	✔ Initial Assessments
✔ Educational/Vocational Records	✔ Discharge Summary	✔ Progress Summary
✔ Service Plan/ICP/Treatment Plan	✔ Social History	✔ All of the above

☐ Other: Please Specify _____

Please indicate the reason for release:

✔ Continuity of Care ☐ Rehab/Disability ☐ Legal ☐ Insurance ☐ Transferring Care
☐ Other: (Please Specify) _____

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send written notification to: Medical Records, Seasons Center, 201 E 11th St., Spencer, IA 51301. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Medical Records at the above address.

Confidentiality of the information is protected by Federal Law (42-CFR-Part 2) and the code of Iowa Chapter 228. Further disclosure is prohibited without specific consent from whom it pertains. General authorization is not sufficient for this purpose.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

_____Substance Abuse _____Mental Health _____HIV-related information _____Genetic tests/info

This agreement will expire one year from the date of signature, or on date specified: _____

_____ _____
Patient Signature Date

_____ _____ _____
Legal Guardian Signature Date Relationship

_____ _____
Witness Signature Date

Only clients 18 years of age or older, or legal representative, can authorize release of mental health information.
Only clients, regardless of age, can authorize release of substance abuse information.

Office Use Only:

Please send records: _____ Date records/request was sent and by whom: _____
Please request records: _____ Description of records sent: _____

CONSENT TO RELEASE OF INFORMATION Northwest
Iowa Mental Health Center (Seasons Center)
201 E 11th St, Spencer, IA 51301
Phone: (800) 242-5101 Fax: (712) 262-3826

Patient's Legal Name _____ Birth Date _____ Medicaid # _____

By signing this form, I am allowing Seasons Center to ✔ release or ✔ obtain written and oral information by telephone, fax, electronic data exchange or mail concerning the above named patient with the following individual or agency:

Pharmacy: Main Street Pharmacy
Name of Person and/or Institution

_____ (___) _____ (____) _____
Address City State Zip Phone # Fax #

Check the information to be disclosed:

____ Psychiatric Evaluation	____ Laboratory Results	____ Medical Records
____ Med/Progress Notes	✔ Billing Info	____ Annual Review
____ Psychological Testing/Assessments	✔ Appointment Dates/Info	____ Initial Assessments
____ Educational/Vocational Records	____ Discharge Summary	____ Progress Summary
____ Service Plan/ICP/Treatment Plan	____ Social History	____ All of the above

✔ Other: Please Specify Insurance Info, Rx Info

Please indicate the reason for release:

____ Continuity of Care ____ Rehab/Disability ____ Legal ____ Insurance ____ Transferring Care
✔ Other: (Please Specify) Precriptions

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Iowa Mental Health Center (Seasons Center)
201 E 11th St, Spencer, IA 51301
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Patient's Legal Name _____ Birth Date _____ Medicaid # _____

By signing this form, I am allowing Seasons Center to ✔ release or ✔ obtain written and oral information by telephone, fax, electronic data exchange or mail concerning the above named patient with the following individual or agency:

Royster & Royster Counseling, PLLC
Name of Person and/or Institution

_____ Cherokee _____ (___)_____ (____)_____
Address City State Zip Phone # Fax #

Check the information to be disclosed:

✔ Psychiatric Evaluation	✔ Laboratory Results	✔ Medical Records
✔ Med/Progress Notes	✔ Billing Info	✔ Annual Review
✔ Psychological Testing/Assessments	✔ Appointment Dates/Info	✔ Initial Assessments
✔ Educational/Vocational Records	✔ Discharge Summary	✔ Progress Summary
✔ Service Plan/ICP/Treatment Plan	✔ Social History	✔ All of the above

☐ Other: Please Specify _____

Please indicate the reason for release:

✔ Continuity of Care ☐ Rehab/Disability ☐ Legal ☐ Insurance ☐ Transferring Care
☐ Other: (Please Specify) _____

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Please request records: _____ Description of records sent: _____

MAGELLAN BEHAVIORAL HEALTH
MEMBERS' RIGHTS AND RESPONSIBILITIES STATEMENT

Statement of Members' Rights

Members have the right to:

- Be treated with dignity and respect.
- Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept private. Only where permitted by law, may records be released without member permission.
- Easily access timely care.
- Know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- Share in developing their plan of care.
- Information in a language they can understand.
- A clear explanation of their condition and treatment options.
- Information about Magellan, its practitioners, services and role in the treatment process.
- Information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Members' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Receive services that will not jeopardize their employment.
- Request certain preferences in a provider.
- Have provider decisions about their care made without regard to financial incentives.

Statement of Members' Responsibilities

Members have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider(s) as soon they know they need to cancel visits.
- Let their provider know when the treatment plan isn't working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

_____

Member Signature Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

_____

Provider Signature Date

NAME: _____
D.O.B.: _____
MEDICAID #: _____

Approved June 20, 2003

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Individual's Name: _____

SS #: _____

Date: _____

Please circle appropriate answer. When finished, please give to receptionist. Thank you.

1. Do you or your spouse work for a company that provides you with health insurance?

   Yes No

   -- If answer is yes, does that company employ 99 or more employees?

   Yes No

2. Are you entitled to Medicare because of disability of End Stage Renal Disease?

   Yes No

3. Is this illness or injury the result of an automobile accident or other injury?

   Yes No

4. Is this illness or injury the result of an accident or illness that occurred at work?

   Yes No

5. Has treatment for this accident or illness been authorized by the Veterans Administration?

   Yes No

6. Are you entitled to any benefits under the federal Black Lung Program?

   Yes No

Signature: _____

NAME: _____

D.O.B.: _____

MEDICAID #: _____

SPI Approved 1-18-06