

Thriving Families Counseling Services

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www.thrivingfamilieservices.com

TFCS Services Agreement

Services

Below is a list of services offered by Thriving Families Counseling Services:

1. Social History/ Psychological Evaluation
2. Outpatient Mental Health Services
3. Drug/ Alcohol/ Gambling Services
4. Family Therapy/ Couples Therapy
5. Group Therapy
6. School-Based Therapy
7. Co-Parenting Class (Children in the Middle)
8. Anger Management
9. IDAP Alternative
10. Guided Supervised Visit Program (GSV)
11. Eye Movement Desensitization and Reprocessing (EMDR)

Hours

The hours at Thriving Families Counseling Services varies per therapist, but in general the hours are from 8am to 6pm - Monday through Friday.

Outside of scheduled appointments/after hours: Please call 911 if an emergency is occurring. Staff will develop an individualized emergency plan identify natural and professional supports who will be able to meet the identified needs of the individual. This will include specific staff interventions that may be required on an "as needed basis".

Client Rights and Responsibilities

<u>Statement of Clients' Rights</u>	<u>Statement of Clients' Responsibilities</u>
Be treated with dignity and respect	Treat those giving them care with dignity and respect.
Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment	Give providers and Magellan information that they need. This is so providers can deliver quality care and Magellan can deliver appropriate services.
Have their treatment and other member information kept confidential. Only where permitted by law may records be released without the member's permission.	Ask questions about their care. This is to help them understand their care.
Easily access care in a timely manner.	Follow the treatment plan. The plan of care is to be agreed upon by the members and provider.
Know about their treatment choices. This is regardless of cost or coverage by their benefit plan.	Follow the agreed upon medication plan.
Share in developing their plan of care.	Tell their provider and primary care physician about medication changes, including medications given to them by others.

Receive information in a language they can understand.	Keep their appointments. Members shall call their provider(s) as soon as they know they need to cancel visits.
Receive a clear explanation of their condition and treatment options.	Let their provider know when the treatment plan is not working for them.
Receive information about Magellan, its providers, programs, services and role in the treatment process.	Let their provider know about problems with paying fees.
Receive information about clinical guidelines used in providing and managing their care.	Report abuse and fraud.
Ask their provider about their work history and training.	Openly report concerns about the quality of care they receive.
Give input on the members' rights and responsibilities policy.	
Know about advocacy and community groups and prevention services. If asked, Magellan will act on the member's behalf as an advocate.	
Freely file a complaint or appeal and to learn how to do so.	
Know of their rights and responsibilities in the treatment process.	
Request certain preferences in a provider.	
Have provider decisions about their care made on the basis of treatment needs.	

Treatment & Consultation

From time to time, your therapist may use Protected Health Information within the practice for the purpose of consulting with a provider for the best practices. This can include consultation, treatment planning, or conferences with other providers (e.g. teachers, physicians, psychologists etc.) Releases of information will be signed for each entity.. I understand that my confidentiality is still intact.

Cancellation Policy

Your therapist has reserved time to work with you, so I agree to contact this office 24 hours in advance of any necessary rescheduling or cancellation. Failure to provide such notice will result in a cancellation fee, and I understand I am responsible for payment of that fee.

Agreement for Psychotherapy with a Minor

As a parent/ legal guardian, you are giving TFCS permission to receive treatment services. You are aware that all information between a clinician and a client is strictly confidential. However, there are exceptions to confidentiality that include: 1) authorized releases of information with my signature; 2) my therapist is ordered by a court to release information; 3) a client presents a physical danger to self or others; 4) child or elder abuse/neglect is suspected. In these latter two cases, my child's therapist is required by law to inform legal authorities so that protective measures can be taken. If this becomes necessary my child's therapist will make every effort to discuss this with us prior to making the report.

TFCS Services Agreement Signature Page

Client Name:

DOB:

By initialing these areas below, I have read, understand, and agree with all sections above.

_____ Services

_____ Hours

_____ Client Rights and Responsibilities

_____ Treatment and Consultation

_____ Cancellation Policy

_____ Agreement for Psychotherapy with a Minor (if needed)

_____ I specifically agree for my child to receive school-based therapy through this agency/ provider

By signing below, it shows that I have been informed of my rights and responsible. By signing, I am saying I understand the rules and obligations I have to Thriving Families Counseling Services and its staff.

Client Signature: _____ Date: _____

Parent/Guardian/Rep: _____ Date: _____

If you are the legal guardian or representative approximated by the court for the client, please attach a copy of this authorization to receive this protected health information.

TFSC Staff/ Witness: _____ Date: _____