LAKE AREA COUNSELING & BEHAVIORAL HEALTH

Lake Area Citizens' Advisory Board (L.A.C.A.B.)

409R W US Highway 54
Camdenton, MO 65020
(P) (573) 317-9061
(F) (573) 317-1970

1253 Butler Drive
Lebanon, MO 65536
(P) (417) 533-5332
(F) (417) 533-7331

PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION

Date:_____

Last Name	First Name	Middle Name/Initial	Prefers To Be Called

Date of Birth	Social Security Number	Gender Assigned At Birth: Male___ Female___ Intersex___ ***Sexual Orientation:*** _____

Marital Status: Married___ Single___ Divorced___ Widowed ___ Life Partner___ Separated___ Other_____

Spoken Language Other Than English:_____ Do You Require An Interpreter? Yes_____ No_____

Race (Optional): American Indian/Alaskan Native___ Asian/Pacific Islander___ Black – Non Hispanic___ Hispanic___ White Non-Hispanic___ Other:_____

Home Address including Apt/Unit Number	City	State	Zip Code

Home Phone	Mobile Phone	Work Phone	Email Address

By initialing at the end of this statement, I consent to receive text messages, emails, or text messages & emails (circle one)_____

Employment Status: Child___ College Student___ Active Duty/Military___ Retired___ Disabled___ Homemaker___
Employed Full-time___ Employed Part-time___ Self-employed___ Not Employed___ Other_____

Employer	Employer Address	Employer Phone Number

Primary Care Provider	Address	Phone Number

Referring Provider	Address	Phone Number

Responsible Party: (if not client/patient) Last Name	First Name	Middle Name/Initial	Relationship to Client/Patient

Date of Birth	Social Security Number	Employer	Employer Phone Number

Home Address including Apt/Unit Number	City	State	Zip Code

Home Phone	Mobile Phone	Work Phone	Email Address

Emergency/Next of Kin: Last Name	First Name	Relationship to Client/Patient

Home Address including Apt/Unit Number	City	State	Zip Code

Home Phone	Mobile Phone	Work Phone	Email Address

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PATIENT INFORMATION

(continued)

Primary Health Insurance Carrier	**Policy Number**	**Group Number**
Name Exactly As Printed On Insurance Card (Give insurance card to staff member for scanning)		
Claims Address/Phone Number	**Policy Holders Name (If other than client/patient)**	
Subscriber's Relationship to Insured	**Subscriber's Social Security Number**	**Date of Birth**
Secondary Health Insurance Carrier	**Policy Number**	**Group Number**
Claims Address/Phone Number	**Policy Holders Name (If other than client/patient)**	
Subscriber's Relationship to Insured	**Subscriber's Social Security Number**	**Date of Birth**

Please read carefully below information and sign if in agreement. You are encouraged to ask questions to the staff or voice any concerns that you may have. If no questions are asked or concerns voiced, it is determined that you have full understanding of the below information and are in agreement with the Assignment of Benefits, Releases of Information, and Notice of Privacy Practices.

Assignment of Benefits:
I hereby authorize my health insurance benefits to be paid directly to Lake Area Citizens' Advisory Board d/b/a Lake Area Counseling & Behavioral Health and/or Dolen Nurse Practitioner Consultant, LLC, d/b/a Elite Mental Health & Wellness, Rhonda Dolen-Hooker, PMHNP-BC, FNP-BC. I understand that I am financially responsible for all non-covered services. I, also, understand that it is my responsibility to verify health insurance coverage for services and to be in compliance with my coverage including for referrals. By signing below, I authorize health insurance benefits payment(s) and acknowledge my responsibilities as laid out.

Release of Information:
I authorize the release of any medical, mental/behavioral health, or other information necessary to process insurance claims on my behalf. By signing below, I authorize assignment of benefits and release of information.

Medicare and/or Medicaid Assignment of Benefits and Release of Information:
I authorize any holder of my medical, mental/behavioral health, or other information to release to the Centers of Medicare & Medicaid Services and its agents any information needed to determine benefits for this or a related Medicare and/or Medicaid claims. I request that payment of authorized Medicare and Medicaid benefits be made either to me or the party who accepts assignment. Be signing below, I authorize benefits payment(s).

Notice of Privacy Practices Acknowledgment:
By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Signature _____ **Date** _____

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Consent for Treatment

Acknowledgement & Consent for Treatment

By signing this document, I am attesting to my consent for health care treatment including, but not limited to, behavioral/mental health treatment at Lake Area Citizens' Advisory Board (L.A.C.A.B.) d/b/a Lake Area Counseling & Behavioral Health. I understand that my individual needs will be matched with the appropriate type of care and services, and I will have the opportunity to participate in treatment planning.

Crisis/Emergencies

I understand that I can access crisis response services 24 hours a day, 7 days a week by calling **911**, the ***National Suicide Hotline*** at 1-800-273-8255, ***State-Wide 24-Hour Crisis Line*** at 1-888-237-4567, or seek treatment at the emergency department at ***Lake Regional Health System*** at 54 Hospital Drive, Osage Beach, MO 65065.

Medication Monitoring

I understand that medication monitoring of prescription controlled medications via onsite urine drug screening or an outside laboratory may be implemented. If requested, I will be asked to provide a urine specimen to monitor the presence of prescribed controlled medications at the request and discretion of my provider. These results will become part of my medical record and are subject to the same privacy practices as any other part of my medical record.

Telehealth Services

I understand that Telehealth services may be offered. The portal used may send communications such as text messages or emails to the contact information I provide. These communications may include, but are not limited to, intake documents, which may contain elements of my (Protected Health Information) PHI, a (Health Insurance Portability Accountability Act (HIPAA) consent form, and appointment reminders. Face to face remote appointments may take place via video conferencing over a HIPAA compliant portal. Audio-only appointments may be conducted by phone. It is my responsibility to protect my privacy and confidentiality by choosing a private location for remote appointments. I understand that, at this time, there are no known risks involved with receiving my healthcare in this manner, but also understand that a breech can and may occur at no fault to the healthcare agency or its providers.

I hereby consent to participate in healthcare services, including behavioral/mental healthcare services and substance use disorder services, and all other offered services as provided by the agency and its providers.

☐ **By checking this box, I choose to opt out of Telehealth services**

Confidentiality

I understand that staff work collaboratively, and that information about me and my treatment needs may be shared between staff members. This information will only be shared when necessary and appropriately based on each staff member's expertise and job function. L.A.C.A.B. staff share information for purposes of coordinating care, receiving consultation, or other reasons related to treatment, payment, and operations.

Applicable Notices of Privacy Practices are posted and copies are available upon request. The Notice of Privacy Practices explains your rights in accordance with RCW 70.02.050, 71.05.390, 71.05.630, CFR 42 part 2, and the Health Insurance Portability and Accountability Act (HIPAA).

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Pediatric Services (advance to the next section if this does not apply to you)

Do any of the following apply to you (or your child, if requesting services for your child)? If yes, please provide a copy of each document marked yes:

☐ Yes Letters of Guardianship

☐ Yes Powers of Attorney

☐ Yes Advanced Directive for Psychiatric Care

☐ Yes Parenting Plan

Court Ordered or Affiliated Services (advance to the next section if this does not apply to you)

Mark the following as appropriate:

- Currently under the Department of Corrections (DOC) supervision? ☐ Yes ☐ No
- Currently under civil or criminal court ordered mental health or chemical dependency treatment? ☐ Yes ☐ No
- Currently on a Less Restrictive Alternative or Conditional Release court order? ☐ Yes ☐ No

If you answered "YES" to any of the above questions, is there a court order exempting you from reporting requirements? ☐ Yes ☐ No If so, you are required to provide a copy of the document for your medical record.

Attendance & Engagement of Services

Thank you for choosing L.A.C.A.B. for your healthcare services. We want to ensure we are meeting your needs and helping you achieve your goals for wellness and recovery. We are here to help you be successful and reach your goals. Regular attendance and engagement in the treatment process is vital. We expect individuals to keep all scheduled appointments. We have a No-Show/Cancellation Policy. An alternative scheduling plan will be put into place if you have two (2) consecutive no-show/late cancellation events within a 60-day period. Clients/Patients who repeatedly cancel, even with notice, may also be provided with an alternative scheduling plan. Alternative scheduling plans will be at the discretion of the provider. Please see *Patient/Client Rights & Responsibilities* and the *No-Show/Cancellation* Policy for further information.

ELECTRONIC HEALTH RECORD

I authorize my health care information, including all records of my substance use disorder treatment (if any), to be included and stored in the electronic health record. I understand that my substance use disorder records are protected under the federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Regarding **substance use disorder treatment**, I understand that my records may be available to agency staff and providers who are not specifically or exclusively assigned to the substance use disorder treatment program. Agency policy prohibits all employees from accessing records except as needed for their job functions. My information may be accessed by staff outside of the substance use disorder program only as needed for purposes of treatment, payment, or healthcare operations. If I have particular concerns about who can access my medical record, I can discuss these concerns with my clinician/provider, the program manager, or director. I have the right to request that access to my record be restricted, however, I understand that my primary clinician(s)/provider(s) cannot be restricted from viewing my records.

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FINANCIAL AGREEMENT (regarding health insurance responsibilities)

I authorize release of medical information necessary to process my claim(s). I agree to the assignment of all health insurance payments I might receive directly to the agency and/or its providers. Health insurance coverage does not guarantee benefits. I am responsible for fees not covered by my health insurance. It is my responsibility to inform the agency of any changes in my financial status and health insurance.

I understand that Telehealth services will be billed to my insurance or to me if not covered by my insurance.

I understand that my portion of my healthcare service fee is due at the time of service, and agree to pay promptly all fees for which I am responsible; **failure to do so may result in termination of services.**

If I lose Medicaid while receiving services, I understand I am fully responsible for all fees incurred, and that income verification may be required.

A copy of the agency's and/or provider's fee schedule is posted at each office location, and is available upon request. I understand that these fees are subject to change based upon the revision of the fee schedule.

I understand that I will be charged a **NO-SHOW FEE** for missed or canceled appointments unless I provider 24-hours' notice; see *No-Show/Cancellation Policy*.

All unpaid fees are subject to collection.

RELEASE OF INFORMATION FOR AUTHORIZATION OF HEALTH INSURANCE BENEFITS

I hereby authorize the agency and/or its providers to disclose all or any part of my medical records, including behavioral/mental health and alcohol and substance use disorder records, to representatives of my insurance companies in order to process this claim.

Unless revoked earlier by me, this authorization shall expire 24 months from the date of my last service. I may revoke this consent at any time by signing and dating a formal request, except to the extent that action has already been taken in reliance upon it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third-party payer.

Information approved for disclosure based on this authorization may be protected by Federal Regulations (42 CFR Part 2), which prohibit a recipient from making any further disclosure of alcohol or substance use disorder treatment information unless expressly permitted by written authorization of the person to whom it pertains or their legal representative or otherwise permitted by 42 CFR Part 2. These Federal Regulations also restrict any use of the information to criminally investigate or prosecute any alcohol or substance use disorder client/patient. 42 CFR Part 2 permits only limited disclosures regarding deceased clients/patients when required by federal or state laws for the collection of vital statistics or an investigation into the cause of death.

By initialing below in the appropriate areas, I attest I have received and understand the intake packet materials:

_____ Consent for Treatment
_____ Client/Patient Rights & Responsibilities
_____ Health Insurance Portability Accountability Act (HIPPA)
_____ No-Show/Cancellation Policy
_____ Sliding Fee Discount Program/Financial Agreement (if applicable)
_____ Clinical Disclosure Statement/Fee Schedule

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I have read, been offered a copy of, and agree to the above conditions. I acknowledge that I have been allowed the opportunity to ask questions, and all questions have been answered to my satisfaction.

_____

Client/Parent/Legal Guardian **Printed Name**

_____ _____

Client/Parent/Legal Guardian **Signature** Date

-

_____ _____

Provider/Clinician/Agency Representative Signature Date

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PATIENT/CLIENT RIGHTS & RESPONSIBILITIES

As a patient/client of Lake Area Citizens' Advisory Board (L.A.C.A.B.) d/b/a Lake Area Counseling & Behavioral Health you have certain rights and responsibilities. Understanding your rights and responsibilities will assist you in receiving the best possible care.

The providers, clinicians, and staff will make every effort to respect your **Patient Rights** and meet your expectations as follows:

- Provide a welcoming, friendly, professional, and respectful environment.
- Be on time for your scheduled appointments unless unforeseen circumstances arise.
- Create a therapeutic relationship with the foundation of trust and respect.
- Be clear about the therapeutic process and attendance expectations, along with problem solving barriers to treatment.
- Be responsive to your requests and follow through in a reasonable amount of time.
- Allow you to express a concern or complaint and receive a prompt response; you have the right to file a formal grievance if you are not satisfied with the resolution of your complaint.
- Receive a clear explanation of all rules, regulations, and guidelines.
- Be provided with the opportunity to examine and receive an explanation of your bill/fees regardless of the source of payment.
- Be informed you are receiving your psychiatric care by a certified nurse practitioner, and you have the right to consult with a physician at any time.
- Be informed when you are receiving mental/behavioral health care from a trainee or intern, which you can decline and request to see a licensed professional therapist/counselor at any time.
- Be involved in your assessment, treatment planning, evaluation, and discharge planning which, with your consent, be conveyed to your current or future health care provider(s) any recommendations regarding your treatment.
- Keep all communications and records about your care confidential.
- Provide you with a copy of your health care record upon written request, and within 30 days of such request.
- Be provided all the appropriate and necessary information you might need to make an informed decision regarding your healthcare, including information about alternative treatment measures, risks and benefits of treatment verses non-treatment, potential treatment outcomes, possible deleterious effects of treatment, who is providing your care, and costs of services.
- Be provided clear written and spoken information in words you can understand.
- Be provided with all available information about possible research participation and obtain your informed consent.
- Be provided with freedom from any type of restraints or seclusion, including chemically based restraints, that is not medically necessary.
- Respect your decision to decline care.
- Be treated with consideration and respect in a safe environment from all forms of abuse and harassment.
- Respect your privacy.

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We ask that you make every effort to adhere to your **Patient Responsibilities** and make every effort to meet the agency's expectations as follows:

- Be friendly and respectful of staff and other clients/patients.
- Arrive on time; if you are more than 15 minutes late, we consider you a no-show.
- Keep all scheduled appointments or call at least **24 hours** ahead of your scheduled appointment time if you need to cancel or reschedule your appointment; **failure to do so will be regarded as a no-show and the No-Show/Cancellation Policy will be implemented.**
- Actively participate in your treatment and follow your treatment plan to achieve your identified goals for recovery.
- Alert your provider/clinician if you have concerns or feel your rights have not been properly respected.
- Asking for clear explanations and information to make well-informed and educated decisions regarding your care and treatment.
- Respect our facility and make every effort to keep it clean and tidy.
- Follow all the rules and guidelines of our agency.
- Inform your provider/clinician of the effectiveness of your treatment.
- Pay your charges/fees/bills promptly.
- Contact the agency if you have any questions or financial issues.
- **Provide the agency with the most up-to-date** address, **phone number(s)**, email address, health insurance information, employment, and all other pertinent patient/client information necessary for the provider/clinician to provide effective and comprehensive care.
- Provide your provider/clinician with any changes in your health status as soon as possible after occurrence to receive safe and effective services/treatment.
- Convey full information about your health including, but not limited to, medical, psychiatric, and substance use conditions and disorders to your provider/clinician to receive safe and effective services/treatment.

****Regular attendance and engagement in the treatment process is vital. We expect individuals to keep all scheduled appointments. We have a No-Show/Cancellation Policy. An alternative scheduling plan will be put into place if you have two (2) consecutive no-show/late cancellation events within a 60-day period. Clients/Patients who repeatedly cancel, even with notice, may also be provided with an alternative scheduling plan. Alternative scheduling plans will be at the discretion of the provider. ****

If you have any concerns or questions, you may tell any staff member and expect assistance. It is your right to express a concern or a complaint and receive a quick response. Furthermore, all communications are guaranteed to be handled in a confidential manner. No adverse reaction will occur because of any comments you make. We value your opinion and use all comments, both positive and negative, to improve our services.

Any comments, complaints, concerns, or requests may be put into writing and addressed to:

Sarah George
Executive Director
409R W. US Highway 54
Camdenton, MO 65020
P: 573-317-9061
F: 573-317-1970

Thank you for entrusting your care to us!

Lake Area Citizens' Advisory Board
d/b/a/ Lake Area Counseling & Behavioral Health (L.A.C.A.B.)

Health Insurance Portability Accountability Act (HIPAA)
Client Rights and Responsibilities
Organizations and Providers Responsibilities

This document contains important information regarding the federal law of the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regards to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payments, and health care operations.

HIPAA requires health care organizations provide clients/patients with a Notice of Privacy Practices (the *Notice*) for use and disclosure of PHI regarding treatment, payments and health care operations. The *Notice* explains HIPAA and its application to a client's/patient's PHI in greater detail.

The law requires that Lake Area Citizens' Advisory Board (L.A.C.A.B.), d/b/a Lake Area Counseling & Behavioral Health [here forward referred to as L.A.C.A.B.] and any of its contracted providers, obtain each client's/patient's signature acknowledging that they have been provided a copy of the *Notice.* It is a client's/patient's right and obligation to ask any questions that may arise regarding HIPPA and/or the *Notice* prior to signing this document acknowledging their understanding of the *Notice,* in order to engage in discussion to address any client/patient concerns and/or questions. Upon signing this document, the *Notice*, it will also represent an agreement between you, the client/patient and L.A.C.A.B. You may revoke this *Notice* agreement in writing at any time.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a client/patient and a health care organization and its providers/staff. In most situations, information is only permitted to be released to outside entities a client's/patient's treatment after the client/patient has signed a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where a health care organization and its providers are permitted and/or required to disclose information to outside entities without client/patient written authorization. If such a situation arises, disclosure shall be limited to what is necessary. Reasons/situations where PHI may be released without consent or written authorization include:

1. If a client/patient is involved in a court proceeding and a request is made for information concerning their diagnosis and treatment. Such information is generally protected under the law for client/patient-provider privilege. However, information may be provided to the court without a client's/patient's (or legal representative's) written consent/authorization, if the organization or provider receives a court order, or a subpoena of which the client/patient has been properly notified and the client/patient fails to inform the organization or provider that the subpoena is opposed. If a client/patient is involved in or contemplating litigation, it is recommended they consult an attorney to determine if a court would be likely to order PHI disclosure.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, the organization or provider may be required to adhere.
3. If a client/patient files a complaint or lawsuit against the organization or provider, they may disclose relevant information regarding that client/patient in order to defend allegations.
4. If a patient files a worker's compensation claim, and an organization and its providers are providing necessary treatment related to that claim, the organization and/or provider must, upon appropriate request, submit treatment reports to the appropriate parties, including the client's/patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.

5. The organization's providers may disclose the minimum necessary PHI to other organizational providers or business associates that perform functions on the client's/patient's behalf or provide the organization's providers with services, if the information is necessary regarding such functions or services. Business associates are also held to HIPPA regulations.

There are some situations in which an organization and/or provider is legally obligated to take actions, which they believe are necessary to attempt to protect others from harm. This may entail release of the client's/patient's PHI. These situations include, but are not limited to:

1. If the organization and/or provider know of, or have reason to suspect, that a child under 18 years of age, has been abused, abandoned, or neglected by a parent, legal custodian/guardian, caregiver, or any other person responsible for the child's welfare. The law requires the organization and/or provider file a report with the **Child Abuse and Neglect Hotline of Missouri** (1-800-392-3738). Once such a report is filed, the organization and/or provider may be required to provide additional information.
2. If the organization and/or provider know of, or have reasonable cause to suspect, a vulnerable adult has been abused, neglected, or exploited, the law requires that the organization and/or provider file a report with the **Adult Abuse and Neglect Hotline of Missouri** (1-800-392-0210). Once such a report is filed, the organization and/or provider may be required to provide additional information.
3. If the organization and/or provider believes that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, they may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT/PATIENT RIGHTS AND ORGANIZATION/PROVIDER RESPONSIBILITIES

Use and Disclosure of Protected Health Information:

- ***For Treatment*** – This organization and its providers use and disclose PHI internally in the course of our client's/patient's treatment. If we wish to provide information outside of our practice for your treatment by another health care provider, we will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – We may use and disclose your health information to obtain payment for services provided to you as delineated in the *Consent to Treatment Agreement.*
- ***For Operations*** – We may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

Client/Patient Rights:

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and *Release of Information* completion is required. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advance and allow 30 (thirty) days to receive the copies. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You are required to make amendment requests in writing. You are required to provide the reasons for the change request at which time we will review your request along with your PHI and determine if the request is appropriate. If we determine your request is not, we will notify you within 60 (sixty) days of your request.
- ***Right to a Copy of This Notice*** – If you received this paperwork electronically, you have a copy in your email. If you completed this paperwork in the office, you will be provided a hard copy.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, we will discuss with you the details of the accounting process.

- ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your PHI; we will confirm the person has the authority to make decisions and act on your behalf before any action is taken.
- ***Right to Choose*** – You have the right to decide not to receive services with L.A.C.A.B. or any of its providers. Upon your request, we can provide you with names of other qualified professionals/organizations.
- ***Right to Terminate*** – You have the right to terminate services with the organization and/or its providers at any time without any legal or financial obligations other than those already accrued. We ask that you discuss your decision with a representative of L.A.C.A.B. prior to terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not we think releasing the information in question to that person or agency might be harmful to you and your well-being.

Organization/Provider Responsibilities:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI. We reserve the right to change the privacy policies and practices described in this *Notice.* Unless we notify you of such changes, however, we are required to abide by the terms currently in effect. If we revise our policies and procedures, we will provide you with a revised *Notice.*

COMPLAINTS

If you are concerned that L.A.C.A.B. and/or its providers have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the **Missouri Department of Health & Senior Services** (1-573-751-6400), or the **U.S. Department of Health and Human Services** (1-877-696-6775)

Your signature below indicates you have read this *Notice* (agreement), and agree to its terms and conditions. In addition, your signature indicates you acknowledge you have received a copy of this HIPPA *Notice* as described within this document.

Client/Parent/Legal Guardian **Printed Name:** _____

Client/Parent/Legal Guardian **Signature:** _____

Date:_____

Provider/Clinician/Agency Representative Signature:_____

Date: _____

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(F) 417-533-7331

NO-SHOW, LATE & CANCELLATION POLICY

Thank you for trusting Lake Area Citizens' Advisory Board d/b/a Lake Area Counseling & Behavioral Health with your care. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment or miss a group session, please contact our office as soon as possible, and no later than 24-hours prior to your scheduled appointment/ group time. For appointments, this allows us the necessary time to schedule other patients/clients who may be waiting for an appointment.

The following is our No-Show, Late & Cancellation Policy:

OVERVIEW: Keep all scheduled appointments or call no later than 24-hours prior to your scheduled appointment/group time if you need to cancel, reschedule, or notify staff. Failure to do so will be regarded as a no-show and the No-Show/ Cancellation Policy will be implemented and you will be charged a $25.00 fee, due to be paid at the next scheduled appointment/group session prior to services being rendered.

We understand that an unforeseen emergency may occur preventing you from keeping your appointment or attending group. If you should experience an extenuating circumstance, please contact the Executive Director at: (573) 317-9061, who may be able to work with you to waive the total or part of the No-Show fee(s).

- Any new patient/client who fails to show or cancel/reschedule/notify more than 24-hours prior to their scheduled appointment/group time for their initial session, will be charged a $25.00 fee, due to be paid prior to receiving services (payment required prior to the initiation of services);
- Any new patient/client who fails to show or cancel/reschedule/notify more than 24-hours prior to their scheduled appointment/group time a second time, will be required to obtain special permission from the provider to reschedule a third appointment/group session (Probation/Parole Officers will be notified of issues);
- Any patient/client who incurs three (3) consecutive, documented no-shows and/or fails to cancel/reschedule/notify more than 24-hours prior to their scheduled appointment/group session, will be at risk for termination from their assigned program. (Probation/Parole Officers will be notified prior to termination);
- In the event a patient arrives more than 15-minutes late for their scheduled appointment (defined as a late arrival), and is unable to be seen by the provider, will be rescheduled for a future appointment as available (no late arrivals will be allowed to enter groups after start time without prior approval);
- No call/No show to 3 or more appointments without communication will result in termination from the assigned program. (Probation/Parole Officers, Judicial system, and State Agency will be notified prior to termination)

By signing below, I hereby attest that I have read and understand the above information and have had the opportunity to ask questions, with questions answered to my satisfaction.

_____ Client/Parent/Legal Guardian Printed Name

_____ Relationship to Patient

_____ Client/Parent/Legal Guardian Signature

_____ Date

LAKE AREA COUNSELING & BEHAVIORAL HEALTH

Lake Area Citizens' Advisory Board (L.A.C.A.B.)

409R W. US Highway 54
Camdenton, MO 65020
(P) (573) 317-9061
(F) (573) 317-1970

1253 Butler Drive
Lebanon, MO 65536
(P) (417) 533-5332
(F) (417) 533-7331

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION/RECORDS

(Required by the health Insurance Portability and Accountability Act – 45CFR Parts 160 & 164)

PATIENT NAME: _____ Date of Birth: _____

NAME OF PARENT/LEGAL GUARDIAN: _____

Address (Mailing): _____ Phone: _____

1. I hereby authorize all medical services and health care providers to use and/or disclose my Protected Health Information ("PHI") described below to Lake Area Citizens' Advisory Board (L.A.C.A.B.) d/b/a Lake Area Counseling & Behavioral Health.

2. Authorization for release of PHI covering the period of health care (check one):
   a. ☐ From (date) _____ to (date): _____
   b. ☐ Authorization expires 365 days from the date of signature, unless I sign a withdrawal authorization prior.

3. I hereby authorize the release of PHI as follows (check one):
   a. ☐ Complete health record (including records relating to psychiatric/mental health care, communicable diseases, HIV/AIDS, and treatment of alcohol/drug use); OR
   b. ☐ Complete health record *with the **exception of the following information*** (check below as appropriate):
      - ☐ Mental health records
      - ☐ Communicable diseases (including HIV/AIDS)
      - ☐ Alcohol/drug use treatment
      - ☐ Other (please specify): _____

4. In addition to the authorization for release of PHI described in paragraphs *3a and 3b* above, I hereby authorize disclosure of information regarding my billing, health conditions (including psychiatric/mental health) and related treatments, and prognosis to the following individual(s):

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

5. This PHI may be used by the person(s) I authorize to receive this information for all types of health care including, but not limited to, medical and psychiatric/mental health, treatments or consultation, billing, claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until nine (9) months after my death or _____(date/event) at which time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time by notifying L.A.C.A.B. or Dolen Nurse Practitioner Consultant, LLC. I understand that revocation is not effective to the extent that any person or entity has already acted in the reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

A New Day Is Dawning
Compassion - Hope - Empathy - Healing - Respect

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8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information use or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

10. I understand that I can request a copy of this form after signing or anytime thereafter.

By signing below, I acknowledge that I have read and understand the Authorization for Release of Health Care Information/Records.

_____
Printed Name of Patient/Parent/Legal Guardian

_____ _____
Signature of Patient/ Parent/Legal Guardian Date

_____ _____
Provider/Clinician/Agency Representative Signature Date