Patient Name: **DOB:** **Medicaid #:**

260 33rd Ave SW Suite J
Cedar Rapids, IA 52404

PH: (319) 361-6529
FAX: (319) 343-1059

REGISTRATION FORM

(Please Print)

Client Information

TODAYS DATE:

Client's last name:	First:	MI:	Marital status:	Social Security number:

Is this your legal name?	If not, what is your legal name?	Phone #:	D.O.B.	Age:	Sex:

Street address:	P.O. Box:	County:	State:	City:	Zip:

Email:	Occupation:	Employer:
School:	DHS Worker:	Court Officer/Probation:

Fill out the following information if client is under 18 years of age

Parent: Lives with	First Name:	Street address:			City:	Phone #:
	Last Name:	P.O Box:	Apt#:	State:	Zip:	Email:
Parent: Lives with	First Name:	Street address:			City:	Phone #:
	Last Name:	P.O Box:	Apt#:	State:	Zip:	Email:
Current Placement:	First Name:	Street address:			City:	Phone #:
	Last Name:					
Relationship:		P.O Box:	Apt#:	State:	Zip:	Alt. phone #:

IMPORTANT: If anyone other than a parent is signing this form (i.e. a guardian), he or she must produce a signed affidavit from the Court authorizing him or her to sign on behalf of the Client. A copy of this affidavit must be kept in GCMAC's files.

How did you hear about us?

☐ Website
☐ School Counselor/ staff
☐ A Doctor or other professional
☐ A Friend
☐ A GCMAC Employee
☐ Other ____

Revised: 06/03/2020

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Insurance Information

PRIMARY PRIVATE INSURANCE					
(Please give your insurance card to the receptionist)			**Date insurance became active:**		
Policy holder name:	D.O.B.:	Street address :	City:	State:	Zip:
Home phone #:	Policy holder's S.S.N.:	Occupation:	Employer:	Is the Client covered by this insurance?	
Please indicate primary insurance: ☐ Blue Cross/Blue Shield ☐ Other: ______________________________	Group #:	Policy #:	Co-payment: $	Insurance Provider Phone #:	
Client's relationship to policy holder:					

MEDICAID/ HAWK-I/ MEDICARE INSURANCE		
Type: **Effective Date:**		
NAME AS IT APPEARS ON THE CARD:	**MEMBER BIRTHDATE**	**MCO MEMBER ID NUMBER:** **MEDICAID ID NUMBER:** **MEDICARE ID NUMBER:**

SECONDARY PRIVATE INSURANCE					
(Please give your insurance card to the receptionist)			**Date insurance became active:**		
Policy holder name:	D.O.B.:	Street address :	City:	State:	Zip:
Home phone #:	Policy Holder's S.S.N.:	Occupation:	Employer:	Is the Client covered by this insurance?	
Please indicate secondary insurance: ☐ Blue Cross/Blue Shield ☐ Other: ______________________________	Group #:	Policy #:	Co-payment: $	Insurance Provider Phone #:	
Client's relationship to policy holder:					

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Grace C Mae Advocate Center, Inc. I understand that I am financially responsible for any balance. I also authorize Grace C Mae Advocate Center, Inc. to release any information required to process my claims. (See Office Payment Policy)

Indicate your preference for appointment reminders:

- ***Phone call to: ________________________________ Is it okay to leave a voice mail?***
- ***Text to: ______________________________________ OR same # listed on front of this form***
- ***Email to: _____________________________________ OR same email listed on front of this form***

Appointment reminders are generated from our Cedar Rapids office, please attend your session at your local GCMAC office.

Texts are for appointment information only.

Patient Name: **DOB:** **Medicaid #:**

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Consent for Treatment

By signing this form, I hereby give my consent for evaluation/treatment to be administered to the client listed above by the employees of Grace C Mae Advocate Center, Inc. with or without my presence. I understand that if I do not revoke my *Consent for Treatment*, it will expire automatically one year from the date of signature.

Receipt of GCMAC Client Handbook

By signing this form, I am acknowledging that I received a copy of the GCMAC Client Handbook containing the information listed below. The policies and practices outlined in the handbook have been explained to me by GCMAC staff and I have been given the opportunity to ask questions about the content of the handbook.

- General information/ Cancellation Policy
- Office Payment Policy
- Client Rights and Responsibilities and Explanation of Services
- Therapists Role/ Therapy Process for children
- Suspected Child and Dependent Adult Abuse Reporting Policy
- Client Grievance Procedure
- Acknowledgement of Receipt of Provider's Notice of Privacy Practices and Client Rights
- DHS and Court Involved Client Policy
- Release of Records and Progress Notes Policy
- Electronic Communication Guidelines and Policy

Video Consent

GCMAC is a learning agency that offers internships to qualified students who will be working in this field. GCMAC uses video monitoring for clinical supervision and learning purposes for both students and staff. Supervision is done through observation of the client session, video recording and clinical consultation in individual and/or group settings. The purpose of the videos are to observe the therapist, not the client. Videos are erased and not stored after being viewed by the supervisor. By initialing this section, I am acknowledging that GCMAC is permitted to video tape my or my child's therapy sessions. I can withdraw my permission at any time, if not this permission is good for one year from the date this form is initialed and signed.
Initial here______ (You may decline)

____ _________________

Client/ Parent/Guardian Signature Date of signature

____ _________________

Witness Signature Date of signature

I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance

Patient Name: DOB: Medicaid #:

260 33rd Ave SW Suite J
Cedar Rapids, IA 52404

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PLEASE CAREFULLY READ THE FOLLOWING AND SIGN BELOW:

OFFICE PAYMENT POLICY

You are financially responsible for all charges and for knowing and understanding policies and benefits of your insurance coverage including co-payment/deductible, covered benefits, and prior authorizations procedures.

Insurance: We participate in most insurance plans and Medicaid. It is your responsibility to contact your insurance provider regarding what your policy covers for mental health services.
Co-payments, Deductibles: All co-payments and deductibles **must be paid at the time of service**, unless prior arrangements have been made with our billing office. Payments can be made by cash, check, Debit card, Flex cards, Health Savings account and Visa/MasterCard. *Please note there is a $30 service charge on all returned checks.*
Proof of insurance: Clients are required to provide a valid photo ID and current insurance card at their initial session and whenever insurance coverage changes. If you fail to provide us with correct insurance information in a timely manner, you will be responsible for the balance of any outstanding claims.
Claims submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. At times your insurance company may request information from you directly- it is your responsibility to comply with their requests. *Please note that it may take 3-4 weeks after your session for our billing office to receive the Explanation of Benefits (EOB) from your insurance provider that shows the amount you are responsible to pay.*
Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes in your chart. We will require you to provide us with the new insurance card, effective date and all updated information.
Lapse of coverage: If your insurance coverage ends or lapses, you will be expected to pay minimum of $50 per session until insurance is reinstated, unless prior authorization is obtained by our billing specialist. Services will be suspended without on-going payment arrangements. If these services are later covered by insurance, GCMAC will issue a full refund within 10 days of payments received on account.
Billing: You will receive a monthly statement from our billing company. Please pay your amount due promptly. ***If you have questions or need to set up a payment plan, please contact Aaron at 319-929-7730 or by email at*** *aaron@advocatecenter.org*. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to make payment arrangements or pay in full. Please be aware that if your balance remains unpaid and you fail to set up a payment plan, we may refer you to a collection agency and may discharge your care. **The client and / or guarantor acknowledges they are responsible for any collection fees and/or court costs related to collecting the balance due.**

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim or obtain authorization for treatment/medications from insurance.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, Medicaid, private insurance and other health plans to the **Grace C. Mae Advocate Center**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

TO MY KNOWLEDGE ALL INFORMATION ON THIS FORM IS CORRECT. I AGREE TO THE ASSIGNMENT AND FINANCIAL RESPONSIBILITIES SHOWN ON THIS FORM.

X____ _______________
Client/Parent/Guardian Signature (*Will be updated yearly*) Date

X____ _______________
Staff Witness Date

I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance

You will receive a copy of this form in the Grace C. Mae Advocate Center Handbook.

Patient Name: **DOB:** **Medicaid #:**

260 33rd Ave SW Suite J
Cedar Rapids, IA 52404

PH: (319) 361-6529
FAX: (319) 343-1059

AUTHORIZATION TO OBTAIN, DISCLOSE AND EXCHANGE PROTECTED HEALTH INFORMATION

AUTHORIZATION-The undersigned hereby authorizes the name/agency listed to Obtain From, Disclose To, and Exchange with, protected health information either orally or in writing to Grace C Mae Advocate Center, Inc.

PRIMARY CARE PHYSICIAN____

Clinic location: City: ____ **State:** _____ **Phone:** ___________________________

A. Any and all information, EXCEPT substance abuse (drugs and alcohol), mental health, and AIDS-related information, must be specifically authorized in Section E to be disclosed: OR ONLY the following information (check only if applicable):

B. Check one(s) that applies:

☐ Summaries and notes of participation in treatment. ☐ Evaluations and Recommendations
☐ Psychological and psychiatric testing & evaluation results ☐ Treatment Plan, Progress & Discharge reports
☐ Information relating to medical history ☐ Information relating to social history
Other information: Care Coordination and medical updates____

C. **PURPOSE-**The purpose for this disclosure is to facilitate effective treatment service coordination. A photocopy or exact reproduction of this Authorization shall have the same effect as the original.

D. **SPECIFIC AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION PROTECTED BY STATE AND FEDERAL LAW-**
I acknowledge that information to be disclosed may include material that is protected by Federal and/or State law applicable to substance abuse, mental health and AIDS.
☐ Substance abuse (drug or alcohol) information
☒ Mental Health information
☐AIDS-related information

E. Furthermore, I SPECIFICALLY AUTHORIZE disclosure of protected health information to all persons referred to in the authorization. The undersigned has a right to inspect the disclosed information and information being obtained from, disclosed to, and/or exchanged with at any time. This authorization shall be in effect for 12 months (or_____months) from the date it is signed, or if applicable, until the date of the final disposition of the conditional release or other court action in connection with which this consent is given {42 CFR 2.35 J(c)}. Also, the undersigned understands he/she may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon, and by giving written notice to Grace C Mae Advocate Center, Inc.

F. I hereby authorize disclosure of protected health information as indicated above and acknowledge that I may receive a copy of this document upon request.

____ _________ ___________________________
Client/ Parent/Legal Guardian Signature Date Relationship to Client

____ ________
Witness Signature Date

I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance

Patient Name: **DOB:** **Medicaid #:**

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Cedar Rapids, IA 52404

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EMERGENCY CONTACT____ **RELATIONSHIP** ___________________________

ADDRESS____ **PHONE:** ________________________________

A. Any and all information, EXCEPT substance abuse (drugs and alcohol), mental health, and AIDS-related information, must be specifically authorized in Section E to be disclosed: OR ONLY the following information (check only if applicable):

B. Check one(s) that applies:

☐ Summaries and notes of participation in treatment. ☐ Evaluations and Recommendations

☐ Psychological and psychiatric testing & evaluation results ☐ Treatment Plan, Progress & Discharge reports

☐ Information relating to medical history ☐ Information relating to social history

Other information: Care Coordination and Emergency situation information___________________

C. **PURPOSE-**The purpose for this disclosure is to facilitate effective treatment service coordination. A photocopy or exact reproduction of this Authorization shall have the same effect as the original.

D. **SPECIFIC AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION PROTECTED BY STATE AND FEDERAL LAW-**
I acknowledge that information to be disclosed may include material that is protected by Federal and/or State law applicable to substance abuse, mental health and AIDS.

☐ Substance abuse (drug or alcohol) information

☒ Mental Health information

☐AIDS-related information

E. Furthermore, I SPECIFICALLY AUTHORIZE disclosure of protected health information to all persons referred to in the authorization. The undersigned has a right to inspect the disclosed information and information being obtained from, disclosed to, and/or exchanged with at any time. This authorization shall be in effect for 12 months (or_____months) from the date it is signed, or if applicable, until the date of the final disposition of the conditional release or other court action in connection with which this consent is given {42 CFR 2.35 J(c)}. Also, the undersigned understands he/she may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon, and by giving written notice to Grace C Mae Advocate Center, Inc.

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____ __________ ______________________________
Client/ Parent/Legal Guardian Signature Date Relationship to Client

____ _________
Witness Signature Date

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SCHOOL ____

ADDRESS____**PHONE**______________________________

A. Any and all information, EXCEPT substance abuse (drugs and alcohol), mental health, and AIDS-related information, must be specifically authorized in Section E to be disclosed: OR ONLY the following information (check only if applicable):

B. Check one(s) that applies:
☐ Summaries and notes of participation in treatment. ☐ Evaluations and Recommendations
☐ Psychological and psychiatric testing & evaluation results ☐ Treatment Plan, Progress & Discharge reports
☐ Information relating to medical history ☐ Information relating to social history
Other information____

C. **PURPOSE-**The purpose for this disclosure is to facilitate effective treatment service coordination. A photocopy or exact reproduction of this Authorization shall have the same effect as the original.

D. **SPECIFIC AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION PROTECTED BY STATE AND FEDERAL LAW-**
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☐ Substance abuse (drug or alcohol) information
☒ Mental Health information
☐AIDS-related information

E. Furthermore, I SPECIFICALLY AUTHORIZE disclosure of protected health information to all persons referred to in the authorization. The undersigned has a right to inspect the disclosed information and information being obtained from, disclosed to, and/or exchanged with at any time. This authorization shall be in effect for 12 months (or_____months) from the date it is signed, or if applicable, until the date of the final disposition of the conditional release or other court action in connection with which this consent is given {42 CFR 2.35 J(c)}. Also, the undersigned understands he/she may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon, and by giving written notice to Grace C Mae Advocate Center, Inc.

F. I hereby authorize disclosure of protected health information as indicated above and acknowledge that I may receive a copy of this document upon request.

____ _________ ___________________________
Client/ Parent/Legal Guardian Signature Date Relationship to Client

____ ________
Witness Signature Date

I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance

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AUTHORIZATION-The undersigned hereby authorizes the name/agency listed to Obtain From, Disclose To, and Exchange with, protected health information either orally or in writing to Grace C Mae Advocate Center, Inc.

NAME/AGENCY____

ADDRESS____**PHONE**_________________________________

A. Any and all information, EXCEPT substance abuse (drugs and alcohol), mental health, and AIDS-related information, must be specifically authorized in Section E to be disclosed: OR ONLY the following information (check only if applicable):

B. Check one(s) that applies:
   ☐ Summaries and notes of participation in treatment.
   ☐ Evaluations and Recommendations
   ☐ Psychological and psychiatric testing & evaluation results
   ☐ Treatment Plan, Progress & Discharge reports
   ☐ Information relating to medical history
   ☐ Information relating to social history
   Other information____

C. **PURPOSE-**The purpose for this disclosure is to facilitate effective treatment service coordination. A photocopy or exact reproduction of this Authorization shall have the same effect as the original.

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   ☐ Substance abuse (drug or alcohol) information
   ☒ Mental Health information
   ☐AIDS-related information

E. Furthermore, I SPECIFICALLY AUTHORIZE disclosure of protected health information to all persons referred to in the authorization. The undersigned has a right to inspect the disclosed information and information being obtained from, disclosed to, and/or exchanged with at any time. This authorization shall be in effect for 12 months (or_____months) from the date it is signed, or if applicable, until the date of the final disposition of the conditional release or other court action in connection with which this consent is given {42 CFR 2.35 J(c)}. Also, the undersigned understands he/she may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon, and by giving written notice to Grace C Mae Advocate Center, Inc.

F. I hereby authorize disclosure of protected health information as indicated above and acknowledge that I may receive a copy of this document upon request.

____ __________ ____________________________
Client/ Parent/Legal Guardian Signature Date Relationship to Client

____ _________
Witness Signature Date

I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance

Telemedicine Informed Consent

I, _______________________, hereby consent to my child, ______________________, to engage in telemedicine (e.g., internet or telephone-based therapy) at the Grace C Mae Advocate Center as the main venue for my child's psychotherapy treatment. I understand that telemedicine includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to other health care practitioners.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.

In addition, I understand that telemedicine based services and care may not yield the same results nor be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I

will be referred to a psychotherapist in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine, but results cannot be guaranteed or assured. The benefits of telemedicine may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

(5) I understand that I have the right to access my medical information and copies of medical records in accordance with Iowa law, that these services may not be covered by insurance and that if there is intentional misrepresentation, therapy will be terminated.

(6) I understand that I am responsible for any out-of-pocket expenses not covered by insurance for teletherapy services. Failure to pay these expenses may and can result in termination of teletherapy services and referral to the patient accounts department for collections purposes, which will include additional fees. Payment is expected at the time of service of service and can be paid with a credit or debit card.

We understand neither the Therapist nor the Patient will record any teletherapy session.

I have read and understand the information provided above, which has also been explained to me verbally. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Signature: ____ Date: ________________

I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance

Teletherapy Crisis Plan

In the case of an emergency or escalating crisis due to the status of my mental health, I understand my therapist may need to contact my designated crisis support system. Releases of information are on file with my signature and consent to contact these supports. However, in addition, I may need emergency personnel to be called in the event that I am escalating to imminent risk. Although this is a rare situation, legal statutes and ethical guidelines prohibit teletherapy from occurring without having a written crisis plan, and to have my location and phone numbers reviewed at the beginning of each teletherapy session.

My emergency contact support person is:

____ Phone: __________________

My local non-emergency service number is:
(we cannot call 911 from our location)

____ Phone: __________________

Signature: __________________________________ Date: __________________

I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance

<u>Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19</u>

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. **COVID-19 is extremely contagious** and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Grace C Mae Advocate Center, has put in place preventative measures to reduce the spread of COVID-19; however, the Grace C Mae Advocate Center **cannot guarantee** that you or your child(ren) will not become infected with COVID-19. Further, attending in-person appointments with Grace C Mae Advocate Center **could <u>increase</u>** your risk and your child(ren)'s risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that myself and/or my child may be exposed to or infected by COVID-19 by attending in-person appointments with Grace C Mae Advocate Center and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at Grace C Mae Advocate Center may result from the actions, omissions, or negligence of myself and others, including, but not limited to Grace C Mae Advocate Center, their employees, volunteers, and other participants and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself and/or my child (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child may experience or incur in connection with my attendance or my child's attendance at in-person appointments with Grace C Mae Advocate Center. On my behalf and/or on behalf of my child(ren), I hereby release, covenant not to sue, discharge, and hold harmless the Grace C Mae Advocate Center, its employees, agents, and representatives of and from the claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of the Grace C Mae Advocate Center, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any in-person appointments with Grace C Mae Advocate Center.

I understand that I can choose to attend sessions via telehealth at any time as an alternative to coming into the office for my sessions. I also understand that, should I or any member of my household, test positive for COVID-19 within 14 days of my visit to any of the Grace C Mae Advocate Center office, I will notify the office of the positive test.

____
Name of Client

______________________________ ______________________________
Signature of client/legal guardian Date

I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance