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 (circle one): Single Mar Div Sep Widowed		Social Security number:
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Phone #:	D.O.B.	Age:	Sex: ☐ M ☐ F
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

Mother: Lives with ☐ Y ☐N	First Name:	Street address:			City:	Phone #:
	Last Name:	P.O Box:	Apt#:	State:	Zip:	Email:
Father: Live with ☐ Y ☐N	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 (circle one): Relative /Foster /Residential		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 _____

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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? ☐ Yes ☐ No	
Please indicate primary insurance: ☐ Blue Cross/Blue Shield ☐ Other: _____	Group #:	Policy #:	Co-payment: $	Insurance Provider Phone #:	
Client's relationship to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____					

MEDICAID/ HAWK-I/ MEDICARE INSURANCE		
Type: ☐ Amerigroup ☐ Iowa Total Care ☐ Iowa Wellness Plan ☐ Medicare ☐ A ☐ B		
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? ☐ Yes ☐ No	
Please indicate secondary insurance: ☐ Blue Cross/Blue Shield ☐ Other: _____	Group #:	Policy #:	Co-payment: $	Insurance Provider Phone #:	
Client's relationship to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____					

The above information is true to the best of my knowledge. By 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?*** ☐ ***YES*** ☐ ***NO***
- ***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.

Revised: 06/03/2020

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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

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

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

PH: (319) 361-6529
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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

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

Revised: 06/03/2020

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

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Cedar Rapids, IA 52404

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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

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

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Cedar Rapids, IA 52404

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EMERGENCY CONTACT_____ **RELATIONSHIP** _____

ADDRESS_____ **PHONE:** _____

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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.

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☒ Mental Health information

☐AIDS-related information

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_____ _____ _____

Client/ Parent/Legal Guardian Signature Date Relationship to Client

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SCHOOL: _____Teacher/counselors name: _____

ADDRESS_____PHONE_____

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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 Coordination of treatment, faxing appointment attendance per parent/guardian request

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.

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☒ Mental Health information

☐AIDS-related information

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NAME/AGENCY_____

ADDRESS_____**PHONE**_____

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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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☒ Mental Health information
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