Front Line Therapy, LLC

3737 Woodland Ave Suite 620

West Des Moines, IA, 50266

(515) 225-7124

Client Information Sheet Date: _____

Name of Client:_____ Gender: _____

Address:_____City:_____State:_____ Zip:_____

Home Phone:_____Cell Phone: _____ Work Phone:_____

DOB: _____ SSN: _____ Email: _____

Age: _____Employer or School: _____Grade Level:_____

Emergency Contact Name and Phone: _____

Marital Status:_____ Spouse Name: _____ Spouse DOB: _____ Spouse Age:_____

Spouse Employer: _____ Spouse Cell/Work Phone:_____

Parent Information (if client is 17 years old and under or Adults covered under parent Insurance)

Mother's Name: _____ DOB:_____ Age:_____ SSN: _____

Address (if different from above):_____ City:_____ State:_____ Zip: _____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Employer:_____ Email: _____

Father's Name: _____ DOB:_____ Age:_____ SSN: _____

Address (if different from above: _____City: _____ State:_____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer:_____Email: _____

Children/Siblings:

Name:_____ Age:_____ DOB_____Name: _____ Age:_____ DOB_____

Name:_____ Age:_____ DOB_____Name: _____ Age:_____ DOB_____

Name:_____ Age:_____ DOB_____Name: _____ Age:_____ DOB_____

Insurance Information

Primary Insurance Company: _____ Secondary Insurance Company: _____

Policy Holder Name:_____ Policy Holder Name:_____

Patient ID #: _____ Patient ID#: _____

Claims Address:_____ Claims Address:_____

Policy Holder DOB:_____Relation to Patient:_____ Policy Holder DOB_____Relation to Patient: _____

Employer Group:_____ Copayment:_____ Employer Group:_____ Copayment:____

(Initial Please) I do_____ I do not_____ want my family physician contacted by this office regarding my or my child's treatment here. If so, you must complete the following information. (All physician fields below must be completed.)

Physician Name:_____ Address: _____City_____ State:_____ Zip:_____

Telephone: _____ Fax:_____

Front Line Therapy, LLC

Client Rights and Responsibilities Statement

Statement of Patient's Rights

• The Client has the right to be treated with dignity and respect.

• The Client has the right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.

• The Client has the right to have their treatment and other member information kept private.

• Only in an emergency, or if required by law, can records be released without member permission.

• The Client has the right to information from staff/providers in a language they can understand.

• The Client has the right to an easy to understand explanation of their condition and treatment.

• The Client has the right to know all about their treatment choices. This would mean no matter of cost or if they are covered or not.

• The Client has the right to get information about services and role in the treatment process.

• The Client has the right to information about providers.

• The Client has the right to know the clinical guidelines used in providing and/or managing their care.

• The Client has the right to provide input on policies and procedures.

• The Client has the right to know about the complaint, grievance and appeal process.

• The Client has the right to know about State and Federal laws that relate to their rights and responsibilities.

• The Client has the right to know of their rights and responsibilities in the treatment plan.

• The Client has the right to share in the formation of their plan of care.

Statement of Client's Responsibilities:

• The Client has the responsibility to give providers information they need. This is so they can deliver the best possible care.

• The Client has the responsibility to let their provider know when the treatment plan no longer works for them.

• The Client has the responsibility to follow their medication plan. They must tell their provider about medical changes, including medications given to them by other providers.

• The Client has the responsibility to treat those giving them care with dignity and respect.

• The Client should not take actions that could harm the lives of employees, providers, or other Client's.

• The Client has the responsibility to keep their appointments. The Client should call their providers as soon as possible if they need to cancel visits.

• The Client has the responsibility to ask their providers questions about their care. This is so they can understand their care and their role in that care.

• The Client has the responsibility to let their provider know about problems with paying fees.

• The Client has the responsibility to follow the plans and instructions for their care. The care is to be agreed upon by the member and provider.

Client Signature _____**Date**_____

Informed Consent for Treatment

I _____, agree and consent to participate in behavioral health services offered and provided by the staff of Front Line Thearpy, LLC, a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the staff member is qualified to provide within the scope of the provider's license, certification, and training.

I understand that staff is available by phone during normal business hours. Staff is not available after hours for emergency consultation and that I will call 911 or go to the hospital if I require emergency services.

If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have the legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

A copy of HIPPA rights was offered to me, and I understand I can access a digital copy as well at www.frontlinetherapyservices.com

Signature_____Date_____

Relationship to Patient (if applicable):_____

MEDICAL FORMS AND LETTERS POLICY

It is the goal of Front Line Therapy, LLC to accommodate paperwork requests in an accurate and timely manner. Please allow 3-5 business days for completion of any medical form or letter request. The completion time may be extended if the clinician is out of the office when the request is made. No request will be completed for same-day pick-up.

1. Release of Information (ROI) must be completed for the intended party prior to the release of mental health information which may be included in the letter or form. Mental health/substance abuse must be initialed on the ROI.

2. Forms and letters will be completed for those accounts in good standing. Outstanding balances must be paid prior to paperwork being released.

3. Most paperwork will require a current examination prior to being completed and clinicians may deny completion at their discretion until seen.

4. The charge for review and completion of medical forms is $20.00 and letters is $15.00. The fee will be billed to the patient account and should be paid in a timely manner.

Signature _____Date _____

Relationship to patient (if applicable) _____

Front Line Therapy, LLC

IMPORTANT FINANCIAL INFORMATION

Please Read Carefully

Authorization for Services

Our clinicians participate with various HMO's, PPO's and other managed-care organizations. Some of these plans require preauthorization before the first visit. I understand it is my responsibility to obtain this authorization. Mental health benefits may differ from medical benefits so it is essential that I have researched my mental health benefits prior to my visit. If I have not done this prior to my visit and/or treatment is not a payable benefit, I will be responsible for the full payment at the time of service. Further, if my insurance carrier determines that the services I receive are not medically necessary, I will be responsible for full payment of the bill.

Payment at the Time of Service

I understand this office's policies regarding payment for services. I will make payment in full at the time of each visit unless other arrangements have been made in advance. Insurance will be filed by the office at no charge and I will make any deductible, co-payments, or non-covered service payments at the time of service. If I must be billed there may be a $10.00 service fee. The parent/guardian signing Front Line Thrapy, LLC's intake documentation is considered the responsible party for payment. All self-pay contracts will be paid at the time of service.

Canceled or Missed Appointments

I understand that when scheduling an appointment, I am reserving professional time in advance. It is my responsibility to keep scheduled appointments. If unable to keep an appointment, I agree to provide a minimum of 24-hour notice during business hours. I acknowledge that a pattern of missed appointments constitutes grounds for unilateral termination of services. I will pay a minimum of $65.00 for all missed

appointments and appointments canceled without 24-hour notice. I acknowledge that my insurance plan will not cover these fees.

Telephone Consultation

I will pay for all telephone consultations requested in lieu of a scheduled appointment or to discuss non-urgent medication or clinical concerns (minimum of $25). I understand I will not be charged for calls the clinician requested of me for updates. I acknowledge that my insurance plan will not cover these charges.

Requests for Records

I agree to pay for any copies of records sent to other facilities, providers, or insurance companies regarding my care (minimum $35). I also agree to pay for any reports or letters requested by or sent to a third party.

Court-Related Work

If my clinician is called upon to appear in court, testify in court, or prepare reports for the court related to services received, I agree to pay for all such services.

I have received a copy of this document and assign any insurance benefits to be payable to Front Line Therapy, LLC

Signature _____**Date** _____