Paula S. Gordy LISW, LLC

Informed Consent for Mental Health Treatment

1. I agree to obtain mental health treatment on a voluntary basis. I understand that I may end treatment at any time, but that my mental health provider may want to discuss this with me. I also understand that I also have the right to discuss any recommendations that are made regarding diagnosis and treatment.

2. I will be given a description of the types of treatment recommended, such as individual/family therapy, group therapy, and other programs offered by this organization. The least restrictive level of care will be strongly considered. In addition, the frequency and length of each appointment will be determined by me and my mental health provider. I also understand that my mental health provider cannot promise certain results or outcomes from treatment.

3. My mental health provider and I will discuss problems to be addressed, my strengths and needs/wants, and treatment interventions that may be used throughout the treatment process. We will also mutually agree upon and develop goals and objectives for continuing/discontinuing mental health treatment.

4. I understand there may be some risks involved in participating in mental health treatment, such as being challenged on difficult or sensitive issues or addressing painful emotions related to past trauma or past losses. I am aware that I can discuss any risks with my mental health provider at any time.

5. I understand that this Informed Consent for Mental Health Treatment is not intended to be absolute, but instead it is intended to provide helpful information before making a decision whether or not to be involved in mental health treatment. I am also aware that at any time, I have the opportunity to ask questions and have them answered satisfactorily.

6. I agree to obtain mental health treatment on a voluntary basis. I understand that I may end treatment at any time, but that my mental health provider may want to discuss this with me. I also understand that I also have the right to discuss any recommendations that are made regarding diagnosis and treatment.

7. I will be given a description of the types of treatment recommended, such as individual/family therapy, group therapy, and other programs offered by this organization. The least restrictive level of care will be strongly considered. In addition, the frequency and length of each appointment will be determined by me and my mental health provider. I also understand that my mental health provider cannot promise certain results or outcomes from treatment.

8. My mental health provider and I will discuss problems to be addressed, my strengths and needs/wants, and treatment interventions that may be used throughout the treatment process. We will also mutually agree upon and develop goals and objectives for continuing/discontinuing mental health treatment.

9. I understand there may be some risks involved in participating in mental health treatment, such as being challenged on difficult or sensitive issues or addressing painful emotions related to past trauma or past losses. I am aware that I can discuss any risks with my mental health provider at any time.

10. I understand that this Informed Consent for Mental Health Treatment is not intended to be absolute, but instead it is intended to provide helpful information before making a decision whether or not to be involved in mental health treatment. I am also aware that at any time, I have the opportunity to ask questions and have them answered satisfactorily.

I have reviewed this “Informed Consent for Mental Health Treatment” with my mental health provider. I have been given the opportunity to ask questions and a copy of this information is available upon request. By signing this, I indicate my understanding of this information.

501 N 12th Street, STE 1, Centerville, Iowa 52544
Phone: (641) 856-2688 Fax: (641) 856-2690

Paula S. Gordy LISW, LLC

Individual / Provider Service Information

Rights and Responsibilities: Paula S. Gordy LISW, LLC is responsible for providing qualified staff who receives ongoing education and training in established and accepted theories and techniques. Staff is, responsible for acting in a respectful manner and performing their duties within their respective professional codes of ethics. Differences of opinions in the mental health process are valued. Paula S. Gordy LISW, LLC has an established " Problem Resolution Process" available to individuals in the event of a perceived ethical infract ion, complaint or grievance. Mental health personnel are responsible for making appropriate referrals for psychiatric and psychopharmacological services as necessary. Mental health personnel will discuss the assessed need with you and will provide you with the information necessary to access this service.

Individuals receiving services are responsible for giving a 24-hour notice if needing to cancel an appointment. You are also responsible for being respectful in action and behavior. We are committed to creating a safe environment for those individuals' receiving services. You have the right to be treated ethically in accordance with established codes. You have the right to receive care that does not discriminate on the basis of your age, race, co lor, religion, sex, sexual orientation, gender identity, gender expression, ethnicity, national origin, disability, marital status, etc. Furthermore, gender identity is how an individual perceives their gender, regardless of their biological sex and you have the right to express your preferred gender pronouns. As a recipient of services, you have the right to be treated ethically in accordance with established codes. If you believe there is an ethical infraction, or have any questions, concerns, complaints or grievances you have the right to contact your therapist or Executive Director. You and /or your guardian have the right to appeal the application of policies, procedures or any staff action that affects you. You may do this by speaking directly to your therapist or his / her associate. It is expected that individuals receiving services will attend sessions free of illegal drugs and/or alcohol.

Confidentiality: What is said in mental health sessions is confidential with the following exceptions:

- You are assessed to be a danger to yourself.
- You are assessed to be a danger to others.
- Child or dependent adult abuse is occurring.
- Records or testimony is subpoenaed from the court.

All records are maintained in a secure manner. An Authorization Form must be signed prior to any disclosure or receipt of confidential information to or from other agencies, organizations or individuals with the exception of necessary communication among staff at Paula S. Gordy U SW, LLC. You have the right to revoke an Authorization Form at any time. You may do this by completing a written revocation and providing this to your therapist.

Emergency Service: Paula S. Gordy LISW, LLC does provide emergency, on-call service to individuals receiving Outpatient Mental Health Service. If you experience a mental health emergency after office hours, please utilize one or more of the following options:

- If you utilize psychiatric services, access this service through the appropriate emergency telephone number.
- 24/7 Suicide Prevention Lifeline 988 or 1-800-273-8255 or En Española 1-888-628-9454
- Telephone 911 for access to emergency room services.
- I have read and understand the above information and consent to Outpatient Mental Health treatment by Paula S. Gordy LISW, LLC.

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Paula S. Gordy LISW, LLC

Member Grievance, Complaints, and Appeals

Policy Statement: Paula S. Gordy. LISW wants to anticipate and prevent any and all possibilities for the abuse and neglect of our members. All parties shall have a right to appeal and a right to file a grievance. In the event of such an occurrence. each instance will be fully documented so that just and equitable action can be taken following the procedures specified below:

Procedure:

I. Upon Admission. each individual will be given a copy of this policy and staff will discuss the contents in a manner to be conveyed so that it is understandable to the individual. The individual or the parent /guardian will sign the policy verifying the acknowledgment and understanding of the organizations grievance policy.

2. The member shall first attempt to settle the dispute with the primary staff within one week of the disputed action.

3. If the dispute is not settled, the client has 3 days to submit a written request (see appendix- Member Grievance /Complaint/Appeal Form) to the Executive Director for a face-to-face meeting. The request must describe the specific complaint/grievance/ appeal. The primary staff shall also submit a written account of the events regarding the dispute.

4. The Executive Director will schedule a meeting with the member within 24 hours of reception of the written grievance.

5. The individual will be able to discuss this matter in private. The staff will be included in the meeting if and when mutually declared appropriate by the Executive Director and the individual receiving services. A meeting will be rendered by the Executive Director at the time of the meeting.

By signing below, I acknowledge that the grievance policy of Paula S. Gordy, LISW was discussed with me, and I was given a chance to discuss any areas in which were unclear to me.

Notice of Privacy Practices

I hereby acknowledge that I was given the opportunity to receive a copy of Paula S. Gordy LISW, LLC Notice of Privacy Practices effective January 1, 2010.

Telehealth / Telemedicine Policy

Telehealth/Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists and/or subspecialists, nurse practitioners, registered nurses, medical assistants and other healthcare providers who are part of my clinical care team. In addition to myself and the members of my clinical care team, my family members, caregivers, or other legal representatives or guardians may join and participate on the telehealth/telemedicine service, and I agree to share my personal information with such family members, caregivers, legal representatives or guardians. The information may be used for diagnosis, therapy, follow-up and/or education.

Paula S. Gordy LISW, LLC

Telehealth/Telemedicine requires transmission, via Internet or tele-communication device, of health information, which may include:

- Progress reports, assessments, or other intervention-related documents
- Bio-physiological data transmitted electronically
- Videos, pictures, text messages, audio and any digital form of data

The laws that protect the privacy and confidentiality of health and care information also apply to telehealth/telemedicine. Information obtained during telehealth/telemedicine that identifies me will not be given to anyone without my consent except for the purposes of treatment, education, billing and healthcare operations. By agreeing to use the telehealth/telemedicine services, I am consenting to Paula S Gordy LISW LLC sharing of my protected health information with certain third parties as more fully described in Paula S Gordy LISW LLC's Privacy Policy. I understand, agree, and expressly consent to Paula S Gordy LISW LLC obtaining, using, storing, and disseminating to necessary third parties, information about me, including my image, as necessary to provide the telehealth/telemedicine services.

As with any Internet-based communication, I understand that there is a risk of security breach. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Individuals other than my clinical care team or consulting providers may also be present and have access to my information for the telehealth/telemedicine session. This is so they can operate or repair the video or audio equipment used. These persons will adhere to applicable privacy and security policies.

Telehealth/telemedicine sessions may not always be possible. Disruptions of signals or problems with the Internet's infrastructure may cause broadcast and reception problems (e.g., poor picture or sound quality, dropped connections, audio interference) that prevent effective interaction between consulting clinician(s), participant, patient or care team.

I hereby release and hold harmless Paula S Gordy LISW LLC and all members of my care team from any loss of data or information due to technical failures associated with the telehealth/telemedicine service.

I understand and agree that the health information I provide at the time of my telehealth/telemedicine service may be the only source of health information used by the medical professionals during the course of my evaluation and treatment at the time of my telehealth/telemedicine visit, and that such professionals may not have access to my full medical record or information held at Paula S Gordy LISW LLC.

I understand that I will be given information about test(s), treatments(s) and procedures(s), as applicable, including the benefits, risks, possible problems or complications, and alternate choices for my medical care through the telehealth/telemedicine visit.

I have the right to withhold or withdraw consent to the use of telehealth/telemedicine services at any time and revert back to traditional in-person clinic services. I understand that if I withdraw my consent for telehealth/telemedicine, it will not affect any future services or care benefits to which I am entitled. I hereby consent to the use of telehealth/telemedicine in the provision of care and the above terms and conditions.

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Paula S. Gordy LISW, LLC

By signing below, I certify that I am the legal representative of the participant or that I am the patient and am 18 years of age or older, or otherwise legally authorized to consent. I have carefully read and understand the above statements. I have had all my questions answered. I understand that this informed consent will become a part of my medical record.

Text Messaging for Public Health Messages and Appointment Reminders

It is the policy of Paula S Gordy LISW LLC to permit the limited use of text messaging to communicate with the public or clients in a manner that is consistent with the HIPAA Security Rule (45 CFR Part 164, Subpart C). This policy provides for the use of two categories of text messages:

- Public health messages sent to members of the public who sign up to receive the messages.
- Appointment reminders sent to local health department clients.

Informed Consent for Treatment

I, _____ (individual's name) _____ (date of birth), agree and consent to participate in or have my child _____ (child's name) _____ (date of birth) participate in behavioral health care services offered and provided by Paula S. Gordy LISW, LLC, a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to provide within: 1) The scope of the provider's license, certification and training; or 2) The scope of license, certification and training of the behavioral health care providers directly supervising the services received by the individual. If the individual receiving services is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or am legally authorized to initiate and consent to treatment on behalf of this individual.

Authorization for Third Party Billing and Assignment of Benefits

I authorize Paula S. Gordy LISW, LLC to furnish my third-party payer (e.g., insurance company, county of legal residence, etc.) all necessary information (per Iowa Code) that may be required in processing claims for service rendered. I hereby assign to Paula S. Gordy LISW, LLC all money to which I am entitled for expenses relating to services performed, not to exceed my indebtedness to Paula S. Gordy LISW, LLC. I understand that any money received from my third-party payer, over and above my indebtedness, will be refunded to me when my bill is paid in full. I also understand that any co-pays, co-insurance, deductible, or any other uncovered charges are my responsibility. Photocopies of this authorization shall have the same force and effect as the original and may be attached to any claim form required by my third-party payer. This authorization shall be in effect until revoked by me in writing. Payment for Services is expected at the time service is provided. Paula S. Gordy LISW, LLC will bill insurance companies and Iowa Medicaid or Iowa's Managed Care Organizations as appropriate when provided the necessary information from the individual or their guardian. Collection of co-pays, co-insurance or private payments will occur at the time of the scheduled session.

If the above paragraph is applicable to you, please sign below. If it is not applicable to you please initial on the following line: _____

I have received the Informed consent for mental health treatment, Notice of privacy practices, Grievance policy, Individual/Provider Service, and Informed Consent, Telehealth policy and Texting policy. I was given the opportunity to ask questions and receive a copy of this information upon request. By signing this, I indicate my understanding of this information.

_____

Client Signature Date:

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Paula S. Gordy LISW, LLC
Individual Care Communication Form

Physician's Name:_____ Telephone Number:_____

Address:_____

Dear Dr._____

Your patient, _____ was recently referred by _____.

We hope that the following information will be helpful in coordinating the care of this mutual patient. We value your input into this patient's treatment and want to keep lines of communication open. Please call if further information would be helpful.

Date of Initial Consultation:_____ Date of Next Appointment:_____

Diagnoses and/or presenting problem(s):_____
_____
_____

Treatment recommendations:_____
_____

Medications:_____

Therapist Name: _____

Primary Address: 501 N 12th St., Ste 1,
Centerville, IA 52544
Telephone Number: 641-856-2688 Fax Number: 641-856-2690

Sincerely,

_____
Therapist signature

Notice to Recipient of Information

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

Authorization

I,_____ hereby authorize _____Paula S. Gordy LISW, LLC_____
(Individual's name – printed)

Please check one: _____To release any applicable mental health information to my primary care physician (PCP) named above.
_____To release any applicable substance abuse information to my PCP named above.
_____To release any medical information to my PCP named above.
_____Not to release any information to my PCP named above.

I may revoke this authorization at any time to the extent that action has been taken in reliance upon it. If I do not revoke this authorization, it will expire one (1) year after I have terminated treatment

Individual's Name Date

Social Security Number Date of Birth