Welcome to Seasons Center for Behavioral Health

Date: _____

Dear _____

Congratulations on taking the first step toward better mental health. We thank you for choosing Seasons Center as your mental health provider.

Attached is the registration paperwork that you will need to complete and sign where indicated. **Please use dark blue or black ink when completing.**

Please return to Seasons Center as soon as possible. Please include a copy – front & back – of your insurance card(s).

Please return by using one of the following:
Mail to: Seasons Center, 201 E 11th St., Spencer, IA 51301 Attn: Client Registration
Email to: clientregistration@seasonscenter.org
Fax to: 712-262-3826

If you would like help in filling out your paperwork, please give us a call at 1-800-242-5101 ext. 1105 and we can assist you over-the-phone or we can set up an appointment with you at one of our other locations.

Full fees effective March 1, 2020 are as follows:

	Rate
Psychiatric Evaluation	**$300**
Medication Management	**$55 - $185**
Therapy Evaluation	**$220**
Substance Use Disorder Evaluation	**$150**
DOT Substance Use Disorder Evaluation	**$125**
Therapy or Substance Use Disorder Session	**$75 - $170**
Intensive Outpatient Program (Daily Rate)	**$150**
Substance Abuse Group (2 hr)	**$64**

Documents for You to Keep Records:
Client Welcome Letter
Description of Services
Rights of Individuals Served
Notice of Privacy Practices
Information on Advance Directives

Documents Requiring Signature & Return:
Consent to Treat and Payment of Services
Individual Appeals Process
Authorizations & Agreements

Please consider not bringing other children to your child's appointments. It is important your provider has as few interruptions as possible to accurately assess and treat your child.

Name: _____ MRN # _____ Medicaid # _____ DOB: _____

I have been informed and given a copy of Seasons Center for Behavioral Health's Privacy Notice. I have been told that if I have trouble reading or understanding the Seasons Center notice, I may request assistance. I understand that if I have questions or concerns, I should contact the Seasons Center Privacy Officer.

I acknowledge I have been provided with descriptions of services provided by Seasons Center. I have also been offered copies of any and all parts of the registration process. By completing these forms, I understand I have completed the registration process and my treatment will begin when I meet with my behavioral health service provider.

My signature below indicates I have received copies of the following forms and been given an opportunity to ask questions.

Signature Obtained	Accept Copy	Decline Copy	Forms
☐ YES ☐ NO ☐ N/A	☐	☐	Consent to Treat & Payment
☐ YES ☐ NO ☐ N/A	☐	☐	Individual Appeals Process
☐ YES ☐ NO ☐ N/A	☐	☐	Authorizations & Agreements
☐ YES ☐ NO ■ N/A	☐	☐	Description of Services
☐ YES ☐ NO ■ N/A	☐	☐	Rights of Individuals Served
☐ YES ☐ NO ■ N/A	☐	☐	Notice of Privacy Practices
☐ YES ☐ NO ■ N/A	☐	☐	Information on Advance Directives

_____ _____

Client/Legal Representative Date

_____ _____

Staff Member Date

Seasons Center for Behavioral Health
Consent to Treat and Payment of Services

Fee Rates, Region Funding, and Insurance: For the services I receive at Seasons, I understand and agree that I will be billed the current full fee rate. If I have insurance, my insurance company will be billed full fee. The Board of Directors has approved a sliding fee scale based upon my gross income, should I choose to apply. Should I choose to make application to the region for a subsidy of my fee, I will be charged at the current full fee rate (100%) until the region has approved or denied funding for mental health services at Seasons. Should the region deny funding, I understand that I am responsible for all charged for my services. **Payment is expected at the time services are rendered.** I understand that fees not paid after 90 days may be sent to collections if no alternative payment agreement has been made.

I understand that if services are supported by third party and/or region, these services may be subject to audit by authorized representatives of those payers for verification purposes. I authorize payment of health benefits otherwise payable to me, directly to Seasons Center, and I consent to reviews of services rendered for such purposes. Seasons has agreed to bill third party payers, such as insurance, upon being provided current and accurate billing information. This Signature on File is valid for all third-party payers, such as insurance, involved in collecting monies for services rendered. **I agree to provide Seasons Center with accurate and current insurance information.** I also understand that Seasons cannot guarantee (insurance) third party payment.

Quality of Service: Members of Seasons' governing board and the State of Iowa have established standards of quality for services provided by Seasons. It is their intent that the staff of Seasons be fully trained and competent health professionals. I understand that there is no assurance that I will feel better. Because behavioral health treatment/services is a cooperative effort between my service provider and me, I will work with my service provider to resolve my difficulties. If I feel the staff is not providing the type or quality of services needed, I will first talk to the staff person involved. The staff member will try to resolve my concern and explain the process for further action if I am not satisfied. If I feel unable to discuss the matter with the staff person, I have the right to contact the staff's supervisor or the consumer concerns department at 712-262-2922 or 1-800-242-5101, who will then fully investigate.

Emergency Services: Emergency services are crisis services that provide a focused assessment and rapid stabilization of acute symptoms of mental illness or emotional distress, and are available and accessible to consumers on a 24-hour basis by calling **1-844-345-4569.**

Appointments: Due to the demand of services and the nature of treatment, **please give 24-hour notice of cancellation. Seasons will charge clients $26.00 unless we are notified of an appointment cancellation.**

Permission to Provide Behavioral Health Services:

Seasons will provide diagnostic and treatment services, or both, upon your written consent to do so. Please sign indicating that you are requesting services.

I request that Seasons perform either diagnostic or treatment services, or both, for _____

DOB: _____ Account # _____ Medicaid # _____

Individual's Signature _____ Date _____

Legal Representative Signature _____ Date _____

Staff Member _____ Signature on file for 3rd Party Payers _____

Individual Appeals Process

Seasons provides and informs all individuals served, and their guardians, of their right to appeal the application of policies, procedures, or any staff action that affects them.

1. When an individual verbally presents a complaint or appeal to an employee of Seasons Center:
    a. The employee will suggest the individual first speak directly with the employee involved with the concern to resolve the matter
    b. If the individual is uncomfortable addressing the staff person directly, the individual will be directed to talk to the employee's supervisor or the CEO.
2. If the individual is dissatisfied with the results of #2, or wishes to pursue the matter further, they will be given an Individual Appeal Form.
    a. If they need assistance with completing the form, the CEO, or whom the CEO designates, will assist with doing so
    b. The CEO, or whom the CEO designates, will write all pertinent information or allow the individual to write their concerns
3. Within 10 days the CEO, or whom the CEO designates, shall investigate the complaint and respond in writing to the individual
4. If dissatisfied with the recommendations, the individual will be informed he/she may submit a written complaint or request to the Executive Committee of the Board of Directors
    a. The Executive Committee will review the complaint, ensure the appeals process was followed, and make their recommendations to the Board of Directors at the next scheduled meeting of the full Board for decision.
    b. A response from the Board President will be written and delivered to the individual within 45 days of receipt of the written complaint/appeal.
    c. The decision of the Board of Directors shall be final.
5. If you believe that your civil rights have been violated, you may also choose to file a complaint with the Crime Victim Assistance Division or Office of Civil Rights at the below links:
    a. https://www.iowaattorneygeneral.gov/manual/chapter-24-discriminationcomplaint-process/civil-rights-complaint-process
    b. https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

My signature below indicates I have received a copy of this form stating the individual appeals process.

Printed Name: _____ Date: _____

Signature of Individual/Representative: _____

DOB: _____ Account #: _____ Medicaid #: _____

Electronic Communications Agreement

Electronic communications, including but not limited to, emails and text messages, provide an opportunity to communicate with the healthcare providers at Seasons Center for Behavioral Health (Seasons Center). As your healthcare provider, Seasons will treat Electronic Communications with the same degree of privacy and confidentiality of written medical records.

This agreement is between _____ and Seasons Center.

Communicating electronically with Seasons can help you in several ways, including being able to reach your provider more quickly, and get reminders of your appointments. However, there are some risks, such as:

- Your email account might not be secure. This could mean that any information sent to or from your email address could be misdirected, disclosed to, read or intercepted by someone else.
- Text messages are not secure. This means that any information sent through text could be misdirected, disclosed to, read or intercepted by someone else.

By checking one of the below boxes, you are saying that you understand that:

- Emails and text messages are not secure.
- Emails and texts should not be used if you need to speak with someone immediately due to a mental health crisis, but that you can always call 800-345-4569 or 988.
- You will provide Seasons with <u>your</u> email address (not an email address belonging to a friend, family member, etc.)
- If your phone number or email address changes, you will let Seasons know and provide Seasons with your updated contact information. You may be asked to update this form at that time.
- Whichever box you choose, you can change your mind at any time by contacting Seasons Center.

My cell phone number: _____

My email address: _____

Please check <u>only one box</u>:

A. ☐ Knowing the possible risks, I still want to communicate with Seasons via email and/or text messages.

B. ☐ Knowing the possible risks, I still want to communicate with Seasons via email and/or text messages ***but only for appointment reminders.***

C. ☐ Knowing the possible risks, I ***do not want*** to communicate with Seasons via email and/or text messages.

If I have checked Box A or B, I release and hold harmless Seasons Center, its provider(s) and their staff, employees, affiliates, agents, officers, and principals from any and all expenses, claims, actions, liabilities, attorney fees, damages, losses of any kind that I may have resulting from Electronic Communications between Seasons Center and me and/or the minor identified based on this agreement.

_____
Client Name (printed)

_____ _____
Client/Legal Representative Signature Date

Telehealth Consent Form

What is telehealth and how do I use it?
Telehealth is a way to visit with a behavioral health provider. You can talk to your provider from any place, including your home. You will need to use video so you and your provider can see each other.

How does telehealth help me?
You don't have to go to a Seasons Center office. You won't risk becoming sick from other people or risk getting others sick; however, your provider may decide you still need an office visit.

Can telehealth be bad for me?
Providers will not be able to physically exam you so come prepared to discuss your physical wellbeing. Additionally, technical problems may interrupt or stop your visit before you are done.

Will my telehealth visit be private?
Seasons does not record visits and providers are required to have a confidential space so nobody else can see or hear you. Telehealth technology that is designed to protect your privacy is used by the agency. You should use a network that is private and secure as well as have a confidential and quiet space so no one can see or hear your appointment. There is a very small chance that someone could use technology to hear or see your telehealth visit.

What if I try telehealth and don't like it?
You can stop using telehealth any time, even during a telehealth visit. If you decide you do not want to use telehealth, talk with your provider or call 800-242-5101 and request office visits.

How much does a telehealth visit cost?
What you pay depends on your insurance. A telehealth visit will not cost any more than an office visit. If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.

Do I have to sign this document? What does it mean if I sign and/or agree to this document?
No. Only sign this document if you want to use telehealth. If you sign and/or tell your provider that you agree with this document, you agree that: the information in this document was discussed, all questions were answered, and you want a telehealth visit. Once signed, a copy will be given if desired.

_____ _____

Client Name (please print) Date

_____

Client Signature

CONSENT TO RELEASE INFORMATION

Northwest Iowa Mental Health Center (Seasons Center)
201 East 11th Street, Spencer, Iowa 51301
Phone: (800) 242-5101 Fax: (712) 262-3826

Client's Legal Name: _____ DOB: _____ Medicaid # _____

By signing this form, I am allowing Seasons Center to ☐ release or ☐ obtain written and oral information by telephone, fax, electronic data exchange or mail concerning the above named client with the following individual or agency:

Seasons Internal Care Team _____ (____)_____
Name of Person and or/ Institution Phone Number

_____ _____ _____ _____ (____)_____
Address City State Zip Code Fax Number

Check the Information to be disclosed:

☐ Psychiatric Evaluation
☐ Med/Progress Notes
☐ Psychological Testing/Assessments
☐ Educational/Vocational Records
☐ Service Plan/ICP/Treatment Plan
☐ Laboratory Results
☐ Billing Information
☐ Appointment Dates/Info
☐ Discharge Summary
☐ Comprehensive Intake (including Social History)
☐ Medical Records
☐ Annual Review
☐ Initial Assessments
☐ Progress Summary
☐ All of the above

☐ Other: (Please Specify) _____

Please indicate the reason for release:

☐ Continuity of Care ☐ Rehab/Disability ☐ Legal ☐ Insurance ☐ Transferring Care
☐ Other: (Please Specify) _____

This authorization is voluntary. I understand that I may revoke this consent at any time except to the extent that action has been taking in reliance on it. If I choose to revoke this consent, I must send written notification to: Medical Records, Seasons Center 201 E 11th Street, Spencer, IA 51301. If I revoke this consent, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Medical Records at the above address. Confidentiality of the information is protected by Federal Law (42-CFR-Part 2) and the code of Iowa Chapter 228. 42 CFR Part 2 prohibits unauthorized disclosure of these records. Part 2 re-disclosure is prohibited, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Part 2 (42 CFR § 2.32).

I understand that Seasons Center may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization, except that a) Seasons may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for such research, b) Seasons may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on the provision of authorization for that third party, and c) I understand that I may be billed for services, otherwise covered by insurance, if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

_____ Substance Abuse _____ Mental Health _____ HIV-related Information _____ Genetic Tests/Info

If I do not revoke consent, this release will expire no more than one year from the date below, or on date specified here, whichever is earlier: _____

_____ _____
Client/Legal Representative Signature Date

_____
Relationship to Client

_____ _____
Witness Signature Date

Only clients 18 years of age or older, or legal representative, can authorize release of mental health information.
Only clients, regardless of age, can authorize release of substance abuse information.

CONSENT TO RELEASE INFORMATION

Northwest Iowa Mental Health Center (Seasons Center)
201 East 11th Street, Spencer, Iowa 51301
Phone: (800) 242-5101 Fax: (712) 262-3826

Client's Legal Name: _____ DOB: _____ Medicaid # _____

By signing this form, I am allowing Seasons Center to ☐ release or ☐ obtain written and oral information by telephone, fax, electronic data exchange or mail concerning the above named client with the following individual or agency:

Emergency Contact:

_____ (____)_____
Name of Person and or/ Institution Phone Number

_____ _____ _____ _____ (____)_____
Address City State Zip Code Fax Number

Check the Information to be disclosed:

☐ Psychiatric Evaluation
☐ Med/Progress Notes
☐ Psychological Testing/Assessments
☐ Educational/Vocational Records
☐ Service Plan/ICP/Treatment Plan
☐ Laboratory Results
☐ Billing Information
☐ Appointment Dates/Info
☐ Discharge Summary
☐ Comprehensive Intake (including Social History)
☐ Medical Records
☐ Annual Review
☐ Initial Assessments
☐ Progress Summary
☐ All of the above

☐ Other: (Please Specify) _____

Please indicate the reason for release:

☐ Continuity of Care ☐ Rehab/Disability ☐ Legal ☐ Insurance ☐ Transferring Care
☐ Other: (Please Specify) _____

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I understand that Seasons Center may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization, except that a) Seasons may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for such research, b) Seasons may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on the provision of authorization for that third party, and c) I understand that I may be billed for services, otherwise covered by insurance, if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

_____ Substance Abuse _____ Mental Health _____ HIV-related Information _____ Genetic Tests/Info

If I do not revoke consent, this release will expire no more than one year from the date below, or on date specified here, whichever is earlier: _____

_____ _____
Client/Legal Representative Signature Date

_____
Relationship to Client

_____ _____
Witness Signature Date

Only clients 18 years of age or older, or legal representative, can authorize release of mental health information.
Only clients, regardless of age, can authorize release of substance abuse information.

CONSENT TO RELEASE INFORMATION

Northwest Iowa Mental Health Center (Seasons Center)
201 East 11th Street, Spencer, Iowa 51301
Phone: (800) 242-5101 Fax: (712) 262-3826

Client's Legal Name: _____ DOB: _____ Medicaid # _____

By signing this form, I am allowing Seasons Center to ☐ release or ☐ obtain written and oral information by telephone, fax, electronic data exchange or mail concerning the above named client with the following individual or agency:

Primary Care Physician:

_____ (____)_____
Name of Person and or/ Institution Phone Number

_____ _____ _____ _____ (____)_____
Address City State Zip Code Fax Number

Check the Information to be disclosed:

☐ Psychiatric Evaluation
☐ Med/Progress Notes
☐ Psychological Testing/Assessments
☐ Educational/Vocational Records
☐ Service Plan/ICP/Treatment Plan
☐ Laboratory Results
☐ Billing Information
☐ Appointment Dates/Info
☐ Discharge Summary
☐ Comprehensive Intake (including Social History)
☐ Medical Records
☐ Annual Review
☐ Initial Assessments
☐ Progress Summary
☐ All of the above

☐ Other: (Please Specify) _____

Please indicate the reason for release:

☐ Continuity of Care ☐ Rehab/Disability ☐ Legal ☐ Insurance ☐ Transferring Care
☐ Other: (Please Specify) _____

This authorization is voluntary. I understand that I may revoke this consent at any time except to the extent that action has been taking in reliance on it. If I choose to revoke this consent, I must send written notification to: Medical Records, Seasons Center 201 E 11th Street, Spencer, IA 51301. If I revoke this consent, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Medical Records at the above address. Confidentiality of the information is protected by Federal Law (42-CFR-Part 2) and the code of Iowa Chapter 228. 42 CFR Part 2 prohibits unauthorized disclosure of these records. Part 2 re-disclosure is prohibited, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Part 2 (42 CFR § 2.32).

I understand that Seasons Center may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization, except that a) Seasons may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for such research, b) Seasons may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on the provision of authorization for that third party, and c) I understand that I may be billed for services, otherwise covered by insurance, if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

_____ Substance Abuse _____ Mental Health _____ HIV-related Information _____ Genetic Tests/Info

If I do not revoke consent, this release will expire no more than one year from the date below, or on date specified here, whichever is earlier: _____

_____ _____
Client/Legal Representative Signature Date

_____
Relationship to Client

_____ _____
Witness Signature Date

Only clients 18 years of age or older, or legal representative, can authorize release of mental health information.
Only clients, regardless of age, can authorize release of substance abuse information.

CONSENT TO RELEASE INFORMATION

Northwest Iowa Mental Health Center (Seasons Center)
201 East 11th Street, Spencer, Iowa 51301
Phone: (800) 242-5101 Fax: (712) 262-3826

Client's Legal Name: _____ DOB: _____ Medicaid # _____

By signing this form, I am allowing Seasons Center to ☐ release or ☐ obtain written and oral information by telephone, fax, electronic data exchange or mail concerning the above named client with the following individual or agency:

Pharmacy: _____ (___) _____
Name of Person and or/ Institution Phone Number

_____ _____ _____ _____ (____) _____
Address City State Zip Code Fax Number

Check the Information to be disclosed:

☐ Psychiatric Evaluation
☐ Med/Progress Notes
☐ Psychological Testing/Assessments
☐ Educational/Vocational Records
☐ Service Plan/ICP/Treatment Plan
☐ Laboratory Results
☐ Billing Information
☐ Appointment Dates/Info
☐ Discharge Summary
☐ Comprehensive Intake (including Social History)
☐ Medical Records
☐ Annual Review
☐ Initial Assessments
☐ Progress Summary
☐ All of the above

☐ Other: (Please Specify) _____

Please indicate the reason for release:

☐ Continuity of Care ☐ Rehab/Disability ☐ Legal ☐ Insurance ☐ Transferring Care
☐ Other: (Please Specify) _____

This authorization is voluntary. I understand that I may revoke this consent at any time except to the extent that action has been taking in reliance on it. If I choose to revoke this consent, I must send written notification to: Medical Records, Seasons Center 201 E 11th Street, Spencer, IA 51301. If I revoke this consent, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Medical Records at the above address. Confidentiality of the information is protected by Federal Law (42-CFR-Part 2) and the code of Iowa Chapter 228. 42 CFR Part 2 prohibits unauthorized disclosure of these records. Part 2 re-disclosure is prohibited, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Part 2 (42 CFR § 2.32).

I understand that Seasons Center may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization, except that a) Seasons may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for such research, b) Seasons may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on the provision of authorization for that third party, and c) I understand that I may be billed for services, otherwise covered by insurance, if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

_____ Substance Abuse _____ Mental Health _____ HIV-related Information _____ Genetic Tests/Info

If I do not revoke consent, this release will expire no more than one year from the date below, or on date specified here, whichever is earlier: _____

_____ _____
Client/Legal Guardian Signature Date

_____
Relationship to Client

_____ _____
Witness Signature Date

Only clients 18 years of age or older, or legal representative, can authorize release of mental health information.
Only clients, regardless of age, can authorize release of substance abuse information.

CONSENT TO RELEASE INFORMATION

Northwest Iowa Mental Health Center (Seasons Center)
201 East 11th Street, Spencer, Iowa 51301
Phone: (800) 242-5101 Fax: (712) 262-3826

Client's Legal Name: _____ DOB: _____ Medicaid # _____

By signing this form, I am allowing Seasons Center to ☐ release or ☐ obtain written and oral information by telephone, fax, electronic data exchange or mail concerning the above named client with the following individual or agency:

Insurance Company:

_____ (____)_____
Name of Person and or/ Institution Phone Number

_____ _____ _____ _____ (____)_____
Address City State Zip Code Fax Number

Check the Information to be disclosed:

☐ Psychiatric Evaluation
☐ Med/Progress Notes
☐ Psychological Testing/Assessments
☐ Educational/Vocational Records
☐ Service Plan/ICP/Treatment Plan
☐ Laboratory Results
☐ Billing Information
☐ Appointment Dates/Info
☐ Discharge Summary
☐ Comprehensive Intake (including Social History)
☐ Medical Records
☐ Annual Review
☐ Initial Assessments
☐ Progress Summary
☐ All of the above

☐ Other: (Please Specify) _____

Please indicate the reason for release:

☐ Continuity of Care ☐ Rehab/Disability ☐ Legal ☐ Insurance ☐ Transferring Care
☐ Other: (Please Specify) _____

This authorization is voluntary. I understand that I may revoke this consent at any time except to the extent that action has been taking in reliance on it. If I choose to revoke this consent, I must send written notification to: Medical Records, Seasons Center 201 E 11th Street, Spencer, IA 51301. If I revoke this consent, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Medical Records at the above address. Confidentiality of the information is protected by Federal Law (42-CFR-Part 2) and the code of Iowa Chapter 228. 42 CFR Part 2 prohibits unauthorized disclosure of these records. Part 2 re-disclosure is prohibited, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Part 2 (42 CFR § 2.32).

I understand that Seasons Center may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization, except that a) Seasons may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for such research, b) Seasons may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on the provision of authorization for that third party, and c) I understand that I may be billed for services, otherwise covered by insurance, if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

_____ Substance Abuse _____ Mental Health _____ HIV-related Information _____ Genetic Tests/Info

If I do not revoke consent, this release will expire no more than one year from the date below, or on date specified here, whichever is earlier: _____

_____ _____
Client/Legal Representative Signature Date

_____
Relationship to Client

_____ _____
Witness Signature Date

Only clients 18 years of age or older, or legal representative, can authorize release of mental health information.
Only clients, regardless of age, can authorize release of substance abuse information.

CONSENT TO RELEASE INFORMATION

Northwest Iowa Mental Health Center (Seasons Center)
201 East 11th Street, Spencer, Iowa 51301
Phone: (800) 242-5101 Fax: (712) 262-3826

Client's Legal Name: _____ DOB: _____ Medicaid # _____

By signing this form, I am allowing Seasons Center to ☐ release or ☐ obtain written and oral information by telephone, fax, electronic data exchange or mail concerning the above named client with the following individual or agency:

Medicaid:

_____ (____)_____
Name of Person and or/ Institution Phone Number

_____ _____ _____ _____ (____)_____
Address City State Zip Code Fax Number

Check the Information to be disclosed:

☐ Psychiatric Evaluation
☐ Med/Progress Notes
☐ Psychological Testing/Assessments
☐ Educational/Vocational Records
☐ Service Plan/ICP/Treatment Plan
☐ Laboratory Results
☐ Billing Information
☐ Appointment Dates/Info
☐ Discharge Summary
☐ Comprehensive Intake (including Social History)
☐ Medical Records
☐ Annual Review
☐ Initial Assessments
☐ Progress Summary
☐ All of the above

☐ Other: (Please Specify) _____

Please indicate the reason for release:

☐ Continuity of Care ☐ Rehab/Disability ☐ Legal ☐ Insurance ☐ Transferring Care
☐ Other: (Please Specify) _____

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SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

_____ Substance Abuse _____ Mental Health _____ HIV-related Information _____ Genetic Tests/Info

If I do not revoke consent, this release will expire no more than one year from the date below, or on date specified here, whichever is earlier: _____

_____ _____
Client/Legal Representative Signature Date

_____
Relationship to Client

_____ _____
Witness Signature Date

Only clients 18 years of age or older, or legal representative, can authorize release of mental health information.
Only clients, regardless of age, can authorize release of substance abuse information.

CONSENT TO RELEASE INFORMATION

Northwest Iowa Mental Health Center (Seasons Center)
201 East 11th Street, Spencer, Iowa 51301
Phone: (800) 242-5101 Fax: (712) 262-3826

Client's Legal Name: _____ DOB: _____ Medicaid # _____

By signing this form, I am allowing Seasons Center to ☐ release or ☐ obtain written and oral information by telephone, fax, electronic data exchange or mail concerning the above named client with the following individual or agency:

Sioux Rivers Mental Health Region (Only clients who live in Dickinson, Emmet, Lyon, O'Brien, Plymouth, or Sioux county need to complete this form) (____)_____
Name of Person and or/ Institution Phone Number

_____ _____ _____ _____ (____)_____
Address City State Zip Code Fax Number

Check the Information to be disclosed:

☐ Psychiatric Evaluation
☐ Med/Progress Notes
☐ Psychological Testing/Assessments
☐ Educational/Vocational Records
☐ Service Plan/ICP/Treatment Plan
☐ Laboratory Results
☐ Billing Information
☐ Appointment Dates/Info
☐ Discharge Summary
☐ Comprehensive Intake (including Social History)
☐ Medical Records
☐ Annual Review
☐ Initial Assessments
☐ Progress Summary
☐ All of the above

☐ Other: (Please Specify) _____

Please indicate the reason for release:

☐ Continuity of Care ☐ Rehab/Disability ☐ Legal ☐ Insurance ☐ Transferring Care
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_____ (____)_____
Name of Person and or/ Institution Phone Number

_____ _____ _____ _____ (____)_____
Address City State Zip Code Fax Number

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Description of Services

Holistic, Person-Driven Care
Seasons Center firmly believes each individual, family, group, or couple deserves to be treated with the utmost respect in their care. Seasons believes recovery is self-directed, individualized, person-centered, and helps to empower the client by using a strengths-based and value-based approach that instills hope, respect, and responsibility to their own care and direction in their lives.

Recovery is the process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Assertive Community Treatment (ACT)
ACT is a community-based service that provides high-quality, coordinated, and comprehensive services to individuals 17 and older who are experiencing serious mental illness. ACT Consists of a multidisciplinary team that provides integrated and intensive outpatient services to aid individuals with living independently in the community, while reducing hospitalizations, unemployment, and substance abuse.

Behavioral Health Intervention Services (BHIS)
BHIS services are skill-based interventions for children aged 0-18 that focus on reducing behavioral health challenges by teaching skills such as conflict resolution, problem solving, coping, impulse control, and relationship building. Seasons offers BHIS services in school-based settings and at Camp Autumn.

Care Coordination
Care Coordination is a team-based approach to assisting clients with identifying needs and resources to fully participate in treatment and maintain safety. A Care Coordinator guides clients and families through the health care system, financial barriers, or social barriers, while advocating on the client's behalf to ensure necessary services are provided to the client.

Emergency and Crisis Services
Emergency services are provided 24-hours per day, 7 days per week to assist individuals and families who have an emergent need. Services can be accessed by dialing 1-844-345-4569. These services are provided when individuals or family members feel they or a loved one are a danger to themselves or others or when individuals feel overwhelmed and need to speak to a crisis counselor right away. Mobile Crisis services are available in some communities and provide on-site, in-person intervention for individuals experiencing a mental health crisis. Community Based Crisis Stabilization is available to individuals within the community. It is designed as a voluntary service for individuals in need of a safe, secure location that is less intensive and restrictive than an inpatient hospital.

Intensive Psychiatric Rehabilitation Services (IPR)
IPR services are designed to restore, improve, or maximize an individual's level of functioning, self-care, independence, and quality of life. Seasons' IPR services are provided where individuals live, work, learn, and socialize, and are offered in individual and group settings.

Outpatient Mental Health Services
Outpatient therapy services focus on alleviating specific mental health problems, enhancing overall functioning, and preventing development of more serious or more disruptive problems for the individual and for those involved in their care. All therapists are licensed or eligible to be licensed in their discipline. Based on the assessment and social history, the therapist and individual(s) develop a mutually agreed upon plan for treatment to facilitate goal achievement. The therapy process is individualized and based on the resources, abilities, and limitations of the individual(s) receiving the service. In addition to individual therapy, outpatient services are also provided in family and/or group modalities.

Outpatient Substance Use Disorder Services
Outpatient Substance Use Disorder services focus on alleviating specific substance abuse/dependency problems, enhancing overall functioning and preventing development of more services or disruptive problems for the individual and their families. All counselors/therapists are certified or eligible for certification through the Iowa Board of Substance Abuse Certification. Services are available for juveniles and adults. Based on the assessment and social history the therapist and individual(s) develop the service. Seasons also provides DOT evaluations.

Psychiatric Services
Psychiatric Services are provided by Psychiatrists, Physicians Assistants, and/or Nurse Practitioners. Comprehensive outpatient psychiatric care is provided to children and adults. The psychiatrist/PA/ARNP diagnose and treat psychiatric disorders. Psychiatric services are completed for the purpose of assessing symptoms, needs, abilities, disabilities, and history, diagnosing illness, and determining treatment and follow-up service needs. Ongoing treatment is provided through medication management in order to monitor medication effects and side effects.

Respite
Respite means a period of rest or relief. Seasons' respite staff care for children in their home or community setting. Seasons' respite staff may also provide services at Camp Autumn, a therapeutic camp for children with behavioral health concerns. Respite care workers ensure the continuation of daily routines otherwise provided by family members, while providing a therapeutic environment for the child to thrive.

Other Specialized Services
Other specialized services may be available to you, such as peer support, parenting education, or nursing support. Please contact Client Registration at Seasons at 1-800-242-5101 if you have questions about additional services that may benefit you.

Safeguarding the Rights of Individuals Served | Rights and Responsibilities

Seasons Center for Behavioral Health holds that its primary obligation is to enhance and safeguard the mental wellbeing of individuals served. Seasons' employees shall provide services in ways that respect and enhance the individuals' sense of autonomy, privacy, dignity, self-esteem, and involvement in treatment. Employees take language barriers, cultural differences, and cognitive deficits into consideration and make provisions to facilitate meaningful individual participation.

Individual Rights include:

- The right to be treated with respect and dignity, regardless of health status, sex, race, color, religion, national origin, age, marital status, sexual orientation, arrest or conviction record
- The right to receive care based on their individual situations/needs
- The right to have the quality of their care assured
- The right to consent or decline services, choose their provider from available providers, or receive services elsewhere
- The right to have their views considered in the making of decisions which affect them.
- The right to have those who are legally responsible for their welfare be fully informed about the nature of services/actions to be provided and their outcome so they may have choices regarding their participation and/or their children's participation
- The right to be informed about the purpose of the services they are receiving
- The right, if over the age of 7, to be informed about and make choices regarding their participation in research as well as the right to have their parents/guardians review and approve it
- The right to receive services without non-clinically determined delays
- The right to be served in the least restrictive setting
- The right to express opinions about the services received and to appeal agency actions, including alleged civil rights violations
- The right to have access to client records, and to have their records protected from an invasion of privacy. To have information held confidential unless consent is given in written forms by signing a release, a court order is issued to Seasons, disclosure is made to medical personnel in a medical emergency, or qualified person for research, audit, or program evaluation, or as otherwise allowable by federal law
- The right to write advance directives and have those followed by their providers

Individual Responsibilities include:

- Individuals will provide Seasons with information that is needed to treat them, including health status, address or phone number changes, and insurance coverage
- Individuals will actively participate in the establishment of treatment goals
- Individuals will keep scheduled appointments and notify Seasons regarding any necessary changes in scheduled appointments
- Individuals will inform their primary clinician of any change in medication and will take medication as prescribed
- Individuals will follow through with sessions, recommendations, or homework assignments between sessions
- Individuals will check with pharmacy regarding refills before contacting Seasons Center
- Individuals will understand the difference between a true emergency and a condition needing urgent care and will utilize the emergency room appropriately
- Individuals will respect the privacy and confidentiality of other clients
- Individuals shall be mindful and respectful of other clients accessing services as well as Seasons staff: no use of profanity in public areas, no physical violence or threats of physical violence or intimidation, and no vandalizing or destroying Seasons Center property. In addition, no drugs or alcohol are permitted on Seasons property

Seasons Center for Behavioral Health does not conduct any experimental treatment procedures; does not conduct any procedure that carries an intrinsic risk such as convulsive therapy, psychosurgery, or aversive conditioning; and does not conduct public education demonstration programs involving audio visual equipment or one-way mirrors.

Clients accessing Seasons services agree to follow Individual Responsibilities noted above. Anyone who believes that Seasons Center's actions are not in accord with this policy should contact the CEO. If you believe that your civil rights have been violated, you may also choose to file a complaint with the Crime Victim Assistance Division or Office of Civil Rights at the below links:
https://www.iowaattorneygeneral.gov/manual/chapter-24-discriminationcomplaint-process/civil-rights-complaint-process
https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

Dan Ries
President | CEO

Seasons Center for Behavioral Health (Seasons)
Notice of Privacy Practices – Effective Date: April 14, 2003

This notice is distributed to clients at time of intake and is on our website: www.seasonscenter.org.

This notice describes:

- How medical information about you may be used
- How you can get access to your medical information

Please review it carefully.

Each time you visit Seasons a record of your visit is made. Typically, this record contains your symptoms, diagnoses, treatment, and a plan for future care or treatment. Understanding what is in your record and how your health information is used helps you to ensure its accuracy. It also helps you to better understand who, what, when, where, and why others may access your health information as well as helps you make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:

Although your health record is the physical property of Seasons, the information belongs to you.

You have the right to:

- Request and obtain a paper copy of this notice
- Request communications of your health information by alternative means or at alternative locations
- Request to inspect and obtain a copy of your health record; however, if there are grounds for denial after review by your service provider, you will be provided with an explanation of the decision to deny access.
- Request a restriction on certain uses and disclosures of your information; however, Seasons is not required to agree to a requested restriction.
- Request an amendment of your protected health information. We may deny your request for the following reasons:
    - It is not in writing or does not include a reason
    - The information was not created by us
    - The information is not part of the information maintained to make care decisions
    - The information is not part of the information you are permitted to request
    - The information is accurate and complete as is
- Revoke your authorization to use or disclose health information except to the extent that:
    - Action has already been taken
    - Authorization was obtained as a condition of obtaining health insurance coverage
- Obtaining an accounting of disclosures of your health information not pertaining to payment, treatment or health care operation or your authorization released after April 14, 2003

To take any of the above actions, contact our Privacy Officer at 201 East 11th Street, Spencer, IA 51301.

Seasons' Responsibilities:

Seasons is required by law to:

- Maintain the privacy of your health information which is protected information according to HIPAA, 42 CFR Part 2, and other state and federal requirements
- Provide you with this Privacy Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post notice of this along with the revised

policy in our reception areas and will supply you with the revised policy upon request to our Privacy Officer. We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem:

If you have questions and would like additional information, you may contact Seasons at 712-262-2922 or 800-242-5101. If you believe your privacy rights have been violated, you can file a written complaint with the Seasons Privacy Officer at 201 E 11th St., Spencer, IA 51301. There is no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment, and Health Operations

We may release your private health information (PHI) in the following circumstances:

- **Treatment:** For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will then record the actions they took and their observations.
- **Payment:** A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.
- **Regular health operations:** Members of the medical staff, quality assurance, or members of a quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
- **With Authorization:** We may release your health information to family members and those you have authorized. Unless you object, we may disclose health information to family member(s) or legal representative(s) who are involved in your care or involved in payment of your care; however, it is our policy to obtain your authorization for all releases of information whenever possible. If you are unable to agree or object to such a disclosure, our health professionals, using their best judgment, may disclose information if it is determined to be in your best interest as permitted by confidentiality laws (HIPAA and 42 CFR Part 2).
- **Workers compensation:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.
- **Public health:** As required by law, we may disclose your health information to public health or legal authorities responsible for preventing or controlling disease, injury, or disability.
- **Correctional institution:** Should you be an inmate of a correctional institution, we may disclose to the institution or agents there of health information necessary for your health and the health and safety of other individuals.
- **Business associates**: There are some services provided in our organization through contracts with business associates. Examples include certain medical laboratory for tests, pharmacies, accounting firm, and computer support. When these services are contracted, we may disclose your health information to our business associate so they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
- **Research:** We may disclose information to researchers when an institutional review board has reviewed the research proposal, and established protocols to ensure the privacy of your health information has approved their research.
- **Food and Drug Administration (FDA)**: We may disclose to the FDA health information related to adverse effects of medication or post marketing surveillance information to enable product recalls.
- **Notification:** We may contact you to provide appointment reminders, information about treatment alternatives, other health-related benefits, and/or services that may be of interest to you.
- **Law enforcement:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.
- **Emergency:** If you have given indication through your words or actions that you are a danger to yourself or someone else, or that there has been incident of child or adult abuse, we are mandated by law and obligated to report this to the appropriate authorities such as the police or DHS.
- **The Federal Department of Health and Human Services (DHHS):** Under the privacy standards, we must disclose your health information to DHS as necessary for them to determine our compliance with those standards.

Psychiatric Advance Directives

1. **What is a Psychiatric Advance Directive (PAD)?**
   A Psychiatric Advance Directive (PAD) is a legal document allowing a person to direct their healthcare in the event that they become unable to make or communicate healthcare decisions, including mental healthcare.

2. **What are some of the benefits of having a PAD?**
   There are multiple benefits for having a PAD, such as giving additional legal support for your right to choose your own treatment. PADs also provide you with an opportunity to discuss planning and recovery with family, friends, and providers, gives providers who may not know you well information that will help them provide you with better care, allows you to give approval in advance for who can receive/release your medical information, and can put in place legal arrangements for the care of your children, finances, and pets at a time of crisis.

3. **Can I write a legally binding psychiatric advance directive (PAD) in the state of Iowa?**
   Yes, by appointing an agent. Iowa's Durable Power of Attorney for Health Care statute allows you to appoint an agent (called an "Attorney in fact") to make healthcare decisions for you if you become incompetent to make those decisions yourself. "Health care" may include mental health care. A recommended form for this purpose is called a Durable Power of Attorney. The form is not mandatory but is recommended.

4. **Before following my PAD, would my mental health care providers need a court to determine I am not competent to make a certain decision?**
   No. The statute does not specify any particular procedure by which your PAD goes into effect. In practice, your PAD will be followed whenever your providers consider that you are unable to understand or communicate treatment decisions yourself.

5. **Does the statute say anything about when my mental health providers may decline to follow my PAD?**
   Yes. Your provider could decline to follow the Attorney in fact's instructions in an emergency. An "emergency" includes a situation in which a person is considered a danger to him/herself or others.

If you would like more information or have questions please let your provider know.

**Information above obtained from the National Resources Center on Psychiatric Advance Directives: http://www.nrc-pad.org/states/iowa-faq and SAMHSA's webinar: Recovery to Practice – Psychiatric Advance Directives, Siebert and Verna, 2016.*