AccessLiving
Counseling and Developmental Services

Client Information

First Name: Last Name: Middle:

Date of Birth: Sex: Occupation:

Address: City: State: Zip:

Primary Phone#: Secondary Phone#:

Okay to leave messages? ☐Yes ☐No

Email Address:

Preferred Method of Contact ***(Please check all that apply)*****:** ☐ **Phone Call** ☐**Text Message** ☐ **Email**

Living Arrangement for Client:

Name(s) of Client's Spouse or Guardian(s):

Reason for Appointment:

Emergency Contact Information

Emergency Contact Name (*first and last*):

Phone:

Relationship to Client:

Emergency Contact Name (*first and last*):

Phone:

Relationship to Client:

By signing below you agree to give Access Living permission to contact the following person(s) in the event of an emergency situation including that of mental health related or physical health related. You have the right request a restriction or limitation on the health information we disclose to someone involved in your care.

_____

Client/Guardian Signature Date

Primary Care Physician Information

Primary Physician Name:

Clinic Name:

Clinic Address,City,State, Zip:

Phone Number: Fax Number:

Pharmacy and Medication Information

Pharmacy Name & Address:

Phone Number: Fax Number:

Please list the name of your current medication(s), dosage, & frequency:

Please list any allergies or special dietary needs:

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History

Please list any other current therapies being received or any past therapies received within the last 5 years.

Current Therapies *(please include therapy type, clinic name, & location)*:

Past Therapies *(please include therapy type, clinic name, & location):*

Billing Information

We may use or disclose your information to obtain payment for services provided to you. We may disclose information to your health insurance company or other payer to obtain preauthorization or payment for treatment or to collect fees. Patients have the right to restrict certain disclosures of PHI to health plans/insurance companies if the patient pays out of pocket in full for the health care service.

Please indicate payment type: ☐ **Insurance** ☐ **Out of Pocket** ☐ **Sliding Scale**
(Sliding Scale applies to counseling services only)

Insurance Company(s):

Policy/ID Number(s):

Group Number(s):

Primary Subscriber Name(s) & DOB(s):

Relationship to Client:

_____ _____

Client/Guardian Signature **Date**

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Payment & Billing Agreement

Please Indicate Your Payment Type:

☐ Insurance ☐Direct Payment ☐Other

As our HIPAA payment policy states, we may use or disclose your information to obtain payment for services provided to you to your health insurance company or other payer to obtain preauthorization or payment for treatment to collect fees. Patients have the right to restrict certain disclosures of PHI to health plans/insurance companies if the patient pays out of pocket in full for the health care service.

For those not utilizing insurance, payment is due at the time of your appointment. If Access Living is billing insurance and you are certain you have remaining benefits, only your copayment is due at the time of your appointment. Once insurance claims have been processed, a monthly bill will be sent out that will inform you of any balance due. It can take up to 60 days for insurance claims to be processed. If your account remains delinquent for 120 days or more, or if your outstanding balance is $200.00 or more, Access Living reserves the right to discontinue services until full payment is received or a payment plan is put into place. Access Living has the right to refer the account to a collection agency. Insurance reimbursement is a contract between you and your insurance carrier. Access Living cannot accept responsibility for collecting on a disputed insurance claim. You are ultimately responsible for full payment on your account.

- **It is the client's responsibility to verify with their insurance company that their provider is considered in-network.**
- Payment may be made by all major credit cards, cash or checks made payable to Access Living. Health Savings Accounts and Flexible Spending Accounts are also accepted as payment. **Note there is a 3% convenience fee for the credit card payment option.*
- Access Living reserves the right to charge 1.5% monthly finance charge on any outstanding balance beyond 90 days.
- Access Living reserves the right to charge $45.00 if appointment is canceled without 24 hour notice, in addition to if a client does not show for scheduled appointment without notice to staff.

Fee Reductions
Access Living has an as-needed sliding fee scale under certain circumstances such as sudden unemployment or loss of health insurance, etc., that occur during the course of treatment. Such fee reductions should be documented in writing with a signed agreement kept in the client's records to avoid misunderstanding about fees and payment schedule.

Direct Payment & Out of Network Clients
Although we do not participate with some insurance plans, most health insurance plans have coverage for out-of-network providers. You can request receipts to submit for reimbursement to your insurance. Please contact your plan to be certain of reimbursement policy. Full payment is always due at the time of service.

Direct Payment/Sliding Scale/Other Payment Client Agreement

I, _____ agree to pay the cost for the service.
Client /Guardian print name

Financial Statements
Monthly statements reflecting all charges and payments will be processed monthly. These statements

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will be mailed or E-mailed to the address(s) provided. Please check below which option you prefer to receive monthly statements.

☐ Mailed Statements ☐Email:_____

By signing below you have read and agreed to the policies and procedures of the payment and billing agreement.

_____ _____

Client/Guardian Signature Date

_____ _____

Witness Date

Cancellation /No Show Policy

Here at Access Living, we will make every effort to provide a courtesy confirmation call, text, or email one day prior to remind you of your appointment the following day. To ensure that every client has fair access to schedule a timely appointment, we have adopted the following policy toward last minute cancellations and no shows.

We expect our clients to inform us within 24 hours if an appointment needs to be canceled or rescheduled. While your personal reasons may vary, the ultimate result of a late cancellation or no show is time that another client was not given for their mental health needs.

We understand emergencies do happen and we ask you to inform Access Living of the emergency reason for late cancellation as soon as possible. If compelling issues are present, please let us know.

Emergencies DO NOT include: forgetting appointment, choosing to do something else, choosing to be elsewhere other than your appointment (work overtime/job responsibilities, and military duty are exempt from this), and other avoidable circumstances. We respect and value your time. We ask that you please respect the provider's time in return.

Failure to cancel or reschedule your appointment in a timely manner will result in the following consequences:

1st Warning: A letter will be sent out including the missed appointment date/late cancellation date and notification of your current status of appointments missed/late cancellations.

2nd Warning: A second letter will be sent out including the missed appointment date/late cancellation date and notification of your current status of appointments missed/late cancellations.
An out of pocket charge of $45.00 will be added to your account
(*insurance does not cover missed appointments/no show appointments/late cancellations*).

3rd Warning: A letter will be sent out including the missed appointment date/late cancellation date. The client will then be removed from the schedule. Client will be notified of removal. At this point if the client wishes to return, it will be the provider's decision whether to terminate services and refer patient to another clinic. The patient can be put back on schedule if and only if requested or approved by provider.

In return of understanding our cancellation/no show policy, our provider's will do their best to have the front desk staff or themselves contact you to inform you of any changes within their scheduled

appointment times or inform you as soon as possible if an emergency uprises during their scheduled appointment times.

I have read and understood the cancellation/ no show policy of Access Living and agree to be bound by its terms. I also understand and agree such terms may be amended periodically by the practice.

Client/Guardian Signature _____ Date _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your personal information is a vital part of the total service we may provide to you. It is used in determining services and treatments, as well as being important for administrative organization. Access Living will only release information in accordance with state and federal laws and the ethics of the counseling profession. This notice describes our policies related to the use and disclosure of our client's heath care information. Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our HIPAA Privacy Official. If you revoke your authorization we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

Use & Disclosure of Protected Health Information for the Purposes of Providing Services

Providing treatment services, collecting payment and conducting health care operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes. We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment: We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer; for a consultation or to make a referral.

Payment: We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain preauthorization or payment for treatment or to collect fees. Patients have the right to restrict certain disclosures of PHI to health plans/insurance companies if the patient pays out of pocket in full for the health care service.

Healthcare Operations: We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff to make decisions affecting the practice; review

treatment procedures; review business activities; staff training; or for compliance and licensing/certification activities.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Other Uses or Disclosures: We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others, including threats to national security.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- For certain issues related to criminal damage
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the police, military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- Affected patients have the right to be notified following a breach of unsecured protected health information.

Uses &Disclosures with Your Written Authorization: Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

Please initial indicating that you have understood all the information above. _____

Client Rights Policy

Right to Inspect and Copy You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the Office Manager. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the

Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the Office Manager.

Right to an Accounting of Disclosures You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Office Manager.

Right to Request Restrictions You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the Office Manager. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Office Manager. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, ask the front desk staff.

Changes to This Notice
We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. The current notice will be posted in the facility and possibly on our web site and include the effective date. In addition, each time you come to the facility for treatment or health care services, you may request a copy of the current notice in effect.

Complaints

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If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, you may mail it, drop it off or fax it to our main office. To file a complaint with the Secretary of the Department of Health and Human Services, mail it to: Secretary of the US Department of Health and Human Services, 200 Independence Ave. S.W., Washington, DC 20201. All complaints must be made in writing. You will not be penalized for filing a complaint.

Please initial indicating that you have understood all the information above. _____

Informed Consent to Treatment

This consent is not intended to be all-inclusive. It is only intended to provide some useful information before deciding to engage in treatment.

Consent to Treatment: Each client will be given a clear description and recommendations from their provider or program supervisor regarding the problems, diagnosis, personal strengths/limitations and treatment interventions proposed. Times, dates and session length will be discussed by your provider or program supervisor. Clients have the right to participate in treatment decisions, seek a second opinion, as well as terminate services or refuse treatment at any time.

Assessment: The first one or two sessions may include a comprehensive assessment of my needs and treatment planning. This is often a requirement of your insurance company and is necessary for treatment and payment.

Right to Terminate: You are voluntarily agreeing to treatment and may terminate at any time. Furthermore, your provider may make diagnostic and treatment recommendations with which you do not agree (e.g. modality of treatment, duration of treatment, frequency of visits, etc.). You have a right to discuss this and will have a part in treatment planning. You may also seek a second opinion for any services which you do not agree. Please discuss termination with your provider so they can conclude services and help give any referrals that may be needed.

No Guarantee: Providers cannot guarantee results (e.g. less depressed, improved marital satisfaction, etc.). However, there will be clearly stated reasons, goals, and objectives for continuing/discontinuing treatment. This will be discussed with your individual provider.

Risks and Benefits: There may be some risks in participating in services. These may include discussing uncomfortable aspects of your life which may bring up unpleasant feelings. However, the benefits of the treatments often outweigh the risks. There are also risks with not participating in recommended treatment. If your provider deems your treatment is medically necessary and your needs cannot be resolved at a higher level of care, there could be negative consequences for not taking action towards treatment. These may include regression or decompensation, treatment requiring a higher level of care, increased impairment could occur. Please discuss these concerns at any point with your provider. In the case of psychiatric care, medications, side effects, and alternative treatments will be discussed.

Emergency Services: In the case of an emergency, Access Living maintains an available after hour's system. Discuss with your provider or program supervisor how to access this service. Emergencies are often life-threatening and you should call 911 or go to the nearest emergency room if you are experiencing a life-threatening emergency.

Grievances: If you have a grievance with a provider, first attempt to communicate this directly to him/her. In the event the grievance is not satisfactorily resolved you can complete a "Grievance Form" (available upon request from any staff member). Clients have a right to file a complaint with the appropriate governing authority without retaliation. Please see "Grievance Process" for more information.

Documentation: Each provider is required to keep documentation of treatment. This includes when, where and how long the appointments lasted, what interventions were utilized and your participation level.

Consent for Minors: State law mandates that each of a minor's custodial guardians must consent to treatment. Please ask the front desk or your provider for the appropriate form for all parties to sign. You can provide appropriate legal documentation regarding guardianship to the front desk or your provider.

Communication: Generally, you will be contacted by phone or mail. Internet e-mail is discouraged unless discussed with your therapist. PLEASE NOTE: Privacy and confidentiality cannot be guaranteed. Access Living does NOT utilize encrypted email at this time.

Court Proceedings: The staff at Access Living does not get involved in court proceedings. This includes writing letters and making court appearances. If subpoenaed, the client will be responsible for the cost of the staff member's time and travel costs. These fees are not covered by insurance and are at a much higher rate than our usual fees. Particularly in the case of minor children we advise against subpoenaing your counselor to testify. This undermines the therapeutic relationship and is not conducive to healing. Please talk more with your counselor about this.
Family Involvement: We encourage family involvement in the treatment process with the adult client's consent for the most effective outcomes. We recommend that parents be involved with their children's treatment planning and follow clinical recommendations from the clinician.

Please initial indicating that you have understood all the information above. _____

Limits of Confidentiality

The information you share with your provider is meant to be kept confidential. However limits of confidentiality only apply to psychotherapy. Certain circumstances cannot be kept confidential. These circumstances include:
Suicide: if you are assessed to be a danger to yourself; cannot guarantee your physical safety against the intention of suicide; and/or have immediate suicidal plans, this information is not considered to be "confidential". Actions may be taken to ensure your safety.
Homicide: if you are assessed to be a danger to others; cannot guarantee their safety; and have immediate, specific plans to cause fatal injury/harm to another person, this information is not considered to be "confidential". Actions may be taken to protect the safety of others. The police may be notified of your intentions as well as the intended victim.
Court order/subpoena: Your Mental Health provider(s) can be required to relinquish a copy of your written records to the appropriate Courts. Providers can also be subpoenaed to testify in court without your permission.

Child, elder, disabled persons abuse/neglect: Idaho Law requires your Provider to report to the appropriate authorities (i.e. Child Protective Services) any suspicion or evidence of abuse or neglect of special populations. This law also applied to past incidents of abuse or neglect.
Emergency: To the extent necessary to provide emergency medical care or to report to law enforcement authorities.

Please initial indicating that you have understood all the information above. _____

Participant Rights Policy

Access Living is committed to ensuring all clients and associates of the company are treated with the highest levels of dignity, compassion, and respect. In order to ensure these conditions exist within Access Living, the following conditions will exist is accordance with IDAPA 16.04.11, 905.01-905.03. All clients/guardians will receive a copy of the client rights as well as have them verbally explained. Each client/guardian will sign documentation that the rights have been received, and are understood.

1. **Humane care & Treatment –** Each client will be respected and treated with the highest levels of dignity, understanding each client is a unique and special individual who has been placed within the trusted care of Access Living.
2. **No Isolation –**Access Living recognizes the inherent damage that can be produced by isolating a child – outside of the context of his or her service plan parameters – who may be experiencing emotional crisis.
3. **Avoidance of Restraint –** Under no circumstance will Access Living use any sort of unauthorized restraint (chemical, mechanical, or physical restraints or use of seclusion) as a method for discipline or client control. Should a situation occur where the client behavior is creating an unsafe situation, the worker will enlist the assistance of available Access Living

personnel to assist with de-escalation of the client. Physical restraint may be utilized only in the case of emergency.

4. **Zero Tolerance for Abuse, Mental or Physical** –Under no circumstances will a client be subjected to physical or emotional abuse. Any Access Living staff shown to be abusive in any way will be terminated immediately.
5. **Privacy** – Access Living will provide, upon request, a private setting where a client can have space for privacy, within reason. Documentation of use will be made and should a client abuse the situation, steps will be taken to redirect and assist the client with appropriate usage.
6. **Visitors** – Clients will be allowed and encouraged to associate with visitors and interact with individuals of a positive nature.
7. **Open Door and Grievance Policy** – At all times, clients and/or guardians are encouraged to offer input, suggestions and recommendations to Access Living management as a means for improving services. Access Living acknowledges there may be a situation where a grievance needs to be addressed. At that time, the client will be able to use the process from the Access Living grievance policy they received upon eliciting services.
8. **Religion** – All clients will be respected for their religious beliefs and allowed to practice it as he or she wishes.
9. **Attire and Possessions** – All clients will use their own attire and maintain use of their personal possessions. When clients bring money with them during sessions, they will be allowed to spend the money as they see fit within guardian parameters as applicable.
10. **Condition, Services and Charges** –Access Living is adamant that clients remain informed about all conditions concerning his or her services, any availability for additional services and the costs associated with any services.
11. **Access to Information** – Clients will have full access to their information upon request, and within reasonable amount of time.
12. **Refusal of Services** – Any client wishing to refuse services or seek services from another agency will be assisted in every way possible to secure the services he or she so desires.
13. **Civil Rights** –Access Living respects all civil rights of clients, unless otherwise specified by courts.
14. **Privacy** –Access Living maintains total patient confidentiality according to federal regulations concerning private information.

15. **Services** – The services rendered to clients of Access Living are intended to improve the overall quality of life for each of the clients. This includes enhancing social image, competencies and higher levels of inclusion in the community.
16. **Performance of Services** –Access Living will not employee clients for any services under any conditions as this is felt to be a conflict of interest by Access Living.
17. **Surveys** – Clients will have access to Department information as it relates to systematic surveys upon request. Additionally, corrective actions will also be related.
18. **Law** – Clients will be privy to all privileges and rights established by law of the land.
19. **Harm** – The all-encompassing task of Access Living is to protect their clients from any form of harm at whatever cost is needed, this includes coercion methods and as such coercion methods will not be used at any time by any employee towards any participant or other employee.
20. **Choice** – Clients are allowed age-appropriate choices throughout each session to increase independence while working on programs. Choices are given in regards to spending personal money, where services take place, and what to do in each location within reason. Parents and/or guardians are also given the opportunity to choose a staff and location of service within reason. Services and activities, including meal times and snacks will take place within parameters set forth by parents/guardians and as requested by the client within reason. Access Living staff will not force a client to engage with individuals with whom the client has refused to engage with.
21. At Access Living programs developed and implemented are age appropriate to the individual client. Evaluations and assessments are utilized to help identify age appropriate programs.

22. Each program plan supports and assists each client promoting inclusion in the client's environments. Each individual client will be evaluated and with feedback from client, their family and Case Manager programs are developed to increase integration and community inclusion.
23. Each Individual client will be encouraged and supported in understanding and exercising their rights. Staff will help clients identify their rights as clients of Access Living LLC. And as citizens.
24. Each program plan is developed in measurable and observable terms. The Clinical Supervisor develops plans that can be defined in measurable terms to indicate progress or lack of progress. Data from each session is evaluated and graphed to show progress.

Please initial indicating that you have understood all the information above. _____

Liability of Destructive Behavior

1. **DDA:** As the Client or Parent/Guardian of a Client, who is currently receiving services through Access Living, I acknowledge that I am responsible for any and all damages that may occur due to the result of the behavior of me or my child. I acknowledge that based on the best practices model incorporated by Access Living, there may be instances when I or my child's behavior will be such that due diligence and industry practices are not sufficient for control, and due to a non-restraint policy, the actions of me or my child my may cause physical harm and/or property damage. I agree to make full restitution for documented damages to either personal or company property. I will receive a statement of damages that will itemize the replacement costs. I likewise acknowledge that damages will be my responsibility and are a charge that cannot and will not be charged to or reimbursed through insurance. This includes damages incurred in the waiting room.
2. **Clinic:** If you cause damage to Access Living property you will be responsible to cover the cost of the damage.

Please initial indicating that you have understood all the information above. _____

Member Participation & Education

In order for you or your child to benefit from services, it is imperative that you are involved in your care. Your counselor will provide you and/or your family with education about symptoms, the standard care of treatment, and recommendations so you can make the best decisions about your treatment and care. Access Living requires clients to be involved in the treatment planning process as well as actively involved in treatment. For a child less than 18 year of age, the child's parent or legal guardian should be actively involved by being present on the premises and available for consultation with staff during the delivery of all services. The child's parent or legal guardian does not have to participate in the treatment session or be present in the room in which services conducted, but must be available for consultation with the staff providing the services.

Please initial indicating that you have understood all the information above. _____

Access Living Grievance Process

In the event that a client feels services are not to their expectations, we encourage a quick and mutual resolution so as to assure patient progress is not hindered in any way. The following outlines available options that can be used in sequence or alone, depending on the nature of the complaint.

Option 1 – The client and or guardian may address any issue with their assigned group Worker/Counselor/ or facilitator as a means for resolving a problem through open communication and discussion. It is anticipated this will be the first step in any conflict resolution and will most

likely resolve the issue due to the commitment and professionalism of Access Living employees. The group facilitator will use all means to resolve the issue as soon as he or she is able.

Option 2 - The client and or guardian may notify, at any time, the Access Living program manager, Victor Myers or Christianne Gracia at (208) 922-2207, concerning an issue or complaint. If it is concerning an issue with the client worker, it is understood the worker will be contacted and be apprised of the complaint. The program manager will then make necessary decisions to resolve the issue with client as soon as possible, however, contact with complainant will be within five (5) business days and a plan for resolution will be presented within 10 business days.

Option 3 – Should an acceptable resolution not forged to the satisfaction of the client, they are encouraged to contact the Idaho Department of Health and Welfare, Region IV. It is understood that IDHW will contact the provider to inform them of the complaint. A resolution will be presented within a reasonable amount of time. This resolution can be accepted or rejected by either party; client or provider.

Option 4 – A formal complaint in writing to the Regional Family and Children's Services Program Manager within ten (10) days of notification of this decision. Additionally, you may appeal this decision through normal contested case procedures.

It is the intent of Access Living to provide quality, safe and productive services to our clients. If a situation is not conducive to these objectives, we will do all in our power to rectify the situation to the satisfaction of all parties involved.

Please initial indicating that you have understood all the information above. _____

Provider Designation

I acknowledge I have been informed there are other agencies which provide DDA & Mental Health services available within Idaho regions III & IV. To obtain a list of other providers in the surrounding area, please contact IDHW at 2-1-1.

As the Client or Parent/Legal Guardian, I have chosen Access Living as the provider for me or my child. This authorizes Access Living to initiate an assessment of mine or my child's needs. If it is determined the identified client would benefit from treatment, Access Living will begin the treatment planning process and therapy. If it is determined medical necessity criteria have not been met, appropriate referrals will be made.

This agreement will remain in place unless written notification is submitted within 30 days from Access Living, or at any point from myself.

Parent Consent and Emergency Medical Care
I hereby authorize and consent to any rendered services under the general or special supervision of any member of the medical/emergency staff licensed under the provisions of the medicine practice act, and on the staff of any acute general hospital holding a current license to operate a hospital from the State of Idaho, Department of Public Health, should the need arise while under the care of Access Living.

It is understood that an effort shall be made to contact all the contacts on file prior to rendering treatment to the patient, but if we cannot be reached, we give our permission to Access Living to provide the necessary care, at my expense, for my or my child's well-being.
It is understood that, by signing this statement, I am also releasing Access Living from any liability arising from any acts or omissions by them.

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Please initial indicating that you have understood all the information above. _____

Consent for Transportation (DDA Services)

As the parent I hereby give consent for my child to be transported in a vehicle driven by a staff member of Access Living during, to and from treatment sessions. I understand that the staff of Access Living is required to have a valid driver's license and insurance. I understand that no other persons are covered by this consent other than the identified client.

Please initial indicating that you have understood all the information above. _____

Billing & Fee Information

Payment: You may discuss your insurance coverage and fees with the billing manager prior to your appointment and at any time. You are responsible for any co-pays or fees not covered by third parties. Payment is required at the time of service and can be made by credit card, cash or check.

Late Cancellation/No Show Policy: Access Living has a 24-hour notice policy. If you miss your appointment for any reason, a $45.00 fee will be added to your account. Your insurance will not cover this cost. After 3 late cancellations or no show/missed appointments, it is then the provider's decision whether to terminate services and refer patient to another clinic.

Sliding Scale: Access Living makes every effort possible to ensure that every client can access affordable services. No client will be denied services based on their income. Clients may access the low-fee intern or sliding scale services by contacting the front office.

Please initial indicating that you have understood all the information above. _____

Counselor Specific Information

Each of our counselors participates in ongoing agency consultation with each other. This collaboration practice is the industry standard for providing the highest level of ethical care to clients and information is kept confidential. Some of our counselors are obtaining additional supervision for licensure both within and outside of the agency. In these cases your information will remain confidential; however they may discuss the general information of your case. Counselor information is provided below:

Victor Myers, LCPC: LCPC-6061. Victor graduated from ISU with a Masters of Counseling and has a theoretical approach of counseling. Victor graduated from Brigham Young University Idaho with a Bachelors in Psychology.

Joyce Kearney, LMFT: Joyce graduated from East Tennessee University with a Masters in Marriage and Family Therapy as well as from Emmanuel School of Religion in Pastoral Counseling. Joyce has a Bachelor of Education from San Jose Christian College.

Stacey Martinez, LPC: LPC - 8206Stacey received her bachelor's degree in Psychology from Boise State University and received her Masters in Mental Health Counseling from Idaho State University.

Keith Moore, LCPC: LCPC -8192 Keith received his Bachelor of Science in Psychology and Anthropology from the University of Idaho and his Masters in Clinical mental Health Counseling from Northwest Nazarene University.

Lisa Omori, LPC: LPC-59850 Lisa has a Masters in Counseling Psychology and Counselor Education from University of Colorado-Denver. Lisa has a Bachelors in Psychology from University of Colorado-Boulder.

Protection and Advocacy

Region IV IDHW Office: 1720 Westgate Drive, Ste. A, Boise, ID 83704 Phone: 208.334.0808

Optum Idaho: 205 East Water Tower Lane Meridian, ID 83642 Phone: 855. 202.0973

IBOL: PO Box 83720 Boise, ID, 83702 Phone: 208.334.3233

Signature on File

By signing this, I indicate I have received and understood all the information I have initialed above. I have had the forms verbally explained to me and have been given the opportunity to ask questions about this information. I submit my signature for the purpose of records verification of authenticity.

_____

Client Name (Print)

_____ _____

Client/Parent/Guardian Signature Date

_____ _____

Clinician Signature Date

AccessLiving
Counseling and Developmental Services

Parental Consent to Treat Children

We at Access Living believe the counseling and therapy treatment of your child is more effective when both parents are involved and consenting to that treatment (this includes unmarried, divorced, or married couples). Unless a court order has given authority to only one parent to decide their child's mental health therapy, it is our recommendation that both parents are in agreement and sign below for their child's or children's treatment.

We the parents of _____ fully consent to our child or children receiving mental health treatment/counseling at Access Living.

Parent Signature:_____ **Date:**_____

Parent Signature:_____ **Date:**_____

AccessLiving
Counseling and Developmental Services

Authorization for Release and Acquisition of Confidential Information

I authorize Access Living to acquire and/or release the following information concerning:

Client:_____ Date of Birth: _____

Address:_____

City:_____ State:_____ Zip Code:_____

☐ Medical Records (Primary Care Physician)

I authorize use of this information as it pertains to the assessment, diagnosis and treatment of a psychiatric or behavioral condition through services offered by Access Living. This includes the following source or contact deemed necessary by the Access Living representative that will increase the quality of services. I acknowledge that information passed with this disclosure may not be further protected by federal law and could be used or redirected by the receiving party. I understand that signing this release is voluntary and do not need to sign it to ensure service or care.

This information may be ☐ acquired and/or ☐ released to/from the following:

Organization:_____ Contact:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____Fax:_____

This release is effective until the following conditions are met or until right to release information is revoked by the authorized signer:

☐ Requested information is exchanged
☐ One year from signature date
☐ Until (date)_____

I acknowledge that I have the legal authority to authorize disclosure of protected health information about:
☐ Myself
☐ My Child
☐ My Ward Describe: _____

_____ _____ _____
Client/Guardian (Print Name) Client /Guardian Signature Date

_____ _____
Minor signature if 14 years or Older Date

AccessLiving
Counseling and Developmental Services

Authorization for Release and Acquisition of Confidential Information

I authorize Access Living to acquire and/or release the following information concerning:

Client:_____ Date of Birth: _____

Address:_____

City:_____ State:_____ Zip Code:_____

☐ Mental Health Records

I authorize use of this information as it pertains to the assessment, diagnosis and treatment of a psychiatric or behavioral condition through services offered by Access Living. This includes the following source or contact deemed necessary by the Access Living representative that will increase the quality of services. I acknowledge that information passed with this disclosure may not be further protected by federal law and could be used or redirected by the receiving party. I understand that signing this release is voluntary and do not need to sign it to ensure service or care.

This information may be ☐ acquired and/or ☐ released to/from the following:

Organization:_____ Contact:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____Fax:_____

This release is effective until the following conditions are met or until right to release information is revoked by the authorized signer:

☐ Requested information is exchanged
☐ One year from signature date
☐ Until (date)_____

I acknowledge that I have the legal authority to authorize disclosure of protected health information about:
☐ Myself
☐ My Child
☐ My Ward Describe: _____

_____ _____
Client/Guardian (Print Name) Client /Guardian Signature Date

_____ _____
Minor signature if 14 years or Older Date

ALERT®

Wellness Assessment - Youth

Completing this brief questionnaire will help us provide services that meet your child's needs. Answer each question as best you can and then review your responses with your child's clinician. Shade circles like this ●

Child's Last Name | First Name | Child's Date of Birth: (mm/dd/yy)

Subscriber ID | Authorization #

Clinician Last Name | First Name | Today's Date: (mm/dd/yy)

Clinician ID/Tax ID | Clinician Phone | State | MRef ○

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

Relationship to child: ○ Mother ○ Father ○ Stepparent ○ Other Relative ○ Child/Self ○ Other

For questions 1-21, please think about your experience in the past week.

Fill in the circle that best describes your child:	*Never*	*Sometimes*	*Often*
1. Destroyed property	○	○	○
2. Was unhappy or sad	○	○	○
3. Behavior caused school problems	○	○	○
4. Had temper outbursts	○	○	○
5. Worrying prevented him/her from doing things	○	○	○
6. Felt worthless or inferior	○	○	○
7. Had trouble sleeping	○	○	○
8. Changed moods quickly	○	○	○
9. Used alcohol	○	○	○
10. Was restless, trouble staying seated	○	○	○
11. Engaged in repetitious behavior	○	○	○
12. Used drugs	○	○	○
13. Worried about most everything	○	○	○
14. Needed constant attention	○	○	○

How much have your child's problems caused:	*Not at All*	*A Little*	*Somewhat*	*A Lot*
15. Interruption of personal time?	○	○	○	○
16. Disruption of family routines?	○	○	○	○
17. Any family member to suffer mental or physical problems?	○	○	○	○
18. Less attention paid to any family member?	○	○	○	○
19. Disruption or upset of relationships within the family?	○	○	○	○
20. Disruption or upset of your family's social activities?	○	○	○	○

21. How many days in the past week was your child's usual routine interrupted by their problems? ☐ Days

Answer the following only if this is your first time completing this questionnaire for this child.

22. In general, would you say your child's health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

23. In the past 6 months, how many times did your child visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+

24. In past month, how many days were you unable to work because of your child's problems? *(answer only if employed)* ☐☐ Days

25. In the past month, how many days were you able to work but had to cut back on how much you got done because of your child's problems? *(answer only if employed)* ☐☐ Days

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Clinician: Please fax to (800) 985-6894

Rev. 2007

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ☐ **Male** ☐ **Female** **Date:**_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child ...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

AccessLiving
Counseling and Developmental Services

Telemental Health Services Informed Consent

Overview of Telemental Health Service

- You will need access to the certain technological services and tools to engage in telemental health-based services with your provider.
- Telemental health has both benefits and risks, which you and your provider will be monitoring as you proceed with your work.
- It is possible that receiving services by telemental health will turn out to be inappropriate for you, and that you and your provider may have to cease work by telemental health.
- You can stop work by telemental health at any time without prejudice.
- You will need to participate in creating an appropriate space for your telemental health sessions.
- You will need to participate in planning for managing technology failures, mental health crises, and medical emergencies.
- Your provider follows security best practices and legal standards in order to protect your health care information, but you will also need to participate in maintaining your own security and privacy.

What is Telemental Health?

"Telemental health" means, in short, "provision of mental health services with the provider and recipient of services being in separate locations, and the services being delivered over electronic media."

Services delivered via telemental health rely on a number of electronic, often Internet-based, technology tools. These tools can include videoconferencing software, email, text messaging, virtual environments, special mobile health apps, and others.

Your provider typically provides telemental health services using the following tools: Doxy.me or Zoom.

- You will need access to Internet service and technological tools needed to use the above-listed tools in order to engage in telemental health work with your provider.
- If you have any questions or concerns about the above tools, please address them directly to your provider so you can discuss their risks, benefits, and specific application to your treatment.

Benefits and Risks of Telemental Health

Receiving services via telemental health allows you to:

- Receive services at times or in places where the service may not otherwise be available.
- Receive services in a fashion that may be more convenient and less prone to delays than in-person meetings.
- Receive services when you are unable to travel to the service provider's office.

- The unique characteristics of telemental health media may also help some people make improved progress on health goals that may not have been otherwise achievable without telemental health.

Receiving services via telemental health has the following risks:

Telemental health services can be impacted by technical failures, may introduce risks to your privacy, and may reduce your service provider's ability to directly intervene in crises or emergencies. Here is a non-exhaustive list of examples:

- Internet connections and cloud services could cease working or become to unstable to use.
- Cloud-based service personnel, IT assistants, and malicious actions ("hackers") may have the ability to access your private information that is transmitted or stored in the process of telemental health-based service delivery.
- Computer or smartphone hardware can have sudden failures or run out of power, or local power services can go out.

Interruptions may disrupt services at important moments, and your provider may be unstable to reach you quickly or using the most effective tools. Your provider may also be unable to help you in-person.

If your services are interrupted

There may be additional benefits and risks to telemental health services that arise from the lack of in-person contact or presence, the distance between you and your provider at the time of service, and the technological tools used to deliver services. Your provider will assess these potential benefits and risks, sometimes in collaboration with you, as your relationship progresses.

Assessing Telemental Health's Fit For You

Although it is well validated by research, service delivery via telemental health is not a good fit for every person. Your provider will continuously assess if working via telemental health is appropriate for your case. If it is not appropriate, your provider will help you find in-person providers with whom to continue services.

Please talk to your provider if you find the telemental health media so difficult to use that it distracts from the services being provided, if the medium causes trouble focusing on your services, or if there are any other reasons why the telemental health medium seems to be causing problems in receiving services. Raising your questions or concerns will not, by itself, result in termination of services. Bringing your concerns to your provider is often a part of the process.

You also have a right to stop receiving services by telemental health at any time without prejudice. If your provider also provides services in-person and you are reasonably able to access the provider's in-person services, you will not be prevented from accessing those services if you choose to stop using telemental health.

Your Telemental Health Environment

You will be responsible for creating a safe and confidential space during sessions. You should use a space that is free of other people. It should also be difficult or impossible for people outside the space to see or hear your interactions with your provider during the session. If you are unsure of how to do this, please ask your provider for assistance.

Our Communication Plan

At our first session we will develop a plan for a backup communications in case of technology failures and a plan for responding to emergencies and mental health crises. In addition to those plans, your provider has the following policies regarding communications:

- The best way to contact your provider between sessions is to call the office phone at 208-922-2207 during business hours, which are 9 am to 5 pm Monday through Friday.
- Your provider will respond to your messages within 3 business days. Please note that your provider may not respond at all on weekends or holidays. Your provider may also respond sooner than stated in this policy. That does not mean they will always respond quickly.

Our work is done primarily during our appointed sessions, which will generally occur during 9 am to 5 pm Monday through Friday. Contact between sessions should be limited to:

- Confirming or changing appointment times.
- Billing questions or issues.

Please note that all textual messages you exchange with your provider, e.g. emails and text messages, will become a part of your health record.

Your provider may coordinate care with one or more of your other providers. Your provider will use reasonable care to ensure that those communications are secure and that they safeguard your privacy.

If communication is lost during the session and it can't be restored the following resources are available:

- Emergency Services: 911
- Idaho Suicide Hotline: 208-398-4357
- National Suicide Hotline: 1-800-273-8255

Our Safety and Emergency Plan

As a recipient of telemental health-based services, you will need to participate in ensuring your safety during mental health crises, medical emergencies, and sessions that you have with your provider.

Your provider will require you to designate an emergency contact. You will need to provide permission for your provider to communicate with this person about your care during emergencies.

You provider will also develop with you a plan for what to do during mental health crises and emergencies, and a plan for how to keep your space safe during sessions. It is important that you engage with your provider in the creation of these plans and that you follow them when you need to.

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Your Security and Privacy

Except where otherwise noted, your provider employs software and hardware tools that adhere to security best practices and appliable legal standards for the purposes of protecting your privacy and ensuring that records of your health care not lost or damaged.

As with all things in telemental health, however, you also have a role to play in maintaining security. Please use reasonable security protocols to protect the privacy of your own health care information. For example: when communicating with your provider, use devices and service accounts that are protected by unique passwords that only you know. Also, use the secure tools that your provider has supplied for communications.

Recordings

Please do not record video or audio sessions without your provider's consent. Making recordings can quickly and easily compromise your privacy and should be done so with great care. Your provider will not record video or audio sessions.

Billing and Fee Information

Payment: You may discuss your insurance coverage and fees with the billing manager prior to your appointment and at any time. You are responsible for any co-pays or fees not covered by third parties. Payment is required at the time of service and can be made by credit card, cash or check. If using a credit card for payment, you will be charged a 3% service fee. When using telemental health you will be contacted prior to your appointment regarding payment for services. At this time, you can pay by card, or choose to have an invoice sent to you.

Late Cancellation/No Show Policy: Access Living has a 24-hour notice policy. If you miss your appointment for any reason, a $45.00 fee will be added to your account. Your insurance will not cover this cost. After 3 late cancellations or no show/missed appointments, it is then the provider's decision whether to terminate services and refer the patient to another clinic.

Sliding Scale: Access Living makes every effort possible to ensure that every client can access affordable services. No client will be denied services based on their income. Clients may access the low-fee intern or sliding scale services by contacting the front office.

Please sign and date saying that you understand Access Living's telemental health policy.

Printed Name _____

Signature _____ Date _____