SERVICE AGREEMENT/ASSIGNMENT OF BENEFITS/AGREEMENT TO PAY /HIPPA ACKNOWLEGEMENT AND INFORMED CONSENT

MISSION/VISION Thank you for choosing MOSAIC FAMILY Counseling Center Inc. for your mental health needs. We believe everyone deserves to be happy and feel capable in life! MOSAIC FAMILY Counseling Center Inc. is a Center of Excellence in supporting the healing of life's challenges. We strive to provide holistic, nurturing and consistent therapeutic services to make meaningful connections. We support growth and change while being culturally responsive in a safe and comfortable environment that encourages others to become autonomous and successful. For clarification the following are our practice policies. We provide this document as reference for future questions.

SCHEDULING Appointments are scheduled at the front desk or by each therapist. Sessions are usually 45-60 minutes in length. Recurring appointments may be scheduled if a client has demonstrated consistence attendance. Early morning, late evening appointments and weekends, and recurring appointments are made by special arrangement with your provider. If a reoccurring appointment is missed without notice, the reoccurrence will automatically end, and the client will need to contact the office to reschedule their appointment. The office is open Monday through Friday from 8AM to 5PM.

PAYMENT is expected at each session, unless other arrangements are made with the billing office. Cash, check, credit card or money orders are accepted. Payments made by a debit/credit card in office will incur a charge of 2.75% of the total balance. Out-of-office credit/debit payments will incur a 3.5% charge. It is the client's responsibility to ensure accurate insurance information is on file. Providing invalid insurance information will result in full payment by the client or the parent/guarantor. Medical insurance does not always cover the full cost of service. If we believe a service is not covered by the insurance plan, MFCC will inform the client. In some instances, however our company does not learn that a service is not covered until after we submit a claim. The client or parent/guarantor is responsible for payment if the insurance company refuses to pay for services. Clients are responsible to know their plan limitations and are fully responsible for payment of services if the number of sessions covered by their insurance plan is exceeded. Returned checks will be charged a $25.00 administration fee plus the bank fee and amount of the check. Be advised that after a check is not honored at the bank, you may be required to pay by cash, credit card, certified check or money order for future sessions. Payment arrangements can be arranged by contacting the billing specialist at 515.724.8920.

_____ **By initialing here, I acknowledge that I have read and understand MFCC's payment policy.**

RECORDS If you need your records please alert your therapist 2- 4 weeks before they are necessary to allow time for organization of your file and printing or e-release. Your therapist will provide a typed compilation of the record when they are notified. There is a $50.00 fee for processing your file, plus ten cents per page that is copied from the file, payable at time of request.

CANCELLATION POLICY

Forty-eight (48) hour notice is expected and appreciated, unless cancellation is due to an emergency. The fee for a cancellation that takes place with less than forty-eight (48) hour notice is $50 for the first late cancellation, after the first you may be charged up to the full amount of the service. If no notice is provided (no call/no show), the charge is $150.00 for the first incident and up to the full amount of the service thereafter. Payment of these fees will be due at the time of the next scheduled appointment, please be prepared to pay the outstanding fees. Insurance cannot be billed for missed appointments or late cancellations and less than forty-eight (48) hour notice does not allow someone else to take advantage of a cancellation. Chronic cancellations, (3 or more) within a (6) six-month time period may result in a suspension of services. If MFCC closes due to inclement weather, there will be no charge for the missed appointments.

NO FEE/LOW FEE SERVICES are available by an intern or provisionally licensed therapist for clients involved with the Department of Human Services who do not have access to insurance. This is a limited capacity program and payment is required at the time the service is rendered. Failure to maintain payments without prior arrangements through the billing office may result in ineligibility for participation in these services. Failure to provide appropriate cancellation notice may also result in ineligibility for participation.

EMERGENCIES Should you have an emergency (life threatening), please call **911** or go to the nearest hospital. You may also call the Mobile Crisis Team in Des Moines at **515.243.4811**. They will help you determine the level of need and assist you in obtaining help for your crisis. Voice mail is usually checked on the weekends but is not guaranteed. If you have had an emergency, please alert your therapist at **515.724.8920** so coordination of care can happen for your wellbeing. The MFCC after hours phone number for emergencies is **515.724.1039**, the on-call therapist can help you access emergency services to assist you. This is an EMERGENCY line only.

_____ **By initialing here, I acknowledge that I have read and understand MFCC's practice policies listed above.**

Paperless Statements and Notifications Please provide us with your e-mail address to be able to set up an online patient portal. The portal will allow you to receive electronic notifications, monthly statements and surveys, and send secure messages to your provider. At no time will MFCC use the provided email for any other purpose than what is stated herein and will not trade, sell or otherwise give your email to any outside entities without express consent.

Email: _____

Go to the following web address: https://www.valantmed.com/Portal/mosaic/AccountSetup/EnterValidationCode

You will be asked to enter your last name and the following validation code: _____

☐ **Check this box if you would *not* like to receive electronic notifications via the patient portal and email.**

I have chosen MOSAIC FAMILY Counseling Center Inc. (MFCC) to provide services to me and/or my family. I hereby give consent for myself and/or my child named herein, to receive therapy and/or skill development or other services by MFCC. My insurance will be notified of my consent to receive services and information will be shared with my insurance company for the purpose of payment and agree to assign my insurance benefits to MFCC, for purposes of payment for services/care rendered and I hereby give consent for information to be shared by and between MFCC and the insurance company or other paying agent.

No information identifying me/my family will be released or disclosed without written consent by me, a parent/legally designated representative. I may be asked to sign a specific release of information to other individuals or agencies which staff deems important to communicate with in the best interest of treatment. MFCC will not knowingly utilize any treatment/procedure, which is experimental, controversial or carries intrinsic risk. I understand the assigned therapist may be under supervision such as an intern/practicum student or therapist working toward licensure. I understand this person is fully supervised and will share information about my care for supervision purposes. This may include video/tape recordings of sessions/verbal processing or reading of file notes. I agree to allow taping or video of my sessions. This is a mandatory process and is for the benefit of the client and therapist. All information is used appropriately. The type of therapy I receive will be determined by me and my therapist. My therapist will provide me with information to explain the method of therapy we decide on. I understand there are risks to receiving therapy such as: not receiving relief, worsening of symptoms; I may get better without receiving therapy with time. I may make decisions as a result of therapy. I may change my lifestyle as a result of therapy. I understand I can try alternatives to therapy such as medications alone, spiritual counseling, better diet and exercise, self-help groups or do nothing, among others. These alternatives may or may not produce benefit to me. If I would like a referral to another service, I will ask my therapist. I understand that all decisions made as a result of therapeutic interventions are voluntary and solely made by me.

We/I, the undersigned, agree to accept services from MFCC. We agree to cooperate with the requirements of the services for self/ child/family and will be participating in counseling or other services until discharged. I understand my child may receive services in the community/school/home with/without my presence. The signature below is equivalent to the signature of agreement for the developed treatment plan unless objected to in writing. I am participating willingly and without coercion.
We/I, the undersigned, understand with the proper release, when information needs to be shared quickly, it may be done via fax, phone or computer e-mail. We/I also understand individual client records may be kept on computer. We/I understand there is no guarantee that information we disclose in a group or family setting will be held confidential by other members of the group or the family. We/I understand in the course of treatment, many subjects will be discussed. Some of these subjects may be, but are not limited to age, education, social and family background, prior treatment efforts, trauma, relationships, marital issues, sexuality, violence, leisure activities, drug/alcohol usage, legal or medical involvement, housekeeping, shopping habits, living skills & hygiene.

This agreement will remain in effect until involvement with MFCC ends either by discharge or termination of services. I hereby acknowledge I have received and have been given an opportunity to read a copy of MFCC's Notice of Privacy Practices, Grievance Policy, Client Rights and Responsibilities. I understand that if I have any questions regarding the Notice or my privacy rights, I can discuss this with my therapist. This signature constitutes informed consent of treatment and agreement to policies as stated herein.

_____ **Initial if you do not wish to sign a release for your Primary Care Physician, Psychiatrist or Other Requested Information.**
_____ ***If you have declined to sign a release* - Initial if you do not wish for assistance in finding a medical home.**
_____ **Please initial if you have provided Emergency contact information and understand this person may be contacted in an emergency.**

I have read and have a full understanding of MOSAIC FAMILY Counseling Center, Inc.'s practice policies.

_____ _____
Client/Parent/Guardian Signature Staff Signature/Credentials & Date

PERMISSION TO RELEASE INFORMATION

I authorize MOSAIC FAMILY Counseling Center Inc. to exchange information with **(please include name, address, phone number and fax)**:

Name: _____ **Relationship to Patient:** _____

Address: _____ **City, State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **Email:** _____

This information is pertinent to the client's mental health, behavioral or academic needs as deemed by either agency. This information may contain:

- ☐ Attendance of Treatment
- ☐ Care Coordination
- ☐ Court Reports
- ☐ Clinical Progress Notes
- ☐ DHS Reports & Case Plans
- ☐ Diagnostic Tests or Assessments
- ☐ Education Records, Testing Data/Information
- ☐ Medical Records
- ☐ Mental Health Treatment Plans
- ☐ Police Reports
- ☐ Progress Summary
- ☐ Psychiatric/Psychological Assessments/Evaluation/Records
- ☐ Termination/Discharge Summary
- ☐ **ALL OF THE ABOVE**

Specific Authorization for Release of Information Protected by State/Federal Law

I specifically authorize the release of data and information relating to: (must be checked in order to provide ANY information even if it is the absence of this information)

☐ 1. Mental Health ☐ 2. Substance abuse (alcohol/drug use) ☐ 3. HIV/AIDS information

The information shared may be written and/or verbal and it may be currently in existence and/or that which is made in the future. This information will only be shared with appropriate personnel on a need to know basis.

I understand I may revoke this authorization at any time by giving written notice to MFCC. I understand that any release made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

Expiration: Specify date, event or condition of expiration. If expiration is not specified, this authorization will automatically expire one year from date of signature: Specific date or condition of expiration: _____

_____ _____ _____

Client/ Parent/Legal Representative Signature Date Staff Signature/Credentials

PROHIBITION ON REDISCLOSURE: This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 22) prohibits further disclosure without the specific written consent of the client or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

* Only persons 18 years of age or his/her legal representative may authorize release of mental health information.

** Only the subject may authorize release of substance abuse information unless the subject is under legal age or incompetent as defined by statute. **Sharing information: It is the responsibility of all agencies listed to provide requested information. The recipient of the information is responsible for maintaining confidentiality of the information.**

CREDIT CARD ON FILE POLICY

At MOSAIC FAMILY Counseling Center Inc., we require keeping your credit or debit card on file as a convenient method of payment for services rendered should your insurance not be active at the time of service, the portion of services that your insurance doesn't cover such as copays, deductibles and co-insurance, and late cancellation and no-show fees.

Your credit card information is kept confidential and secure and payments to your card are processed at the time of service. Your insurance claims will continue to be filed. This authorization will remain in effect until the account is in good standing and it is cancelled in writing with 30-day notice.

*There is a 3.5% service fee charged of the total balance for **all** credit/debit transactions. (Fees will be charged unless otherwise prohibited by law.)

☐ I **decline** to provide my credit/debit card information.

☐ I **authorize and request** MOSAIC FAMILY Counseling Center, Inc. to charge the portion of my bill that is my financial responsibility to the following credit or debit card.

☐ **Amex** ☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **Health Savings Account (HSA)**

Credit Card Number _____

Expiration Date _____ **CVV (3 digits on back of card)** _____

If American Express, 4 digits on front of card _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ **State** _____ **Zip Code**_____

Client Name (Print): _____

Client/Parent Signature: _____ _____
Todays' Date

Staff Signature: _____

What's Your Resilience Score?

This questionnaire was developed by the early childhood service providers, pediatricians, psychologists, and health advocates of Southern Kennebec Healthy Start, Augusta, Maine, in 2006, and updated in February 2013. Two psychologists in the group, Mark Rains and Kate McClinn, came up with the 14 statements with editing suggestions by the other members of the group. The scoring system was modeled after the ACE Study questions. The content of the questions was based on a number of research studies from the literature over the past 40 years including that of Emmy Werner and others. Its purpose is limited to parenting education. It was not developed for research.

Please choose the most accurate answer for each statement:	Definitely true	Probably true	Not sure	Probably not true	Definitely not true
I believe that my mother loved me when I was little.					
I believe that my father loved me when I was little.					
When I was little, other people helped my mother and father take care of me and they seemed to love me.					
I've heard that when I was an infant someone in my family enjoyed playing with me, and I enjoyed it, too.					
When I was a child, there were relatives in my family who made me feel better if I was sad or worried.					
When I was a child, neighbors or my friends' parents seemed to like me.					
When I was a child, teachers, coaches, youth leaders or ministers were there to help me.					
Someone in my family cared about how I was doing in school.					
My family, neighbors and friends talked often about making our lives better.					
We had rules in our house and were expected to keep them.					
When I felt really bad, I could almost always find someone I trusted to talk to.					
As a youth, people noticed that I was capable and could get things done.					
I was independent and a go-getter.					
I believed that life is what you make it.					

How many of these 14 protective factors did I have as a child and youth? (How many of the 14 were circled "Definitely True" or "Probably True"?) _____ Of these circled, how many are still true for me? _____

Any positive memories that you feel has increased your ability to handle adversity? (Please explain)

_____

_____

_____

_____

Adverse Childhood Experience (ACE) Questionnaire

Please choose the most accurate answer for each statement

While you were growing up, during your first 18 years of life:	Yes	No
1. Did a parent or other adult in the household often		
a. Swear at you, insult you, put you down, or humiliate you?		
b. Act in a way that made you afraid that you might be physically hurt?		
2. Did a parent or other adult in the household often…		
a. Push, grab, slap, or throw something at you?		
b. Ever hit you so hard that you had marks or were injured?		
3. Did an adult or person at least 5 years older than you ever…		
a. Touch or fondle you or have you touch their body?		
b. Try to or actually have oral, anal, or vaginal sex with you?		
4. Did you often feel that		
a. No one in your family loved you or thought you were important or special?		
b. Your family didn't look out for each other, feel close to each other, or support each other?		
c. You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?		
d. Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?		
5. Were your parents ever separated or divorced?		
6. Was your mother or stepmother:		
a. Often pushed, grabbed, slapped, or had something thrown at her?		
b. Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?		
c. Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?		
7. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?		
8. Was a household member depressed or mentally ill or did a household member attempt suicide?		
9. Did a household member go to prison?		
Add up your "Yes" answers. Each "Yes" is worth 1 towards your total score.		

Comments/Questions: _____

_____

_____