



Informed Consent to Treatment

By placing my initials next to the following statements, I am voluntarily consenting to mental health services provided by Woodward Community-Based Services. My initials also represent that I acknowledge my rights as a client.

_____ I have chosen to receive mental health/tele health treatment services and I understand I may terminate services at any time.

_____ I understand there is no assurance that I will feel better. Because these services are a cooperative effort between me and my counselor I will work with my counselor in a cooperative manner to resolve my difficulties.

_____ I understand that during the course of my treatment, material may be discussed that will be upsetting in nature and this may be necessary to resolve my problems.

_____ I understand that records and information collected about me will be held or released in accordance with federal and state laws regarding confidentiality of such records and information.

_____ I understand that state and local laws require that my therapist report all cases of suspected abuse or neglect of minors or vulnerable adults.

_____ I understand that state and local laws require that my therapist report all cases in which there exist a danger to self or others.

_____ I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

_____ I understand that I may be contacted by my health plan to ensure continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment.

CONSENT TO THERAPY:

Your signature below indicates that you have read this agreement and the notice of Privacy Practices and agree to the terms.

Printed Name of Client: _____

Signature of Client or Representative: _____

Date: _____

Representatives Relationship to client: _____



Telehealth Consent Form

Client Name: _____ **Date of Birth:** _____

Location of Client: _____

Provider Name: Woodward Community Based Services @ 6200 Aurora Avenue, Urbandale, Iowa 50322

I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when client is located at a different site than the provider; and hereby consent to **Woodward Community Based Services** providing health care services to me via telehealth.

I understand that the telehealth visit will be done through a two-way video and audio link. The provider will be able to see my image on the screen and hear my voice. I will be able to hear and see my provider. I understand that I am responsible to have a private setting for my telehealth sessions and to disclose, at each session, if anyone else is in the room or listening in on the telehealth session.

I understand that the laws that protect privacy and confidentiality of medical information also apply to telehealth. I authorize the release of any relevant medical information about me to the consulting health care provider, any staff the consulting health care provider supervises, third party payers and other healthcare providers who may need this information for continuing care purposes. I understand that I will be responsible for any copayments or coinsurances that apply to my telehealth visit.

I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care of treatment. I may revoke my consent orally or in writing at any time by contacting **WCBS at (515) 274-9607**. As long as this consent is in force and has not been revoked, **WCBS** may provide health care services to me via telehealth without the need for me to sign another consent form.

I understand there are potential risks with telehealth technology, which include: the video connection may not work or it may stop working during the consultation, the video picture or information transmitted may not be clear or enough to be useful for the consultation, and/or I may be required to go to the location of the consulting provider if it is felt that the information obtained via telehealth was not sufficient to make a diagnosis. I understand that the benefits of telehealth consultation include that include that I may not need to travel to the consult location and I will have access to a specialist through this consultation.

I have read this document and understand the risk and benefits of the telehealth consultation and have had my questions regarding the procedure explained and I hereby consent to participate in a telehealth visit under the conditions described in this document.

Client/Legal Representative Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____



Woodward Community Based Services
Acknowledgement of Receipt

Please read the following regarding receipt of the Client Handbook and Notice of Privacy Practices. Please only sign one of two options below:

- 1. I agree that I have received a copy of Woodward Community Based Services Client Handbook that includes the Blueprint reference guide and Notice of Privacy Practices.

Client Signature: _____ Date: _____

OR

- 2. I have been offered a copy of the Client Handbook that includes the Blueprint reference guide and Notice of Privacy Practices and I have declined copies. I understand that I can get a copy from my provider at any time.

Client Signature: _____ Date: _____

**Please note that additional copies of the following items are also available at our Urbandale office upon request.

Substance Abuse service: I agree that I have been made aware of:
_____ Knowledge of the Fee Schedule
_____ Treatment agreement with program rules and expectations.

If receiving services in my home, I have participated in completing a:
_____ Home Safety Assessment

ADVANCE DIRECTIVE

Advance Directive Choice: (please select your choice by initialing next to it):

- _____ To formulate an Advance Directive and will provide Woodward Community Based Services with a copy, or an update on any progress made towards completion by _____ (date).
_____ I already have an advance directive completed and will provide with a copy no later than _____.
_____ Not to formulate an advance directive at this time. I may choose to do so at a later date.
_____ This client is under 18 years of age and does not require an Advanced Directive or the service provided is an assessment only.

If you are 18 or older, please indicate your choice below:

- _____ I give Woodward Community Services permission to obtain copies of my advance directive and to keep them in my medical record. I understand that I may revoke these advance directives at any time or may change them at any time.
_____ I understand that it is my responsibility to notify any providers or agents of any revocations or changes I may make.

Printed Name: _____ Date: _____

Client Signature: _____ Date: _____



NOTICE OF PRIVACY PRACTICES

The effective date of this notice is: _____ (date of initial service)

I acknowledge that I have been provided a copy of the Facility's "Notice of Privacy Practices" which provides a description of the manner in which the Facility may use and disclose my protected health information. If I have any questions, I know that I have the right to contact Woodward Community Based Services and ask the Privacy Officer about my concerns.

If you believe that your privacy rights have been violated, you can file a complaint without fear of retaliation with Sara Strom at 6200 Aurora Avenue, Suite 400W, Urbandale, Iowa 50322 or with the Secretary of the Department of Health and Human Services. All complaints must be in writing.

Client Name (printed): _____

Client/parent/guardian signature: _____ Date: _____

Witness Signature: _____ Date: _____

Collaboration of Care and Releases of Information (ROI)

Mental Health, substance use, medical, and/or educational multidisciplinary treatment teams provide integrated treatment in which team members work collaboratively to provide quality care for the client served. To effectively communicate, it is recommended that client's complete a release of information for all providers.

I have completed a Release of Information for the following providers.

Mental Health Therapist: YES REFUSE N/A Name/Agency: _____

Substance Use Counselor: YES REFUSE N/A Name/Agency: _____

Medication Provider: YES REFUSE N/A Name/Agency: _____

Primary Care Physician: YES REFUSE N/A Name/Agency: _____

Adult/Juvenile Probation: YES REFUSE N/A Name/Agency: _____

DHHS: YES REFUSE N/A Name/Agency: _____

Other: (please specify) _____



CLIENT PORTAL USER AGREEMENT

We are pleased to provide a Client Portal in partnership with our electronic medical records provider, Willetts Technology, for the exclusive use of established Clients. The Client Portal is designed to enhance patient – physician communication.

We strive to keep all of the information in your records correct and complete. If you identify any discrepancy in your records, you agree to notify us immediately. Additionally, by using the Client Portal, the user agrees to provide factual and correct information.

The Client Portal provides access to your health information. You may view a clinical health record summary concerning your most recent visit, as well as current medications, vitals, lab and test results. You are able to sign any consents, releases, and other important documents. You may request an electronic copy of your health information. Additional functionality may be added in the future.

The Client Portal is not intended to provide internet based diagnostic medical services. The following limitations also apply:

- No internet-based triage and treatment requests. Diagnosis can only be made and treatment rendered after the Client is SEEN by the physician.
- No emergent communication or services. Any emergent conditions should be handled by calling the office directly, going to an urgent care clinic or emergency room or *calling 911* should the emergency be life threatening.
- No requests for narcotic/controlled medications will be accepted.
- No requests for new prescriptions or refills for conditions for which you are not being treated by our clinic will be accepted.
- It may take 72 hours to receive a response to an email request. If you do not receive a response within 72 hours you should contact your local office.
- If you lose your password or username, you may request a new one by contacting your local office and by providing valid identification.
- Always remember to log out and close your browser when you are finished accessing password protected Client Portal services. This prevents someone else from accessing your personal information. You should avoid using a public computer to access the patient portal.

This Client Portal is provided as a courtesy to our clients. However, if abuse or negligent usage of the Client Portal persists, we reserve the right, at our discretion, to terminate Client Portal offering, suspend user access, and modify services available through the Patient Portal.

The Client Portal is provided in partnership with Willetts Technology, our EHR software vendor and provider. That data is HIPAA compliant with high level encryption that exceeds the HIPAA standards. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. To the extent possible, our office has undergone rigorous IT implementation and security standards exceeding industry recommendations.



Please read our HIPAA policy for information on how private health information is used in our office. All Clients have signed a HIPAA agreement form. If you do not recall having signed a HIPAA agreement or need to reacquaint with the HIPAA policy, we will be happy to provide you with a copy.

Once you have signed the Patient Portal User Agreement and have provided our office with an email address and/or cell phone number that is secure, you will receive an invitation to this email address and/or phone number to set up your portal access.

Client Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of the Client Portal and agree that I understand the risks associated with online communications between my physician and myself, and consent to the conditions outlined herein.

I acknowledge that using the Client Portal is entirely voluntary and will not impact the quality of care I receive should I decide against using the Client Portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications. I have been given an opportunity to ask questions related to this agreement and all of my questions have been answered to my satisfaction.

Client Name (printed) _____

Client Signature _____ **Date** _____

Guardian/Legal Representative Printed Name _____

Guardian/Legal Representative Signature _____ **Date** _____

Email Address for Portal Use _____

Cell Phone Number for Portal Use _____

Would you like to have access for the Portal through email, text, or both? _____

_____ I do not wish to use the Patient Portal. **(Please initial)**



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Client Name		Date of Birth
Client Phone Number	Client Email	
Client Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV RELATED INFORMATION** only if I place my initials on the appropriate line in Box 9. In the event the health information described below includes any of these types of information, and I initial the line in Box 9, I specifically authorize release of such information to the person(s) or category of person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law

1. Name and address of person(s) or category of person(s) to release this information: Woodward Community Based Services, 6200 Aurora Ave, Suite 400W, Urbandale, IA 50322	
2. Name and address of person(s) or category of person(s) to whom this information will be sent:	
3. Specific information to be released (please initial) <input type="checkbox"/> Medical Record from (insert date) _____ to (insert date) _____ <input type="checkbox"/> Psychiatric Assessment and Psychiatric Progress Notes (except psychotherapy notes) <input type="checkbox"/> History and Physical <input type="checkbox"/> Most recent discharge summary and Master Treatment Plan <input type="checkbox"/> Testing results (lab, x-ray, EEG, EKG, etc.) <input type="checkbox"/> Records sent to you by other health care providers <input type="checkbox"/> Physician orders and progress notes <input type="checkbox"/> Billing records <input type="checkbox"/> Verbal conversations with family members: (name person) _____ <input type="checkbox"/> Verbal conversations with non-family members: (name person) _____ <input type="checkbox"/> Court testimony and related services <input type="checkbox"/> Other (please specify): _____ Include: <i>(Indicate by Initialing)</i> <input type="checkbox"/> Alcohol/Drug Treatment <input type="checkbox"/> Mental Health Information <input type="checkbox"/> HIV-Related Information	
4. Reason for release of information: (please initial) <input type="checkbox"/> At the request of the individual <input type="checkbox"/> Other: _____	5. If I do not specify a date or event in this box, this authorization shall expire 24 months from the date of my signature below.
6. If not the client completing this form, printed name of person signing:	7. Authority to sign on behalf of patient (attach supportive documentation if applicable):



I understand that after I sign this Authorization I may receive a copy. I also understand that I may inspect or copy the information to be used or disclosed, as provided for in 45 C.F.R. § 164.524. HIPAA10

Client Signature: _____ **Date:** _____
Signature of patient or representative authorized by law