COVENANT
FAMILY SOLUTIONS

# Medication Managment Demographic Intake

## Personal Information

| First Name | Middle Initial | Last Name | Today's Date |
|---|---|---|---|
| | | | |

| Street Address | City | Zip |
|---|---|---|
| | | |

| Birth Date: | Gender: | Employer Name: | Occupation: |
|---|---|---|---|
| | | | |

| Home Phone: | Cell Phone: | Work Phone: | Social Security #: |
|---|---|---|---|
| | | | |

| Email Address: | Preferred Method of Contact: |
|---|---|
| | |

| List present or previous health problems: | List any medications you are currently taking: |
|---|---|
| | |

## ☐ Spouse/Partner ☐ Parent / Guardian Information (if Applicable)

| First Name | Middle Initial | Last Name | Marriage Date |
|---|---|---|---|
| | | | |

| Street Address (if different): | Phone Number (if different): |
|---|---|
| | |

| Birth Date: | Gender: | Employer Name: | Occupation: |
|---|---|---|---|
| | | | |

| Email Address: | Is email contact OK: ☐Yes ☐No |
|---|---|
| | |

## ☐ Parent / Guardian Information (if Applicable)

| First Name | Middle Initial | Last Name | Relationship to Client |
|---|---|---|---|
| | | | |

| Street Address (if different): | Phone Number (if different): |
|---|---|
| | |

| Birth Date: | Gender: | Employer Name: | Occupation: |
|---|---|---|---|
| | | | |

| Email Address: | Is email contact OK: ☐Yes ☐No |
|---|---|
| | |

## ☐ Parent / Guardian Information (if Applicable)

| First Name | Middle Initial | Last Name | Relationship to Client |
|---|---|---|---|
| | | | |

| Street Address (if different): | Phone Number (if different): |
|---|---|
| | |

| Birth Date: | Sex: ☐ Male ☐ Female | Employer Name: | Occupation: |
|---|---|---|---|
| | | | |

| Email Address: | Is email contact OK: ☐Yes ☐No |
|---|---|
| | |

| Signature | Signature |
|---|---|
| | |

1655 Blairs Ferry Rd · Marion, Iowa 52302 · Phone 319.261.2292 · Fax 319.200.2516

# Informed Consent for Medication Management Treatment

At Covenant Family Solutions, LLC we believe that sometimes one may need medication to help achieve their behavioral health goals. It is important that medication is monitored, and ongoing discussion occurs with a licensed professional to ensure the right medication and treatment plan is implemented to improve one's behavioral health. The following information is important for your consideration.

## No Show/Late Arrival Policy

Our goal is to provide quality individualized psychiatric care in a timely manner. No-shows, late arrivals, and same day cancellations inconvenience those individuals who need access to mental health care. As a courtesy, if you need to change or cancel an appointment please notify us at least ***24 hours*** in advance. You may be charged $75 for not showing to an appointment or $50 for same day cancellations, except in emergency situations. Patients who no-show or late cancel two or more times in a 12-month period, may be asked to seek medication management services elsewhere. We understand that delays can happen. That said, we must try to keep the other patients and families on time. If you arrive ***10 minutes*** past your scheduled appointment time, you may be charged $50 for a late appointment fee and we will have to ask you to reschedule.

## Guardians of Minors Receiving Services

I agree to be on Covenant Family Solutions' premises during initial and follow-up medication management appointments. This allows the clinician to review/update the treatment plan and address any questions.

## Methods of Contact

On occasion, there may be times where you need to contact a clinician outside of a scheduled appointment. Our office number is 319-261-2292. If we are not available to take your call or if it is after hours, please leave a message and someone will get back to you within 1-2 business days. **If a situation is emergent, such as an individual is a risk to self or others and cannot remain safe, go to nearest ER or call 911.**

## Prescription Refill Request

We require **72 hours** advance notice to call in prescriptions with no refills remaining and for writing scripts for controlled substances. If you have refills, please contact your pharmacy to request a refill if there is no response please reach out to office as second step.

## Release of Information

Information will not be released without a signed release of information. Please ask the front desk for a release for any individual or agency that you would like involved in your care. Any paperwork or correspondence that you need completed will require a signed release of

information. If individual is hospitalized coordination of care is essential for best outcome. Therefore, multidisciplinary staff will be allowed to schedule follow up appointments to assist with coordination of care. No personal health information will be shared without release of information.

## Confidentiality

We understand that the information you share can be very personal and by signing this Informed Consent for Medication Management Treatment, you acknowledge receipt of the Notice of Privacy Practices**.** That document describes your rights and our obligations regarding the use and disclosure of that information.

Clinicians at Covenant Family Solutions are required to hold information about sessions and clients in confidence and are not allowed to disclose such information without the expressed written consent of all those involved in treatment, except in the following circumstances:

1. There is clear and imminent danger to you or others in which case the clinician may be required to inform the responsible authorities and warn the identified victim. If this occurs, the clinician may inform you of their responsibilities and actions.
2. In situations of suspected physical, emotional, or sexual abuse of a child, or dependent adult abuse, clinicians are required to submit a report to the Department of Human Services and may be required to contact authorities. Again, in this situation you may be informed of the clinician's responsibilities and actions.
3. Covenant Family Solutions maintains records of treatment, diagnosis, assessment, and treatment planning in accordance with state law, and to better guide your treatment and assess the effectiveness of treatment provided. You may request restrictions as to how your case information may be used or shared among staff of the group practice, but Covenant Family Solutions is not required to agree to those restrictions.
4. If the release of information is mandated by law. Some litigation may require the release of records even without the client's authorization. Clinician's will not typically testify in court as this creates an irreconcilable role conflict that harms the therapeutic relationship.

## Billing and Fees

For your convenience we will submit the claim for your visit to your insurance company. Your portion of the charges (copay) and balances are due at the time of service. Payments will be accepted form of check or credit card only**.** Our office cannot guarantee insurance coverage for services provided. Questions about insurance payment and/or coverage should be directed to the insurance company.

**In signing this form, you authorize Covenant Family Solutions to bill and seek payment from third-party payers on your behalf. In addition, if insurance denies coverage or payment for any reason, you remain responsible for paying any outstanding balance.**

If there is a returned check, the charge will be $25. Please be aware that if your outstanding balance exceeds $145 we will not be able to schedule further appointments until the balance is paid. Outstanding balances will be forwarded to a collection agency after 90 days of nonpayment.

Fees for court appearances, whether by subpoena or client request, are $145 per hour. The fee includes travel and prep time that may be required for the appearance. Emails or phone calls with attorneys, even at the request of a client, will be charged at $75 per incident. In addition, there is a cost-based fee to process a request for records to be released to court, an attorney, or other individual. These fees are incurred on top of regular session fees. Covenant Family Solutions reserves the right to not respond to requests to appear in court or provide documents.

If you choose to pay for visits as a private payer, the rates are:

1. Initial medication evaluation $200.00
2. Follow up medication management appointments $100.00

**By signings this form, you acknowledge that a copy of the Covenant Family Solution's Grievance Policy, as well as a copy of a Patient's Rights and Responsibilities have been made available to you.**

I have read the above information, and understand that I am encouraged to ask questions, and give input regarding the medication management process at any time. If there is anything in this form I do not understand, it is my responsibility to seek clarification. In addition, I recognize that I can withdraw my consent for medication management treatment at any time.

_____

Patient Name (Print)

_____ _____

Patient/Guardian Signature Date

**Please fill out this form so we can communicate with your Doctor, School/Teacher, Therapist, etc.**

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## Release of Information

**Client name:** **DOB:**

I, hereby authorize Covenant Family Solutions to release verbal and/or written information to:

_____ _____ _____

**Name of person or entity information is to be released/received** **Phone** **Fax**

_____

**Address**

For the following purposes:

□ All of the following: □ Treatment and assessment □ Coordination of care □ Referral of new or additional services
□ Other_____

Specific information to be released includes:

□ All of the following: □ Assessment and diagnosis □ Treatment goals □ Session content □ Discharge
□ Other_____

I understand that by signing this General Authorization I am authorizing Covenant Family Solutions to disclose my health information to the persons and entities listed above and that any health information or other confidential information in the possession of the persons and entities listed above may be disclosed to Covenant Family Solutions.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to Covenant Family Solutions. I understand that my revocation of this General Authorization will not affect a disclosure that Covenant Family Solutions has already made under this authorization. I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by Covenant Family Solutions' confidentiality rules. I waive any right of privacy that I may have in connection with the disclosures hereby authorized. I understand that signing this is not a condition of receiving services. This authorization will expire on _____ or 12 months from the date it was signed.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND/OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT, HIV/AIDS-RELATED INFORMATION AND GENETIC INFORMATION

I understand that this will include information relating to the following categories unless I specifically deny the release.
(**Initial any category <u>NOT</u> to be released**)

_____HIV/AIDS_____ Genetic information including genetic test _____Mental Health _____Substance Abuse

| | |
|---|---|
| _____ _____<br>Printed name and signature of Client and/or Client's Parent or Legal Guardian | Date |
| _____ _____<br>Printed name and signature of Client and/or Client's Parent or Legal Guardian | Date |
| _____ _____<br>Printed name and signature of Doctor, Therapist, or Witness | Date |

**Please fill out this form so we can communicate with your Doctor, School/Teacher, Therapist, etc.**

COVENANT FAMILY SOLUTIONS

## Release of Information **Client name:** **DOB:**

I, hereby authorize Covenant Family Solutions to release verbal and/or written information to:

_____ _____ _____

**Name of person or entity information is to be released/received** **Phone** **Fax**

_____

**Address**

For the following purposes:

□ All of the following: □ Treatment and assessment □ Coordination of care □ Referral of new or additional services
□ Other_____

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□ All of the following: □ Assessment and diagnosis □ Treatment goals □ Session content □ Discharge
□ Other_____

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| | |
|---|---|
| _____ _____<br>Printed name and signature of Client and/or Client's Parent or Legal Guardian | Date |
| _____ _____<br>Printed name and signature of Client and/or Client's Parent or Legal Guardian | Date |
| _____ _____<br>Printed name and signature of Doctor, Therapist, or Witness | Date |