1953 1st Ave SE Suite A-6
Cedar Rapids IA 52402
PH: (319) 364-1953
FAX: (319) 364-1970

Client Name:______________________
DOB:_____________________

REGISTRATION FORM

(Please Print)

Today's date:							
PATIENT INFORMATION							
Patient's last name:	First:	MI:	Marital status (circle one): Single /Mar/Div/Sep/Wid		Social Security number: - -		
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Phone #:	D.O.B. / /	Age:	Sex: ❑ M ❑ F		
Street address:	P.O. Box:	Apt #:	City:	State:	Zip:		
Occupation:	Employer:						
DHS Worker:	Juvenile Court Officer:	Child Mental Health Worker:					
Mother:	First Name:	Street address:			City:	Phone #:	
	Last Name:	P.O Box:	Apt#:	State:	Zip:	Alt. phone #:	
Father:	First Name:	Street address:			City:	Phone #:	
	Last Name:	P.O Box:	Apt#:	State:	Zip:	Alt. phone #:	
Current Placement:	First Name:	Street address:			City:	Phone #:	
	Last Name:						
Relationship (circle one): Relative /Foster /Residential		P.O Box:	Apt#:	State:	Zip:	Alt. phone #:	

IMPORTANT: If anyone other than a parent is signing this form (i.e. a guardian), he or she must produce a signed affidavit from the Court authorizing him or her to sign on behalf of the patient. A copy of this affidavit must be kept in Life Connections' files.

How did you hear about us?

☐ Website
☐ Commercial
☐ Literature
☐ A Friend
☐ A Life Connections Employee
☐ Other ______________________________

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Client Name:____________________
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Insurance Information

PRIMARY PRIVATE INSURANCE

(Please give your insurance card to the receptionist)

Policy holder name:	D.O.B.: / /	Street address :	City:	State:	Zip:

Home phone #: ( )	Policy holder's S.S.N.: - -	Occupation:	Employer:	Is the patient covered by this insurance? ❑ Yes ❑ No

Please indicate primary insurance: ❑ Blue Cross/Blue Shield ❑ Other ____________	Group #:	Policy #:	Co-payment: $	Insurance Provider Phone #: ( )

Patient's relationship to policy holder: ❑ Self ❑ Spouse ❑ Child ❑ Other________________

TITLE 19 INSURANCE

(Please give your Title 19 card to the receptionist)

Name as it appears on the Title 19 card :	Title 19 member's D.O.B.: / /	Title 19 number:

SECONDARY PRIVATE INSURANCE

(Please give your insurance card to the receptionist)

Policy holder name:	D.O.B.: / /	Street address :	City:	State:	Zip:

Home phone #: ( )	Policy Holder's S.S.N.: - -	Occupation:	Employer:	Is the patient covered by this insurance? ❑ Yes ❑ No

Please indicate secondary insurance: ❑ Blue Cross/Blue Shield ❑ Other ____________	Group #:	Policy #:	Co-payment: $	Insurance provider's phone #: ( )

Patient's relationship to policy holder: ❑ Self ❑ Spouse ❑ Child ❑ Other________________

IN CASE OF EMERGENCY

Name of local relative or friend (not living at the same address):	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Life Connections, L.C. I understand that I am financially responsible for any balance. I also authorize Life Connections, L.C. to release any information required to process my claims.

____
Client Signature/Date

____
Guardian Signature/Date

Revised: 1-27-2010

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DOB:____________________

SUSPECTED CHILD AND DEPENDANT ADULT ABUSE REPORTING POLICY

It is our duty at Life Connections, L.C., as mandatory reporters, to immediately report any suspected child and dependent adult abuse to the local Department of Human Services. The employee shall report suspected abuse orally to the local Department of Human Services within 24 hours, followed by a written report to the local Department of Human Services within 48 hours after such oral report. The employee shall also make an oral report to the appropriate law enforcement agency, if the employee believes that immediate protection of the child or adult is advisable.

Types of Child Abuse include the following: physical abuse, mental injury, sexual abuse, denial of critical care, child prostitution, presence of illegal drugs in the body of a child, manufacture or possession of dangerous substances in the presence of a child, bestiality in the presence of a child, and cohabitation with a registered sex offender.

Types of Dependent Adult Abuse include the following: Physical injury to, or which is at variance with the history given of the injury or unreasonable confinement, unreasonable punishment, or assault of a dependent adult; commission of a sexual offense under Iowa Code 709 or section 726.2 with or against a dependent adult; exploitation of a dependent adult which means taking unfair advantage of a dependent adult or the adult's physical or financial resources for one's own personal or pecuniary profit, without the informed consent of the dependent adult, including theft, by the use of undue influence, harassment, duress, deception, false representation, or false pretensions; deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a dependent adult's life or health; deprivation of the minimum food, shelter, clothing, supervision, physical, or mental health care, and other care necessary to maintain a dependent adult's life or health as a result of the acts or omissions of the dependent adult; sexual exploitation of a dependent adult who is a resident of a health care facility, as defined in section 135C.1, by a caretaker providing services to or employed by the health care facility, whether within the health care facility or at a location outside of the health care facility.

You or your child's records cannot be released to any other individual or agency without your written consent. However, certain information about suspected child or dependant adult abuse may be released without your authorization to the Court and to the Guardian Ad Litem when applicable. Certain information about the suspected child or dependant adult abuse may also be released without your authorization under the following legal circumstances: in the event of a legitimate subpoena for a court appearance, in the event of a medical emergency, or for auditing purposes to review records for program effectiveness.

____
Client Signature/Date

____
Guardian Signature/Date

____
Agent Signature/Date

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Client Name:____________________
DOB:____________________

ACKNOWLEDGEMENT OF RECEIPT OF PROVIDER'S NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

I, ____________________________ acknowledge that I have received a copy of the *Notice of Privacy Practices*
(Client and Guardian names)
that summarizes the ways my identifiable health information may be used and disclosed by this provider, and also states my rights with respect to my medical information. I understand that this provider has the right to revise and to amend the *Notice of Privacy Practices*. I have been informed that in the event this provider revises the *Notice of Privacy Practices*, a revised *Notice of Privacy Practices* will be posted at Life Connections, L.C. at 1953 1st AVE SE, STE A6, Cedar Rapids, IA 52402, and that I may obtain a current notice at any time from Life Connections, L.C. I also acknowledge that I have received a copy of the *Client Rights* that details the ways I will be treated by Life Connections, L.C. employees.

____
Client Signature/Date

____
Guardian Signature/Date

____
Agent Signature/Date

CONSENT FOR TREATMENT

I hereby give my consent for evaluation/treatment to be administered to ______________________________by
(Client name)
the employees of Life Connections, L.C. with or without my presence. I understand that if I do not revoke my *Consent for Treatment*, it will expire automatically one year from the date of signature.

____
Client Signature/Date

____
Guardian Signature/Date

____
Agent Signature/Date

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DOB:____________________

CONSENT FOR MOTOR VEHICLE TRANSPORTATION

I herby give my consent for employees of Life Connections, L.C. to transport ____________________ in a
(Client name)
motor vehicle without my being in attendance. I understand that I can revoke my *Consent for Motor Vehicle Transportation* at any time. I understand that if I do not revoke my *Consent for Transportation*, it will expire automatically one year from the date of signature.

____
Client Signature/Date

____
Guardian Signature/Date

____
Agent Signature/Date

CLIENT GRIEVANCE PROCEDURE

The purpose of the *Client Grievance Procedure* is to allow you, as the client or guardian of the client, the opportunity for recourse should there be unhappiness with the services provided or decisions made.

Life Connections, L.C. views your complaint as an opportunity to resolve differences. The following procedures are available to assist you in resolving your complaint.

Upon initial complaint, a supervisor will conduct a preliminary investigation, and, if deemed necessary by the supervisor, or at your request, a meeting will be held with you, your worker from Life Connections, L.C, and your worker's supervisor. The purpose of this meeting will be to resolve any dispute, if possible. If the outcomes of the meeting are unsuccessful, Life Connections, L.C. will arrange for an owner of Life Connections, L.C. to hear and to further address your grievance.

____
Client Signature/Date

____
Guardian Signature/Date

____
Agent Signature/Date

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Client Name:____________________
DOB:____________________

AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT:______________________________________DOB:_____________________
ADDRESS:___________________________City:__________State:_________Zip:______
PHONE:____

Parent/Guardian/Eligible Client: Your signature on this *Authorization for Release of Information* will give the individuals, programs, and organizations listed on Page 2 of this *Authorization for Release of Information* permission to exchange the information indicated on Page 2 of this *Authorization for Release of Information*. This release is strictly for information related to mental health and/or substance abuse and is limited to the extent indicated on Page 2 of this *Authorization for Release of Information.*

I understand that I may choose to sign a separate *Authorization for Release of Information* for the purpose of keeping the individuals, organizations, or programs listed on Page 2 of this release confidential. ______ (initial)

The purpose for this disclosure is to facilitate effective treatment service coordination. A photocopy or exact reproduction of this *Authorization for Release of Information* for the release of information shall have the same effect as the original.
I understand that I may revoke this *Authorization for Release of Information* at any time, except to the extent that information has already been released as authorized, by giving written notice to Life Connections, L.C.
I understand that I have the right to review the disclosed information by contacting Life Connections, L.C.
Once this *Authorization for Release of Information* has expired, or has been revoked, it can be renewed only by proper execution of another *Authorization for Release of Information*. I acknowledge that information to be released may include material that is protected by state and/or federal law, including applicable mental health, alcohol/drug abuse, and/or HIV/AIDS information.
I understand that information authorized by this consent cannot be released to anyone other than those listed on Page 2 of this release unless I give written permission.

____
Client Signature/Date

____
Guardian Signature/Date

____
Agent's Signature/Date

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Revised 1-27-2010

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I understand my rights related to this exchange of information. As per the conditions described on Page 1 of this *Authorization for Release of Information,* I consent Life Connections, L.C. to RELEASE INFORMATION TO, SECURE INFORMATION FROM, OR EXCHANGE INFORMATION WITH the individuals, programs, and organizations listed below (From #1 through _______ (enter number).

____ ____

Signature of Parent,/Guardian/ Eligible Client **Date**

1. Name:	2. Name:
Agency/Relationship:	Agency/Relationship:
Address: ______________________________ ______________________________ ______________________________	Address: ______________________________ ______________________________ ______________________________
Phone:	Phone:
Fax:	Fax:
Life Connections, L.C. is permitted to exchange the following information with the entity listed above. This authorization will expire one year from the date of signature unless otherwise specified: _________ ☐ Diagnosis Assessment ☐ Termination/Treatment Summary ☐ Evaluation/Testing Results ☐ Substance Abuse Treatment ☐ Mental Health Treatment ☐ Case Coordination ☐ Ongoing Services ☐ Other (specify) ____________________	Life Connections, L.C. is permitted to exchange the following information with the entity listed above. This authorization will expire one year from the date of signature unless otherwise specified: _________ ☐ Diagnosis Assessment ☐ Termination/Treatment Summary ☐ Evaluation/Testing Results ☐ Substance Abuse Treatment ☐ Mental Health Treatment ☐ Case Coordination ☐ Ongoing Services ☐ Other (specify) ____________________
3. Name:	4. Name:
Agency/Relationship:	Agency/Relationship:
Address: ______________________________ ______________________________ ______________________________	Address: ______________________________ ______________________________ ______________________________
Phone:	Phone:
Fax:	Fax:
Life Connections, L.C. is permitted to exchange the following information with the entity listed above. This authorization will expire one year from the date of signature unless otherwise specified: _________ ☐ Diagnosis Assessment ☐ Termination/Treatment Summary ☐ Evaluation/Testing Results ☐ Substance Abuse Treatment ☐ Mental Health Treatment ☐ Case Coordination ☐ Ongoing Services ☐ Other (specify) ____________________	Life Connections, L.C. is permitted to exchange the following information with the entity listed above. This authorization will expire one year from the date of signature unless otherwise specified: _________ ☐ Diagnosis Assessment ☐ Termination/Treatment Summary ☐ Evaluation/Testing Results ☐ Substance Abuse Treatment ☐ Mental Health Treatment ☐ Case Coordination ☐ Ongoing Services ☐ Other (specify) ____________________
5. Name:	6. Name:
Agency/Relationship:	Agency/Relationship:
Address: ______________________________ ______________________________ ______________________________	Address: ______________________________ ______________________________ ______________________________
Phone:	Phone:
Fax:	Fax:
Life Connections, L.C. is permitted to exchange the following information with the entity listed above. This authorization will expire one year from the date of signature unless otherwise specified: _________ ☐ Diagnosis Assessment ☐ Termination/Treatment Summary ☐ Evaluation/Testing Results ☐ Substance Abuse Treatment ☐ Mental Health Treatment ☐ Case Coordination ☐ Ongoing Services ☐ Other (specify) ____________________	Life Connections, L.C. is permitted to exchange the following information with the entity listed above. This authorization will expire one year from the date of signature unless otherwise specified: _________ ☐ Diagnosis Assessment ☐ Termination/Treatment Summary ☐ Evaluation/Testing Results ☐ Substance Abuse Treatment ☐ Mental Health Treatment ☐ Case Coordination ☐ Ongoing Services ☐ Other (specify) ____________________

Potential releases: parent(s) if a guardian signs, doctor, therapist, psychiatrist, extended family members, school, daycare, DHS, CMH, Juvenile Court, respite, foster care, or anywhere you might drop off/pick up/meet with a client.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

3839 Merle Hay Road Suite 270
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NOTICE OF PRIVACY PRACTICES

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

If you have any questions about this *Notice of Privacy Practices*, please contact our Human Resources Office at (319) 366-0453.

This Notice of Privacy Practices describes how we may use and disclose your protected information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected information. "Protected information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED INFORMATION

Your protected information may be used and disclosed by your provider, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected information may also be used and disclosed to pay your health care bills and to support the operation of your provider's practice.

Following are examples of the types of uses and disclosures of your protected information that your provider's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office. Treatment: We will use and disclose your protected information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected information, as necessary, to a home health agency that provides care to you. We will also disclose protected information to other providers who may be treating you. For example, your protected information may be provided to a provider to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you. In addition, we may disclose your protected information from time-to-time to another provider or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your provider, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your provider. **Payment:** Your protected information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected information be disclosed to the health plan to obtain approval for the hospital admission. **Health Care Operations:** We may use or disclose, as needed, your protected information in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected information, we will have a written contract that contains terms that will protect the privacy of your protected information.

We may use or disclose your protected information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your provider, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object
We may use or disclose your protected information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include: **Required By Law:** We may use or disclose your protected information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures. **Public Health:** We may disclose your protected information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability. **Communicable Diseases:** We may disclose your protected information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition. **Health Oversight:** We may disclose protected information to a health oversight agency for activities authorized by law, such as audits,

investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws. **Abuse or Neglect:** We may disclose your protected information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws. **Food and Drug Administration:** We may disclose your protected information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required. **Legal Proceedings:** We may disclose protected information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process. **Law Enforcement:** We may also disclose protected information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred. **Coroners, Funeral Directors, and Organ Donation:** We may disclose protected information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected information may be used and disclosed for cadaveric organ, eye or tissue donation purposes. **Research:** We may disclose your protected information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected information. **Criminal Activity**: Consistent with applicable federal and state laws, we may disclose your protected information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected information if it is necessary for law enforcement authorities to identify or apprehend an individual. **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized. **Workers' Compensation:** We may disclose your protected information as authorized to comply with workers' compensation laws and other similar legally-established programs. **Inmates:** We may use or disclose your protected information if you are an inmate of a correctional facility and your provider created or received your protected information in the course of providing care to you.

Uses and Disclosures of Protected Information Based upon Your Written Authorization
Other uses and disclosures of your protected information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object
We may use and disclose your protected information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected information. If you are not present or able to agree or object to the use or disclosure of the protected information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected information. This means you may inspect and obtain a copy of protected information about you for so long as we maintain the protected information. You may obtain your medical record that contains medical and billing records and any other records that your provider and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

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Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected information. This means you may ask us not to use or disclose any part of your protected information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If your provider does agree to the requested restriction, we may not use or disclose your protected information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your provider. You may request a restriction by requesting the appropriate form from your provider.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your provider amend your protected information. This means you may request an amendment of protected information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Human Resources Office at (319) 366-0453 for further information about the complaint process.

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CLIENT RIGHTS

The following applies to all clients of our therapy and mental health services.

The client has the right:

A) to be treated with dignity, consideration and respect at all times;

B) to expect quality service provided by concerned, trained, professional and competent employees;

C) to expect complete confidentiality within the limits of the law, and to be informed about the legal exceptions to confidentiality, and to expect that no information will be released without the client's knowledge and written consent;

D) to a clear working contract in which business items, such as time of sessions, payment plans/fees, absences, access, emergency procedures, and third-party reimbursement procedures are discussed;

E) to a clear statement of the purposes, goals, techniques, rules of procedure and limitations, as well as the potential dangers of the services to be performed, and all other information related to or likely to affect the ongoing professional relationship;

F) to appropriate information regarding employee education, training, skills, license and practice limitations and to request and receive referrals to other clinicians when appropriate;

G) to full, knowledgeable, and responsible participation in the ongoing treatment plan to the maximum extent feasible;

H) to obtain information about case records and to have this information explained clearly and directly;

I) to request information and/or consultation regarding the conduct and progress of services:

J) to refuse any recommended services and to be advised of the consequences of these action;

K) to a safe environment free of emotional, physical and sexual abuse;

L) to a client grievance procedure, including requests for consultation and/or mediation, and to file a complaint with a supervisor, and/or the appropriate credentialing body; and

M) to a clearly defined ending process, and to discontinue services at any time.

Adapted from AMHCA Code of Ethics 2002

Revised: 1-27-2010