Ability Health & Rehabilitation, LLC.

Patient Information

Name: _____
DOB: _____ SSN: _____ Gender: _____
Address: _____
City: _____ State: _____ Zip code: _____
Phone: _____ Alternate Phone: _____

Parent/Guardian: _____
DOB: _____ SSN: _____ Gender: _____
Address: _____
City: _____ State: _____ Zip code: _____
Phone: _____ Alternate Phone: _____

Insurance

MEDICAID:

Medicaid Number: _____
Primary Care Physician: _____ Phone: _____
New clients that have not seen their PCP within the last 12 months for annual history and physical will be referred to their current PCP. For those clients that do not have a current PCP we will refer you to Idaho Department of Health and Welfare.

Insurance:

Provider Name: _____ Provider Phone: _____
Enrollee/ID#: _____ Co-Pay Amount: _____
Deductible Amount: _____ Eligibility Date: _____

Participant's Signature **Date**

Parent/Guardian Signature **Date**

Agency Staff Signature **Date**

MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights

Ability Health and Rehabilitation believes and supports the proposition that every Member has the right to:

- Receive information about Ability Health and Rehabilitation services, network practitioners and Member's rights and responsibilities.
- Be treated with respect and recognition of his or her dignity and right to privacy
- Participate with network practitioners in making decisions about his or her health care
- A candid discussion of appropriate or medically necessary treatment options for his or her condition.
- Voice complaints or appeals about Optum for the services provided by Optum
- Make recommendations regarding Optum's Member's rights and responsibilities policies
- Care that is considerate and that respects his or her personal values and belief systems
- Personal privacy and confidentiality of information
- Reasonable access to care regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability
- Have family members participate in treatment planning. Members over 12 years old have the right to participate in such planning.
- Individualized treatment, including:
    - Adequate and humane services regardless of the source(s) of financial support
    - Provision of services within the least restrictive environment possible
    - An individualized treatment or program plan
    - Periodic Review of the treatment plan or program
    - An adequate number of competent, qualified and experienced professional clinicians to supervise and carry out the treatment or program plan
- Participate in the consideration of ethical issues that may arise in the provision of care and services, including:
    - Resolving conflict
    - Withholding resuscitative services
    - Forgoing or withdrawing life-sustaining treatment
    - Participating in investigational studies or clinical trials
- Designate a surrogate decision-maker if he or she is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care

- Be informed, along with his or her family, of his or her Optum rights in a language they understand
- Choose not to comply with recommended care, treatment, or procedures and be informed of the potential consequences of not complying with the treatment recommendations
- Be informed of rules and regulations concerning his or her own conduct
- Be informed of the reason for any non-coverage determination, including the specific criteria or benefits provisions used in the determination
- Have decisions about the management based on behavioral health benefits Optum does not reward network practitioners or other individuals for issuing non-coverage determinations.
- Inspect and copy their protected health information (PHI) and in addition:
    - Request to amend their PHI
    - Request an accounting of non-routine disclosures of PHI
    - Request limitations on the use or disclosure of PHI
    - Request confidential communications of PHI to be sent to an alternate address or by alternate means
    - Make a complaint regarding use or disclosure of PHI
    - Receive a Privacy Notice
- Receive information about Optum's clinical guidelines and Quality Assurance and Performance Improvement (QAPI) program

Member Responsibilities

In addition to the rights listed above, every Member has the responsibility to:

- Supply information (to the extent possible), that Optum and its network practitioners need in order to provide care
- Follow plans and instructions for care that they have agreed on with his or her network practitioner
- Understand his or her health problems and participate in developing mutually agreed upon treatment goals to the degree possible
- Keep scheduled appointments and actively participate in treatment

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 session may include a comprehensive assessment of your 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; 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, Ability Health and Rehabilitation maintains an available 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 legal 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 office staff or to 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. Ability Health and Rehabilitation does NOT utilize encrypted email at this time.

Court Proceedings: The staff at Ability Health and Rehabilitation 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 conductive to healing. Please talk more with your therapist about this.

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. Ability Health and Rehabilitation 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 health 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 AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR THE PURPOSE 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 healthcare 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 services.

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 the 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 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, 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 AND 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 Ability Health and Rehabilitation. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

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, and 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 applies to past incidents of abuse or neglect.

BILLING/FEE INFORMATION

Payment: You may discuss your insurance coverage and fees with your insurance provider and/or Ability Health and Rehabilitations billing manager prior to your appointment and at any time thereafter. 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 cash or check.

Late Appointments: If you are more than 10 minutes late for your appointment, this will be considered a missed appointment. If at any time you have missed more than three scheduled appointments with Ability Health and Rehabilitation will send a referral for you to seek services with another provider.

Cancellation Policy: Ability Health and Rehabilitation has a 24 hour cancellation policy. If there is any reason that you need to reschedule/cancel your scheduled appointment please call Ability Health and Rehabilitation at 208-333-9578. Ability Health and Rehabilitation will send referrals for clients to seek services from another provider once the client has accumulated three missed appointments without proper 24 hour notice.

ACKNOWLEDGEMENT OF LIABILITY

As the Client/Legal Guardian who is currently receiving services through Ability Health and Rehabilitation, 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 Ability Health and Rehabilitation, 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 may cause physical harm and/or property damage. I agree to make full restitution for documented damages to either personal property 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.

CLIENT GRIEVANCE PROCESS

In the event that a client feels services are not to their expectations, we encourage a quick and mutual resolution 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 staff 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 Ability Health and Rehabilitation staff members. The provider 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, any member of Ability Health and Rehabilitation management team at (208) 333-9578, concerning an issue or complaint. If it is concerning an issue or complaint. The program manager will then make necessary decisions to resolve the issue with the client as soon as possible, however, contact with the complainant will be within 5 business days and a plan for resolution will be presented within 10 business days.

Option 3: Should be acceptable resolution not be forged to the satisfaction of the client; they are encouraged to contact the Idaho Department of Health and Welfare, for their region or the state licensing board where appropriate. It is understood the state authority will contact the provider to inform them of the complaint. A resolution will be presented with a reasonable amount of time. This resolution can be accepted or rejected by either party; client and provider. Additionally, you may appeal this decision through normal contested case procedures.

Protection & Advocacy
Region IV IDHW
Office
1720 Westgate Drive,
STE A
Boise, ID 83704
208-334-0808

Region III IDHW
Office
3402 Franklin Rd
Caldwell, Idaho 83605
208-459-0092

IBOL
PO Box 83720
Boise, Idaho 83720-0063
208-334-3233

PROVIDER DESIGNATION

I acknowledge I have been informed there are other agencies which provide outpatient behavioral health services available with Idaho Regions III and IV. To obtain a list of other providers in the surrounding area, please contact IDHW at 2-1-1.

As the Client or Legal Guardian, I have chosen Ability Health and Rehabilitation as the provider for me/my child. This authorizes Ability Health and Rehabilitation to initiate an assessment of mine/my child's needs. If it is determined the identified client would benefit from treatment, Ability Health and Rehabilitation will begin the treatment planning process and therapy. Medical necessity is a requirement to receive services. If medical necessity criteria have not been met Ability Health and Rehabilitation will make appointment referrals.

This agreement will remain in place unless a written 30 day notification is submitted from Ability Health and Rehabilitation or at any point from the client/client's guardian.

PARENTAL CONSENT TO TREAT CHILDREN

We at Ability Health and Rehabilitation 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 engaged in the treatment of their child.

EMERGENCY MEDICAL CONSENT

As the Client/Legal Guardian, I do 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 Ability Health and Rehabilitation.

It is understood that an effort shall be made to reach all the contacts on file prior to rendering treatment, but if contacts cannot be reached, I give permission to Ability Health and Rehabilitation to provide the necessary care, at my expense for me or my child's wellbeing.

It is understood that, Ability Health and Rehabilitations Acknowledgement of Forms Received that I am also releasing Ability Health and Rehabilitation from any liability from any acts or omissions by them.

CONSENT FOR TRANSPORTATION (CBRS ONLY)

I hereby give my consent for myself or my child to be transported in a vehicle driven by an employee of Ability Health and Rehabilitation during CBRS sessions. I understand that employees of Ability Health and Rehabilitation are required to have a valid driver's license and current insurance.

Ability Health & Rehabilitation, LLC.

Consent to Transport

I _____have agreed too and understand that my son/daughter _____ is receiving outpatient behavioral health services through Ability Health and Rehabilitation. These services may be conducted outside of the home at places, which are specifically states in the treatment plan.

- ☐ I grant _____ permission to transport my son/daughter to community areas that may be appropriate for treatment. I will provide provider with any required safety seats, as needed.
- ☐ I do not grant you permission to transport.

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

I have read and understood the following Ability Health and Rehabilitation Policies in regards to my health.

- ♥ Member Rights And Responsibilities
- ♥ Informed Consent To Treatment
- ♥ HIPAA Notice Of Privacy Practices
    - ♦ Limits Of Confidentiality
- ♥ Billing/Fee Information
    - ♦ Acknowledgement Of Liability
- ♥ Client Grievance Process
- ♥ Provider Designation
    - ♦ Parental Consent To Treat Children
    - ♦ Emergency Medical Consent
    - ♦ Consent For Transportation

Participant's Signature	**Date**
Parent/Guardian Signature	**Date**
Agency Staff Signature	**Date**

Ability Health and Rehabilitation
10101 W. Overland Rd. #110 Boise, ID 83709

Participant Consent to Obtain or Release of Information Disclosure Form

Participant Name: _____ DOB: _____

Address: _____ Phone: _____

- ☐ I hereby give _____ my authorization to disclose my protected health and/or personal information. Below describes the information that I am requesting you disclose to Ability Health and Rehabilitation_____.
- ☐ I hereby give Ability Health and Rehabilitation my authorization to obtain my protected health and/or personal information. Below describes the information that I am requesting you obtain from_____.

Specific description of information to be disclosed:

- ☐ Assessments ☐ Treatment Plans ☐ H&P
- ☐ Medication List Other: _____
- ☐ Exchange of Information regarding treatment
- ☐ In patient records: Dates: _____
- ☐ Reason: Continuity Of Care Expires on: _____

I understand that this authorization provides that:

- I have the right to access my protected health information to be used or disclosed.
- I may revoke this authorization at any time in writing to the address listed above.
- Information used or disclosed pursuant to this authorization may be subject to re-discloser by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition my treatment on my providing authorization for the requested use or disclosure.
- I will receive a copy of this completed and signed authorization form.

Participant/Legal Guardian Signature: _____Date: _____
Relationship to participant:_____
Agency Staff: _____Date: _____

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- This practice will not condition my treatment on my providing authorization for the requested use or disclosure.
- I will receive a copy of this completed and signed authorization form.

Participant/Legal Guardian Signature: _____Date: _____
Relationship to participant:_____
Agency Staff: _____Date: _____

Authorization for Release of Health Information

Individual's Full Name	Date of Birth	Member or Subscriber ID #

Individual's Street Address	City	State	Zip Code

I understand and agree that:

- this authorization is voluntary;
- my health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;
- this authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying Optum in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Who May Receive and Disclose my Information:

I authorize Optum and its affiliates to disclose my individually identifiable health information to the following person(s) or organization(s):

_____
(Full Name of Person(s) or Organization(s))

_____
(Full Address of Person(s) or Organization(s))

Type of Information to be Disclosed:

☐ I authorize disclosure of all my health information, including information relating to medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information; **or**

☐ I authorize only the disclosure of the following information:

_____
(Type of Information)

Purpose of Disclosure:

☐ My health information is being disclosed at my request or at the request of my personal representative; **or**

☐ My health information is being disclosed for the following purpose:

_____
(Explain Purpose)

****

_____ _____
Signature of Individual Date

_____ _____
Witness Signature *(For Illinois Residents Only)* Date

Please note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the member.

_____ _____
Signature of Individual's Representative Date

Personal Representative's:

_____ _____
Name Phone Number

_____ _____ __ _____
Street Address City State Zip Code

(*For California and Georgia residents only*) I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Idaho Department of Health & Welfare
Authorization for Disclosure

Please complete and return this form to a Department of Health and Welfare office.

Available in Spanish. We provide interpreter services at no cost. Call 2-1-1 or 1-800-926-2588 for interpretation assistance. Disponible en espanol. Proveemos servicios de intérprete sin costo alguno. Llame al 2-1-1 ó al 1-800-926-2588 para obtener la ayuda de un intérprete.

Client Information

Client Name_____ Date of Birth _____ Telephone_____
(First, MI, Last)

Mailing Address_____ State_____ Zip Code_____

Requestor Information
(To be completed if authorization is being made by someone other than the subject of the information. Please provide documentation of your authority).

Requestor Name (if different than client)_____ Telephone _____

Mailing Address_____ State_____ Zip Code_____

Authorization Details

I authorize the following individual, organization or business _____

_____

to disclose my confidential information to: Name_____

Address: _____ State_____ Zip Code_____

for the purpose of _____

*Please describe in detail the information to be disclosed*_____

_____

_____

_____

This authorization will expire in 6 months unless another date or event is specified here_____

_____

I understand that, at my request, a copy of the completed and signed authorization form will be made available to me. I understand that I may revoke this authorization in writing, at any time, except to the extent that action has been taken in reliance upon this authorization. I may submit my written statement of revocation to a Department of Health and Welfare office. I understand that the person or entity who receives my confidential information may not be required to prevent unauthorized use or disclosure.

I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of my treatment including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV infection, alcohol and/or drug abuse and mental health conditions.

I understand that my signature on this form is not required for treatment, payment, enrollment, or eligibility for benefits, and that a copy of this authorization shall be as valid as the original.

Your signature_____ **Date** _____

Your signature must be notarized if you submit this request by fax, mail or e-mail and we cannot verify it with information already on file.