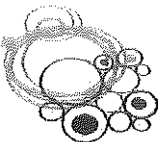


Full Circle Therapy Center, LLC
Phone: 712-352-0917 Fax: 712-352-0837
Primary Office Location: 803 3rd Avenue, Council Bluffs, Iowa 51501
Atlantic Office: 808 E. 7th Street, Atlantic, Iowa 50022 Logan Office: 313 E. 7th Street Ste. 1, Logan, Iowa 51546
Des Moines Office: 4685 Merle Hay Road Ste. 205, Des Moines, Iowa 50322
Iowa City Office: 332 S. Linn Street Ste. 7, Iowa City, Iowa 52240

Authorization for the Release of Information

____
Client Name

____
Address, City, State, Zip Code, Phone

I authorize Full Circle Therapy Center, LLC to: Release to, Secure from, Or Exchange with:
Name: __Availity______________________
Address: ______________________________
Phone/Fax: ____________________________

The information being requested or released from the above agency/individual includes:

Treatment/Progress Notes	History and Physical	Educational/School Reports
Planning & Coordinating	Diagnostic	_X_ Other (Specify)
Lab/Testing Results	Evaluation/Assessment	**Billing** __________
Case Consultation	Termination/Treatment Summary	

*The purpose of this disclosure is to facilitate effective treatment service coordination.
*I understand this authorization may be revoked at any time, except to the extent that information has already been released prior to the authorization that has been revoked. If I decide to revoke an authorization, a written and dated notice must be given to Full Circle Therapy Center, LLC. Unless otherwise revoked, this authorization will expire at the end of one year from the date of signature. *I acknowledge and understand that I am waiving my rights to confidentiality and hereby release Full Circle Therapy Center, LLC from any and all liability arising from release of information and records requested.
*I understand that information authorized by this consent cannot be released to anyone other than those listed above unless I give written permission.
*I understand that authorizing the disclosure of information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to receive treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may no longer be protected by federal confidentiality laws. If I have any questions about disclosure of my information, I can contact Full Circle Therapy Center, LLC at (712)352-0917.

______________________________________ ____________________
Signature-Client/Partner/Parent/Legal Guardian Date

X This information has been disclosed to you from records which may be 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.

Specific Authorization for Release of Information protected by State or Federal Law:

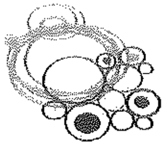
I hereby specifically authorize the release of data and information relating to: (Circle Y/Yes or N/NO)

Y N HIV/AIDS (Y) N Mental Health info Y N Substance Abuse info

______________________________________ ____________________
Signature-Client/Partner/Parent/Legal Guardian Date

______________________________________ ____________________
Signature-Therapist/Provider Date

Rev 11/2021



Full Circle Therapy Center, LLC

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Primary Office Location: 803 3rd Avenue, Council Bluffs, Iowa 51501

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Authorization for the Release of Information

____

Client Name

____

Address, City, State, Zip Code, Phone

I authorize Full Circle Therapy Center, LLC to: Release to, Secure from, Or Exchange with:

Name: _ICANotes___________________________________

Address: ______________________________________

Phone/Fax: ____________________________________

The information being requested or released from the above agency/individual includes:

Treatment/Progress Notes	History and Physical	Educational/School Reports
Planning & Coordinating	Diagnostic	_X_ Other (Specify) • **EHR System**
Lab/Testing Results	Evaluation/Assessment	
Case Consultation	Termination/Treatment Summary	

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I hereby specifically authorize the release of data and information relating to: (Circle Y/Yes or N/NO)

Y N HIV/AIDS Y N Mental Health info Y N Substance Abuse info

____ ____________________

Signature-Client/Partner/Parent/Legal Guardian Date

____ ____________________

Signature-Therapist/Provider Date

Rev 11/2021

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Authorization for the Release of Information

____

Client Name

____

Address, City, State, Zip Code, Phone

I authorize Full Circle Therapy Center, LLC to: Release to, Secure from, Or Exchange with:

Name: IOU Billing ______________________

Address: ______________________

Phone/Fax: ______________________

The information being requested or released from the above agency/individual includes:

Treatment/Progress Notes	History and Physical	Educational/School Reports
Planning & Coordinating	Diagnostic	X Other (Specify) •Billing
Lab/Testing Results	Evaluation/Assessment	
Case Consultation	Termination/Treatment Summary	

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Y N HIV/AIDS (Y) N Mental Health info Y N Substance Abuse info

______________________________________ ______________

Signature-Client/Partner/Parent/Legal Guardian Date

______________________________________ ______________

Signature-Therapist/Provider Date

Rev 11/2021

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Authorization for the Release of Information

Client Name

Address, City, State, Zip Code, Phone

I authorize Full Circle Therapy Center, LLC to: Release to, Secure from, Or Exchange with:

Name: Dr.

Address: ______________________

Phone/Fax: ______________________

The information being requested or released from the above agency/individual includes:

Treatment/Progress Notes	_X_ History and Physical	Educational/School Reports
Planning & Coordinating	Diagnostic	_X_ Other (Specify)
Lab/Testing Results	Evaluation/Assessment	•**Courtesy Letter**
_X_ Case Consultation	Termination/Treatment Summary	

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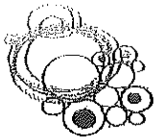
Signature-Client/Partner/Parent/Legal Guardian Date

Signature-Therapist/Provider Date

Rev 01/2022



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Authorization for the Release of Information

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Client Name

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Address, City, State, Zip Code, Phone

I authorize Full Circle Therapy Center, LLC to: Release to, Secure from, Or Exchange with:
Name: ______________________________
Address: ______________________________
Phone/Fax: ______________________________

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Treatment/Progress Notes	History and Physical	Educational/School Reports
Planning & Coordinating	Diagnostic	Other (Specify) • ________
Lab/Testing Results	Evaluation/Assessment	________
Case Consultation	Termination/Treatment Summary	

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Y N HIV/AIDS Y N Mental Health info Y N Substance Abuse info

______________________________ ______________
Signature-Client/Partner/Parent/Legal Guardian Date

______________________________ ______________
Signature-Therapist/Provider Date

Rev 11/2021

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Phone: 712-352-0917 Fax: 712-352-0837

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Iowa City Office: 332 S. Linn Street Ste. 7, Iowa City, Iowa 52240

Informed Consent and Privacy Policy

Please read and sign at the end stating you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

AVAILABLE SERVICES: Full Circle Therapy Center, LLC offers a wide array of counseling services, including individual, family, couples, and group services. We are staffed by skilled and experienced licensed professional counselors. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

THERAPY: We provide short-term (short term/long term) therapy designed to address many of the issues our clients are dealing with. Sessions might be conducted in person (face-to-face) or via telehealth. All consents, regulations, policies, laws and ethical standards outlined in this paperwork also apply to telehealth sessions. Your first visit will be an assessment session in which you and your Therapist will determine your concerns, and if both agree that Full Circle Therapy Center, LLC can meet your therapeutic needs, develop a plan of treatment (which includes a variety of modalities which you and your therapist will discuss). Should you choose not to follow the plan of treatment provided to you by your Therapist, services to you may be terminated.

The goal of Full Circle Therapy Center, LLC is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current Therapist are not a good fit, please discuss this matter with your Therapist to determine if transferring to a more suitable Therapist is right for you. If you and your Therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your Therapist. If you must cancel or reschedule your appointment, we ask that you call your therapists direct line which is provided at the initial session, at least 24 hours in advance, whenever possible. This will free your appointment time for another client. I agree to allow Full Circle Therapy Center, LLC. provider to transport myself/child to and/or from therapy sessions or support services if necessary.

FEE SCHEDULE: Private Pay and Sliding Fee Scales are available. Ask your provider for these details. A reasonable fee will be charged for copies of any records requested by the Client. If any out of pocket expenses occur, you will be responsible for the remaining balance. Three no-shows will result in termination of services. A referral will be given at that time.

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact our office regarding the nature and urgency of the circumstances. We will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However,

we will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours or on a weekend, your Therapist's cell number will be given to you in the initial session. Please utilize this number in the event of a serious crisis, and your Therapist will call you back as soon as possible. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. When your Therapist is out of town, you will be advised and given the name of an on-call Therapist.

CRISIS PLAN: If ______________ is experiencing a crisis they are to utilize self-soothing techniques 1) ______________ 2) ______________ Or call your natural support system of: 1) ______________ 2) ______________. If your self-soothing techniques fail and contact cannot be made with your natural support system, then contact your therapist or dial 911 or go to the nearest emergency room. **Client/Parent initials agreeing to plan** ________

CONFIDENTIALITY: Full Circle Therapy Center, LLC follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/ HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

CELL PHONE POLICY: Full Circle Therapy Center, LLC has an office phone with a voice mail system. Messages that are left on that voice mail are confidential. If there is an emergency or crisis, then you need to hang up and call 911 or go to the closest hospital.

It is up to the staff if they want to give out their cell phone numbers. If they choose to give out their cell phone numbers, then these numbers must be respected. If you call a staff's cell phone it is not guaranteed that they will answer the call. Cell phones should be looked at as a means to get a quick message to a staff person, but not to necessarily expect a return call or a conversation. If there is a crisis or emergency, then you need to hang up and call 911 or go to the closest hospital.

COMMUNICATION: Full Circle can communicate with you through the following: email, text, cell phone, work phone, primary phone, Fax and other social media avenues. Full Circle cannot guarantee complete confidentiality with these means of communication. It is the client's responsibility to let the provider know if they don't approve of these forms of communication and to also inform the provider if contact information changes.

DUTY TO WARN/DUTY TO PROTECT: If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name	Telephone Number
______________	______________
______________	______________

Full Circle Therapy Center, LLC

PAYMENT/ INSURANCE FILING: Payment of fees, including any required co-pays, is expected at the time of each appointment. We request that payment be made before your session begins. If you are using insurance benefits, Full Circle Therapy Center, LLC will file insurance claims for you, and we will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are not using a Managed Care/ PPO/HMO insurance plan and wish to file your own claim, we expect full payment at the time of service, and we will provide you with a statement for services rendered. Furthermore, I SPECIFICALLY AUTHORIZE disclosure and re-disclosure of this confidential information to my insurance carrier. Furthermore, I SPECIFICALLY AUTHORIZE the provider to use this form as approval authorizing payment of medical benefits to the undersigned as outlined on HCFA-1500 blocks 12 & 13. I understand that I have the right to inspect the disclosed information at any time.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I authorize and request Full Circle Therapy Center, LLC to perform an LPHA Behavioral Health Clinical Assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Full Circle Therapy Center, LLC will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.

Client Informed Consent Regarding Provisional/Non-Credentialed Practitioners

Specifics regarding supervision as it relates to the clients: During the course of treatment you might be under the care of a provisional/non-credentialed therapist, which means a license to practice marital and family therapy or mental health counseling under direct supervision of a qualified supervisor as determined by the Iowa board by rule to fulfill the postgraduate supervised clinical experience requirement in accordance with state requirements. You have the right to refuse to be treated by a provisional/non-credentialed therapist. **Methods of supervision (taping, case consultation, etc.) and who will be involved:** The type of supervision to be used during your treatment will be direct observation where the supervisor will be sitting in on session, case presentation during individual and group supervision, and taped sessions at the discretion of the supervisor. The supervisor and other agency clinicians will be involved in case presentations.

We/ I, the undersigned [redacted] parent(s) and/or guardian(s) of a minor child [redacted] give you full and unconditional authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me/ us as parent(s) and/ or guardian(s) of said child. We/ I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child. I understand that it is my responsibility to inform the other parent as deemed necessary by any and all legal custody arrangements. Furthermore, I understand that as the parent/guardian who is initiating services, I am the party responsible for fees associated with my child's account. It is clearly understood that you are hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that your duties are performed with standard care and responsibility to the best of your professional ability.

This authorization is in effect for the duration of my treatment following the date it is signed.

[redacted] [redacted]

Signature-Client/Partner/Parent/Legal Guardian Date

Signature-Therapist/Provider Date

Full Circle Therapy Center, LLC

Phone: 712-352-0917 Fax: 712-352-0837
Primary Office Location: 803 3rd Avenue, Council Bluffs, Iowa 51501
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Iowa City Office: 332 S. Linn Street Ste. 7, Iowa City, Iowa 52240

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 THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors, clinical colleagues or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Full Circle Therapy Center, LLC

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

*Abuse and Neglect *Judicial and Administrative Proceedings *Emergencies *Law Enforcement *National Security *Public Safety (Duty to Warn) *Health Oversight *Public Health

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as state licensing boards or health department) Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to Full Circle Therapy Center, LLC. 803 3rd Avenue, Council Bluffs, IA 51501.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend (Change of Information).** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this Notice. o Electronic Transactions Standards.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing to Full Circle Therapy Center, LLC, 803 3rd Avenue, Council Bluffs, IA 51501, or with the Region VII, Office for Civil Rights, US Department of Health and Human Services, 601 E. 12th Street Rm 248, Kansas City, MO 64106. Voice Telephone: 816-426-7278 Fax: 816-426-3686 ml): 816-426-7065.

We will not retaliate against you for filing a complaint. The effective date of this Notice is

Full Circle Therapy Center, LLC

Phone: 712-352-0917 Fax: 712-352-0837
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Advance Directive Handout

What is an advance directive?
An advance directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions (if you are in a coma, for example). If you are admitted to the hospital, the hospital staff will probably talk to you about advance directives.

What is a living will?
A living will is one type of advance directive. It is a written, legal document that describes the kind of medical treatments or life-sustaining treatments you would want if you were seriously or terminally ill. A living will doesn't let you select someone to make decisions for you.

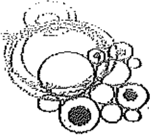
What is a durable power of attorney for health care?
A durable power of attorney (DPA) for health care is another kind of advance directive. A DPA states whom you have chosen to make health care decisions for you. It becomes active any time you are unconscious or unable to make medical decisions. A DPA is generally more useful than a living will. But a DPA may not be a good choice if you don't have another person you trust to make these decisions for you.

What is a do not resuscitate order?
A do not resuscitate (DNR) order is another kind of advance directive. A DNR is a request not to have cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing. (Unless given other instructions, hospital staff will try to help all patients whose heart has stopped or who have stopped breathing.) You can use an advance directive form or tell your doctor that you don't want to be resuscitated. In this case, a DNR order is put in your medical chart by your doctor. DNR orders are accepted by doctors and hospitals in all states.

Should I have an advance directive?
By creating an advance directive, you are making your preferences about medical care known before you're faced with serious injury or illness. This will spare your loved ones the stress of making decisions about your care while you are sick. Any person 18 years of age or older can prepare an advance directive.
People who are seriously or terminally ill are more likely to have an advance directive. For example, someone with terminal cancer might write that he/she does not want to be put on a respirator if he/she stops breathing. This action can reduce his/her suffering, increase his/her peace of mind and increase his/her control over his/her death. However, even if you are in good health, you might want to consider writing an advance directive. An accident or serious illness can happen suddenly, and if you already have a signed advanced directive, your wishes are more likely to be followed.

How can I write an advance directive?
You can write an advance directive in several ways: *-Use a form provided by your doctor. -Write your wishes down by yourself. -Call your health department or state department on aging to get a form. -Call a lawyer. -Use a computer software package for legal documents.*
Advance directives and living wills do not have to be complicated legal documents. They can be short, simple statements about what you want done or not done if you can't speak for yourself. When you are satisfied with your directives, the orders should be notarized if possible, and copies should be given to your family and your doctor.

Can I change my advance directive?
You may change or cancel your advance directive at any time, as long as you are able to think rationally and communicate your wishes in a clear manner. Again, your changes must be made, signed and notarized according to the laws in your state. Make sure that your doctor and any family members who knew about your directives are also aware that you have changed them.



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Receipt and Acknowledgment of Privacy Practices

Client Name: ______________________________

DOB: ______________________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Full Circle Therapy Center, LLC Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can write to: Full Circle Therapy Center, LLC, 803 3rd Avenue, Council Bluffs, IA 51501.

______________________________ ______________________

Signature-Client/Partner/Parent/Legal Guardian Date

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).____

____

____

______________________________ ______________________

Signature-Therapist/Provider Date

Client/Parent/Legal Guardian Refuses to Acknowledge Receipt

Receipt of Mental Health Advance Directive Information Sheet

I have received the mental health advance directive information sheet and my mental health provider has explained the intent and purpose of an advance directive. If I want further information regarding advance directives then I will seek assistance from a lawyer.

______________________________ ______________________

Client/Partner/Parent/Legal Guardian Date

______________________________ ______________________

Signature-Therapist/Provider Date

Client/Parent/Legal Guardian Refuses to Acknowledge Receipt

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Client's Rights and Responsibilities

Clients have the right to:

- To receive services without discrimination against race, religion, creed, ethnicity, gender, sexual orientation, economic status, handicap or disability.
- To receive services which respect the client's personal, religious, civil and political freedoms.
- To receive services that are free from intimidation, coercion, reprisal, harassment or punishment. ▪ To receive services without the approval of others, except in the case of minor children or adults under guardianship as prescribed by law.
- To receive services whenever identified services are available and without arbitrary transfer or discharge.
- To receive services in an environment that promotes dignity and self-respect.
- To receive services that are provided in a safe, secure environment that is free from known healthy and safety hazards.
- To consent to services and to receive services that are free from involuntary treatment, unless the client has been involuntarily committed by appropriate court order or in cases of Protective Custody.
- Full Circle Therapy Center, LLC has the obligation to inform the courts, probation officer, parole office, Board of Mental Health or the referring party of a client's lack of attendance and compliance with services referred by one of the aforementioned entities. ▪ To receive services that are free from any restraint or form of punishment.
- To receive services that are free from any abuse, neglect or seclusion.
- To receive services without misappropriation of money and/or personal property.
- To receive advance orientation to the program in which services are requested or to be provided. ▪ To be informed prior to or at the time of admission of any charges, fees, expected payment or related expenses for care and/or treatment.
- To participate by means of direct involvement and self-determination in service planning and decision making and to include appropriate family members or guardians in this planning. ▪ To be informed, in advance, about any changes in care or treatment that might affect the client's well-being.
- To refuse treatment or services, unless the treatment or service is court ordered, required by law or Board of Mental Health.
- To receive appropriate referrals for services whenever requested, recommended or indicated. ▪ To emergency support.
- To request and receive information about the therapist's professional capabilities, including licensure, education, training, expertise, membership in professional associations, specialized areas of practice and limitations on practice.

Full Circle Therapy Center, LLC reserves the right to deny services for any or all of the following reasons: the level of care referred is inappropriate, there is a conflict of interest or potential for a conflict of interest, etc. In the event that any of the aforementioned occurs, Full Circle Therapy Center, LLC will make every effort to provide the referral source and/or the client other resources/providers in the community.

Clients have the right to confidentiality (unless waived by a custodial parent, guardian or mandated by law) including:

- Clients have the right to expect that their records are kept confidential (see privacy practices).
- Clients have the right to review their records in the presence of Full Circle Therapy Center, LLC personnel. Such reviews must be done on agency premises.
- When the client is a minor, the specific content of the sessions between the minor and service provider will remain confidential. The minor has the right to request that the information about his/her treatment/service provision not be shared with the parent/guardian, referral source or probation officer.

Full Circle Therapy Center, LLC

Confidentiality Clarification/Expectations:

Disclosure of Abuse/Endangerment: If the client discloses information that someone is being abused or endangered, Full Circle Therapy Center, LLC and its employees are required by law to report this information to Protective Services.

Duty to Warn: If a Full Circle Therapy Center, LLC employee believes that a client poses a threat to himself or others, Full Circle Therapy Center, LLC is ethically bound to disclose this information to the appropriate persons/agencies.

Court Subpoena of Records: It is within the power of the court system to subpoena client records from the agency and/or subpoena the Full Circle Therapy Center, LLC employee at which time confidentiality may not be guaranteed.

Client Release of Information: Client signs a release of information allowing a Full Circle Therapy Center, LLC employee to disclose information on their behalf to the individual/agency listed on the document.

Consultation: Full Circle Therapy Center, LLC employees are required to seek supervision of their cases as needed or requested by Full Circle Therapy Center, LLC staff. Review of video tapes of sessions may be used for training and/or supervision purposes but as stated earlier, this will not be done without the client's written consent.

Child Protective Services/Legal Guardian: If the referral for services came from an individual who has legal custody over the minor, the representative form this entity has the right to obtain any or all records in their position as the client's guardian.

Client Responsibilities
Full Circle Therapy Center, LLC expects clients to:

- Be considerate and respectful of the rights of fellow clients and staff.
- Be considerate and respectful of the property of fellow clients, staff and Full Circle Therapy Center, LLC
- Adhere to confidentiality with regard to other clients.
- Be cooperative and actively take part in identifying and resolving problems.
- Attend scheduled sessions, keep scheduled appointments and provide 24-hour notice when an appointment cannot be kept.
- Adhere to Full Circle Therapy Center, LLC smoking and drug free environment.
- Meet the financial obligations incurred for treatment services.

______________________________ Signature-Client/Partner/Parent/Legal Guardian

______________________________ Date

______________________________ Therapist/Provider Signature

______________________________ Date

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Medication Consent Form

____________________(prescribing provider or representative) has educated me regarding the medication that has been prescribed for me. I have been educated regarding the possible side effects of this medication, possible drug and/or food interaction that could occur, and the possible effects of this medication on a person who becomes pregnant. I have also been informed of the reason this medication has been prescribed.

If the person for whom the medication has been prescribed is under the age of eighteen (18) or is unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment on behalf of this person.

Client Name: ____________________

Client/Partner/Parent/Legal Guardian: ____________________

Therapist/Provider Signature: ____________________

Date: ____________________

- It is recommended that women who are or may become pregnant, or are breastfeeding, discuss this with their doctor before taking any medication.
- It is recommended that clients be educated on reporting all side effects they experience, including but not limited to, which side effects to report immediately to a health care provider.
- It is recommended that any provider prescribing medication obtain a thorough client history, including but not limited to:
  - What medication, including prescribed and over the counter medications, the client is or has been taking.
  - What food and/or drug allergies the client has.
  - What medical conditions the client has.

Current Medications:

Name of Medication	Daily Dosage	Authorizing Physician

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Description of Services

Therapy Services:

Therapy is an in-office service with the purpose of exploring and processing feelings, beliefs, perceptions, and attitudes that are leading to maladaptive behaviors and symptoms caused by the client's mental health diagnosis.
Our therapists specialize in various areas including: Parent Child Interaction Therapy (PCIT), Trauma Focused-Cognitive Behavior Therapy (TF-CBT), Play Therapy, Eye Movement Desensitization and Reprocessing (EMDR), and working with Children, Adolescents and Teens & Young Adults of Separated/Divorced Parents.

BHIS Services:

Behavior Health Intervention Services (BHIS) are home based services specifically designed to teach the skills needed to alleviate symptoms of many mental health disorders. BHIS is available at Full Circle Therapy for Children, Adolescents, and Teens.

BHIS utilizes a variety of methods to teach these skills (such as games, role play, coaching, demonstrating, instruction and giving feedback) and to help your family incorporate these skills into your daily life. The goal of BHIS services is to find the perfect "fit" for you and your family. Your BHIS provider will work with you to identify specific areas to be addressed and a personalized treatment plan to address the family's goals will be developed. Your BHIS provider will offer both individual and family sessions for your child and yourself.

Grievances and Appeals Process

Client or a person acting on a client's behalf has the right to ask at any time for information about policies or actions client does not understand. Client also has the right to appeal decisions or actions by Full Circle Therapy Center staff.

When client has a grievance or wish to appeal first follow these steps:

1. Try to resolve the issue by first speaking to the Full Circle Therapy Center staff involved.
2. If still unresolved, ask the next level of supervisory staff to schedule arbitration and attempt to resolve the issue. Supervisory staff will set up the arbitration within seven days of notification.
3. If the issue continues to be unresolved. Client may submit a formal appeal in writing to the supervisor. This written appeal must be received within seven days after the arbitration. Client, client's BHIS provider, or any third party may deliver the appeal.
    a. When client requests a formal appeal client needs to include the following statement: "I disagree with the (describe the decision or action) by Full Circle Therapy Center and wish to appeal."
    b. Include client's signature with this statement.
    c. If client is unable to write client's request to appeal, client may ask the Supervisor or another representative to help client with the process.
4. After consultation with the appropriate persons, supervisory staff will make a decision and notify client of that decision within ten working days.
5. If client is dissatisfied with that decision the client may next appeal to the CEO in writing.
6. Within ten working days of notification, the CEO will set a meeting to review Client's appeal.
    a. Client, client's BHIS service provider, or any third party that client has identified will be sent a written notice of the meeting date and time so that client, client's BHIS service provider, or any third party may attend.
    b. Failure to appear at the review meeting will void the appeal unless client notifies the administration before the hearing date.
    c. The CEO will determine a decision in five working days after the meeting and all parties will be notified in writing of the decision.
    d. If the issue continues to be unresolved then client has the right to seek legal counsel.

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Notice of Patient Being Seen

Date: ____________________

Dear: Dr. ________________________

This is a courtesy note to notify you that your patient, ____________________________, is now being seen for therapy and/or BHIS services by, ______________________________, a therapist/provider in our office. If you have any questions or require further information, please have the patient sign appropriate authorizations. Thank you for partnering with our agency in this matter.

Sincerely,

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Concerns Checklist

Please circle all the items below that you currently experience or are having difficulty with, and feel free to add any others at the bottom. You may add details as needed to clarify.

- Abortion
- Abuse – emotional
- Abuse – neglect
- Abuse – physical
- Abuse – sexual
- Addiction – gambling
- Addiction – prescription
- Addiction – sexual
- Addiction – street drugs
- Adoption
- Aggression – Temper
- Alcohol – use/abuse
- Ambition - Motivation
- Anger
- Anxiety
- Arguing
- Attention Problems
- Blended family
- Childhood issues
- Children – care of
- Children – custody
- Children – parenting
- Codependence
- Communication
- Compulsive spending
- Confusion
- Crying – sadness

- Deaths – grieving
- Debt
- Decision Making
- Dependence
- Depression
- Distractibility
- Divorce – separation
- Domestic Violence
- Education
- Employment problems
- Emptiness
- Exhaustion
- Failure
- Fatigue – low energy
- Fears – phobias
- Feeling helplessness/hopeless
- Gambling
- Gender Identity
- Guilt
- Physical Health – Illness
- Hearing Voices
- Hyperactivity
- Impulsiveness
- Indecision
- Inferiority Feelings
- Infertility
- Inhibitions

- Interpersonal conflicts
- Irresponsibility
- Irritability
- Judgment problems
- Laziness
- Legal maters
- Loneliness
- Loss of control
- Loss of interest in activities
- Low Income
- Low mood
- Marital problems
- Memory problems
- Menopause
- Menstrual problems
- Mixed feelings
- Mood swings
- Nail-biting
- Nervousness
- Nightmares
- Obsessions – compulsions
- Outbursts
- Oversensitive to criticism
- Oversensitive to rejection
- Panic or anxiety attacks
- Perfectionism
- Pessimism

- Poor self-care
- Procrastination
- Relationship problems
- Relaxation
- Risk-taking
- Running Away
- School problems
- Self-abuse – burning
- Self-abuse – cutting
- Self-abuse – pulling hair out
- Self-abuse – scratching
- Self-centeredness
- Self-control
- Self-esteem
- Sexual conflicts
- Shyness
- Sleeping problems
- Spirituality
- Stress – Tension-
- Suicidal Thoughts – Actions
- Suspiciousness
- Thought Disorganization
- Tobacco use – or vaping
- Violence – victim of crime
- Weight and diet issues
- Withdrawal – isolating
- Worry all the time