MRL
COUNSELING

New Client Intake Packet
Table of Contents

- ☐ PSR Participant Demographic Information
- ☐ HIPAA Privacy Statement
- ☐ Acknowledgement of Receipt of Privacy Notice
- ☐ Confidentiality Statement
- ☐ Authorization for Release of Confidential Information
- ☐ Authorization for Exchange of Confidential Information
- ☐ Consent to Treatment and Recipient's Rights
- ☐ Agreement to Accept Case Management, Rehabilitation, and/or Clinic Services and Informed Consent
- ☐ Recipient's Rights Notification
- ☐ Information on Services to be received
- ☐ Information on Benefits
- ☐ Financial Policy
- ☐ Complaint, Grievance and Appeal Rights

Psychosocial Rehabilitation Services:

- Alternative Forms of Services Available
- Choice of Providers
- Protection and Advocacy Information
- Risk Associated with Services
- Information on Legal Assistance
- Participant Rights Information

Get copies of ID and Insurance cards

Participant Demographic Information

PLEASE PRINT CLEARLY. THIS FORM MUST BE FILLED OUT COMPLETELY.

Client's Name (First & Last): _____

Address: _____ City: _____State: _____ Zip: _____

Phone: _____ [ ] Home [ ] Cell [ ] Other [ ] Add'l Phone: _____ [ ] Home [ ] Cell [ ] Other

Social Security #: ___ ___ ___-___ ___ - ___ ___ ___ ___Birthdate: _____/_____/_____ Age: _____Gender: [ ] F [ ] M

Race: _____ Preferred Language: _____

Name of Spouse

Guardian: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Is this person responsible for payment? [ ] Yes [ ] No If not, who is: _____

Signature of person responsible for payment: _____ (Must be signed for services to begin)

Emergency Information

In case of emergency, contact:

Name (1): _____ Relationship to client: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Name (2): _____ Relationship to client: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Add'l Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Current Medications: _____

_____

Allergies_____

Employment Information

(If client is a child, use parent/guardian's employment)

Place of employment: _____Phone: _____ Hrs: _____

Spouse's place of employment: _____Phone: _____ Hrs: _____

Insurance Information

Primary Insurance: _____

Phone: _____

ID #: _____

Group #: _____

Primary Insured: _____

Primary Insured's DOB: _____

Client's relationship to Primary Insured: [ ] Self [ ] Spouse [ ] Child [ ] Other: _____

Secondary Insurance: _____

Phone: _____

ID #: _____

Group #: _____

Primary Insured: _____

Primary Insured's DOB: _____

Client's relationship to Primary Insured: [ ] Self [ ] Spouse [ ] Child [ ] Other: _____

Referral Source

How did you hear about our clinic: _____

_____

HIPAA PRIVACY STATEMENT

Medicaid Provider Agreement 1.1-1.6

Notice of Privacy Practices
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUTYOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

1. The agency respects you and your privacy. We are committed to keeping all information received or created confidential.
2. We want you to have a clear understanding of how we use and safeguard information about you. This Notice of Privacy Practices describes how we may use and disclose your protected health information in order to carry out services, voucher for payment and for other purposes permitted or required by law. It also describes your rights to access and control your information.
3. We are required by law to maintain the privacy of your protected health information and to provide you with notice of the legal duties and privacy practices with respect to your protected health information.
4. Health information means any information, whether oral or recorded in any form, that is created or received by the agency, relates to the past, present or future physical, mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual.

How Your Protected Health Information May Be Used or Disclosed

1. The agency uses protected health information about you for services, payment and regular health care operation purposes. We do not require authorization to use your protected health information for these purposes.
   - **Services**
     Providing you with care and services related to your health, such as working with other agencies involved with the delivery of services.
   - **Payment**
     Information needed for billing, insurance, or compensation for services, if necessary. We may provide necessary portions of your protected health information to our billing department and to your health plan to get paid/reimbursed for the services we provide to you.
   - **Regular Health Care Operations**
     Activities that may include quality assessment, program evaluation and auditing.
   - **Emergency Care**
     To help you obtain treatment in a medical emergency. An authorization is required as soon as reasonably possible after the emergency and the provider should document the reasons as to why the authorization could not be received.
   - **When Legally Necessary**

a. If required by federal, state or local law. We may make disclosures when a law requires that we report information to government agencies or law enforcement personnel about victims of abuse, neglect, domestic violence or to avoid serious threat to health or safety of a person or the public.
b. We may provide protected health information to a family member, friend or other person that you indicate is involved in your services or the payment for your services unless you object, in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.
c. ALL OTHER USES AND DISCLOSURES REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION.

IN ADDITION, ANY ALCOHOL OR SUBSTANCE ABUSE RECORDSARE PROTECTED UNDER FEDERAL REGULATIONS GOVERNING CONFIDENTIALITY. (42CFR Part II)

ANY HIV RECORDS ARE PROTECTED UNDER PUBLIC HEALTH LAW GOVERNING CONFIDENTIALITY. (Article 27-F)

When the agency May Not Use or Disclose Your Health Information

1. Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights

1. You have the right to inspect and obtain a copy of your health information.
2. You have the right to request restrictions on certain uses and disclosures of your health information. We are not required to agree to the requested restriction.
3. You have a right to request that we amend your health information. An amendment can only be granted if the information requested to be amended is created by the agency.
4. You have a right to receive an accounting of disclosures.
5. You have a right to receive confidential communications of protected health information and the manner in which it is sent to you. Within reason, you have the right to ask that we send information to you at an alternate address (such as requesting that we send information to your work address rather than your home address) or by alternate means (such as by regular mail versus e-mail, if such methods are reasonably available).
6. You have a right to a paper copy of this Notice of Privacy Practices. You will be asked to sign an Acknowledgement of Receipt of this Notice.
7. You have a right to complain if you believe your privacy rights have been violated or if you are dissatisfied with the services you are receiving. You will not be punished in any way for filing a complaint. (Please refer to our Complaint Form for information regarding internal and/or external complaints.) The agency will provide you with any or all of the form(s) upon your request.

Changes to This Notice of Privacy Practices

1. We are bound by the terms of this notice currently in effect and reserve the right to amend this Notice of Privacy Practices at any time in the future. If such amendment is made, all individuals currently active in our programs will be provided are vised Notice of Privacy Practices by mail or at their next scheduled meeting.
2. If you have any questions regarding this notice or need further information please contact the Compliance Officer at .

By signing this form I verify that I have read, understood, received an explanation of the information listed above and provided copies of each. This was done pursuant to relevant language in IDAPA Code, the Medicaid Provider Agreement, and credentialing standards.

_____ _____

Client Signature / Guardian **Date**

_____ _____

Witness **Date**

Acknowledgement of Receipt of Privacy Notice

Client Name: First: _____ Last: _____ MI: _____

Federal privacy laws (HIPAA) require us to ask you to sign this form to acknowledge that you have received a copy of our privacy notice.

This Privacy Notice explains how your health information may be used and disclosed and your rights regarding access and restrictions of your health information.

By federal law, our Privacy Notice should be provided to you on your first date of service with us.

If your first date of service with us was due to an emergency, we must give your our Privacy Notice and ask you to sign this acknowledgement of receipt of the Privacy Notice as soon as we can after the emergency is over.

TO BE COMPLETED AND SIGNED BY THE CLIENT

[ ] I HAVE RECEIVED A Privacy Notice from MRL Counseling.

[ ] I HAVE been given the chance to discuss my concerns and questions about the privacy of my health information with a member of the staff at MRL Counseling.

By signing this form, you acknowledge that we have given you a copy of our Privacy Notice

_____ _____

Client Signature / Guardian **Date**

_____ _____

Witness **Date**

FOR INTERNAL USE ONLY

If the client does not agree to sign this acknowledgement form, a staff member must answer the following questions:

Did the client receive a copy of the Privacy Notice? [ ] Yes [ ] No

Why was the client unable to sign an acknowledgement form for the receipt of the Privacy Notice?

_____

What efforts were made to try to obtain the client's signature on the acknowledgement form?

_____

Confidentiality Statement

All Staff are obligated to respect your privacy. Your records and private conversations with our staff will be kept in strict confidence, even after you stop coming here for services. Others cannot see your records unless you agree in writing, or unless they law allows them to. However, because we are a state funded public agency, your name and basic identifying data are submitted to a computerized billing system for billing purposes. State auditors may also review your file in regard to billing and collection.

We are required to report a life endangering situation if it comes to our attention, and if ordered to do so under law, we are obligated by law to report any child sexual abuse, physical abuse, or neglect that is disclosed. We must warn others about threats you may make toward them. For additional detail on your privacy rights under HIPAA, please see the accompanying Notice of Privacy Practices.

I have read and understand the MRL Counseling Policy on confidentiality.

_____ _____

Client Signature / Guardian **Date**

_____ _____

Witness **Date**

Authorization for Release of Confidential Information

Program Participant Name: _____ D/O/B: _____

Other Names Used:

_____

I, _____, authorize MRL Counseling, PLLC (Agency) to

[ ] disclose to or [ ] to request from:

_____

The following information: [ ] All Health Records

Or, mark one or more of the following:

[ ] Comprehensive Medical Assessment
[ ] Psychological Evaluation
[ ] Medical Social Assessments
[ ] Developmental Therapy Progress Charts/Reports
[ ] Developmental Therapy Evaluation
[ ] Psychosocial Rehabilitation Reports
[ ] Vocational Reports
[ ] Person Centered Plans
[ ] Vocational Progress Information
[ ] Other (Specify) _____

The purpose or need for such disclosure:

[ ] Diagnosis and Treatment Plan [ ] Determining eligibility for services [ ] Discharge Plan
[ ] Other (Specify) _____

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. You have my additional authorization to release information that may pertain to mental health care or treatment and/or to alcohol, drug, or substance abuse. I understand that the information disclosed pursuant to this Authorization may potentially be re-disclosed by the recipient and may no longer be protected by state and federal privacy laws.

If an agency (e.g. probation, parole, etc.) has taken an action on my behalf which relies upon this release, I understand that I will abide by the stipulations of that action.

I also understand that I may revoke this consent in writing at any time, except to the extent that it has been relied upon by the Agency, by contacting the Agency at the address above. This consent automatically expires 6 months after my termination from the Agency program. I release the Agency from any or all responsibility and liability concerning the release of information I have consented to the above. I agree that a copy of this release may serve as the original.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out, and initialed it. **[ ] Yes [ ] No _____ Initials**

_____ _____

Client Signature / Guardian **Date**

_____ _____

Witness **Date**

This authorization will expire: _____ (insert date or event)

**** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ****

Authorization for Exchange of Confidential Information

Client's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Address: _____

A. The names of parties exchanging information:

I authorize:

MRL Counseling: Matthew Larson LCSW

4700 N. Cloverdale RD, Suite 213, Boise ID 83713 (208)866-3427

To Obtain Information from:

Name/Organization: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone: _____ Fax: _____

B. The Information to be released:

[ ] Psychological test results
[ ] Social histories
[ ] Developmental Assessments
[ ] Treatment plans of care
[ ] Occupational therapy reports
[ ] Speech therapy reports
[ ] IEP/504 Plans
[ ] Medical history/physical
[ ] Counseling Records
[ ] Academic records
[ ] Psychiatric test results
[ ] Vocational Assessments
[ ] Vocational Plans
[ ] Vocational History
[ ] Other _____

Such information may be freely exchanged by the above parties in writing (by fax, electronic mail, or other electronic file transfer mechanisms), by postal delivery, in person, or by telephone, but such exchange is limited to the agencies or people listed and to necessary information related to care and treatment of the client, unless otherwise specified. I release the parties involved from all liability arising from such exchange of information. I accept full responsibility for any and all action or consequences that may directly or indirectly result from the release of this information.

I understand that this release of information is intended to allow me to provide my informed consent for an exception to my confidentiality and the protection of my privacy guaranteed under federal law, including, but not limited to, the Federal Privacy Act (P.L. 93-579), the Freedom of Information Act (P.L. 93-502), and the Code of Federal Regulations (42, Part 2).

C. Effective date of authorization:
This Authorization takes effect the day that you sign in and terminates on: _____ or one year from the date it is signed.

_____ _____
Client Signature / Guardian **Date**

_____ _____
Witness **Date**

Consent to Treatment and Recipient's Rights

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at MRL Counseling, hereby referred to as the Agency. Further, I consent to have treatment provided by a psychiatrist, psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The Agency encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights:

I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the Recipient's Rights Advisor.

Non-Voluntary Discharge from Treatment:

A participant may be terminated from the Agency non-voluntarily, if: A) the participant exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or B) the participant refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The participant will be notified of the non-voluntary discharge by letter. The participant may appeal this decision with the Clinic Director or request to re-apply for services at a later date.

Participant Notice of Confidentiality:

The confidentiality of patient records maintained by the Agency is protected by Federal and/or State law and regulations. Generally, the Agency may not say to a person outside the Agency that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: 1) the participant consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation. Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the Agency, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. Health care professionals are required to report admitted prenatal

exposure to controlled substances that are potentially harmful. It is the Agency's duty to warn any potential victim, when a significant threat of harm has been made. In the event of a participant's death, the spouse or parents of a deceased participant have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related participant records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor participants have the right to access the participant's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about participant, not clinical information. My signature below indicates that

I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Participant data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above stated policies and agreements with MRL Counseling.

_____ _____

Client Signature / Guardian **Date**

_____ _____

Witness **Date**

**** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ****

Agreement to Accept Case Management/Rehabilitation and/or Clinic Services, and Informed Consent

THE PURPOSE OF CASE MANAGEMENT SERVICES IS TO ASSIST ELIGIBLE INDIVIDUALS IN GAINING ACCESS TO NEEDED PSYCHIATRIC, MEDICAL, SOCIAL, HOUSING, COMMUNITY, LEGAL, EDUCATIONAL, AND OTHER SERVICES.

SERVICES OFFERED UNDER REHABILITATION INCLUDE INDIVIDUAL THERAPY, AND INDIVIDUAL PSYCHO-SOCIAL REHABILITATION.

CLINIC SERVICES INCLUDE MEDICATION MANAGEMENT, INDIVIDUAL AND FAMILY THERAPY FOR ADULTS AND CHILDREN.

I know I have a choice of case management/rehabilitation provider agencies. I have been provided with a list of all the agencies in the community. I have chosen MRL Counseling to provide my services.

As a consumer, I know I have the right to change providers at any time upon my request.

In signing this document, I acknowledge that I understand and consent to:

[ ] Case Management

[ ] Rehabilitation Services

[ ] Clinic Services

_____ _____

Client Signature / Guardian **Date**

_____ _____

Witness **Date**

Recipient's Rights Notification

As a recipient of services at our facility, we would like to inform you of your rights as a participant. The information contained in this brochure explains your rights and the process of complaining if you believe your rights have been violated.

Your Rights as a Participant

1. Complaints: We will investigate your complaints.
2. Suggestions: You are invited to suggest changes in any aspect of the services we provide.
3. Civil Rights: Your civil rights are protected by federal and state laws.
4. Cultural/spiritual/gender Issues: You may request services from someone with training or experiences from a specific cultural, spiritual, or gender orientation. If these services are not available, we will help you in the referral process.
5. Treatment: You have the right to take part in formulating your treatment plan.
6. Denial of Services: You may refuse services offered to you and be informed of any potential consequences.
7. Medical/Legal Advice: You may discuss your treatment with your doctor or attorney.
8. Rights under HIPAA: Please see the accompanying Notice of Privacy Practices.

Your Rights to Receive Information

1. Medications used in your treatment. We will provide you with information describing any potential risks of medications prescribed at our facility.
2. Costs of services. We will inform you of how much you will pay.
3. Termination of services. You will be informed as to what behaviors or violations could lead to termination of services at our agency.
4. Policy changes.

Our Ethical Obligations

1. We dedicate ourselves to serving the best interest of each client.
2. We will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.
3. We maintain an objective and professional relationship with each client.
4. We respect the rights and views of other mental health professionals.
5. We will appropriately end services or refer clients to other programs when appropriate.
6. We will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. We will continually attain further education and training.

7. We hold respect for various institutional and managerial policies, but will help improve such policies if the best interest of the client is served.

Participant's Responsibilities

1. You are responsible for your financial obligations to the agency as outlined in the Payment Contract for Services.
2. You are responsible for following the policies of the agency.
3. You are responsible to treat staff and fellow participants in a respectful, cordial manner in which their rights are not violated.
4. You are responsible to provide accurate information about yourself.

What to Do if You Believe Your Rights Have Been Violated

If you believe that your participant rights have been violated, contact our Agency Director and / or Program Director at 467-2673.

_____ _____

Client Signature / Guardian **Date**

_____ _____

Witness **Date**

Information on Services to be Received

Medicaid Provider Agreement E-2

In 1985, the International Association of Psychosocial Rehabilitation Services (IAPRS) published the following definition of psychosocial rehabilitation as

'The process of facilitating an individual's restoration to an optimal level of independent functioning in the community .... While the nature of the process and the methods used differ in different settings, psychosocial rehabilitation invariably encourages persons to participate actively with others in the attainment of mental health and social competence goals. In many settings, participants are called members. The process emphasizes the wholeness and wellness of the individual and seeks a comprehensive approach to the provision of vocational, residential, social/recreational, educational and personal adjustment services.' (Cnaan et al, Psychosocial Rehabilitation Journal, Vol. 11, No. 4: April 1988, p.61)

Psychosocial rehabilitation is based on a number of assumptions, including two essential ones

- People are motivated by a need for mastery and competence in areas, which allow them to feel more independent and self-confident.
- New behavior can be learned and people are capable of adapting their behavior to meet their basic needs.

Psychosocial Rehabilitation Principles

- Utilization of full human capacity.
- Equipping people with skills (social, vocational, educational, inter-personal and others).
- People have the right and responsibility for self-determination
- Services should be provided in as normalized environment as possible.
- Differential needs and care.
- Commitment from staff members.
- Care is provided in an intimate environment without professional, authoritative shield and barriers.
- Early intervention.
- Changing the environment.
- No limits on participation.
- There is an emphasis on a social rather than a medical model of care.
- Emphasis is on the client's strengths rather than on pathologies.
- Emphasis is on the here and now rather than on problems from the past.
- Flexibility of structure and service models.

- Non-obligatory attendance.
- Support for mobility and choice of service options.
- Active participant involvement in services.
- Support for participant decision-making.
- Concentration on quality of relationships and interactions between participants and staff.
- Encouragement of peer support.
- Responsiveness to participants' needs.
- Provision of most 'normal' environment.
- Utilization of a broad range of skills.
- Active community education.
- Active advocacy.
- Cost-effectiveness: both operational and preventative.

By signing this form I verify that I have read, understood, and received an explanation of the information listed above and provided copies of each and understand the information provided regarding services. This was done pursuant to relevant language in IDAPA Code, the Medicaid Provider Agreement, and credentialing standards.

_____ _____

Client Signature / Guardian **Date**

_____ _____

Witness **Date**

Information on Benefits

Medicaid Provider Agreement E-2

The USPRA has published the following information regarding the benefits of psychosocial rehabilitation services:

Psychosocial rehabilitation services promote recovery, full community integration and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs functioning. Psychosocial rehabilitation services are collaborative, person directed, and individualized, and an essential element of the human services spectrum, and are evidence-based. They focus on helping individuals re-discover skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning and social environments of their choice.

It is the principle behind numerous evidenced-based practices. Psychiatric rehabilitation services directly address the high risks that many persons with serious and persistent mental illness experience of repeated hospitalizations, high utilization of emergency room services, low levels of functioning in the community, homelessness, and unemployment

1. Recovery is the ultimate goal

2. Services may help people re-establish normal roles in the community and their reintegration into community life.

3. Services facilitate the development of personal support networks.

4. Services facilitate an enhanced quality of life for each person receiving services.

5. People receiving services have the right to direct their own affairs, including those that are related to their disability.

6. Culture and/or ethnicity play an important role in recovery.

7. Services build on the strengths of each person.

8. Services are to be coordinated, accessible, and available as long as needed.

9. All services are to be designed to address the unique needs of each individual, consistent with the individual’s cultural values and norms.

10 .Services actively encourage and support the involvement of persons in normal community activities, such as school and work, throughout the rehabilitation process.

11. The involvement and partnership of persons receiving services and family members is an essential ingredient of the process of rehabilitation and recovery.

As you can see, there are many potential benefits to receiving services. We look forward to assisting you in accomplishing your goals!

16.03.10.129.03, 16.03.10.130.10. Crisis Service Availability. PSR agencies must provide twenty-four (24) hour crisis response services for their participants or make contractual arrangement for the provision of those services.

For crisis response services, please contact _____ at _____

By signing this form I verify that I have read, understood, and received an explanation of the information listed above and provided copies of each and understand the information provided regarding services. This was done pursuant to relevant language in IDAPA Code, the Medicaid Provider Agreement, and credentialing standards.

_____ _____

Client Signature / Guardian **Date**

_____ _____

Witness **Date**

Financial Policy

The staff at MRL Counseling (hereafter referred to as the Agency) is committed to providing caring and professional mental health care to all of our participants. As part of the delivery of mental health services we have established a financial policy which provides payment policies and options to all consumers. The financial policy of the Agency is designed to clarify the payment policies as determined by the management of the Agency.

The Person Responsible for Payment of the Account is required to sign this financial policy form. Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.

As a service to you, the Agency will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amount s covered, and is not responsible for the collection of such payments. In some case insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. We charge our participants the usual and customary rates for the area. Participants are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The Person Responsible for Payment will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 30 days. Payments not received after 90 days are subject to collections. A 1% per month interest rate is charged for accounts over 30 days.

If your account is sent to collections, it may be subject to a one-time fee of $20.00 and 12% annual interest.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amount s may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that were prior to the first session at the Agency), this amount will be collected by the Agency until the deductible payment is verified to the Agency by the insurance company or third-party provider.

All insurance benefits will be assigned to this Agency (by insurance company or third-party provider) unless The Person Responsible for Payment of Account pays the entire balance each session. Participants are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved credit plan or payment at the time of service.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged to the participant or guardian of the participant receiving services. The fee is $35.00.

Payment methods include check or cash. We currently are not set up to take credit or debit cards. In Idaho, dishonored checks, plus fees, must be paid within 15 days after the holder of such checks sends notice of dishonor or the following penalties may apply: "$100.00 or triple the amount of the check, whichever is greater." If you do not pay within the allotted time and further collection is warranted, you may also be held responsible for any collection fees and court costs.

Questions regarding the financial policies can be answered by the Program Director.

I (we) have read, understand, and agree with the provisions of the Financial Policy.

_____ _____

Person Responsible for Account Signature **Date**

_____ _____

Co-Responsible Party Signature **Date**

_____ _____

Witness **Date**

Complaints, Grievances and Appeals

In accordance with the Participant Rights Statement, participants and their families as well as, Medicaid, advocates are offered the opportunity report complaint and/or grievances. The complaint, grievance and appeal policy and procedure must be posted in every room of the office in all relevant languages so as to be easily understood. Complaints and/or grievances may be filed as a result of problems with training, service delivery, supervision, funding, planning, service barriers, staff, etc. The agency has a rigorous, internal process for assuring quality services and resolving problems in a prompt fashion. Please refer to the Problem Resolution policy and procedure for additional information. All grievances will be solved verbally as quickly as possible when appropriate. If a formal written grievance is filed, the right to file a grievance is outlined below:

A grievance is made by calling the Administrator _____, at _____or by filling out a grievance report.

- The Administrator or designee of will investigate the grievance in a timely fashion (within 1 week).
- The Administrator or designee will consult with other Administrative team members regarding the appropriate actions required.
- The Administrator or designee will implement any required changes (Within 1 week).
- The Administrator will report findings of the investigation to the participant/guardian and advocate within 1 week.
- Any grievances made by a participant and their family, must be documented and placed in their file.
- At any time, the participant and his/her family may appeal the findings of the review and request a second, independent review of the complaint and/or grievance.
- A local mediator will be procured if necessary to resolve the complaint and/or grievance. The mediator will be agreed upon by all parties to the grievance in writing.

Complaint/Grievance reports are to be handled with the utmost confidentiality. The report is to remain amongst the Administrative team and the people directly involved in any corrective actions. The content or context of the report may be used as training material as decided by the Administrative team.

If appropriate, the Administrator or designee is responsible for notifying the participant and or person filing the grievance report of the corrective action.

EXPLANATION/RECEIPT OF COMPLAINT, GRIEVANCE, AND APPEAL PROCEDURES

Upon initiation of services, participants and/or guardian, where applicable, shall be provided with a packet of information, which outlines rights, responsibilities, access to grievance procedures, and the names, addresses, and telephone numbers of protection and advocacy services and legal assistance. This packet will be reviewed with the participant or guardian and written in easily understood terms. Participants will be encouraged to reflect their understanding of the grievance by the agency's staff to encourage optimum independence. The agency will assure one copy of the packet is filed in the company's administrative records to be used for employee training and quality assurance with respect to assuring the exercise of participant's right to file a grievance. Participants and their families will be encouraged to have a team consisting of paid and non-paid advocates. All applicable advocates will also receive information regarding participants' rights with the agency.

SERVICE DELIVERY PROBLEM RESOLUTION

Policy I:

Services provided produce measurable outcomes, are high quality, and are consistent with individual choices, interests, needs, and current standards of practice.

Procedure I:

1. The administrator or designee will review the contents and findings of service delivery investigations into problems within one week, so as to implement corrective actions and provide feedback.
2. As needed the administrator or designee will instruct the participant, guardians, Medicaid, advocates or staff to use the grievance procedure to report service delivery problems

Quality Assurance Probes will be conducted covering Administrative issues such as utilization trends, finances, Rights, services delivered, and others which may arise, on an on-going basis. These will be conducted by designated administrative staff.

Participant satisfaction surveys will be conducted to ensure individuals are satisfied with the services received at all levels of the organization.

Any quality assurance probes, which document problems of significance, will be turned over immediately to administrative personnel so immediate corrective action can be taken. These include but are not limited to negligence, inadequate supervision of the participant, problems with the environment, lack of dignity in regard to interactions with the participant, insubordination, etc.

In the case of significant problems, the following may result: If warranted, Administrative staff will immediately contact adult/child protection with any issues of abuse/neglect. Reviewing employee schedules and assignments, transferring employees to other work assignments on both a temporary and/or permanent basis may occur. Issues and concerns will be outlined in writing approved by the QA committee.

Note: Newly discovered problems need to be added to the initial and ongoing training done with staff.

Further training will generally be assumed as the first course of action. This will include time lines for correction. During the next follow up QA, corrective action time lines must be met as specified. If not, the administrator will determine what disciplinary action to take related to the seriousness of the concern.

A QA committee will meet to review all QA's and determine the need for further training, adjustment of programmatic procedures, and to recognize employees for doing a good job.

By signing this form I verify that I have read, understood, received an explanation of the information listed above and provided copies of each. This was done pursuant to relevant language in IDAPA Code, the Medicaid Provider Agreement, and credentialing standards.

_____ _____

Client Signature / Guardian **Date**

_____ _____

Witness **Date**

Psychosocial Rehabilitation Services
Alternate Forms of Services Available

(Medicaid Provider Agreement E-2)

Psychosocial rehabilitation is an intensive treatment program designed to reduce the risk of future hospitalization and other impending crises. Our goal, as a rehab treatment provider is to facilitate enough progress among our clients that we are no longer needed. We do this by incorporating a wide range of services and supports.

Alternate Services and Supports Available:

- Psychotherapy
- Group and Individual PSR
- Crisis services
- Case management
- Service coordination
- Developmental services
- Vocational services
- Residential services
- Personal care services
- OT, PT, Speech, Audiology
- Friends
- Family
- Churches
- Civic groups
- Community organizations

We encourage, and will help you cultivate all of the supports you need to be successful and accomplish your goals. We will actively pursue unpaid service options to promote optimum independence.

By signing this form I verify that I have read, understood, received an explanation of the information listed above, provided copies of each and understand the alternate forms of services and supports available to me. This was done pursuant to relevant language in IDAPA Code, the Medicaid Provider
Agreement, and credentialing standards.

_____ _____

Client Signature / Guardian **Date**

_____ _____

Witness **Date**

Psychosocial Rehabilitation Services
Choice of Providers

(16.03.10.116.04, 16.03.10.136.07)

Participant Name: _____ Date of Birth: _____

Provider Name:	**City:**
Abundance Behavioral Health Services	Caldwell
Four Rivers Mental Health Inc.	Caldwell
Human Supports of Idaho Inc.	Caldwell
Idaho Department of Health and Welfare	Caldwell
Integrity Therapeutic Services	Caldwell
Witco Inc.	Caldwell
Adams County Behavioral Health Services	Council
Emmett Family Services	Emmett
Treasure Valley Behavioral Health	Fruitland
All Seasons Mental Health	Nampa
Centerpointe Inc.	Nampa
Community Outreach Counseling Llc.	Nampa
Life Counseling Center	Nampa
Pioneer Health Resources	Nampa
Renewed Life Center	Nampa
V & T Mental Health Services Inc.	Nampa
Valley View Mental Health	Nampa
Core Counseling Center	Nampa

[ ] I verify that I desire to receive services.
[ ] I verify that I have been informed of my rights to choose providers.
[ ] I verify that I have selected as the provider to assist me in accomplishing the objectives stated in my individualized treatment plan.
[ ] I verify that I have been informed of my rights to refuse services.

Client Signature / Guardian **Date**

Witness **Date**

*Provider List Updated April 17, 2017

Psychosocial Rehabilitation Services
Choice of Providers

(16.03.10.116.04, 16.03.10.136.07)

Participant Name: _____ Date of Birth: _____

Provider Name:	City:
About Balance Mental Health Llc.	Boise
Access Behavioral Health Services Inc.	Boise
All Together Now Inc.	Boise
Aspen Mental Health	Boise
Community Connections, Inc.	Boise
Community Partnerships of Idaho	Boise
Clearwater Rehabilitation	Boise
Cornerstone Psychological Associates Pll.	Boise
Healthy Place Counseling Boise Reg 4 Psr	Boise
Human Supports of Idaho Inc.	Boise
Idaho Department of Health and Welfare Amh	Boise
Idaho Department of Health and Welfare Cmh	Boise
Leyline Advocates	Boise
Mountain States Group Inc.	Boise
Pioneer Health Resources	Boise
Rocky Mountain Behavioral Health	Boise
The Arc Inc Reg 4 Psr	Boise
Treasure Valley Community Counseling	Boise
Warmsprings Counseling Center	Boise
Riverside Rehab	Garden City
Kuna Counseling Center	Kuna
Access Living	Meridian
A New Leaf Meridian Inroads, Llc.	Meridian
Creating Options Llc Reg 4 Psr Adult	Mountain Home
Sufficiency Advocates Reg 4 Psr	Mountain Home
Pathways, Inc.	Weiser

Steller Mental Health and Mediation — Nampa
Renewed Hope Counseling and Wellness — Meridian

[ ] I verify that I desire to receive services.
[ ] I verify that I have been informed of my rights to choose providers.
[ ] I verify that I have selected as the provider to assist me in accomplishing the objectives stated in my individualized treatment plan.
[ ] I verify that I have been informed of my rights to refuse services.

_____ _____
Client Signature / Guardian **Date**

_____ _____
Witness **Date**

*Provider List Updated April 17, 2017

Psychosocial Rehabilitation Services
Protection and Advocacy Information

(Medicaid Provider Agreement E-9)

In accordance with the method of informing participants of their rights described in the Medicaid Provider Agreement, the agency provides participants and their family's information pertaining to protection and advocacy services.

REGIONAL MENTAL HEALTH OFFICES

Children's Mental Health /Adult Mental Health
Region 3
823 Park Centre Way
Nampa, ID 83651
Phone (208) 459-0092

DISABILITY RIGHTS OFFICES IDAHO

Boise Office
4477 Emerald Street, Suite B-100
Boise, ID 83706-2066
(208) 336-5353 (TDD/Voice)
(208) 336-5396 Fax
Email: info@disabilityrightsidaho.org
info@disabilityrightsidaho.org

Pocatello Office
845 West Center Street, C107
Pocatello, ID 83204-4237
(208) 232-0922 (TDD/Voice)
(208) 232-0938 Fax
Email:

Moscow Office
428 West 3rd Street, Suite 2
Moscow, ID 83843-2907
(208) 882-0962 (TDD/Voice) (208) 883-4241 Fax
Email: info@disabilityrightsidaho.org
Website: http://www.disabilityrightsidaho.org/

OTHER SERVICES

Child Protection Services
823 Park Centre Way
Nampa, Id 83651

24-hour emergency: 208-465-8452(Nampa),
455-7000(Caldwell)

Adult Protection Services
125 East 50th Street Boise, ID 83714-1413
(208) 489-6909 1.800.859.0321

By signing this form I verify that I have read, understood, received an explanation of the information listed above and provided copies of each. This was done pursuant to relevant language in IDAPA Code, the Medicaid Provider Agreement, and credentialing standards.

_____ _____

Client Signature / Guardian **Date**

_____ _____

Witness **Date**

Psychosocial Rehabilitation Services
Risks Associated with Services

(Medicaid Provider Agreement E-2)

Psychosocial rehabilitation is an intensive treatment program designed to reduce the risk of future hospitalization and other impending crises. Our goal, as a rehab treatment provider is to facilitate enough progress among our clients that we are no longer needed. To reiterate, the point of rehab treatment is to eliminate the need for it. This is especially important as the State, who provides funding for this program, views rehab as both intensive and SHORT TERM.

Risks

Risks associate with PSR services include, but are not limited to the following items. Remember, all services provided must be clinically appropriate in content, service location and duration.

- There are inherent risks associated with receiving services in the home or community.
- There is a risk associated with transportation.
- Working with various therapists could be a source of frustration and pose some behavioral risk
- Therapy might be difficult, but worth it.
- You may need to occasionally reset your expectations of activities and therapy.
- You might get worse before you get better.
- Our agency is here to support you, but hold you accountable to the goals you've helped develop.
- There is some risk associated with interacting with others in the community.

The ultimate goal is for you to not need services, which can be intimidating to realize.
We believe that assuming some of these risks will enable you to make the most progress in the shortest amount of time. We are committed to supporting to minimize the risk to you as you received services.
Please actively participate with us in managing the risks. Remember, you are part of a team and we're all striving for the same goal!

By signing this form I verify that I have read, understood, received an explanation of the information listed above and provided copies of each and understand some of the risks associated with the services. I also agree that the risks associated with services are not limited to those identified in this document or in conversation with representatives of the agency.

_____ _____

Client Signature / Guardian **Date**

_____ _____

Witness **Date**

Psychosocial Rehabilitation Services
Information on Legal Assistance

(Medicaid Provider Agreement E-9)

Idaho Volunteer Lawyers
PO Box 895
Boise ID 83701-0895
1-800-221-3295
www.state.id.us/asb/pub_info/ivlp.htm

Services available:
Statewide network of volunteer attorneys that provide free legal assistance in family law cases to persons living in poverty. Services may include advice and consultation, brief legal services, and representation.
Eligible case types include custody and visitation, guardianship for adults or children, wills in non-property matters, or limited debt defense, enforcement or modifications of court orders, and divorce. Domestic violence cases are given priority.

Disability Rights of Idaho
Pocatello Office
845 West Center C-107
Pocatello ID 83204
(208) 232-0922 (TDD/voice) or 1-866-262-3462
(208) 232-0938 (fax)
www.disabilityrightsidaho.org

Services available:
Disability Rights of Idaho is a private, nonprofit legal services organization which manages several federally funded programs designed to protect the rights of people with disabilities and is the designated Protection and Advocacy system for Idaho.

Disability Rights of Idaho provides advocacy for people with physical disabilities, developmental disabilities, mental illness, or traumatic brain injury who have experienced abuse or neglect, have been denied service or benefits, have had their rights violated or experienced discrimination because of a disability; or have experienced problems with voting accessibility. Disability Rights of Idaho also assists persons in getting assistive technology or services; people seeking information about applying for receiving services from rehabilitation programs; and SSI and/or SSDI beneficiaries with return to work concerns. Disability Rights of Idaho also administers the WIPA Program, which

provides work incentive planning, assistance and outreach services to SAA beneficiaries receiving SSI/SSDI, and who are seeking employment.

Disability Rights of Idaho provides information and referral; direct advocacy; assistance with negotiation and mediation; short term and technical assistance; and legal advice and/or representation to persons with disabilities on issues related to their disability.

The following programs are offered:

- **PADD – Protection and Advocacy for Persons with Developmental Disabilities**. Services to address disability related rights violations for individuals who have a severe and chronic developmental or physical disability.
- **PAIMI – Protection and Advocacy for Individuals with Mental Illness**. Priority representation is provided to individuals with mental illness alleging abuse, neglect or violations of rights occurring in treatment facilities. Services may also be provided to address rights violations in the community.
- **PAIR – Protection and Advocacy for Individual Rights**. Services addressing disability related rights violations for all other individuals with physical and/or mental disabilities who are not eligible for services under the PADD, PAIMI, or CAP Programs.
- **CAP – Client Assistance Program**. Services to provide information and advocacy to individuals who are involved with federally funded rehabilitation programs.
- **PAAT – Protection and Advocacy for Assistive Technology**. Services to individuals with disabilities who need information or assistance enforcing legal rights to obtain assistive technology devices and services.

- **PABSS – Protection and Advocacy for Beneficiaries of Social Security**. Services to provide information and advocacy to beneficiaries of Social Security seeking to secure, retain, or regain gainful employment.
- **PATBI – Protection and Advocacy for Individuals with Traumatic Brain Injuries**. Services to individuals with traumatic brain injury and their families to improve access to health and other services.
- **PAVA – Protection and Advocacy for Voting Accessibility.** Services to ensure the full participation of individuals with disabilities in the electoral process.
- **WIPA – Work Incentives Planning and Assistance.** Provides work incentive planning, assistance and outreach services to SSA beneficiaries receiving SSI/SSDI seeking employment

Contact Disability Rights of Idaho for individual program eligibility criteria.

By signing this form I verify that I have read, understood, received an explanation of the information listed above and provided copies of each. This was done pursuant to relevant language in IDAPA
Code, the Medicaid Provider Agreement, and credentialing standards.

_____ _____

Client Signature / Guardian **Date**

_____ _____

Witness **Date**

Psychosocial Rehabilitation Services
Participant Rights Information

(Medicaid Provider Agreement E-9)

1. **Policy:** The purpose of this section is to inform of participant rights in receiving services from the agency. Upon initiation of services, participants and/or guardian, where applicable, shall be provided with a packet of information, which outlines rights, access to grievance procedures, and the names, addresses, and telephone numbers of protection and advocacy services. This packet will be written in easily understood terms.

2. **Procedure:** The agency will provide the following rights for participants:
   a) Humane care and treatment
   b) Not be put in isolation
   c) Be free of mechanical restraints, unless necessary for the safety of that person or for the safety of others
   d) Be free of mental and physical abuse
   e) Voice grievances and recommend changes in policies or services being offered
   f) Practice his own religion
   g) Wear his own clothing and to retain and use personal possessions
   h) Be informed of his medical and habilitative condition, of services available at the agency and the charges for the services
   i) Reasonable access to all records concerning himself
   j) Refuse services
   k) Exercise all civil rights, unless limited by prior court order.

3. **Additional Participant Rights.** The agency will also ensure the following rights for each participant:
   a) Privacy and confidentiality
   b) Be treated in a courteous manner
   c) Receive a response from the agency to any request made within a reasonable time frame
   d) Receive services that enhance the participant's social image and personal competencies and, whenever possible, promote the agency in the community
   e) Refuse to perform services for the agency. If the participant is hired to perform services for the agency the wage paid must be consistent with state and federal law
   f) Review the results of the most recent survey conducted by the Department and the accompanying plan of correction
   g) All other rights established by law
   h) Be protected from harm.

4. **Policy II:** The agency will ensure and document that each person receiving services is informed of his rights in the following manner:

5. **Procedure II:**
   a) Upon initiation of services, the agency will provide each participant and his parent or guardian, where applicable, with a packet of information which outlines rights, access to grievance procedures, and the names, addresses, and telephone numbers of protection and advocacy services. This packet will be written in easily understood terms, i.e. in the participants' native language.
   b) When providing facility-based services, the agency will prominently post a list of the rights contained in the regulations.
   c) The agency will provide each participant and his parent or guardian, where applicable, with a verbal explanation of their rights in a manner that will best promote individual understanding of these rights. d.
   d) Upon initiation of services, or within one week after the ITP is developed, each individual will be informed of their rights and responsibilities, grievance procedure, and the names, addresses, and telephone numbers of protection and advocacy agencies.
   e) Each individual will be given a copy of the rights statement for their own use, and verification of the receipt of rights will be placed in their file.
      - The agency, its employees and subcontractors interact with participants in a respectful manner.
      - Provider interventions promote participant empowerment and choice. Participants are recognized as primary decision-makers in accessing any and all services, unless an appropriate guardianship has been established by a court or the participant is a minor.
      - Services are provided at a time and location that is convenient, acceptable and suitable for the participant and the participant's Provider, and are coordinated, consistent and not a duplication of any other service the participant is receiving.
      - The agency's decision to accept or continue services for a participant is based on its ability to meet the needs of the participant.
      - The agency schedules services to ensure that the treatment plan for each service is developed and implemented effectively.
      - The agency conducts a quality assurance program consisting of: sufficient training sessions to ensure staff qualifications and competence to provide the services the Agency delivers; quarterly audits of services; participation surveys; and annual professional credential and competency review.
      - The agency shall implement a Quality Improvement plan for any deficiencies identified by the Department or its designee.
      - The agency informs each participant (or legal guardian) of the services to be received, the expected benefits and attendant risks of receiving those services, of the right to refuse services, and alternative forms of services available.

By signing this form I verify that I have read, understood, received an explanation of the information listed above and provided copies of each. This was done pursuant to relevant language in IDAPA
Code, the Medicaid Provider Agreement, and credentialing standards.

_____ _____

Client Signature / Guardian **Date**

_____ _____

Witness **Date**

Crisis Intervention Protocol

At MRL Counseling we offer a 24 hour 7 day a week crisis line.

If you are in crisis, you can reach us at **(208) 489-6866**.

A crisis can include:

- Thoughts of suicide or self-harm
- Domestic Violence
- Homelessness
- Homicidal Thoughts

Eye Movement Desensitization and Reprocessing

EMDR is a type of psychotherapy that can treat a variety of problems such as

- post-traumatic stress disorder,
- personality disorders
- panic attacks
- complicated grief
- dissociative disorders
- body dysmorphic disorders
- disturbing memories
- phobias
- eating disorders
- performance anxiety
- stress reduction
- addictions
- sexual and/or physical abuse
- pain disorders

A typical EMDR session lasts from 60-90 minutes. The type of problem, life circumstances and the amount of previous trauma will determine how many treatment sessions are necessary. EMDR may be used within a standard "talking" therapy or as a treatment all by itself.

One or more sessions are required for the clinician to understand the nature of the problem and to decide whether EMDR is an appropriate treatment, during this time, the clinician will discuss EMDR more fully and provide an opportunity to answer any questions you may have about this treatment option.

Sometimes after an EMDR session, some things can still come up. As you work with the clinician in the EMDR therapeutic process, you will learn coping skills, if and when this occurs. However, if you need help processing through the EMDR crisis, you can contact your clinician at **(208) 489-6866.** Please be aware that an emergency session may be needed to resolve the particular problem, which may add sessions to your EMDR treatment.

By signing this form I agree to the treatment of EMDR as needed and discussed with the clinician. I understand that I have a right to refuse this treatment at any time and work with my clinician in creating a treatment plan that works for me. I understand that I have a right and responsibility to contact the clinician in case of a crisis situation.

_____ _____

Client Signature / Guardian **Date**

_____ _____

Witness **Date**

Audio/Video Recording Release Form

As part of our aim in offering a high quality service, we have found it helpful to the work that people do with us to make recordings of sessions. Review of tapes usually furnishes us with more ideas that you might find helpful in your circumstances. It is also sometimes helpful in training people who are learning the job. Please read the following paragraphs and, if you are in agreement, sign where indicated.

I consent to video/audio tapes being made of these sessions and to these tapes being used to aid in the treatment process.

_____ _____

Client Signature / Guardian **Date**

I consent to the excerpts from these recordings, or descriptions of them, being used by the MRL Counseling staff for the purposes of supervision, research and/or teaching. I understand that the MRL Counseling staff may need to use these recordings in the case of a legal proceeding. I understand that the MRL Counseling staff will edit out from these recordings, or from descriptions of the recordings, as much identifying information as is possible.

_____

_____

Client Signature / Guardian **Date**

On behalf of the MRL Counseling, I undertake that, in respect of any video/audio tapes made, every effort will be made to ensure professional confidentiality and that any use of video/audio tapes, or descriptions of video/audio tapes, will be for professional purposes only and in the interests of improving professional standards through research or training programs. Every effort will be made to protect the anonymity of all those involved in the sessions.

_____ _____

Matt Larson, LCSW **Date**

Forensic Social Work Services

LCSW provides forensic social work services in consulting with the judicial system which could include attorneys, law firms, judges and the client, if the client is in need of services. Below you will find a copy of clinician's fee agreement.

LICENSED CLINICAL SOCIAL WORKER-CLIENT FEE CONTRACT

(HOURLY/LITIGATION)

This agreement is made between Matt Larson, a Licensed Clinical Social Worker, 4700 N. Cloverdale RD, Suite 213, Boise ID 83713, with MRL Counseling L.L.C., referred to in this agreement as "MRL Counseling" and _____ **,** referred to in this agreement as "Client," in order to set out the terms and conditions under which L.C.S.W. will represent client.

SECTION I

EFFECTIVE DATE

This agreement shall take effect upon its execution by both parties and the payment of an initial retainer as set forth in Section Third of this Agreement.

SECTION II

SCOPE OF SERVICES

MRL Counseling will represent client and provide those reasonable services as are necessary in adjudicating case.

SECTION III

L.C.S.W.'S FEES

Client agrees to pay MRL Counseling.'s fees in accordance with the following Rate Schedule:

a. Retainer	$600
b. General administration of the file	$70 per hour
c. Court appearances/depositions	$200 per hour
d. General preparation for court	$200 per hour

e. Assessments $170 per hour

MRL Counseling will charge client for the time MRL Counseling spends on telephone calls relating to client's case, including calls with client, travel time, court appearances, or any other reasonable efforts in serving the requests of the client. MRL Counseling will charge for waiting time in court and in such other place as necessary, and travel to and from court and any other case related proceedings.

SECTION IV

COSTS AND EXPENSES

a. In addition to the hourly fees set forth in Section Three of this Agreement, client agrees to pay all costs and expenses incurred in connection with client's case including, but not limited to, costs fixed by law or assessed by courts and other agencies, transcriptionist's fees, long distance telephone calls, messenger fees, delivery fees, postage, parking, highway and bridge tolls, photocopying and other reproduction costs, FAX transmission costs, clerical staff overtime, word processing charges, charges for computer research time, and other similar items. All costs and expenses will be charged at MRL Counseling's cost, except for the items listed on the Rate Schedule.

b. Client agrees to pay for transportation, meals, lodging and all other costs of any necessary out-of-town travel by MRL Counseling's personnel. Client also agrees to pay for the time MRL Counseling and his personnel spend traveling.

c. In the event it becomes necessary to hire consultants or investigators, MRL Counseling will not hire these persons, unless client agrees to pay their fees and charges, and deposits with MRL Counseling an amount sufficient to pay these fees and charges.

SECTION VI

L.C.S.W.'S LIEN

Client grants MRL Counseling a lien on all claims in which MRL Counseling represents client under this agreement. The lien shall cover any sums due and owing to MRL Counseling at the termination of MRL Counseling's services and will attach to any money or property recovered by client. MRL Counseling shall also have a lien on client's records, money, or property in MRL Counseling's possession for any sums due and owing to MRL Counseling at the termination of MRL Counseling's services.

SECTION VII

CLIENT'S DUTIES

Client agrees to tell MRL Counseling the truth, to cooperate with MRL Counseling, to keep MRL Counseling informed of any developments that are relevant to the case, to faithfully comply with this

agreement, to pay MRL Counseling's fees on time, and to keep MRL Counseling advised of client's address and telephone number and any changes of address or telephone number.

SECTION VIII

TERMINATION AND WITHDRAWAL

Client may terminate this agreement at any time. MRL Counseling may withdraw from the case with client's consent or without client's consent for good cause, such as failure to comply with client's duties as provided for in Section Seven, refusal and/or failure to promptly pay MRL Counseling's fees, costs and/or expenses, failure to follow MRL Counseling's advice on any matter material to client's case, or if circumstances arise that would render MRL Counseling's continuing representation unlawful or unethical.

Upon the termination of MRL Counseling's services, whether or not it is terminated by client or by MRL Counseling, all unpaid charges shall immediately become due and payable to MRL Counseling. will likewise deliver to client all records of the case and all property of client in MRL Counseling's possession, except those subject to any lien.

SECTION IX

DISCLAIMER OF GUARANTEE

MRL Counseling will use MRL Counseling's best efforts in representing client, but makes no promises or guarantees regarding the outcome of client's case. MRL Counseling's comments regarding the outcome of the case are mere expressions of opinion. Neither does MRL Counseling guarantee any time frame within which client's case will be resolved.

By signing this document, the client acknowledges that they have carefully read and fully understood every word in this agreement and agrees to its terms and conditions, and agrees to faithfully comply with them.

CLIENT (OBLIGOR):

_____ Date:_____

NAME

_____

NAME

_____

COMPANY & TITLE (If necessary)

_____ Date:_____

MATT LARSON LCSW

Fees of Service

MRL Counseling is a provider for mental health outpatient treatment and EMDR therapy and we do our best to accommodate our clients as much as possible. Client agrees to pay all or part of what is not covered by insurance, including but not limited to insurance co pays. MRL Counseling is not responsible if your insurance refuses to pay for treatment rendered. The individual client is responsible for any outstanding payments that have occurred during the course of treatment. **Missed appointments or cancellations less than 24 hours prior to the appointment are charged to the participant or guardian of the participant receiving services**. **The fee is $35.** Some case by case exceptions do exist, to include, but not limited to; occasional illnesses, bad weather conditions, or family emergencies. Failure to keep appointments on a regular basis will result in the client being removed from a clinician's schedule and discharged for treatment noncompliance. Any outstanding fees will be applied immediately after discharge. If the client wants to continue treatment with MRL Counseling and has a history of treatment noncompliance, they will come to do so, however they may be placed on a cancellation list or waiting list to receive treatment. MRL Counseling offers a sliding scale for services if the potential client is unable to pay the full amount and qualifies for such accommodations.

A Breakdown of services:

- General Counseling Session $100 per hour
- EMDR therapy $110 per hour
- Assessments $100 per hour

By signing this form, the client agrees to pay all costs and/or copayments that occur over the course of treatment. The client acknowledges that they are responsible for all outstanding fees during the course of treatment.

_____ _____

Client Signature / Guardian **Date**

_____ _____

Witness **Date**