MRL COUNSELING LLC

New Client Intake Packet

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Get copies of ID and Insurance cards

MRL COUNSELING LLC

Participant Demographic Information

THIS FORM MUST BE FILLED OUT <u>COMPLETELY</u>, PLEASE PRINT CLEARLY.

Client's Name (First & Last): _____

Address: _____ City: _____State: _____ Zip: _____

Phone: _____ [ ] Home [ ] Cell [ ] Other [ ]

Additional Phone: _____ [ ] Home [ ] Cell [ ] Other

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

Race: _____ Preferred Language: _____

Name of Guardian/ Spouse

Name (First & Last): _____ [ ] Guardian [ ] Spouse

Phone: _____

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

Email Address: _____

Is this person responsible for the 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: _____

Additional Physician: _____ Phone: _____

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

Current Medications: _____

_____

Allergies_____

MRL COUNSELING LLC

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: _____

_____

MRL COUNSELING LLC

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 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)

MRL COUNSELING LLC

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 way 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 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 an 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: _____ Date: _____

Spouse/ Guardian: _____ Date: _____

Clinician: _____ Date: _____

MRL COUNSELING LLC

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 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: _____ Date: _____

Spouse/ Guardian: _____ Date: _____

Clinician: _____ 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?

_____

MRL COUNSELING LLC

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 the 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 regarding 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 details 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: _____ Date: _____

Spouse/ Guardian: _____ Date: _____

Clinician: _____ Date: _____

Authorization for Release of Confidential Information

Program Participant Name: _____ D/O/B: _____
Other Names Used: _____
I _____, authorize MRL Counseling, LLC (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 creating protected health information for disclosure to a third party.

MRL COUNSELING LLC

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: _____ Date: _____
Spouse/ Guardian: _____ Date: _____
Clinician: _____ 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 LLC: Matthew Larson
Office Address: 9460 Fairview Ave., Boise, ID 83704 Office Phone # 208-377-0221
Alternate Address Alternate Phone #

To Obtain Information from:

Name/Organization: _____
Address: _____ City: _____ State: _____
Zip Code: _____ Phone: _____ Fax: _____

B. The Information to be released:

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

[ ] 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 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)
- 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: _____ Date: _____
Spouse/ Guardian: _____ Date: _____
Clinician: _____ Date: _____

MRL COUNSELING LLC

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 against this decision with the Clinic Director or request to re-apply for services later.

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 the 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 **Date**

_____ _____

Spouse/Guardian **Date**

_____ _____

Witness **Date**

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

EMDR Treatment Consent

What is the actual EMDR session like:

During EMDR, the therapist works with the client to identify a specific problem as the focus of the treatment session. The client calls to mind the disturbing issue or event, what was seen, felt, heard, thought, etc., and what thoughts and beliefs are currently held about that event. The therapist facilitates the directional movement of the eyes or other dual attention stimulation of the brain, while the client focuses on the disturbing material, and the client just notices whatever comes to mind without making any effort to control direction or content. Each person will process information uniquely, based on personal experiences and values. Sets of eye movements are continued until the memory becomes less disturbing and is associated with positive thoughts and beliefs about oneself; for example, "I did the best I could." During EMDR, the client may experience intense emotions, but by the end of the session, most people report a great reduction in the level of disturbance.

What kind of problems can EMDR treat:

Scientific research has established EMDR as effective for post-traumatic stress. However, clinicians also have reported success using EMDR in the treatment of the following conditions but not limited to:

- 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

How long does EMDR take:

One or more sessions are required for the therapist to understand the nature of the problem and to decide whether EMDR is an appropriate treatment. The therapist will also discuss EMDR more fully and provide an opportunity to answer questions about the method. Once the therapist and client have agreed that EMDR is appropriate for the specific problem, the actual EMDR therapy may begin.

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

By signing I consent to treatment and agree to the above stated policies and agreements with MRL Counseling.

_____ _____

Client **Date**

_____ _____

Spouse/Guardian **Date**

_____ _____

Witness **Date**

MRL COUNSELING LLC

Crisis Agreement

At MRL Counseling we offer a 24hr Crisis line where a client or anyone at risk of a crisis or needs additional EMDR assistance can talk to a clinician that is on call if they are experiencing a crisis. Some examples of a crisis are as follows but not limited to:

- If you are suicidal
- Homicidal
- Having thoughts of self-harm
- Experiencing domestic violence
- Having serve anxiety
- At risk at becoming homeless
- Feeling in danger or at danger towards others
- Overall feeling out of control

May call our 24hr Crisis help line at (208)-489-6866 or you feel it's an emergency and need immediate attention please call 911.

Client: _____ Date: _____

Spouse/ Guardian: _____ Date: _____

Clinician: _____ Date: _____

(Please note some insurance companies may not cover this and you will be expected to cover the charges.)

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.

MRL COUNSELING LLC

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 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 for treating staff and fellow participants in a respectful, cordial way so their rights are not violated.
4. You are responsible for providing 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 (208)-866-3427.

Client: _____ Date: _____

Spouse/ Guardian: _____ Date: _____

Clinician: _____ Date: _____

Information on Services to be Received

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 people 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 several 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 can adapt 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 normal an 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 a 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: _____ Date: _____

Spouse/ Guardian: _____ Date: _____

Clinician: _____ Date: _____

MRL COUNSELING LLC

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 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 everyone, consistent with the individual's cultural values and norms.
10. Services actively encourage and support the involvement of people 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!

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: _____ Date: _____

Spouse/ Guardian: _____ Date: _____

Clinician: _____ 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 to report complaints and/or grievances. The complaint, grievance and appeal policy and procedure must be posted in every room of the office in all relevant languages to be easily understood. Complaints and/or grievances may be filed because 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 designer 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 designer will implement any required changes (Within 1 week).
- The Administrator will report the 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 ensure 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 from 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 designer will review the contents and findings of service delivery investigations into problems within one week, 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 regarding 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 timelines for correction. During the next follow up QA, corrective action timelines 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: _____ Date: _____

Spouse/ Guardian: _____ Date: _____

Clinician: _____ Date: _____

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 support.

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 the support 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 support available to me. This was done pursuant to relevant language in IDAPA Code, the Medicaid Provider Agreement, and credentialing standards.

Client: _____ Date: _____

Spouse/ Guardian: _____ Date: _____

Clinician: _____ Date: _____

Protection and Advocacy Information

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

Pocatello Office

845 West Center Street, C107
Pocatello, ID 83204-4237
(208) 232-0922 (TDD/Voice)
(208) 232-0938 Fax
Email: info@disabilityrightsidaho.org

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

Information on Legal Assistant

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 people living 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, for limited debt defense, enforcement or modifications of court orders, and divorce. Domestic violence cases are given priority.

Disability Rights of Idaho

Pocatello Office
845 W Center C-107
Pocatello, ID 83204
1-208-232-0922 (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.
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- ***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**

Financial Policy

The staff at MRL Counseling (hereafter referred to as the Agency) is committed to providing caring and professional mental health care for all 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 for 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 collection. 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 48 hours prior to the appointment are charged to the participant or guardian of the participant receiving services. The fee is $40.00.

Payment methods include check or cash, debit, and credit cards. Credit cards processing fee of 6%. 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**

MRL COUNSELING LLC

FEE SCHEDULE

MRL Counseling LLC is a provider of 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 treatment.* ***Missed appointments or cancellations less than 48 hours prior to the appointment are charged to the participant or guardian of the participant receiving services. The fee is $40.00****. Some case-by-case exceptions do exist, to include, but not limited, 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 accommodation.*

A Breakdown of services.

- *General Counseling Session* *$150.00 per hour*
- *Assessment* *$200.00 per hour*
- *EMDR therapy* *$250.00 per hour*

By signing this form, the client agrees to pay all costs and/or what the insurance company does not pay plus copayments that occur over the course of treatment. The client acknowledges that they are responsible for all outstanding fees during treatment.

_____ _____

Client Signature/Guardian *Date*

_____ _____

Witness Date