Insight and Empowerment, LLC
1908 Jennie Lee Drive, Idaho Falls, ID 83404
(208) 932-7048 phone
(208) 970-6188 fax
Insightandempowerment@outlook.com

Clients Name: _____DOB_____
Address_____
City: _____State: _____Zip code: _____
Phone Number: _____Alternate Number: _____
Social Security: _____
Age: _____Gender: _____
Employer: _____Time at current employment: _____

Responsible Party Name: _____DOB_____
Relationship to child: _____
Primary Guardian's phone number: _____

Responsible Party Name: _____DOB_____
Relationship to child: _____
Secondary Guardian's phone number: _____
Address (if different): _____

Insurance: Primary
Name of Insurance Company: _____
Name of Insured: _____DOB: _____
SS: _____ Employer: _____
Relationship to the client: Self Child Spouse Guardian Other
Address: _____
State: _____ Zip code: _____

Does the client have addi
Secondary Insurance
Name of Insured: _____DOB: _____
SS: _____Employer: _____
Relationship to the client: Self Child Spouse Guardian Other
Address: _____ City: _____
State: _____ Zip code: _____

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Financial Policy

Insight and Empowerment accepts most major insurance companies, Optum Medicaid and self-pay clients. Our standard self-pay rates are $60 for thirty minutes, $90 for forty-five minutes and $110 for one hour and $172.50 for a comprehensive assessment.

Payments are due at the time of service. We bill most major insurance companies as a courtesy and at no cost to you. If insurance is billed, payment of outstanding balance is expected within 30 days. New insurance and changes in insurance must be reported to Insight and Empowerment, LLC at the time of service. If changes in information are not reported timely, the client will be charged a $30.00 reprocessing fee. It is your responsibility to know if a provider or a service provided in our agency is in network with your insurance plan. We are not responsible for determining whether our providers are in network with your plan. If insurance does not pay for the service being seen for, it will be the responsibility of the client. Ultimately, you are responsible for all services rendered. If a minor, the authorizing adult/adults is/are responsible.

Payments are due at minimum once per month and will be due by the 5th of the month. Co-payments are expected at time of service. There will be a $20.00 charge on all returned checks. Counseling Services will be suspended if an agreed upon payment has not been made and the client's balance is over $200.00. Payment agreement forms may be requested. Late fees of 5$ per month may be charged and after four months of attempts being made by mailed statements, accounts will be assigned to an outside collection agency. If collection attempts are made on your behalf, you will be charged a $20.00 Late fee, potential reasonable attorney fees and court costs, in the event your account is assigned to a collection agency. Clients will be required to pay all attorney fees that accumulate if court proceedings are necessary.

A 3.5% processing fee will be charged for all credit card payments at time of payment.

I, _____, understand that I am fully responsible for all charges regardless of insurance coverage and payments to satisfy required therapy costs.

I authorize Insight and Empowerment, LLC to receive insurance payments and release any medical records to my health insurance company that are deemed necessary for claims processing.

Responsible Party Signature: _____Date: _____

Responsible Party Signature: _____Date: _____

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Recurring Card Payment Authorization

You authorize regularly scheduled charges to your credit card. You will be charged the amount indicated below following each session. A receipt for each payment will be provided to you at your request and the charge will appear on your credit card statement. You agree that no prior-authorization will be provided unless the amount changes, in which case you will receive notice from us prior to the charge occurring.

I _____ authorize Insight and Empowerment, LLC to charge my credit card indicated below for $_____and the 3.5% processing fee following each session, for _____.

Billing Information
Billing Address: _____ Phone: _____
City, State, Zip: _____ Email: _____

Card Details
___Visa ___ Mastercard ___ Discover ___ American Express

Cardholder Name: _____
Account Number (CC): _____
Expiration Date: _____
CVV: _____
Zip Code: _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Insight and Empowerment, LLC immediately for changes that need to be made to the card on file or to terminate this authorization. This authorization only applies to self-pay clients, or co-pays and co-insurances, or when meeting the deductible. This does not apply to late cancellation fee's or no-show fee's that may also need to be charged.

Cardholder Signature: _____ Date: _____

Termination of Authorization:

I am terminating my authorization for automatic credit card processing to Insight and Empowerment, LLC for the following reason:

_____

Date: _____

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Informed Consent

Hours of Operation:
Insight and Empowerment is generally available for appointments from the hours of 9am – 6pm Monday through Thursday and 9am – 5pm on Friday's. Individual clinician's hours may vary from this time. If there is an emergency, please let us know and we will accommodate those needs on an emergent basis.

Assessments and Appointments:
Insight and Empowerment will gather any demographic and insurance information when a client calls to schedule an appointment. An intake packet will either be emailed to the client, or the client can pick up the intake paperwork at Insight and Empowerment, LLC to have ready for the first appointment. If the client fails to have necessary forms ready to complete the Comprehensive Diagnostic Assessment, they will be asked to reschedule the appointment. A Comprehensive Diagnostic Assessment will be required for all patients and is expected to take approximately 1 hour in session. Each additional therapy session is expected to take approximately 45 minutes unless otherwise stated by the clinician.

Confidentiality:
All information that is discussed in session at Insight and Empowerment, LLC will be kept confidential unless the client has given written permission to disclose information to another party. Consent to release information will be attached to the client's file. Mandatory reporting requirements will be followed by clinicians and information pertaining to 1) threat of harm to self and/or others, 2) suspected abuse or neglect of a child or elder, 3) or suicidal/homicidal ideations with a plan, or 4) court ordered information. In this case, the clinician will contact the appropriate individuals and/or authorities to meet state requirements.

Minors Over the Age of 14:
Idaho law prohibits the release of confidential statements made by clients over the age of 14 without their written consent unless such information is necessary to obtain insurance coverage, carry out the treatment plan, prevent harm to the child or others, or as authorized by court order. The minor also has the right to access treatment information unless that information would be damaging to the client.

All personal information will be kept within the walls of Insight and Empowerment, LLC and out of sight from other clients and/or persons. Exceptions to the confidentiality agreement will include coordinating care with medical providers if the client allows this and signs a release of information to this effect. In the case that insurance companies require clinical summaries, Insight and Empowerment will provide them with this information in order to continue

participating in network with said company. Insurance claims will have the diagnoses code as well as the code for the type of services that have been rendered. Insight and Empowerment, LLC will not speak about your attendance or care at our agency with anyone other than the responsible party that has completed the intake information, other than if there are court documents stating that another parent has legal custody of the child.

Non-compliance and/or Cancellations:
If the client needs to cancel an appointment, we ask that the client give Insight and Empowerment, LLC a 24-hour notice when possible. If the client calls the same day of the appointment to cancel, the therapist may charge a late cancellation fee up to $50.00. If the client no shows an appointment, the therapist may charge a no-show fee of up to $50.00. Following three no-show appointments, the client will be discharged from the agency. We kindly ask that if another obligation comes up causing you to cancel your appointment, to contact us immediately at (208) 932-7048. Likewise, if a client has been attending therapy sessions and the therapist deems the sessions to be ineffective based on non-compliance, we will ask that services be discontinued immediately.

Emergencies:
Insight and Empowerment, LLC provides an after-hours crisis line for emergencies, by calling 208-360-2964 where a clinician will be available. The crisis line is co-facilitated with Wright Step Counseling and Recovery, LLC with a business associates' agreement in place. The client may also contact, Behavioral Health Crisis Center of East Idaho at 208-522-0727, Eastern Idaho Medical Center at (208) 529-6111 or Region VII Mental Health at (208) 528-5700 or go to the nearest emergency room.

Treatment:
Services provided will be from evidenced based therapeutic models and the clinicians will allow the client time for questions and/or feedback regarding frequency, intensity, and duration of treatment recommended based on diagnoses. There is no guarantee that the services provided will decrease the symptoms that are being presented. Therapy sessions will include individual and group therapy. Risks associated may include an increase in symptoms, and possible recommendations for medication review and management at another location. It is our goal to assist you in gaining insight into your mental health and/or substance use needs as well as provide skills to decrease symptoms and improve your condition. Services may be modified based on insurance caps and/or policies. Billing is provided at no additional cost to our clients unless as noted prior, the insurance information has changed, and this was not disclosed by the client (see financial policy).

By signing this consent, I agree that I have read and agree to the information listed above. I also understand that I have the right to withdraw my consent at any time.

Responsible Party Signature: _____Date: _____

Responsible Party Signature: _____Date: _____

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Clients Rights, Responsibilities

Rights

- Client has the right to receive information about services provided, network practitioners and member's rights and responsibilities.
- Client has the right to be treated with respect and recognition of his or her dignity and right to privacy.
- Client has the right to participate with network practitioners in making decisions about his or her healthcare. (Provider disputes should not interfere with the professional relationship between you and the member).
- Client has a right to a candid discussion of appropriate or medically necessary treatment options for his or her condition.
- Client has the right to voice complaints or appeals to Insight and Empowerment, LLC and/or the insurance provider.
- Client has the right to make recommendations regarding member' rights and responsibilities policies.
- Client has a right to care that is considerate and that respects his or her personal values and belief system.
- Client has a right to Personal Privacy and Confidentiality of information.
- Client has a right to reasonable access to care regardless of race, religion, gender, sexual orientation, ethnicity, age or disability.
- Client has a right to have family members participate in treatment planning. Members over 12 years old have the right to participate in such planning.
- Client has a right to individualized treatment, including adequate and humane services regardless of the source(s) of financial support, receive provision for services within the least restrictive environment possible, an individualized treatment or program plan, periodic review of the treatment or program plan, an adequate number of competent, qualified and experienced professional clinicians to supervise and carry out the treatment plan.
- Client has a right to participate in the consideration of ethical issues that may arise in the provision of care and services including: resolving conflict, withholding resuscitative services, forgoing or withdrawing life-sustaining treatment, participating in investigational studies or clinical trials.
- Client has a right to designate a surrogate decision-maker if he or she is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care.
- Client has a right to be informed, along with his or her family, of his her or her rights in a language they understand.
- Client has a right to be informed of rules and regulations concerning his or her own conduct.

- Client has the right to choose not to comply with recommended care, treatment, or procedures and be informed of the potential consequences of not complying with the treatment recommendations.
- Client has the right to be informed of the reason for any non-coverage determination, including the specific criteria or benefit provisions used in the determination.
- Client has the right to have decisions about the management of their behavioral health benefits made based on appropriateness of care.
- Client has a right to inspect and copy their protected health information (PHI) and in addition, request to amend their PHI, request an accounting of non-routine disclosures of PHI, request limitations on the use or disclosure of PHI, request confidential communications of PHI to be sent to an alternate address or by alternate means, make a complaint regarding use or disclosure of PHI, receive a Privacy Notice.
- Client has a right to receive information about the network's clinical guidelines and quality assurance and performance Improvement program (QAPI).

Responsibilities

- Client will be responsible for supplying information needed to provide care.
- Client will be responsible to follow plans and instructions for care that they have agreed on with his or her network practitioner.
- Client will be responsible to understand his or her health programs and participate in developing mutually agreed upon treatment goals to the degree possible.
- Client will be responsible to keep their scheduled appointments and actively participate in treatment.

Grievances:

- In the event a client feels like their treatment at Insight and Empowerment, LLC is unfair or inappropriate, they will be asked to contact the owner, Sarah Hernandez, LCSW at (208) 932-7048 to discuss their concern. Client will be asked if they wish to write a formal grievance.

- Formal Grievances will be submitted to the insurance company within 14 days. The insurance company may further investigate the complaint. A corrective Action Plan may result from the complaint. A written response will be given to the client and kept in his/her file for a minimum of 2 years.

I acknowledge the rights, responsibilities, and grievance procedures written by Insight and Empowerment, LLC. I understand that if I have any further questions, I am encouraged to ask a professional at the agency for further explanation.

Responsible Party Signature: _____Date: _____

Responsible Party Signature: _____Date: _____

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HIPAA NOTICE OF PRIVACY PRACTICES

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

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

Uses and disclosure of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you or may be provided to a physician to whom you have ben referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. We may also call you by name in the waiting room when your clinician is ready to see you. We may disclose your protected health information, as necessary to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situation include: as By Law, Public Health issues are required by law, Communicable situation include: as Required Abuse Or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donation: Research: Criminal Activity: Military Activity and Nation Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we much make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other permitted and Required Uses and Disclosures will be made only with your consent, authorization or Opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. However, under Federal Law, you may not inspect or copy the following record: psychotherapy notes: information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action/proceeding. You may not inspect your protected health information that is subject to law that prohibits access to protected health information.
You may request a copy of your medical record by appearing at the office in person or calling our office at 208-932-7048. With a signed consent for us to disclose your medical records, electronic transmissions of your medical record may be sent to another provider at no cost.

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

Your provider is not required to agree to a restriction that you may request. In the event the provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional. Records will be sent to your new provider at no cost, once a signed consent to disclose records is received.

You have the right to request to receive confidential communications from us by alternative means. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice. You then have the right to object or withdraw as provided in this notice.

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

- U.S. Department of Health and Human Services
  200 Independence Avenue, S.W.
  Room 509F HHH Bldg.
  Washington, D.C. 20201

- Email to OCRComplaint@hhs.gov

  Filing a Complaint | HHS.gov

This notice was published and becomes effective on/or before February 1, 2022. You have the right to discuss the contents of this notice.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Office, Sarah Hernandez, LCSW, in person or by phone at our mail phone number.

You can also reach her via email at Insightandempowerment@outlook.com We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. Signature below is only an acknowledgment you have received this notice.

Responsible Party Signature: _____Date: _____

Responsible Party Signature: _____Date: _____

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Electronic Private Health Information ePHI Communication

Client's may request communication through email and/or text messages regarding scheduling or for administrative functions at Insight and Empowerment, LLC. We would like you to be aware that there may be various privacy risks associated with this form of communication. This is also up to the discretion of the professional counselor whether to utilize this form of communication. E-mails and text messages will become part of your mental health records at the agency. Security safeguards are put in place in accordance with HIPPA practices.

Standard emails are not secure and pose some risk that data can be intercepted if the wrong email address is accidently used. There is no assurance of the confidentiality of either of these two communication methods. The use of electronic communications may increase the risk of unauthorized disclosure of and/or access to ePHI. When inappropriate access has occurred, Insight and Empowerment, LLC has an obligation to inform the patient of a breach in privacy.

It is our policy to respond to emails within 24 business hours. Should you wish to request an appointment or telephone call sooner, please contact the office at 208-932-7048.

If you are fully aware of these and other potential risks and still would like to have communication through email and/or text, please sign below: "I agree to not hold Insight and Empowerment, LLC responsible for unauthorized disclosure of and/or access to ePHI that was obtained accidentally through these methods. By signing below, you are also certifying that the email address and phone number provided on this request is accurate, and that you accept full responsibility for messages sent to and from this email address and/or phone number.

Email only _____ Text only _____ Email and Text _____ None _____

E-Mail Address: _____

Responsible Party Signature: _____Date: _____

Responsible Party Signature: _____Date: _____

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Release of Protected Health Information

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your health information for the purposes described below unless there is a serious or imminent threat to the health and safety of you or to others. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed.

Individual Information (For Person whose Information will be shared)

Name: _____ Date of Birth: _____

Address: _____
City: State: Zip:
Telephone Number: _____

I authorize that I am the individual or the individual's legal representative_____ (DOB) _____ and authorize Insight and Empowerment, LLC to share, give, and receive health information with the following individuals and/or agencies:

Name/Agency: _____
Address: _____
Phone: _____FAX_____
This information will be limited to: (please initial)
___ Physical or Medical Records
___ Scheduling
___ Comprehensive Diagnostic Assessment
___ Entire Treatment Record (except notes)
___ Appointment Times
___ Other: _____

Name/Agency: _____
Address: _____
Phone: _____FAX_____
This information will be limited to: (please initial)
___ Physical or Medical Records
___ Scheduling

___ Comprehensive Diagnostic Assessment
___ Entire Treatment Record (except notes)
___ Appointment Times
___ Other: _____

Name/Agency: _____
Address: _____
Phone: _____FAX_____

This information will be limited to: (please initial)
___ Physical or Medical Records
___ Scheduling
___ Comprehensive Diagnostic Assessment
___ Entire Treatment Record (except notes)
___ Appointment Times
___ Other: _____

I understand that my records are protected under Federal Regulations governing Confidentiality of Protected Health Information (PHI) under HIPPA and Confidentiality (42 CFR part 2).

I understand I have the right to change or revoke this authorization at any time. This authorization will automatically expire within 12 months from the date of signature. A photocopy of this form will be considered as valid as the original. You may rescind this authorization at any time.

I understand that if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to Insight and Empowerment, LLC.

_____
Signature of Individual or Legal Representative:

_____
Printed Name of Individual or Legal Representative:
Date_____

_____
Signature of Minor (age 14+)

_____
Printed Name of Minor
Date_____

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Telemental Health Informed Consent

Client Name: _____ Date: _____

Email address: _____ Phone:_____

I understand and agree to the following with respect to medical/mental health services:

I, _____, hereby consent to participate in telemental health with, Insight and Empowerment, LLC as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to telemental health:

1) Privacy and confidentiality are shared responsibilities of the provider and the client. It is my responsibility to maintain privacy on the client end of communication. I agree to use reasonable security protocols to protect the privacy of my own health care information. The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

2) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

3) I understand that it is my responsibility to check with my insurance plan to determine coverage of telehealth services.

4) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

5) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

6) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

7) In addition, I understand that telehealth services and care may not yield the same results nor be as effective as face to-face service. I understand that if my provider believes I would be better served by another form of psychotherapeutic service (e.g. in-person), I will be referred to a provider in my area who can provide such service. My provider and I will regularly reassess the appropriateness of continuing to deliver services to me using the technologies we have agreed upon today, and modify our plan as needed.

8) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required. Furthermore, if I believe I may be facing an emergency situation that could result in harm to me or to another person; I am not to seek a telehealth, instead I agree to seek care immediately through my own local health care provider or at the nearest hospital emergency department or by calling 911.

9) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to discuss since we may reconnect within ten minutes, please call me at (208) 932-7048 to discuss since we may have to re-schedule.

10) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____
and my emergency contact person's name, address, phone:
_____
_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Client's Signature: _____
Date: _____

Parent/Guardian Signature:_____
Date: _____