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

Clients Name: _____DOB_____
Address_____
City: _____State: _____Zip code: _____
Phone Number: _____Alternate Number: _____
Age: _____ Gender: _____ Social Security: _____
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: _____
If Medicaid, Type of Funding: _____
Name of Insured: _____DOB: _____
SS: _____ Policy Number: _____
Employer: _____
Relationship to the client: Self Child Spouse Guardian Other
Address: _____ City: _____
State: _____ Zip code: _____

Does the client have additional insurance?
Secondary Insurance
Name of Insurance Company: _____
If Medicaid, Type of Funding: _____
Name of Insured: _____DOB: _____
SS: _____ Policy Number: _____
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 $72 for thirty minutes, $108 for forty-five minutes and $132 for one hour and $207 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. Services may be modified based on insurance caps and/or policies. 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 a minimum once per month and will be due by the 5th of the month. Co-payments are expected at the 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. It is at times medically necessary for providers within this agency, or contracted with this agency, to consult with other professionals in order to provide the best quality of care; appropriate safeguards and HIPPA standards are followed.

No Show to Scheduled Appointments and Late Cancellations
Please be advised that the agency and clinicians do not get reimbursed if appointments are not kept. If the client needs to cancel an appointment, we ask that a 24-hour notice be provided. If the client calls to cancel and it's within the 24-hour period prior to the scheduled appointment, the therapist may charge a late cancellation fee of up to $50.00. If the client no-shows an appointment, the therapist may charge a no-show fee of up to $50.00. The fee must be paid before or at your next session. If the provider determines that the safety and/or confidentiality of a telemental health session cannot be ensured and elects to terminate the session, the client may be charged a late cancellation fee.
Following three no-show appointments and/or late cancellations, the client will be discharged from the agency. If you show up more than 15 minutes late for the appointment the clinician may

not see you and a no-show fee may be assessed. Likewise, if a client has been attending therapy sessions and the therapist deems the sessions to be ineffective based on non-compliance, we will have to look at discontinuing services for inconsistent/in-effective treatment. If you would like us to contact you to try to get you in with another therapist, please consent below.

Consent for Re-Engagement: (Please select one)
_____ (initial) Yes, I give consent to be contacted about scheduling with a new therapist.
_____ (initial) No, I do not give my consent to be contacted for re-engagement of services.

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 Idaho Suicide and Crisis Line (988), 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. An individualized safety plan will be developed at the initiation of treatment.

Treatment:
Services provided will be based on evidence 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. Therapists may encourage use of interactive tools to assist the client outside of therapy. If you choose to elect to utilize an interactive third-party tool, the agency is not liable for any release of HIPPA information.
If at any point during therapy, you request couples therapy, please be aware that one individual within the relationship will need to complete the intake packet and participate in the comprehensive diagnostic assessment. This individual is considered the identified client. Should couples therapy be terminated, for whatever reason, this individual may continue to receive individual therapy services, and the other individual may be referred to another clinician and/or agency for continued care.

Consent for Student to Attend Appointment: (Please select one)
_____ (initial) Yes, I give consent for student to participate in my appointment.
_____ (initial) No, I do not give consent for student to participate in my appointment.

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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Members Rights and Responsibilities

Member Rights:

1) Get information required by the law
2) Get information about the Idaho Behavioral Health Plan by mail, email, on the phone, or on our website at no cost to you. This includes getting the Member Handbook by mail, email or on our website.
3) Get information about IBHP benefits you are eligible for and how to get those services
4) Get information about services that are not covered by the IBHP, or you are not eligible for and how to get those services
5) Know about services that Magellan does not cover because of moral or religious reasons and how to get those services
6) Be treated with respect, dignity, and respect for privacy by Magellan staff and network providers
7) Not be discriminated against due to your race, color, national origin, religion, disability, sex, gender identity, marital status, national origin, health status, need for services, or age
8) Talk with providers and Magellan staff in private and have your information and records kept private by your provider and Magellan
9) Understand that if the law permits, your information and records may be released without your permission
10) Get IBHP services you are eligible for in a timely fashion
11) Get information and IBHP services you are eligible for in a way that respects your culture and language, regardless of cost or coverage
12) Give input on your plan of care at any time
13) Get oral interpretation help at no cost in a language you understand
14) Use auxiliary aids to help you communicate at no cost (TTY, TDD, ASL)
15) Get written information in prevalent languages at no cost
16) Get materials that are needed to get services or help you understand and access your benefits in alternate formats at no cost
17) Get information about:
    a) Magellan
    b) Our services
    c) Providers that can help you
    d) Your role in your health
    e) Your rights and responsibilities
18) Get information about Clinical Guidelines we use to help you get care
19) Pick any Magellan network provider that you want to treat you based on your preferences and switch if you want to
20) Ask any provider about their work history and training
21) Not be kept alone or forced to do something you do not want to do
22) Give input on these Rights and Responsibilities
23) Have providers make decisions about your care based on treatment needs
24) Get IBHP services you are eligible for according to Federal and State laws about your rights

25) Make decisions about your treatment
    a) If you cannot make them by yourself, you can have someone help you or do it for you.
    b) You can refuse treatment unless the law makes you get it.
26) Ask for and get a second opinion at no cost when you:
    a) Need more information about a treatment
    b) Think the provider is not giving you the right care
27) Not be kept alone or held back because Magellan or a provider wants to:
    a) Force you to do something
    b) Discipline you
    c) Make things easier for a provider
    d) Punish you
28) File a Complaint about Magellan, a provider, or your care
29) File an Appeal about an action or decision Magellan made
30) Ask for a State Fair Hearing if you are not happy with the outcome of your appeal
31) Ask for and get a copy of your records for free and ask for changes or corrections to them 32) Exercise your rights without it negatively affecting the way Magellan or network providers treat you
33) Get written information about psychiatric advance directives (Mental Health Declarations) and your rights under State law
34) Get IBHP services you are eligible for whether or not you have completed a psychiatric advance directive (Mental Health Declaration)
35) Get information you can understand from your providers and be able to talk to them about your options without any interference from Magellan or regard to cost or coverage
36) Get a written statement of Patient Rights and Responsibilities from your or your child's provider, before you or your child get mental health services, that has information on who to contact with questions, concerns or complaints
37) To request reasonable accommodations if you have a visual, hearing, or physical disability to ensure you can get all services you are eligible for
38) Know that Magellan complies with applicable Federal and State laws including:
    a) Title VI of the Civil Rights Act of 1964
    b) The Age Discrimination Act of 1975
    c) The Rehabilitation Act of 1973
    d) Titles II and III of the Americans with Disabilities Act
    e) Other laws about privacy and confidentiality
39) Be protected by parity requirements for total lifetime and annual dollar limits, and requirements for financial requirements and treatment limitations
40) Not have to pay for services if: a) Magellan goes out of business b) The State of Idaho does not pay Magellan or a provider c) A provider bills you for amounts over what Magellan covers 41) Get conflict-free case management if you are eligible for case management
42) Get emergency help when and where you need it without Magellan's approval
43) If you are under age 18, keep your treatment records private and:
    a) If you are 14 or older, decide whether or not you want to let your parent/guardian see them (unless your provider thinks that would hurt you in some way)
    b) Look at and copy them (unless your provider thinks that would hurt you in some way)
    c) Add your own notes to them
44) Reject services
45) Talk to us and your child's providers about changes made to their care plan for visitation or care arrangements when placed out of the home, such as residential treatment or foster care 46) At the time of out-of-home placement (voluntary or involuntary), be informed through a service agreement, in terms you understand, of the rights and obligations of you, your child or ward, providers and Magellan while the child is there
47) Have a six (6)-month review for a child in out-of-home placement

48) If you or your child is admitted to a facility (voluntary or involuntary), be informed, orally and in writing, of your and your child's rights and obligations in terms you can understand
49) If you or your child have been taken to a social detoxification facility (where you/they can stay for up to 3 days), you/your child have the right to:
    a) Request and take a test to see if you are intoxicated or using a substance of abuse
    b) Be released if the tests show you are not
    c) Have the facility keep a record of your test results
50) If your child is in a facility, they have the right to:
    a) Be treated nicely in a clean and safe place
    b) Leave for a short time if it is safe for you/them to do so
    c) Not be restrained or secluded if you/they don't need to be
    d) Not get hit or otherwise abused
    e) Get enough food, liquid and exercise
    f) Have visitors in private if appropriate
) Send and get mail and get help writing letters
    h) Talk on the phone in private and get help using the phone
    i) Call people who are far away if you/they can pay what it might cost
    j) Pray, meditate, or do other religious acts and not be punished
    k) Have personal belongings as long as they cannot be used to hurt you/your child
    l) Tell people what your/your child's rights are and not be punished
    m) Have a lawyer help you/your child
    n) Not take too many or unhelpful medicines
    o) Get schooling
51) If your child 's admission to a facility was voluntary with your consent:
    a) Tell the facility if they can give your child medicine
    b) Tell the facility to stop giving your child medicine at any time unless it is an emergency
    c) Have your child's facility admission reviewed after 30 days
    d) Be notified seven (7) days in advance of your child's 30-day admission review
52) If your child goes to a facility because of an emergency, you/they have the right to:
    a) Be told by the provider what services they may need and how long they might take
    b) Be released to you within 24 hours, unless a court says your child needs an evaluation
    c) If a court says your child needs an evaluation, be told orally and in writing:
        i) Why the court ordered it
        ii) What might happen
        iii) Your right to talk to a lawyer
        iv) Your right to get treatment
53) If a court orders your child to go to a facility for 120 days, they have the right to:
    a) Talk to the court about it within three (3) days of the order
    b) Have a lawyer help them
    c) Have their lawyer go to the court without them
54) Have a lawyer help your child at any time and get free help from a lawyer if you/they can't pay for one

Member Responsibilities:
Whether you are an adult or a youth, Magellan needs your help so that you get the services and supports you need. You have the responsibility to:
1. Get treatment you need from a provider
2. Respect other patients, provider staff and provider workers
3. Give providers and Magellan information they and we need so you can get appropriate and quality care
4. Ask their providers questions about their care to help you understand your care.
5. Follow the care plan that you agreed to with your provider and family/guardian

6. Tell your providers about medicine changes, including:
    a) Medicine given to you by others
    b) Over-the-Counter medicine
    c) Vitamins
    d) Herbs or other natural medicine
7. Keep your appointments
8. Call your provider as soon as you know you need to cancel a visit
9. Tell your provider if your care plan is not working for you
10. Tell your provider if you have problems paying for care
11. Report fraud and abuse to Magellan at 1-800-755-0850 (TTY 711)
12. Tell Magellan if you are concerned about quality of care.
13. Learn about Magellan coverage, including all covered and non-covered benefits and limits 14. Use only network providers unless Magellan approves an out-of-network provider
15. As a child, or parent/guardian of a child, review and sign acknowledgement of documents outlining specific rights during treatment

If you have any questions about these Rights and Responsibilities, please call us at 1-800-424-7721 (TTY 711).

Grievances:
If you believe your Rights have been violated, you can contact us by mail, phone, or email:

Mail: Magellan Healthcare, Inc. Civil Rights Coordinator Corporate Compliance Department 8621 Robert Fulton Drive Columbia, MD 21046
Phone: 1-800-424-7721 (TTY 711)
Email: compliance@magellanhealth.com

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.

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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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

Effective July 1, 2024, Idaho healthcare providers must obtain parental consent to treat unemancipated minors or face civil liability except in emergency cases. In addition, parents will have the right to access the medical records of their minor children subject to very limited exceptions; as well as subject to HIPPA laws.

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. These duties and rights are set forth more fully in 45 C.F.R. part 164. We are required by law to abide by the terms of our Notice that is currently in effect.

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 been 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 officer 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 questions or objections about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact our Privacy Contact:

Privacy Officer: Sarah Hernandez, LCSW, Owner/Clinical Supervisor
Phone: (208) 932-7048
Address: 1908 Jennie Lee Dr., Idaho Falls, ID 83404
E-mail: sarah@insightandempowerment.com

You can also reach her via email at IE@Insightandempowerment.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.

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. The same applies if you are the parent or legal guardian of a minor child, you must give written permission and consent for the minor client to receive email and/or text messages as well.

By signing below, you are also certifying that you understand and agree to the terms of this consent and that permissions you have granted in this consent are without limitation.

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

E-Mail Address: _____

Minor Email 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 Wellness Exam
___ 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 Wellness Exam
___ 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 Wellness Exam
___ 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_____

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

Telemental Health Informed Consent

Client Name: _____ **Date:** _____

Email address: _____ **Phone:**_____

I understand and agree to the following with respect to medical/mental health services. The same also applies if I am the parent or legal guardian of a minor, participating in telemental 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:

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.

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.

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

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.

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.

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).

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.

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.

I understand I am solely responsible for ensuring my safety during telehealth sessions, I understand that it is unsafe to participate in a telehealth session (audio only and/or video) while driving OR as a passenger in a moving vehicle. I will always park in a safe location before initiating a session if I am in a vehicle. If I find myself in a situation where I cannot safely participate in a telehealth session due to driving, I will immediately inform the provider and reschedule the appointment. Failure to adhere to this policy will result in the provider promptly ending telehealth communication.

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.

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: _____

Email intake packet and CDA forms to confidential email address:
Reception@Insightandempowerment.com