ForWard Consulting, LLC

INTAKE FORM

Initial Session Date:_____ Insurance Carrier/ #:_____ DOB:_____

Referred by: _____

CLIENT INFORMATION:

Last Name:_____ First Name:_____ MI:_____ Age:_____

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

Home Phone:_____ Alt. Phone:_____ Work Phone:_____

Email Address:_____

Race: White African-American Hispanic/Latinx Native American Other:_____

Preferred Pronouns: _____

PRIMARY PARENT/GUARDIAN/CARETAKER (IF APPLICABLE):

1 – Name:_____ Age:_____ Relationship to Child:_____ Marital Status:_____

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

Home Phone:_____ Alt. Phone:_____ Work Phone:_____

Employment Status: Full Time Part Time Retired Student Homemaker Other: _____

Yearly household Income: _____

Emergency Contact Information:

1 – Name:_____Relationship to Client:_____

Home Phone:_____ Alt. Phone:_____ Work Phone:_____

2 – Name:_____Relationship to Client:_____

Home Phone:_____ Alt. Phone:_____ Work Phone:_____

ForWard Consulting, LLC

Authorization to Release and Obtain Information from Family Members

Many of our clients allow family members to call and communicate with providers and therapists. Under the requirements of HIPPA we are not allowed to release information to anyone without the patient's consent. If you wish to have your medical/mental health information released and discussed with family members other than a legal parent/guardian and/or caregiver then you must sign this form. Signing this form will only give consent to release or obtain this information from the family members indicated below. This consent form will not allow ForWard Consulting, LLC to release any other information to these family members. This consent will expire one year from the date of signature unless a shorter period is specified (specific number of days/months or date):_____. You have the right to revoke this consent in writing.

I authorize/allow ForWard Consulting, LLC to release or obtain medical/mental health information to the following individual(s):

1.) _____ Relationship to Client: _____

2.) _____ Relationship to Client: _____

3.) _____ Relationship to Client: _____

_____ _____
Signature of Client or Representative Date Signed

_____
Relationship to Client

Authorization to Leave Voice and Text Messages with Approved Support Persons

Occasionally it is necessary for the staff of ForWard Consulting, LLC to leave messages for patients. The purpose of these messages is to remind clients that they have an appointment, to notify the client that staff would like to discuss or to the client/parent/guardian/or caregiver regarding issues and/or concerns. At no time will a representative of ForWard Consulting, LLC discuss medical/mental health conditions without the consent of the client/parent/guardian/or caregiver. The purpose of this consent is to leave messages with members of your household or on your answering machine. This consent will expire one year from the date of signature unless a shorter period is specified (specific number of days/months or date):_____.
You have the right to revoke this consent in writing.

_____ _____
Signature of Client or Representative Date Signed

_____
Relationship to Client

ForWard Consulting, LLC

Treatment Agreement

This document contains important information about our professional services and business policies. Please read this document carefully. Once you sign this, it will constitute a binding agreement between you and ForWard Consulting, LLC. The purpose of individual therapy is to gain insight into what changes **YOU** need to make in order to improve your life circumstances. We will not concentrate on how others have wronged you, what *they* need to change, or if you have system (DHS, JCS, DOC) involvement. The focus here will be on **YOU**.

You will be expected to sign necessary Releases of Information that will allow ForWard Consulting, LLC to talk to those you permit or are required to so the 3rd party can gain information relevant to your care. If you are court ordered to therapy, the court order will take precedence. Any information requested by the 3rd party will be released.

If you are involved with juvenile, civil, or criminal court system, refrain from disclosing information you'd like "kept off the record." Clinicians of ForWard Consulting, LLC are mandatory reporters and will report any suspected child or dependent adult abuse, neglect, or potential threat/harm to a child or dependent adult.

I acknowledge that I am voluntarily authorizing treatment for myself (or for my dependent, _____), at ForWard Consulting, LLC Further, it is understood that treatment will be rendered by appropriate trained, licensed, or certified professional personnel. ForWard Consulting, LLC offers therapeutic services. Services and treatment may vary depending on the personality and needs of the individual. There are a number of different approaches which can be utilized to address each individual's needs. Mental Health Services are not like visiting a doctor, in that it requires collaboration, partnership, and strong involvement on the part of the individual and their support. In order to be most successful, you will have to work both during sessions with the Clinician and at home.

There are benefits and risks to Mental Health Services. Risks sometimes include experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness. Psychotherapy often requires recalling unpleasant aspects of the individual's life. Psychotherapy and other Mental Health Services offered by ForWard Consulting, LLC has also shown to have benefits for people who undertake it. It often leads to a significant reduction of feelings of distress, healthy relationships with others, and resolution of specific problems. But there are no guarantees about what will happen. In some circumstances it may be beneficial and/or necessary to referral a client to alternative programs and services to better meet the needs of the client.

I understand that ForWard Consulting, LLC may exchange any and all information from my health plan representative and/or primary care physician pertaining to my therapy to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance, and/or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent. I understand that if I do not revoke this consent, it will expire automatically one year (12 months) after all claims for treatment have been paid as provided in the benefit plan.

_____ _____
Print Name Date

_____ _____
Signature of Client or Representative Date

_____
Relationship to Client

ForWard Consulting, LLC

TELEHEALTH CLIENT CONSENT FORM

A telehealth service means that the client's visit with a licensed mental health clinician at another location (distant site) will happen by using special audiovisual equipment.

I, for myself (or as the parent/legal guardian for the minor client), also understand and agree that:

- I can decline the telehealth service at any time without affecting my right to future care or treatment, any program benefits to which I would otherwise be entitled cannot be taken away.
- I may have to travel to see a licensed health care practitioner in-person if I decline the telehealth service.
- If I decline the telehealth services, the other options and alternatives available to me, including in-person services, are as follows: to be seen at ForWard Consulting, LLC in the Central Iowa area.
- 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).
- I will have access to all medical information resulting from the telehealth service as provided by law.
- 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 will be informed of any individuals who will be present at the originating site and the distant site (ForWard Consulting, LLC) during my telehealth service.
- 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 reconnect within ten minutes, please call me at_____ to discuss since we may have to re-schedule.
- I may see an appropriately trained Clinician in-person immediately after the telehealth service if an urgent need arises or I will be told ahead of time that this is not available. I have read this document carefully, and my questions have been answered to my satisfaction.

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 Clinician. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Client Name (Printed): _____
Client Signature: _____ Date: _____
Parent/Legal Guardian Name (Printed): _____
Parent/Legal Guardian Signature: _____ Date: _____
Originating Site Witness - Authorized Signature Required By: _____
Date: _____

ForWard Consulting, LLC

GRIEVANCE PROCEDURES

The purpose of the grievance procedure is to allow you, as the individual, the opportunity for recourse should there be unhappiness with the services provided or decisions made. Upon initial complaint a meeting will be held with you and the Clinician from ForWard Consulting, LLC. The purpose of this meeting will be to resolve any dispute if possible. If the meeting is unsuccessful, ForWard Consulting, LLC will arrange for an owner from ForWard Consulting, LLC to hear and address your grievance.

If you are not satisfied with the responses given, you may contact the Bureau of Professional Licensure at 515-281-0254 in order to discuss your concern.

ABUSE REPORTING AND RELEASE OF INFORMATION POLICY

It is our duty, as mandatory reporters, to immediately report any suspected child and dependent adult abuse to department of human services (DHS). ForWard Consulting, LLC shall report suspected abuse orally to DHS, followed by a written report to DHS within 48 hours after such oral report. ForWard Consulting, LLC shall also make an oral report to an appropriate law enforcement agency if the worker believes that immediate protection of the child is warranted.

Types of Child Abuse

1. Physical Abuse
2. Mental Injury
3. Sexual Abuse
4. Denial of Critical Care
5. Child Prostitution
6. Presence Of Illegal Drugs In The Body Of A Child
7. Manufacture Or Possession Of Dangerous Substances In The Presence Of The Child
8. Bestiality In The Presence Of A Minor
9. Cohabitation With A Registered Sex Offender

Please sign below if this agreement was explained in a way that you understand.

_____ _____

Signature of Client or Representative Date Signed

_____

Relationship to Client

ForWard Consulting, LLC

MISSED APPOINTMENT POLICY

We strive to provide individuals with the utmost professionalism and excellence of service. Our commitment to your well being and the provision of quality services is taken seriously by ForWard Consulting, LLC and cannot occur without regular attendance of scheduled appointments. Regular attendance of all scheduled appointments is a critical component of services provided at ForWard Consulting, LLC and the overall benefits received by the individuals: therefore; we have certain rules that need to be followed in regards to clients attendance. We expect you to keep all your appointments. You will receive text message reminders upon your approval. We also encourage that you write down the date & times of your future appointments.

Concerning Appointments

Missed Appointments: ForWard Consulting, LLC operates on an appointment only basis. If you fail to attend an appointment without calling/canceling 24 hours in advance, this is considered a 'no show' and you will be charged **$50**. If this persists consecutively three times in a row, ForWard Consulting, LLC reserves the right to terminate services and refer to another community agency with equivalent services. Remember, therapy is a commitment on both our parts, and you will be expected to be on time and use the time productively.

Reoccurring Appointments: If you are given a reoccurring appointment (same time each week for a number of weeks) and fail to attend an appointment (no 24 hour notice given), your appointment may be automatically canceled for the following weeks and you will be charged **$50**. To preserve your appointments, you must make contact with the Clinician to share the barriers of getting to the appointment. The Clinician will use her discretion as to if the reoccurring appointment will remain.

Same Day Scheduling: If you are struggling with keeping your appointments, but remain engaged with the Clinician, you will be given the option to schedule on the day that you call for an appointment. There may not be available openings, so you will have to call the following business days until you are scheduled with the Clinician.

- **How to Cancel Your Appointment**: To cancel your appointment, please contact ForWard Consulting, LLC at *(515) 996-5935 or emailing at moveforwardconsulting.llc@gmail.com*. If you cannot reach the Clinician, please leave a message on our agency voicemail, with your name and a phone number so that we can return your call promptly.

- **Late Cancellations:** A cancellation is considered late when an individual contacts ForWard Consulting, LLC to cancel the same day of their scheduled appointment. We do understand there are times when a 24 hour notice is not possible. Emergency cancellations will be evaluated on an individual basis and as long as the individual called, the $50 late fee will be waived.

As an individual receiving services from ForWard Consulting, LLC, you have the right to contact ForWard Consulting, LLC to develop a plan so that services are not terminated. ForWard Consulting, LLC is dedicated to help assist with finding solutions to help individuals be successful with attending their scheduled appointments and making therapeutic process.

I have read and understand the above Missed Appointment Policy.

_____ _____

Signature of Client or Representative Date Signed

_____

Relationship to Client

ForWard Consulting, LLC

STATEMENT OF CONFIDENTIALITY

Although the information provided to ForWard Consulting, LLC are generally confidential, there are important exceptions of which you should be aware.

1. **Responsibility to Therapy**
If, in the opinion ForWard Consulting, LLC, therapy cannot properly continue unless information shared during a session must be addressed with other support persons. ForWard Consulting, LLC reserves the right to give the individual the option to tell others themselves, have the ForWard Consulting, LLC Clinician address the issue with family/support system, or terminate therapy services. Likewise, if an individual is engaged in family or couples therapy services, ForWard Consulting, LLC has an ethical obligation to balance the interests of all family members. If a client informs ForWard Consulting, LLC of a situation that is harmful or unethical, ForWard Consulting, LLC may give the client the option of fixing the situation (where/if possible), informing other family members, having the ForWard Consulting, LLC address the issue, or ending therapy services.

2. **Duty to Warn and Protect**
If, in the opinion of ForWard Consulting, LLC, a client poses a danger to themselves or others, ForWard Consulting, LLC has a legal duty to act. For example, if a client threatens someone's life, ForWard Consulting, LLC is legally obligated to warn that person, even if you terminate therapy services. If a client threatens to commit suicide, the ForWard Consulting, LLC may have to notify members of the client's family, the local law enforcement, or other agencies. If ForWard Consulting, LLC is informed of the physical or sexual abuse of a child, the ForWard Consulting, LLC is legally required to contact DHS protective services.

3. **Court Orders and Subpoenas**
ForWard Consulting, LLC do not voluntarily participate in litigation or other adversarial actions. If a proper subpoena is served, a judge can compel ForWard Consulting, LLC to release records to the court. ForWard Consulting, LLC charges **$200/hour** if subpoenaed to testify in a court hearing.

4. **Treatment Planning**
Every 6 months ForWard Consulting, LLC will conduct a reassessment. The purpose of this is to ensure that every effort is being made to ensure that every client is receiving the best possible services provided by ForWard Consulting, LLC.

5. **Privacy of Minors**
ForWard Consulting, LLC encourages parents to allow their child/children therapeutic privacy (excepting for cases such as listed above). Parents do, however, have the right to be informed of what takes place in therapy with their underage children.

6. **Professional Misconduct**
In the event that unethical behavior of the Clinician is reported and/or discovered, a complaint needs to be filed.

7. **Fee Payment**
If the financial obligation to ForWard Consulting, LLC becomes neglected by the individual receiving services, a collection agency may be given ample amount of information to settle the debt owed.

_____ _____
Signature of Client or Representative Date Signed

_____
Relationship to Client

ForWard Consulting, LLC

AUTHORIZATION TO OBTAIN OR RELEASE HEALTH CARE INFORMATION

Client Name: _____ Insurance Carrier and ID: _____

Date of Birth: _____ Parent/Guardian: _____

I authorize the following individual or agency to share written and oral information (two-way or reciprocal release) about my needs and the services I receive…

Name or agency to release and receive information: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

With the following individual or agency:

Name or agency to release and receive information: ForWard Consulting, LLC

Address: 4309 University Avenue

City/State/Zip: Des Moines, Iowa 50311-3423

Phone: (515) 410-1716 Fax: (515) 414-7638

The information released or shared may include:

- ☐ Discharge summary
- ☐ Admission status
- ☐ Diagnosis/allergies
- ☐ Initial assessment
- ☐ Receiving phone calls
- ☐ Consultation reports from (doctor/specialty name): _____
- ☐ Other (please specify): _____
- ☐ Family data photos
- ☐ Medication history
- ☐ X-ray/imaging reports
- ☐ Immunization record
- ☐ Face sheet
- ☐ Lab results
- ☐ Team notes
- ☐ Social history
- ☐ School Records
- ☐ Psychological reports
- ☐ Treatment and aftercare plans
- ☐ History & Physical Exam
- ☐ Evaluation & recommendations
- ☐ Court documents

This information is being used ONLY for (state purpose):

The purpose for this disclosure is to facilitate effective treatment service coordination. A photocopy or exact reproduction of this form for release of information shall have the same effect as the original. This authorization will automatically expire one year from the date of signature unless a shorter period is specified (specific number of days/months or date): _____. This authorization is valid for information already in existence and any information that may be generated while this authorization is effective. I understand that I have the right to see any information that is disclosed pursuant to this authorization for release. I may request to see this information during normal business hours. I understand that I may revoke this authorization at any time, except to the extent that information has already been released as authorized by giving written notice to ForWard Consulting, LLC I understand that I have the right to review the disclosed information by contacting ForWard Consulting, LLC once this authorization has expired or has been revoked, it can be renewed only by proper execution of another authorization. I acknowledge that information to be released may include material that is protected by state and/or federal law, including applicable mental health, alcohol/drug abuse, HIV/AIDS information, or all of these. My signature authorizes release of only the information specified above. I understand that information authorized by this consent cannot be released to anyone than those listed above unless I give written permission. I have read this form, or it has been read and explained to me, and I understand its content.

_____ _____

Signature of Client or Representative Date Signed

_____ _____

Witness Signature Date Signed