# Client Information

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## Client Demographics

**First Name:** _____ **MI:** _____ **Last Name:** _____

**Address:** _____
*(Street)* *(City)* *(State)* *(Zip)*

**Caregiver:** _____ **Relationship to Client:** _____

**Home Phone:** _____ **Cell Phone:** _____ **Work Phone:** _____

**Email Address (Parent/Guardian):** _____

**Default Method of Contact** ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

**Client's Date of Birth:** _____ **Sex Assigned at Birth:** ☐ Male ☐ Female **Pronouns:** _____

**Race:** ☐ White ☐ African American ☐ Asian ☐ Bi-Racial ☐ Hispanic ☐ Native American ☐ Pacific Islander ☐ African

**Primary Care Physician:** _____ **Office Location:** _____

**School Attending:** _____ **Grade:** _____

**Annual Household Income (circle one):**

**Less than $40,000** **$40,000-$99,999** **$100,000-$149,999** **$150,000-$199,999** **$200,000 or more**

## Individual Financially Responsible for Account ☐ Legal Guardian

**Name:** _____ **Relationship to Client:** _____ ☐ **Same As Above**

**Address:** _____
*(Street)* *(City)* *(State)* *(Zip)*

**Home Phone:** _____ **Cell Phone:** _____ **Email:** _____

## Emergency Contact Information (if Client is 18 or over) ☐ ROI on File

**Name:** _____ **Relationship to Client:** _____ ☐ **Same As Above**

**Address:** _____
*(Street)* *(City)* *(State)* *(Zip)*

**Home Phone:** _____ **Cell Phone:** _____ **Email:** _____

## Insurance Information ☐ has Medicare

**Primary**
Insurance Company: _____
Policy ID: _____
Group #: _____
Relationship to Insured: ☐ Child ☐ Spouse ☐ Self ☐ Other
**Subscriber information:**
Name: _____
DOB: _____ Gender: ☐ Male ☐ Female
Phone #: _____

**Secondary (if applicable)**
Insurance Company: _____
Policy ID: _____
Group #: _____
Relationship to Insured: ☐ Child ☐ Spouse ☐ Self ☐ Other
**Subscriber information:**
Name: _____
DOB: _____ Gender: ☐ Male ☐ Female
Phone #: _____

# Universal Acknowledgement

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Client Name: _____ DOB _____
First Middle Last MM/DD/YYYY

Medicaid ID: _____

*Please sign below to indicate your understanding and/or to indicate the documents indicated have been made available for your review.*

**Duty to Warn:** I understand that it is the responsibility of my provider to report if a client or other identifiable person is in clear or imminent danger. If my provider believes that the client is a threat of harm to themselves, or someone else, it is their duty to report that threat to the authorities. In situations where there is clear evidence of danger to the client or other persons, the provider must determine the degree of seriousness of the threat and notify the person in danger and others who are in a position to protect that person from harm.

**Mandatory Reporting:** I understand that my provider is a mandatory reporter; therefore it is their obligation to make a report to the Department of Health and Human Services if they become aware of suspected abuse. This can include, but is not limited to, sexual abuse, physical abuse, mental injury, neglect and witness to domestic violence. The clinician is not responsible for investigating or authenticating any allegations and it is not their role to determine if the reported abuse meets qualification for reception of an investigation by the Department of Health and Human Services.

**Foster Care:** I understand that my provider is responsible for providing information to the Iowa Foster Care Review Board, as outlined in Iowa Code 237.21 for any child receiving treatment while in foster placement.

**Notice of Privacy Practices:** Notice of Privacy Practices provides information about how we may use and disclose protected health information. I understand that Tanager has the right to change this Notice at any time. I may obtain a current copy by contacting Tanager directly or through their website. By signing this form, you are acknowledging that Tanager has made our Notice of Privacy Practices available to you for review.

☐ Copy provided ☐ Declined Copy

**Client Handbook:** I hereby acknowledge that I have received a copy of Tanager Client Handbook, which includes detailed information regarding client rights and other related information.

Date: ____ /_____/_____

**Printed Name:** _____
(Patient or Authorized Representative)

**Signature:** _____
(Patient or Authorized Representative)

_____
(Relationship if other than Client)

# Informed Consent for School Services

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**Client Name:**_____ **DOB:** _____

*Please sign below to indicate your understanding. If choosing to opt out of any services (group or BHIS), indicate in bottom section.*

**Informed Consent Therapy**: I have chosen to receive treatment through the Tanager Mental Wellbeing Clinic at school. I understand that I may terminate treatment at any time. I understand that treatment is cooperative and that I have the right to be fully informed regarding the benefits or potential problems associated with any treatment I receive. I understand that information collected about me shall be confidential unless a release of information is given. Any release of information is only valid for the time period indicated and may be rescinded at any time. Exceptions will apply only in circumstances that legally require sharing information.

**Group Therapy (as applicable):** I have chosen to participate in group therapy. I understand that other children and a Tanager clinician will be involved in these sessions.

☐ Not authorized

**Informed Consent BHIS (as applicable):** I have chosen to receive treatment through Tanager. I understand that I may terminate treatment at any time. I understand that treatment is cooperative and that I have the right to be fully informed regarding the benefits or potential problems associated with any treatment I receive. I understand that information collected about me shall be confidential unless a release of information is given. Any release of information is only valid for the time period indicated and may be rescinded at any time. Exceptions will apply only in circumstances that legally require sharing information.

☐ Not authorized

Date: _____

**Printed Name:** _____
(Client or Authorized Representative)

**Signature:** _____
(Client or Authorized Representative)

_____
(Relationship if other than Client)

# Authorization to Exchange ePHI

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**Client Name:** _____ **DOB:** _____

**Alert for Electronic Communication**
Patients and/or personal representatives who want to communicate with their health care providers via electronic means should consider all of the following issues before signing an Authorization to Exchange Protected Health Information electronically:

1. Electronic communication can be forwarded, intercepted, printed and stored by others.
2. Electronic communication is a convenience and is not appropriate for emergencies or time-sensitive issues**.**
3. Highly sensitive or personal information should only be communicated electronically at the patient's discretion (i.e., HIV status, mental illness, chemical dependency, and workers compensation claims).
4. Employers generally have the right to access any email received or sent by a person at work.
5. Staff other than the health care provider may read and process email.
6. Clinically relevant messages and responses will be documented in the medical record at the provider's discretion.
7. Communication guidelines must be defined between the clinician and the patient, including (1) how often email will be checked, (2) instructions for when and how to escalate to phone calls and office visits, and (3) types of transactions that are appropriate for email.
8. Email message content must include (1) the subject of the message in the subject line (i.e., prescription refill, appointment request, etc.) and (2) clear patient identification including patient name, telephone number and date of birth or patient identification number (if known) in the body of the message.
9. Tanager will not be liable for information lost or misdirected due to technical errors or failures.

**Authorization for email communication**

_____ I authorize the Tanager Staff to email me regarding the course of my medical care, treatment and diagnostic test results, including information concerning mental health, substance abuse and sexually transmitted disease.

_____ I authorize Tanager Billing and Patient Accounts to email me with questions regarding my account status.

Patient/representative's email address: _____

**Authorization for text communication**

_____ I authorize the Tanager Staff to text me regarding the course of my medical care, treatment and diagnostic test results, including information concerning mental health, substance abuse and sexually transmitted disease.

Patient/representative's phone number: _____

**I have read and understand the Alert for Electronic Communications and agree that email messages and/or text exchanges may include protected health information about me / the patient, whenever necessary. This authorization will not expire unless revoked in writing.**

Date: _____ **Printed Name:** _____
(Patient or Authorized Representative)

**Witness:** _____ **Signature:** _____
(Patient or Authorized Representative)

_____
(Relationship if other than client)

# Release and Exchange of Information

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CLIENT NAME:_____ DOB: _____/_____/_____
First Middle Last

I hereby voluntarily authorize Tanager to disclose information to/from:

Maquoketa Valley Community School District
Name of Person / Organization

Address

(____) _____ (____) _____
Phone Fax Number

**PURPOSE:** _____

☒ Treatment ☐ Personal Use

☐ Insurance or Legal ☐ Other: _____

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW**

**I specifically authorize the exchange and release of confidential information to or from the above individual(s) and/or organization. The information exchange may be in oral or written form. I understand that my authorization will remain effective from the date of my signature until _____ /_____/_____ (MM/DD/YY), and that information will be handled confidentially in compliance with all applicable federal laws.**

The purpose of this exchange of information is to ensure that pertinent information is available to Tanager staff for provision of the most comprehensive treatment possible. Services rendered, however, are not contingent upon the receipt or exchange of this information. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

I understand that I may review the disclosed information at the discretion of the sending person, institution or organization. I understand I can revoke my consent by writing to all concerned parties involved in the information exchange. However, any information already exchanged may be used as stated in this consent. Disclosure of this information carries with it the potential for unauthorized re-disclosure and once information is disclosed it may no longer be protected by federal privacy regulations.

**I authorize the release of confidential information, which requires specific consent under federal law.**

| **Type of information: (Indicate Yes or No for all)** | | |
|---|---|---|
| Mental Health* | ☒ Yes | ☐ No |
| Substance Abuse ** | ☐ Yes | ☐ No |
| HIV / AIDS related Info. | ☐ Yes | ☐ No |

**Information to be released –** from ____/____/_____ to ____/____/_____

☐ Admission/Induction Records ☐ Progress Note(s) ☐ Medical Records
☐ Laboratory Tests ☐ Social History ☐ Medication Records
☐ History & Physical ☐ Discharge Summary ☐ Psychological Report
☐ Other: _____

Date: ____ /_____/_____

**Printed Name:** _____
(Patient or Authorized Representative)

**Witness:** _____

**Signature:** _____
(Patient or Authorized Representative)

_____
(Relationship if other than Client)

* Only a person 18 years of age or older or a person's legal representative can authorize release of mental health information.
** Only the subject can authorize release of substance abuse information unless the subject is of such age and mental maturity that they are unable to authorize release.

**COPY OF CONSENT GIVEN TO PARENT/GUARDIAN AND CLIENT**_____ **OR DECLINED COPY** _____

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# Release and Exchange of Information

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**Notice to Recipients of Mental Health Information** In accordance with "Disclosure of Mental Health and Psychological Information" (Iowa Code, Chapter 228), a recipient of mental health information may further disclose this information only with the written authorization of the subject or the subject's legal representative or as otherwise provided in Chapters 228 and 229. Unauthorized disclosure is unlawful and civil damages and criminal penalties may apply. Federal confidentiality rules (42 CFR Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Notice to Recipients of Substance Abuse Information** This information has been disclosed from records whose confidentiality is protected by federal law. Iowa Code, Chapter 125 and federal regulations (42 CFR, Part 2) prohibit any further disclosure without the specific written authorization of the person to whom the information pertains, or as otherwise permitted by such statute and regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Notice to Recipients of HIV-Related Testing Information** This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of the information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. (Iowa Code Section 141A.9) Federal confidentiality rules (42 CFR, Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.