REGISTRATION FORM

A. CLIENT

Client Name: _____

Client Address: _____

City: _____ State: _____ Zip: _____

County: _____ Date of Birth: _____ Race: _____

Primary Phone: _____ Alternative Phone: _____ Email address: _____

Sex: _____ Religion: _____ Primary Language: _____

Primary Care Physician: _____Contact? ___Y____N

B. RESPONSIBLE PARTY INFORMATION

If same as client information, please check here and skip to part C below. _____

Name: _____ Relationship: _____

If different from Client: Address: _____ City: _____ State: ___ Zip: _____

If different from Client: Home Phone: _____ Alternative Phone: _____

C. EMERGENCY CONTACT: (SOMEONE NOT IN YOUR HOUSEHOLD)

Name: _____ Relationship to Client: _____

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

Primary Phone: _____ Alternative Phone: _____

D. INSURANCE INFORMATION

1. Insurance? YES NO

Name of subscriber (who policy is under): _____DOB:_____

Address of subscriber (street, city, and zip) _____

Insurance Contact Phone #: _____

Insurance company: _____ Policy number: _____

Insurance company: _____ Policy number: _____

Deductible: _____ Co-pay or Co-insurance: _____

2. Medicare? YES NO #_____

3. Medicaid? YES NO #_____ Amerigroup#_____ or

Amerihealth#_____ or

United Healthcare#_____

_____ _____

Client or Parent/Guardian's Signature Date

Name: T19# DOB:

CONSENT FOR TREATMENT

Date: _____

I hereby give consent for myself or my dependent _____ to receive therapy and/or skill development services with Candeo.

I understand that if myself or parent/guardian of the child does not sign this agreement, a Court Order must be attached to this form indicating who has legal authorization to grant permission to treat.
This agreement will remain in effect for one year.

_____ _____
Signature of client Date

_____ _____
Signature of parent/ guardian Date

_____ _____
Witness Signature Date

Name: T19# DOB:

PATIENT RESPONSIBILITY

INDIVIDUAL'S FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. Co-payments are due at time of service. If my plan requires a referral, I must obtain it prior to my visit. In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at time of service. Where allowed by law, I may be responsible for a no-show or cancellation fee of $50.

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Candeo on my behalf for any services furnished to me by the providers.

AUTHORIZATION TO RELEASE RECORDS I hereby authorize Candeo to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Candeo. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of client Date

_____ _____

Signature of parent/ guardian Date

_____ _____

Witness Signature Date

Additionally, by providing my email address here I am indicating a desire to receive any invoices for services rendered electronically:

_____ (Email address). No protected health information will be sent via email, but allows Candeo to sign you up for our online portal. If there is a balance owed, an email notice to view your statement will be sent to the above email address the first

If you would like to receive appointment reminders via text message please indicate your cell phone number here_____. You will receive a notice 24 hours before the appointment to remind you, if you need to change your appointment you are responsible to contact the provider directly.

Name: T19# DOB:

SIGNATURE PAGE

Please initial each document you were offered a copy of:

_____ Notice of Privacy Practices

_____ Client Rights

_____ Description of Services

_____ Informed Consent

By signing below I acknowledge that I have reviewed and have been offered a copy of the above documents.

_____ _____
Signature of client Date

_____ _____
Signature of parent/ guardian Date

_____ _____
Witness Signature Date

Name: T19# DOB:

PERMISSION TO RELEASE INFORMATION

Client Name: _____ DOB: _____ T19#: _____

I, _____, authorize Candeo to exchange information with (please include name, address and phone number):
_____
_____
_____

This information is pertinent to the client's mental health, behavioral or academic needs as deemed by either agency. This information may contain:

Yes ☐ No ☐ Discharge Summaries
Yes ☐ No ☐ Diagnostic Tests or Assessments
Yes ☐ No ☐ Mental Health Treatment & Plan
Yes ☐ No ☐ Education Records, Testing Data/Information
Yes ☐ No ☐ Medical Records
Yes ☐ No ☐ Evaluation records
Yes ☐ No ☐ Clinical Progress Notes
Yes ☐ No ☐ Progress

Yes ☐ No ☐ Additional Information as indicated:_____

The information shared may be written and/or verbal and it may be currently in existence and/or that which is made in the future. This information will only be shared with appropriate personnel on a need to know basis. This authorization is good for one year from the date signed. I understand I may revoke this authorization at any time by giving written notice to Candeo. I understand that any release made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

Specific Authorization for Release of Information Protected by State/Federal Law
I specifically authorize the release of data and information relating to:

Yes ☐ No ☐ Substance use/abuse (alcohol/drug)

Yes ☐ No ☐ Mental Health

_____ _____
Signature of Client or Parent/Legal Representative Signature Date

PROHIBITION ON REDISCLOSURE

This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 22) prohibits further disclosure without the specific written consent of the client or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

* Only persons 18 years of age or his/her legal representative may authorize release of mental health information.
** Only the subject may authorize release of substance abuse information unless the subject is under legal age or incompetent as defined by statute.

Sharing information: It is the responsibility of all agencies listed to provide requested information. The recipient of the information is responsible for maintaining confidentiality of the information.

Name: T19# DOB:

PERMISSION TO RELEASE INFORMATION

Client Name: _____ DOB: _____ T19#: _____

I, _____, authorize Candeo to exchange information with (please include name, address and phone number):
Primary care Physician: _____
_____
_____

This information is pertinent to the client's mental health, behavioral or academic needs as deemed by either agency. This information may contain:

Yes ☐ No ☒ Discharge Summaries
Yes ☒ No ☐ Diagnostic Tests or Assessments
Yes ☒ No ☐ Mental Health Treatment & Plan
Yes ☐ No ☒ Education Records, Testing Data/Information
Yes ☒ No ☐ Medical Records
Yes ☒ No ☐ Evaluation records
Yes ☐ No ☒ Clinical Progress Notes
Yes ☐ No ☒ Progress

Yes ☒ No ☐ Additional Information as indicated: Informing of service participation and coordination of services as needed

The information shared may be written and/or verbal and it may be currently in existence and/or that which is made in the future. This information will only be shared with appropriate personnel on a need to know basis. This authorization is good for one year from the date signed. I understand I may revoke this authorization at any time by giving written notice to Candeo. I understand that any release made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

Specific Authorization for Release of Information Protected by State/Federal Law
I specifically authorize the release of data and information relating to:

Yes ☐ No ☐ Substance use/abuse (alcohol/drug)

Yes ☒ No ☐ Mental Health

_____ _____
Signature of Client or Parent/Legal Representative Signature Date

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** Only the subject may authorize release of substance abuse information unless the subject is under legal age or incompetent as defined by statute.

Sharing information: It is the responsibility of all agencies listed to provide requested information. The recipient of the information is responsible for maintaining confidentiality of the information.

Name: T19# DOB:

NOTICE OF PRIVACY PRACTICES

This notice describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This organization is required by law to provide you with this Notice so that you will understand how we may use or share your information from your Designated Record Set. The Designated Record Set includes financial and health information referred to in this Notice as "Protected Health Information" (PHI) or simply "health information." We are required to adhere to the terms outlined in this Notice. If you have any questions about this Notice, please contact our Privacy Officer at515-259-8110.

Understanding Your Health Record and Information

Each time you are served by our organization, a record of our service is made containing health and financial information. Typically, this record contains information about your needs, the service we provide and payment for the treatment. We may use and/or disclose this information to:

- Plan your care and treatment
- Communicate with other health professionals involved in your care
- Document the care you receive
- Educate health professionals
- Provide information for medical research
- Provide information to public health officials
- Evaluate and improve the care we provide
- Obtain payment for the care we provide

Understanding what is in your record and how your health information is used helps you to:

- Ensure it is accurate
- Better understand who may access your health information
- Make more informed decisions when authorizing disclosure to others.

How We May Use and Disclose Protected Health Information About You

The following categories described the ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall into one of the categories.

A. Uses and Disclosures for Treatment, Payment and Administrative Operations

1. **For Treatment**. We may use or disclose health information about you to provide you with services. We may disclose health information about you to doctors, nurses, therapists or other organization personnel in order to coordinate and manage your services. *For example, we may need to disclose information to a case manager who is responsible for coordinating your care. We may also disclose your health information among our staff or we may disclose your health information to your primary physician. We may consult with other health care providers and in the process of that consultation share your health information with them.*
2. **For Payment.** We may use or disclose your protected health information (PHI) so that the services you receive are billed to, and payment is collected from, your funders or other interested parties. *For example, we may disclose your PHI to permit funders to approve or pay for your services. This may include: making a determination of eligibility for services, reviewing your services, reviewing your services to determine if they were appropriately authorized, reviewing your services for purposes of utilization review, to ensure the appropriateness of your services, or to justify the charges for your services.*

3. **For Administrative Operations.** We may use and disclose PHI about you for our day to day administrative operations. These uses and disclosures are necessary to run our organization and make sure that you receive quality services. *For example, these activities may include quality reviews, medication reviews, licensing, business planning and development, and general administration activities.* We may also combine health information about many individuals to help determine what additional services should be offered, what services should be discontinued, and whether certain new treatments are effective. Health information about you may be used by the administrative offices for business development and planning, cost management analyses, insurance claims management, risk management activities, and in developing and testing information systems programs. We may also use and disclose information for professional review, performance evaluation, and for training programs. Other aspects of health care operations that may require use and disclosure of your health information include accreditation, certification, licensing and credentialing activities, review and auditing, including compliance reviews, medical review, legal services and compliance programs. Your health information may be used and disclosed for the business management and general activities of the organization including resolution of internal grievances, customer service and due diligence in connection with a sale or transfer of the organization. In limited circumstances, we may disclose your health information that identifies you so that the health information may be used to study health care and health care delivery without learning the identities of the clients.

   We may also provide your PHI to other service providers or to your funders to assist them in performing their own operations. We will do so only if you have or have had a relationship with the other provider or funder. For example, we may provide information about you to your funder to assist them in their quality assurance activities.

Other Allowable Uses of Your Health Information

B. Other Allowable Uses

1. **Business Associates** – There are some services provided in our organization through contracts with business associates. Examples include outside attorneys and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
2. **Providers** – Many services provided to you, as part of your care at our facilities, are offered by participants in one of our organized healthcare arrangements. These participants include a variety of providers such as physicians (e.g. MD, DO, Podiatrist, Dentist, Optometrist), therapists (e.g. Physical therapist, Occupational therapist, Speech therapist), portable radiology units, clinical labs, hospice, caregivers, pharmacies, psychologists, LCSW's and suppliers (e.g. prosthetic, orthotics).
3. **Treatment Alternatives** – We may use and disclose health information to tell you about possible treatment options or alternatives that may be of interest to you.
4. **Health Related Benefits and Services and Reminders** – We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
5. **Fundraising Activities** – We may use health information about you to contact you in an effort to raise money as part of fundraising effort. We may disclose health information to a foundation related to Candeo so that the foundation may contact you in raising money for the Candeo. We will only release contact information, such as your name, address and phone number and the dates you received treatment or services from our organization. You have the right to opt out of any use of protected health information for fundraising activities. If you do not want Candeo or its foundation, to contact you for fundraising you must notify the Privacy Officer at 515-259-8110.

6. **Individuals Involved in Your Care or Payment for Your Care** – Unless you object, we may disclose health information about you to a friend or family member who is involved in your care. Such information will be directly relevant to that person's involvement in your care We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. In the event of your death, we may disclose information, to those persons who were involved in your care prior to your death, PHI unless doing so is inconsistent with any preference, known to us, expressed by you prior to your death. If there is a family member or personal friend that you do not want to receive information about you, please notify the Privacy Officer at 515-259-8110.
7. **As Required By Law** – We will disclose health information about you when required to do so by federal, state or local law.
8. **To Avert a Serious Threat to Health or Safety** – We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.
9. **Organ and Tissue Donation** – If you are an organ donor, we may disclose health information to organizations that handle organ procurement to facilitate donation and transplantation.
10. **Proof of Immunization** – We may use or disclose immunization information to a school about you: (a) if you are a student or prospective student of the school; (b) the information is limited to proof of immunization; (c) the school is required by State of other law to have the proof of immunization prior to admitting you; and (d) we obtain and document the agreement to the disclosure from either: (1) you, your parent or guardian, or (2) from you if you are an adult or an emancipated minor.
11. **Victims of Abuse, Neglect or Domestic Violence** – We may disclose PHI to a government authority authorized by law to receive reports of abuse, neglect or domestic violence, if we believe you are a victim of abuse, neglect or domestic violence. This will occur to the extent the disclosure is: (a) required by law; (b) agreed to by your; or (c) authorized by law and we believe the disclosure is necessary to prevent serious harm to you or to other potential victims, or, if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.
12. **Military and Veterans** – If you are a member of the armed forces, we may disclose health information about you as required by military authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.
13. **Workers Compensation** – We may disclose health information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.
14. **Reporting** – Federal and state laws may require or permit the organization to disclose certain health information related to the following:
    a. **Public Health Risks** – We may disclose health information about you for public health purposes including:
        1) Prevention or control of disease, injury or disability
        2) Reporting births and deaths
        3) Reporting child abuse or neglect
        4) Reporting reactions to medications or problems with products
        5) Notifying people of recalls of products
        6) Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease
        7) Notifying the appropriate government authority if we believe an individual has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
    b. **Health Oversight Activities** – We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

c. **Judicial and Administrative Proceedings** – If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

15. **Law Enforcement** – We may disclose health information when requested by a law enforcement official:

a. In response to a court order, subpoena, warrant, summons or similar process;
b. To identify or locate a suspect, fugitive, material witness, or missing person;
c. About you, the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;
d. About a death we believe may be the result of criminal conduct;
e. About criminal conduct at the Facility; and
f. In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

16. **Coroners, Medical Examiners and Funeral Directors** – We may disclose medical information to a coroner or medical examiner. This may be necessary to identify a deceased person to determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.

17. **National Security and Intelligence Activities** – We may disclose health information about you to authorized federal officials for intelligence, counterintelligence, or other national security activities authorized by law.

18. **Correctional Institution** – Should you be an inmate of a correctional institution, we may disclose to the institution or its agents health information necessary for your health and the health and safety of others.

Other Uses of Health Information

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that we have already made with your permission, and that we are required to retain our records of the care that we provided to you. Specifically, without your written authorization we will not use or disclose your health information for the following purposes: 1. Most uses and disclosures of psychotherapy notes; 2. Uses or disclosures for marketing purposes; and 3. Uses and disclosures that involve the sale of your protected health information.

Your Rights Regarding Health Information About You

Although your health record is the property of the organization, the information belongs to you. You have the following rights regarding your health information:

A. **Right to inspect and copy.**

You have the right to request to inspect or copy health information used to make decisions about your care - whether they are decisions about your services or payment of your care. You must submit your request in writing to our Privacy Officer. If you request a copy of the information, we may charge you a fee for the cost of copying, mailing and supplies associated with your request. We may deny your request to inspect or copy your health information in certain limited circumstances, such as psychotherapy notes or if the information is compiled in anticipation of, or use in, a civil, criminal or administrative action or proceeding. In some cases, you will have the right to have the denial reviewed by a licensed health care professional not directly involved in the original decision to deny access. We will inform you in writing if the denial of your request may be reviewed. Once the review is completed, we will honor the decision made by the licensed health care professional reviewer. If your health information is kept electronically, you have the right to receive an electronic copy of your health information subject to the restrictions set forth above.

B. Right to amend.

For as long as we keep records about you, you have the right to request us to amend any health information used to make decisions about your care - whether they are decisions about your service or payment of your care. To request an amendment, you must submit a written request to our Privacy Officer and tell us why you believe the information is incorrect or inaccurate. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend health information that:

1. Was not created by us, unless the person or entity that created the health information is no longer available to make the amendment;
2. Is not part of the health information we maintain to make decisions about your care;
3. Is not part of the health information that you would be permitted to inspect or copy; or
4. Is accurate and complete.

If we deny your request to amend, we will send you a written notice of the denial stating the basis for the denial and offering you the opportunity to provide a written statement disagreeing with the denial. If you do not wish to prepare a written statement of disagreement, you may ask that the requested amendment and our denial be attached to all future disclosures of the health information that is the subject of your request. If you choose to submit a written statement of disagreement, we have the right to prepare a written rebuttal to your statement of disagreement. In this case, we will attach the written request and the rebuttal (as well as the original request and denial) to all future disclosures of the health information that is the subject of your request.

C. Right to an accounting of disclosures.

You have the right to request that we provide you with an accounting or list of disclosures we have made of your health information. This list will not include certain disclosures of your health information, *for example, those we have made for purposes of service, payment and health care operations; disclosure made to you or authorized by you; disclosures that are incident to another use or disclosure, etc.* To request an accounting of disclosures, you must submit your request in writing to the Privacy Officer. The request must state the time period for which you wish to receive an accounting. This time period should not be longer than six years and not include dates before April 14, 2003. The first accounting you request within a twelve month period will be free. For additional requests during the same 12 month period, we will charge you for the costs of providing the accounting. We will notify you of the amount we will charge and you may choose to withdraw or modify your request before you incur any costs.

In addition to your right to an accounting of disclosures, we have a legal obligation to notify you if your protected health information is affected by any security breach that may occur.

D. Right to request restrictions.

You have the right to request a restriction on the health information we use or disclose about you. You may also ask that any part or all of your health information not be disclosed to family members or friends who may be involved in your care or for notification purposes. We are not required to agree to a restriction that you may request. If we do agree, we will honor your request unless the restricted health information is needed to provide you with emergency care. You must submit your request in writing to the Privacy Officer and list: (a) what information you want to limit; (b) whether you want to limit use or disclosure or both; and (c) to whom you want the limits to apply. The above notwithstanding, you have the right to request a restriction of disclosures to a health plan for payment or health care operations regarding any services you have paid for, in full, out of pocket and we are required to honor that request.

E. Right to request confidential communications.

You have the right to request that we communicate with you about your health care only in a certain location or through a certain method. *For example, you may request that we contact you only at work or by e-mail*. To request such a confidential communication, you must make your request in writing to the Privacy Officer. We will accommodate all reasonable requests. You do not need to give us a reason for the request; but your request must specify how or where you wish to be contacted.

F. Right to a paper copy of this notice.

You have the right to obtain a paper copy of this Notice of Privacy Practices. You may request a copy at any time by contacting the Privacy Officer. A copy of the Notice of Privacy Practices is on our web site at www.candeoiowa.org

Changes to this Notice

We reserve the right to change the terms of our Notice of Privacy Practices. We also reserve the right to make the revised or changed Notice of Privacy Practices effective for all health information we already have about you as well as any health information we receive in the future. We will post a copy of the current Notice of Privacy Practices at our primary business office and at each site where we provide services. You may also obtain a copy of the current Notice of Privacy Practices by calling us at 515-259-8110 and requesting a copy be sent to you in the mail or by asking for one any time you are at our business office or service sites.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. All complaints must be submitted in writing. Our Privacy Officer will assist you with writing your complaint, if you request such assistance. We will not retaliate against you for filing a complaint. To file a complaint with us, contact our Privacy Officer by telephone at 515-259-8110 or by mail at 9550 White Oak Lane, Johnston, IA 50131.

Name: T19# DOB:

CLIENT RIGHTS AND RESPONSIBILITIES STATEMENT
OUTPATIENT MENTAL HEALTH

1. You have the right to receive considerate and respectful treatment without discrimination because of race, religion, gender identity, ethnicity, age, disability, sexual orientation or cultural background.

2. You have the right to participate in the development of your treatment plan.

3. You have the right to confidentiality of treatment records and communications pertaining to your treatment. Your written consent for disclosure of information is obtained prior to any release.

4. You have the right to decide not to receive therapeutic assistance from this agency. If you wish, you may be provided with the names of other qualified professionals in the area by therapy personnel.

5. You have the right to end services at any time, without any moral, legal or financial obligations other than those already incurred, unless ordered by the court.

6. You have the right to appeal and receive due process concerning services provided by this agency. We will provide you with a copy of that procedure upon request.

7. As a client, you should know that there are times when personnel are required by law to reveal information obtained during therapy to other persons or agencies without your permission. Personnel are not required to inform you of such actions. The situations are as follows:

    - If you threaten serious, foreseeable, and imminent harm to yourself or to another person, your therapist is required by law to inform the intended victim and appropriate authorities.
    - If a court of law issues a legitimate subpoena, your therapist is required by law to provide the information specifically described in the subpoena.
    - If you reveal information relative to child or dependent adult abuse or neglect, your therapist is required by law to report this to the appropriate authorities.
    - If you are in therapy as a result of a court order, your therapist is required to report progress to the court.

As a client with Candeo you are responsible to:

1. Treat everyone I interact with at Candeo with respect.
2. Attend my appointments as scheduled. If you need to cancel you will give as much notice as possible. If you cancel frequently you may be assessed a cancellation or no-show fee of $50.
3. Pay your copay/coinsurance or any other client responsibility for sessions at each session.
4. Inform us of any changes to your insurance or contact information.
5. Actively participate in treatment planning and treatment to ensure you meet your goals.

Name: T19# DOB:

DESCRIPTION OF SERVICES

Below is a list of services offered by Candeo:

Outpatient mental health Services are treatment services, provided by qualified mental health professionals and directed toward reversing symptoms of acute mental health disorders, or maintaining stability and functional autonomy for persons with severe and persistent forms of mental health disorders. Outpatient services are specific in targeting the symptoms or problem being treated. Therapy occurs individually, as a family, or in a group setting. Candeo offers these services in our office location at 9550 White Oak Lane in Johnston.

Behavioral Health Intervention Services are designed to improve skills associated with the impact of a mental illness. They are always offered as part of a comprehensive clinical treatment plan. Skill development should focus on needed improvement due to a mental health diagnosis. The improvements should focus on mental health symptoms and improvements in functioning related to the mental illness. The focus of the service should be an individual goal the member has developed to help attain work, school, social or living areas. The focus of intervention is skills and supports needed to reach this goal.

Supported Community Living (SCL) is intended to provide individuals support to live independently in their own community. This service is community based and individuals live either in their own apartment / duplex / house or live in their parental home. Candeo's SCL instructors work alongside the clients to assist them with meeting daily living needs, building healthy relationships, accessing the community, maintaining health and safety and ongoing education of rights and responsibilities

Home-based habilitation is a state plan service provided to those individuals who have chronic mental illness. Our Mental Health instructors assist the clients in living everyday life which includes teaching skills, symptom recognition, wellness recovery action plan steps etc. that make it possible to accomplish tasks they would otherwise be unable to accomplish due to symptoms and repercussions of the mental illness. Our mental health staff is also available to assist with medication management and appointments with mental health professionals.

Employment Services facilitate competitive employment for clients in their own communities. Employment services are provided by our trained and certified Employment Consultants to discover the talents, skills and aspirations of our clients. Together our consultants and clients search the community's job market for employment options. Within this search a match to corporate culture is stressed. We believe that a focus on finding the right employment for an individual includes using a job match to both culture and task, not just a focus on job placement. Our Employment services include job exploration, development and coaching.

All services at Candeo are scheduled by appointment directly with your provider. Outside of scheduled appointments and afterhours **please call 911/mobile crisis if an emergency is occurring.** If needed, your provider will develop an individualized crisis plan identifying natural and professional supports able to meet identified needs including specific staff interventions that may be required on an "as needed basis", Our services are by appointment only, but are flexible to meet the needs including evening and weekend appointments in the office or if appropriate in the community.

Name: T19# DOB:

INFORMED CONSENT

1. You have chosen to receive treatment services through the Candeo. The type and extent of services that you will receive will be based on a discussion with you the client and/or guardian, following an initial assessment, if appropriate to the service requested.
2. You understand that there is no assurance that services will improve current concerns or stressors, but understand services are a cooperative effort between the provider and client. It is important to work with my provider in a cooperative manner in an attempt to resolve concerns and stressors.
3. You understand that if using a 3rd party payer Candeo may be required to provide a diagnosis to describe a client's condition. Once that information is provided Candeo or its employees can accept no liability for impacts to insurability or employment.
4. You understand that all information shared with the providers at Candeo is confidential and no information will be released without clients consent.
5. You understand that there are expectations and local laws require that my provider report the following:
    - When there is risk of imminent danger to myself or to another person the provider is ethically bound to take necessary steps to prevent such danger.
    - When there is a suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the provider is legally required to take steps to protect the child, and to inform the proper authorities.
    - When a valid court order is issued for medical records, the agency is bound by law to comply with such requests.
6. It may be helpful or necessary for Candeo to consult with other professionals. During consultation, every effort is made to avoid revealing the identity of a client. The consultation is also legally bound to keep the information confidential. If you do not object Candeo staff will at times use consultation.

If I have any questions regarding this consent form or about the services offered at Candeo, you may discuss them with your provider. I have read and understand the above. I consent to participate in the services offered by Candeo. I understand that I may stop services at any time. I understand that I can revoke my consent at anytime except to the extent that if I do not revoke this consent, it will expire automatically one year after all claims for services have been paid. I also understand that I have the right to inspect records pertaining to my treatment.

By signing the signature page, I acknowledge that Informed Consent has been explained to me and I understand the rights identified in this document.