Southwest Iowa Families, Inc.
215 E. Washington St., Clarinda, IA 51632
Phone: (712) 542-3501 Fax: (712) 542-4725

Client Demographics

Client Name:		**DOB:**	**Title 19#:**
Legal Client Name	**Last:**	**First:**	**Middle Initial:**
Client Address	**Street:**		
	City:	**State:**	**Zip Code:**
Phone	**Home: ( )** □ May leave message ☐ May leave text	**Cell: ( )** ☐May leave message ☐ May leave text	**Work: ( )** ☐May leave message ☐ May leave text
Age:	**Birthdate:**	**Birthplace:**	
Religious/Spiritual Affiliation:		**Race/Ethnicity:**	
Education	**Grade Completed:** **Student at:**	**Field:**	**Degree:**
Were you raised by:	**Both Parents ☐**	**Single Parent ☐**	**Relative ☐**
Foster Parent ☐	**Institution ☐**	**Adoptive Parent ☐**	**Step Parent ☐**
Father's Name: **Occupation:**			**Age:**
Mother's Name: **Occupation:**			**Age:**
Brothers & Sisters (including yourself) in birth order:			
Name:	**Age:**	**Name:**	**Age:**
Name:	**Age:**	**Name**	**Age:**
Relationship Status	**Single**	**Divorced**	**Widowed**
	Married; Spouse Name:		**Years Married:**
	Age:	**Occupation:**	
Children	**M F Name:** **M F Name:** **M F Name:**		**Age:** **Age:** **Age:**
Employment	**Student** **Employed by**	**Unemployed**	**Disabled** **How long?**
EMERGENCY CONTACT:_____		**Relationship: _____**	
	Home: ( ) ☐Yes, may leave message	**Cell: ( )** ☐Yes, may leave message	**Work: ( )** ☐Yes, may leave message

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Consent for Services

Client's Name: **Client's DOB:** **Title 19#:**

Billing Authorization – Please check the insurance that applies

	IA Health Link / Iowa Medicaid Member **or** Social Security #	
	MCO – Amerigroup or UnitedHealthcare	MCO #
	I understand and agree to pay the amount of $_____ at the beginning of each session, which is the fee based on the established sliding fee scale, if applicable	
	I understand my EAP is covering _____ sessions.	
	Client or Guardian employed by:	
	Insurance will be billed. Co-Pay due at the beginning of each session $	
	Insurance Company:	
	Client or Guardian Employed by:	
	Name of Insured:	DOB of Insured:
	Member Number:	Group Number:

- I hereby authorize the clinician to furnish information to insurance carriers concerning my treatment. I authorize the insurance carrier to pay the provider directly. I understand that I am responsible for all payments. Any monies received by the clinician from the insurance companies over and above my indebtedness will be refunded to me when my bill is paid in full.

- I understand that Southwest Iowa Families and my health plan representatives may exchange any and all information 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 after all claims for treatment have been paid as provided in the benefit plan.

PLEASE INITIAL BELOW to confirm that you were notified of & offered a copy of
_____Client Rights & Responsibilities
_____Grievance Policy included in the Client Rights & Responsibilities.
_____ Notice of Privacy Practices (HIPAA), including Limits of Confidentiality and Access to Records.
_____Description of therapy and its possible risks, benefits, and alternatives
_____I agree to pay for services not covered by my health plan & understand what will be shared for billing purposes. Sessions cost $125.

My signature indicates my Consent for Services based on my opportunity to review the information on this page and acknowledges that a copy of all of these documents were offered to me and can be requested at any time.

_____

Client's Signature ☐Photo ID on file Printed Name Date

_____

Legal Guardian's Signature ☐Photo ID on file Printed Name/Relationship Date
Is there anyone else who is able to legally sign for this individual? Yes No
Name_____

_____

Witness Date