Innovative Learning Professionals, LC Client Information

Full Legal Name _____ Preferred Name (if different) _____

Birthdate _____ Age _____ Gender ☐male ☐female ☐_____ SS# _____

Address_____ City _____State _____ ZIP_____

Phone #s Home _____ Cell _____ Work _____

School/Employer _____Highest Ed/Current Grade_____

Occupation _____ Email _____

Primary Physician _____ Psychiatrist _____

How did you hear about us (or referred by)? _____

Relationship Status: ☐single ☐live together* ☐married* ☐separated* ☐divorced ☐ _____

*Spouse/Partner name _____ DOB _____ Age _____

Address if different _____

Phone #s Cell _____ Home_____ Work _____ Occupation _____

School/employer _____Email _____

Parent/Guardian Information (if applicable) (may use back for additional information)

Name _____	Name _____
Relationship _____	Relationship _____
Address _____	Address _____
City/ZIP _____	City/ZIP _____
Phone(s) _____DOB_____	Phone(s) _____DOB_____
Employer _____	Employer _____
Email _____	Email _____

Person Responsible for Payment ☐ self ☐ mother ☐ father ☐ other _____

Emergency Contact _____ Relationship _____

Cell Phone_____ Home_____ Work _____

Primary Insurance (please have insurance cards available to copy)

Policy Holder _____ Relationship _____ DOB _____

SS# _____ Address _____

Insurance company _____ Insurance ID # _____

Secondary Insurance

Policy Holder _____ Relationship _____ DOB _____

SS# _____ Address _____

Insurance company _____ Insurance ID # _____

Signed _____ Date _____

Only adult client, birth/legal parent or legal guardian may sign forms

Verification of Receipt of Psychotherapy Practice Information, Informed Consent Information, Consumer Rights Statement, & Notice of Privacy Rights

I verify that I have been provided with a copy of informed consent for educational and psychological/ behavioral/mental health services including information regarding risks and benefits of services, limitations of confidentiality, and information about my rights and responsibilities as a client. I also verify that I have been provided a copy of Notice of Privacy Rights under HIPAA, a general statement about consumer rights, and information regarding emergency contact procedures. Written copies of each document are available in the waiting room, an electronic copy is available on the company website (www.innovativelearningpros.com/forms.cfm), and a personal written copy is available upon request. I understand that Innovative Learning Professionals staff is willing to answer any questions I may have about these written documents at any time.

Your signature below indicates you have received, or have been provided the opportunity to review, these documents, agree to the terms described therein, and provide consent for evaluation and/or treatment for yourself or your dependent. You may revoke this Agreement in writing at any time. Revocation is binding on me unless we have taken action in reliance on it.

_____ _____
Client Name (print) Date of Birth

_____ _____
Signature Date

_____ _____
Signature (if applicable, for example witness or older minor child) Date

****

(If applicable)

Authorization for Release of Information to Insurance Company

I authorize Innovative Learning Professionals LC to release billing information, which may include client name, date and type of services, diagnoses codes, substance abuse information, and/or treatment plans, to my insurance company(ies) for the purpose of:

❑ collecting insurance benefits ❑ authorization of additional sessions

for:_____
(Client Name) (Date of Birth)

I understand that I have the right to inspect the information released through this authorization and such an inspection will occur in a meeting with Innovative Learning Professionals staff.

I understand I may revoke this authorization by providing written revocation. I also understand any information released prior to the revocation may be used for the purpose(s) listed above. A photocopy of this authorization shall have the same force as the original.

This release shall be valid for six months following our last appointment, unless otherwise restricted.

_____ _____
Signature Date

_____ _____
Signature (if applicable, for example witness or older minor child) Date

Insurance/Payment Notice

It is your responsibility to contact your insurance company prior to your appointment so as to understand your benefits and your portion of fees. Any and all fees not reimbursed by insurance policy are your responsibility. Mental health and medical benefits may differ, so it is important for you to understand what benefits you have. It is your responsibility to know if pre-authorization is required per your insurance policy, and it is ultimately your responsibility to seek that pre-authorization by calling your insurance company. If your insurance company determines any services as not payable for any reason (e.g., not a benefit or deemed not medically necessary), you are responsible for the full payment at the time of service.

Appointment times are reserved for you. If you are unable to keep a scheduled appointment, please give a 24-hour notice. Voicemail is available 24 hours a day seven days a week—515-270-0280. Failed appointments mean a loss of productivity for our providers. Providers are rarely able to fill a session canceled shorter than 24 hours in advance.

If you do not give a 24-hour cancellation notice you may be charged a no-show fee of $35 up to the full service fee, depending on circumstances. Insurance companies do not typically reimburse for missed appointments. If appointments are failed repeatedly, clients may be asked to find a new provider.

You are ultimately responsible for the cost of our services. In the case of shared custody, the parent who brings a child in for services is responsible for fees incurred. Copayments, coinsurance, deductibles are to be paid at the time of service. We accept major credit/debit cards, checks, and cash. We are not able to process all health savings account cards.

We have the capacity to keep your credit card information on file within our billing software. In doing so, we can charge your credit card for your ongoing copayments (including coinsurance and deductibles) with each session, which reduces the need for monthly statements. If you would like to take advantage of that capacity, please complete the form below.

My signature below authorizes all future copayments, coinsurance, and deductible charges to be billed to the credit card below.

❑ Visa ❑ Master Card ❑ Discover Card ❑ American Express

Name as on Card: _____

Card Number:_____ Expiration Date: _____

Billing ZIP Code: _____CVV Number (on back):_____

Signature: _____ Date: _____

By signing below, I have read and understand I am responsible for all fees for service. I have decided to receive services at Innovative Learning Professionals, and I understand some services are not, or may not, be covered by my insurance. I understand if I choose to use an insurance benefit, there is no guarantee any portion will be covered, and I agree to pay any remaining portion. Failure to pay my portion of fees could result in a fee collections agency being contacted on behalf of ILearn.

Print Name _____

Signed _____ Date _____

Please let the provider know if you have questions.

I LEARN
INNOVATIVE LEARNING PROFESSIONALS, LC

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Des Moines, IA 50312-5365
(515) 270-0280 (515) 270-1647 (fax)
www.innovativelearningpros.com

Authorization for Release of Confidential Information

In the interest of integrative health care (which is meant to provide you or your child the best possible overall care), it is often important that your primary care provider (e.g., family doctor, pediatrician) be able to access your records. In addition, if you have a psychiatrist, it is important to be able to coordinate with him or her. Please indicate your desires below. ***One form must be completed for every individual/agency for whom you wish to release information.*** *Additional forms can be provided as needed.*

❑ **Please Release to Primary Care Provider**: If you agree, please complete the release below.

or ❑ **Please Release to Psychiatrist or other provider.** If you agree, a second form will be provided if needed.

or ❑ **DO NOT AGREE**: I have read the above information and **do not agree** to release health care information.

Regarding [client name] _____ Date of Birth _____

I authorize Innovative Learning Professionals, LC to either verbally and/or in writing (paper or electronic interchange) ☑ release and/or ☑ obtain the following protected health information:

- ❑ As much information as judged necessary
- ❑ Mental health information
- ❑ Substance abuse information
- ❑ HIV Status
- ❑ Progress Notes
- ❑ Academic/Educational Information
- ❑ Treatment Plan
- ❑ Admission/Discharge Summary(ies)
- ❑ Psychosocial History
- ❑ Psychotherapy/Process Notes
- ❑ Psychological testing [If release includes raw data, it is to be released directly to_____].
- ❑ Other [specify] _____

To/from [agency or person]: _____

For the purpose of: _____.

This release shall be renewed on an annual basis, unless further restricted as indicated:

❑ Authorization ends upon release. ❑ Valid for _____ months. ❑ Other _____.

I understand I have the right to inspect any written information released through this authorization and such an inspection, if requested, will occur in a meeting.

I understand I may revoke this authorization by providing written notice of revocation. I also understand any information released prior to the revocation may be used for the purpose listed above.

I understand I do not have to sign this authorization. Treatment, payment, enrollment, or eligibility for benefits cannot be conditioned upon the signing of this authorization.

I understand if the person or organization that receives my information (described above) is not a health care provider or health insurer the information may no longer be protected by federal or state privacy regulations (e.g., HIPAA and other privacy regulations).

I understand and agree that a copy of this authorization (including electronic copy, fax, or photocopy) shall have the same force as the original.

NOTICE TO PERSON/AGENCY RECEIVING MENTAL HEALTH INFORMATION**:** The mental health information disclosed herein has been disclosed, and may only be redisclosed, pursuant to the written authorization of the client or the client's legal representation or as otherwise provided in Chapter 228, Code of Iowa. Any unauthorized redisclosure of mental health information is unlawful and is subject to civil and criminal penalties.

Signed _____ Date_____ Relationship _____

Signed _____ Date_____ Relationship _____