Serving Southwest Iowa
Therapy
PCIT, Aftercare,
Family Team Meetings
www.therapyplaceinc.com

Therapy Place, Inc.
Phone: 712-254-9018
Fax: 712-254-9019

Email: therapyplc@fmctc.com
Mailing Address:
P.O. Box #1
Panama, IA. 51562

OFFICE SITES: **Atlantic, Harlan, Council Bluffs, Harlan, Manning, and Waterloo**

THERAPY PLACE, INC. – Aftercare Program

***BILLING/MAILING ADDRESS*:**
P.O. Box #1
Panama, Iowa 51562
***CELL PHONE NUMBERS*:**
Joni Griffin, BA: 402-680-3554 **Jeff Smith, BA: 712-249-1817**
Traci Smith, BA: 712-249-94949 **Deborra M. Smith, MSW/LISW: 712-249-0739**
E-Mail address: therapyplc@fmctc.com

SERVICES CONSENT FORM (Aftercare & Pre – Pal Program ONLY)

We, the undersigned, agree to accept services for participation in the Aftercare/PAL Program from Therapy Place, Inc., (Therapy Place).

We understand that in the course of treatment or supportive services, many subjects will be discussed. Some of these subjects may be, but are not limited to: age, educational achievement, family background, prior treatment efforts, family relationships, marital issues, sexuality, violence, leisure activities, drug/alcohol usage, medical involvement, housekeeping, shopping habits and hygiene.

We understand that Therapy Place is a private service that endeavors to provide a safe place for people to converse about their concerns. You may be invited to construct new ways of understanding your present situation and you will be asked to think about how you might change that situation should you want to.

No information identifying you or your family will be released or disclosed without written consent by a parent or your legally designated representative. You may be asked to sign specific releases of information to any other individuals or agencies which Therapy Place staff deem important to communicate with, in the best interests of your family. Therapy Place will not knowingly utilize any treatment or procedure, which is experimental, controversial, or carries an intrinsic risk. You have the right to ask questions about any procedures used during sessions.

I agree to allow Therapy Place staff to transport myself to and/or from sessions or support services.

Any grievance concerning the quality of services provided by Therapy Place should be made in writing to the President of Therapy Place, Inc. A review of the grievance will take place within thirty days.

This agreement was entered into and signed on the _____ day of _____

_____ _____
(Client signature) (Date)

_____ _____
(Signature of Contractor) (Date)

This agreement will remain in effect until one year after the family's/individual's involvement with Therapy Place, Inc. has discharged. *Signature(s) indicate the form was read, understood, and agreed on by the client/parent/guardian.

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CLIENT RIGHTS

Your rights as a client are as follows:

1. You have the right to ask questions about any procedures used during services provided to you with the Aftercare/PAL program. If you wish, I will explain my usual approach and methods of providing these services to you.

2. You have the right to decide not to receive Aftercare/PAL assistance from this agency. If you wish, I will provide you with the names of other qualified professionals in this area.

3. You have the right to end the Aftercare/PAL program any time without any moral, legal, or financial obligations other than those already incurred.

4. As a client, you should know that there are certain situations in which I am required by law to reveal information obtained during therapy to other persons or agencies without your permission. I am not required to inform you of my actions in this regard. These situations are as follows:
   A. If you threaten grave bodily harm or death to another person, I am required by law to inform the intended victim and the appropriate authorities.
   B. If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in the subpoena.
   C. If you reveal information relative to child abuse or neglect, I am required by law to report this to the appropriate authorities.
   D. If you are in therapy as a result of a court order, I am required to report progress to the court.

_____ _____
(Client signature) (Date)

_____
(Signature of SSA/Contractor)

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AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT/FAMILY NAME:
ADDRESS: _____
PHONE: _____

I, the undersigned, authorize Therapy Place, Inc. to:
RELEASE TO, SECURE FROM, or EXCHANGE WITH: **Children's Square U.S.A.**

information from the records of: _____ the following information:

_____ Diagnostic assessment
_____ Evaluation/Testing results
_____ Mental health treatment
_____ Termination/Treatment summary
_____ Substance Abuse Treatment
☒ Other (specify) **Aftercare Program**

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): _____

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 Therapy Place, Inc., or their representative.

I understand I have the right to review the disclosed information by contacting the office of Therapy Place, Inc. 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 other than those listed above unless I give written permission. *Signature(s) indicates client/parent/guardian given a copy of the confidentiality/privacy policy for Therapy Place, Inc.

_____
(Client signature)

_____
(Parent/guardian signature if client under age 18)

_____
(Date)

_____
(Relationship to client)

_____
(Therapist/Contractor signature)

_____
(Parent/guardian signature if client under age 18)

_____
(Relationship to client)

CC: Client File

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AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT: _____ **– Pre – Pal & Aftercare Program**

I, the undersigned, authorize Therapy Place, Inc. to:
RELEASE TO, SECURE FROM, or EXCHANGE WITH: _____
(agency, person, or organization)

information from the records of: _____the following information:

_____ Diagnostic assessment
_____ Evaluation/Testing results
_____ Mental health treatment
_____ Termination/Treatment summary
_____ Substance abuse treatment
_____ Other (specify): **Case Consultation**

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): _____

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 Therapy Place, Inc., or their representative.

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_____ _____
(Client signature) (Date)

_____ _____
(Signature of Contractor) (Date)

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(agency, person, or organization)

information from the records of: _____the following information:

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_____ Evaluation/Testing results
_____ Mental health treatment
_____ Termination/Treatment summary
_____ Substance abuse treatment
_____ Other (specify): **Case Consultation**

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_____ _____
(Client signature) (Date)

_____ _____
(Signature of Contractor) (Date)

CONSENT TO OBTAIN AND RELEASE INFORMATION

Name:	Date of Birth: (MM/DD/YY)	Obtained High School Diploma or GED? ☐ Yes ☐ No Date:
Current Address: County: Phone:	Forwarding Address: County: Phone:	State ID# Date exited from Care:

I authorize the Iowa Department of Human Services (IDHS) and the Iowa Aftercare Services Network (IASN) to share written and oral information about my needs and the services I receive or have received, for the purpose of determining eligibility for IASN and assisting in the coordination of ongoing services and data collection. This information can only be released to the following authorized agencies of the IASN:

American Home Finding Association
Children's Square, USA
Youth and Shelter Services
Youth Homes of Mid-America

Family Resources
Foundation 2
Francis Lauer
Children and Families of Iowa

Four Oaks
Boys and Girls Home
Young House Family Services
Youth Policy Institute of Iowa
Quakerdale

I understand that this information shall be kept confidential and shall be used for the purpose of determining my eligibility for aftercare services, planning and delivering my services, and ongoing coordination of aftercare related services and supports, including but not limited to the Iowa Aftercare Services program (including the Preparation for Adult Living (PAL) program) and the Medicaid for Independent Young Adults (MIYA) coverage program. I understand that I have the right to see this information at any time. This consent is valid for information already in existence and any information that may be generated during future service involvement. I understand that I can revoke my consent at any time by providing written notification. This consent shall expire the later of 1 year after termination of my involvement in the Iowa Aftercare Services Program or on my 21st birthday. I understand that IDHS will not be able to determine my eligibility for benefits if I do not complete this authorization.

I have read this form, or it has been read and explained to me, and I understand its content.

Authorizing Signature (*youth at least 18 years old or legal guardian*)	Date
A photocopy of this signed Authorization shall have the same force and effect as this original.	

I understand that I am not required to authorize the release any of the following information to receive services:

SPECIFIC AUTHORIZATION FOR RELEASE

I authorize the release of the following information, which requires specific consent under federal or state law:

Type of Information	Nature and Source of Information	Authorizing Initials
SED: ❑ YES ❑ NO ❑ NATR[1] Mental health Evaluation/treatment Including Diagnosis/Dates*		
AIDS/HIV-related		
Substance abuse**		

[1] Not authorized to release (NATR)

*Only a person 18 years of age or older or such 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.

Office Use Only: **Youth's Name:**

DHS TRANSITION PLANNING SPECIALIST Name: Address: Phone: Fax:	☐ Not Eligible for Aftercare Reason:	☐ Eligible for Aftercare **Please select if any circumstances apply: ☐ Left before 18th birthday (not eligible for room and board) ☐ In state paid foster care on 18th birthday ☐ In care 6 of the previous 12 months prior to leaving care ☐ Adopted or placed in subsidized guardianship from foster care on or after age 16 (effective 10/7/08)
IASN AGENCY: SSA: Address: Phone: Fax	IASN COORDINATOR Phone: (515) 727-4220 Fax: (515) 727-4223	Exception to policy granted for eligibility: ☐ Yes ☐ No Eligible for voluntary foster care: ☐ Yes ☐ No TPS signature : Date:

RECORD OF DISCLOSURES:
(Required for mental health information)

Date	Name of Recipient	Contents Disclosed	Sent by

Notice to Recipients of mental health information

In accordance with the Iowa Mental Health Information Disclosure Act (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 consent 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 141.23) Federal confidentiality rules (42 CFR, Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

POLICY ON NONDISCRIMINATION

Federal law prohibits employment discrimination on the basis of race, color, age, religion, national origin, sex or disability. State law prohibits employment discrimination on the basis of race, color, creed, age, sex, sexual orientation, gender identity, national origin, religion, pregnancy, mental or physical disability, or political belief. State law also prohibits public accommodation (such as access to services or physical facilities) discrimination on the basis of race, color, creed, religion, sex, sexual orientation, gender identity, religion, national origin, or mental or physical disability. If you believe you have been discriminated against in any activity, facility or program of the Iowa Department of Human Services, you may file a complaint with the Department by contacting the Iowa Department of Human Services, Diversity Programs Unit 1st Fl, 1305 E Walnut St., Des Moines IA 50319-0114 or by Fax at 515-281-4243 or by email at stopit@dhs.state.ia.us.