Hillcrest family services
2005 Asbury Rd
Dubuque, Iowa 52001
PH: (563)583-7357

To help move your process along quicker please check which location you are interested in starting services with. Please feel free to route your application directly to the center of your choosing as this will help with the process as well.

☐ Mental Health Center- **Asbury**

2005 Asbury Rd.
Dubuque, IA 52001
PH: 563-583-7357
Fax: 563-583-7026

Services provided
•Counseling

☐ Mental Health Center- **Mercy**

200 Mercy Dr.
Suite 200
Dubuque, IA 52001
PH: 563-582-0145
Fax: 888-526-5456

Services provided
•Counseling
•Medication
•Crisis Walk-In

☐ Mental Health Center- **Crescent**

1789 Elm St.
Dubuque, IA 52001
PH: 563-690-2850

Services provided
•Counseling

☐ Mental Health Center- **Solutions*****

5900 Saratoga Rd.
Suite 11
Dubuque, IA 52002
PH: 563-231-3521
Fax: 563-231-3522

Services provided
•Counseling
•Medication

☐ Mental Health Center- **Henry**

106 N Jackson St.
Mt Pleasant, IA 52641
PH: 319-385-7177
Fax: 319-385-9567

Services provided
•Counseling
•Medication
•Crisis Walk-In

☐ Mental Health Center- **Louisa**

218 N Second St.
Wapello, IA 52653
PH: 319-527-4455
Fax: 319-527-4458

Services provided
•Counseling
•Medication
•Crisis Walk-In

☐ Mental Health Center- **Washington**

2175 Lexington Blvd
Building 2
Washington, IA 52353
PH: 319-653-6161
Fax: 319-863-1311

Services provided
•Counseling
•Medication
•Crisis Walk-In

☐ Mental Health Center- **Maquoketa**

117 S. Olive St.
Maquoketa, IA 52060
PH: 563-652-4958
Fax: 563-652-2418

Services provided
•Counseling
•Medication

☐ Needing medication management services

Thank you for your application for services through Hillcrest Family Services. Please allow 3 business days for our office to confirm and verify insurance eligibility. It is our goal to ensure you are aware of any cost to you.
If you are needing to speak to someone before you are contacted please utilize our Crisis Recovery Team at 1-855-800-1239 OR call 9-1-1.

Thank you
Hillcrest Family Services

****Not all insurances are accepted at this location*

HILLCREST FAMILY SERVICES
DEMOGRAPHIC FORM

Client Legal Name: _____
(Last) *(First)* *(MI)* *(Suffix)*
Alias/Maiden Name: _____
(Last) *(First)* *(MI)*

Client Address: _____

City/State/Zip: _____ **County:** _____

Mailing Address: *(if different)* _____

City/State/Zip: _____

OK to send mail? ○ **Yes** ○ **No** ○ **Unknown**

Primary Phone #: _____ **Special Calling Instructions:** _____

Work Phone #: _____ **Special Calling Instructions:** _____

Other Phone #: _____ **Special Calling Instructions:** _____

Email Address: _____ **OK to send email?** ○ **Yes** ○ **No**

Client Legal Status: ○ **Adult** ○ **Adult with Guardian** ○ **Minor with Guardian** ○ **Emancipated Minor**

Legal Guardian Name: _____ **Relationship to Client:** _____

Address: _____

City/State/Zip: _____ **Phone:** _____

Does Client have an Emergency Contact? ○**Yes** ○ **No**

Emergency Contact Name: _____ **Relationship to Client:** _____

Address: _____

City/State/Zip: _____ **Phone:** _____

Date of Birth: _____ **Gender:** ○ **Male** ○ **Female** ○ **Transgender**

Social Security #: _____ **Reason why SS# not provided:** _____

Race: _____ **Marital Status:** _____ **Ethnicity:** _____

Language: _____ **Religion:** _____ **Is this person in special education:** ○ **Yes** ○ **No**

Last Grade Completed: _____ **School:** _____

Interpreter needed? ○ **Yes** ○ **No** **School District:** _____

Employment Status: _____ **Household Income:** _____

Living Arrangement: _____ **Household Composition:** _____
(foster care, group home, etc.) *(single adult, significant other, etc.)*

Does Client have an Advance Directive? ○ **Yes** ○ **No**

Smoking Status: ○ **Current, every day smoker** ○ **Current, some day smoker** ○ **Former smoker**
○ **Never smoker** ○ **Smoker, current status unknown** ○ **Heavy tobacco smoker**
○ **Light tobacco smoker** ○ **Unknown if ever smoked**

Relationship Information *(Household Members Detail)*

Relationship:________________________ If other, please specify:________________________

Name:____________________________ **DOB:**____________ **Gender:**________________

Address *(If different):*____

City/State/Zip:____

Home Phone:________________________ **Work Phone:**________________________

Relationship:________________________ If other, please specify:________________________

Name:____________________________ **DOB:**____________ **Gender:**________________

Address *(If different):*____

City/State/Zip:____

Home Phone:________________________ **Work Phone:**________________________

Relationship:________________________ If other, please specify:________________________

Name:____________________________ **DOB:**____________ **Gender:**________________

Address *(If different):*____

City/State/Zip:____

Home Phone:________________________ **Work Phone:**________________________

Relationship:________________________ If other, please specify:________________________

Name:____________________________ **DOB:**____________ **Gender:**________________

Address *(If different):*____

City/State/Zip:____

Home Phone:________________________ **Work Phone:**________________________

Referral Source:______________________ **Referral Information:**______________________

Presenting Problem:

Scheduling Requirements:____

Did the Client Provide the Information? ○ **Yes** ○ **No**

Name of person providing information: *(if not the client)*____________________________________

Relationship to Client:________________________ **Phone Number:**______________________

Signature:____ **Date:**________________

HILLCREST FAMILY SERVICES
CLIENT RIGHTS & RESPONSIBILITIES and CONSENT FOR TREATMENT

No list of client rights can ensure the respect of those rights. It is the intent of Hillcrest Family Services to make sure that all aspects of care, treatment and service reflect concern and respect for clients' rights as well as high ethical standards. Any changes or deviation from these rights will be discussed with the client and if appropriate, documented in the client's case record. If you are enrolled in Medicaid and receive services through a managed care organization, you have additional rights and responsibilities under that organization. You have a right to request and receive a copy of these rights and responsibilities.

RIGHTS

1. Each client has the right to considerate care with the client's safety and personal dignity being of prime importance. This includes the client's right to be screened, assessed and re-assessed, and managed for pain.

2. Each client shall have reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age or disability.

3. Each client has the right to have his or her cultural, psychosocial, spiritual and personal values, beliefs, and preferences respected.

4. Each client shall receive individual treatment within the least restrictive environment possible.

5. Each minor client or surrogate decision-maker has the right to include his or her parent/family member in the treatment process unless otherwise prohibited. All clients have the right to access protective and advocacy services at any time during services. Hillcrest will provide this information upon request.

6. Each client has the right to express comments or complaints about any aspect of the treatment process. The client may express concerns through informal discussions or through the formal grievance procedure. Each client has the right to request an internal review of their plan of care, treatment, or services.

7. Each client has the right to an environment that preserves dignity and contributes to a positive self-image.

8. Each client has the right to privacy, confidentiality and security, in accordance with agency, state and federal regulations governing the confidentiality of information. Client confidentiality will be maintained during case consultations, clinical supervision and all internal or external audits of clinical records. All records reviewed by auditors, external entities and business associates, will be noted on the accounting summary form for HIPAA purposes.

9. Each client, and when appropriate the family or surrogate decision-maker, has the right to complete information about treatment including, but not limited to: ♦limits to confidentiality ♦treatment planning ♦outcomes of care ♦rules and regulations of the program ♦medication therapy ♦risks of treatment ♦alternatives to treatment ♦cost of service ♦pastoral and other spiritual services (for residential programs), and ♦any changes in treatment recommendations (including changes in clinical staff). It is the intent of this information to empower the client to actively and knowledgeably participate in the treatment process.

10. Each client has the right to access, request amendment to, and receive an accounting of disclosures regarding his or her own clinical/service information as permitted under applicable law. (See HIPAA Notice of Privacy Practices)

11. Treatment services are provided regardless of whether authorization for release of information is signed.

12. Each client who seeks services voluntarily has the right to refuse and/or terminate care, treatment or services at any time.

13. Each client, and family/guardian as appropriate, has the right to effective communication that he or she can understand. Effective communication includes appropriate age, understanding and population, information translated, as needed, and meeting the needs of those with vision, speech, hearing, language, and cognitive impairments.

14. Each client has the right to request an advocate, consultant or representative decision-maker in the event the client is incapable of understanding a proposed treatment procedure or is unable to communicate his/her wishes regarding care.

15. When a client chooses to delegate decision-making to a surrogate decision-maker, Hillcrest involves the surrogate in decisions about care, treatment and services including respecting their right to refuse care, treatment, or services on behalf of the client in accordance with law and regulation.

16. Clients in 24-hour care programs shall have the right to: personal privacy, maintain personal property, receive verbal/written correspondence and receive visits from family members (unless regulated by the court or otherwise prohibited).

17. All rights are limited only to the extent determined by a court of law or that the client when exercising their rights unduly infringes upon the rights of others.
18. Each client has the right to be free from mental, physical, sexual and verbal abuse, neglect and exploitation.

19. Each client has the right to exercise citizenship privileges, such as voting.

20. Clients in 24-hour care programs are informed about Hillcrest policies and procedures regarding the handling of medical emergencies.

21. Each client or surrogate decision-maker shall be informed that adverse events that relate to sentinel events are considered reviewable by Joint Commission.

RESPONSIBILITIES

1. *Providing Information* – Client and families, as appropriate, must provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalization, medications, and other matters relating to their behavioral and physical health. Clients and their families must report perceived risks in their care, and unexpected changes in their condition. They can help the organization understand their environment by providing feedback about service needs and expectations.

2. *Asking Questions* – Clients and families, as appropriate, must ask questions when they do not understand their care, treatment, and service or what they are expected to do.

3. *Following Instructions* – Clients and their families must follow the care, treatment, and service plan developed. They should express any concerns about their ability to follow the proposed care plan or course of care, treatment, and services. The organization makes every effort to adapt the plan to the specific needs and limitations of the clients. When such adaptations to the care, treatment, and service plan are not recommended, clients and their families are informed of the consequences of the care, treatment, and service alternatives and of not following the proposed course.

4. *Accepting Consequences* – Clients and their families are responsible for the outcomes if they do not follow the care, treatment, and service plan. If the client or family refuses care, treatment, or services, Hillcrest will inform client and family about obligation in accordance with professional standards to terminate relationship with reasonable notice or to seek orders for involuntary treatment or other legal alternatives.

5. *Following Rules and Regulations* – Clients and their families must follow the rules and regulations of Hillcrest Family Services and service(s) being sought.

6. *Showing Respect and Consideration* – Clients and their families must be considerate of Hillcrest Family Services' staff and property, as well as other clients and their property.

7. *Meeting Financial Commitments* – Clients and their families should promptly meet any financial obligations agreed to with Hillcrest Family Services. Client or legal guardian may be responsible for copays, deductibles or charges associated with denial of benefits.

CONSENT FOR TREATMENT

I hereby acknowledge that I am willing and without coercion, taking part in therapy, counseling, evaluation, treatment, other related mental health services and/or programming activities as mutually determined by myself and the professional staff at Hillcrest Family Services. This consent is effective for 12 months (or _____) after it is signed. This release will automatically be revoked 30-days after discharge.

I understand these Rights and Responsibilities and agree to treatment. My signature or the signature of a guardian in my place indicates that this consent form has been explained to me in a language that I can understand, and that I or my guardian agree with the above.
My initial treatment plan and/or services have been explained to me by: _____
Is the client willing and able to sign in agreement? ◯ Yes ◯ No
If not, explain: _____

_____

_____

_____ _____ _____ _____
Client Signature Date Birth Date Medicaid #

To the best of my judgement, the above-named client and/or guardian was capable of understanding the nature of the above authorization at the time it was signed.

_____ _____
Witness Signature (staff member) Date

Original: *Client Record* ***Copy to:*** *Client and Parent/Guardian/Family Member Signature*

If the above-named client is a minor or is not capable of appreciating the nature of treatment and/or his/her need for it, and is therefore incapable of giving consent, legal guardian must sign on next page. N/A is appropriate.

_____ _____
Parent/Guardian/Family Member Signature Date

HILLCREST FAMILY SERVICES, INC
MODEL ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of Notice of Privacy Practices:

_____ _____ _____
Name: Date: Time:

Is this an Emergency Treatment Situation? ○ Yes ○ No

HOW NOTICE WAS PROVIDED

Was written Notice of Privacy Practices Provided? ○ Yes ○ No

Was Notice given in another way? ○ Yes ○ No

If written Notice was not provided, method of Notice: ○ Verbal ○ Fax ○ E-mail ○ Website

ACKNOWLEDGEMENT OF RECEIPT

Has client signed Notice of Receipt of Privacy Practices? ○ Yes ○ No

If no, did client otherwise acknowledge Notice of Privacy Practices? ○ Yes ○ No

If Notice was acknowledged in another way, method of acknowledgement:

○ Verbal ○ Fax ○ E-mail ○ Website

If no acknowledgement was received, document why you were unable to get an acknowledgement from the client and the efforts you made to get the acknowledgement:

_____

_____

Signature of Person Recording Acknowledgement of Receipt of Privacy Practices:

_____ _____ _____
Name: Date: Time:

HILLCREST FAMILY SERVICES
PRIMARY CARE PHYSICIAN CONTACT AUTHORIZATION

☐ Asbury MHC
2005 Asbury Rd
Dubuque, IA 52001
P: (563) 583-7357
F: (563) 582-7026

☐ Dubuque MHC
200 Mercy Dr.
Suite 200
Dubuque, IA 52001
P: (563) 582-0145
F: (888) 526-5456

☐ Maquoketa MHC
117 S. Olive St
Maquoketa, IA 52060
P: (563) 652-4958
F: (563) 652-2418

☐ Washington MHC
2175 Lexington Blvd.
Building 2
Washington, IA 52353
P: (319) 653-6161
F: (319) 863-1311

☐ Henry MHC
106 N Jackson St.
Mt Pleasant, IA 52641
P: (319) 385-7177
F: (319) 385-9567

☐ Louisa MHC
218 N Second St.
Wapello, IA 52653
P: (319) 527-4455
F: (319) 527-4458

☐ MH Solutions
5900 Saratoga Rd.
Suite 11
Asbury, IA 52002
P: (563) 231-3521
F: (563) 231-3522

Client Name: _____ **Date of Birth:** _____

Physician Name: _____

Physician Address: _____

☐ **I DO** ☐ **I DO NOT**

authorize Hillcrest Mental Health Center staff to contact my primary care physician to provide information about my diagnosis and my treatment at Hillcrest Family Services' Mental Health Center. I understand that mental illness can have biological causes and that it is recommended that I consult my doctor about my symptoms. To facilitate care coordination, this consent for release of the below information and subsequent verbal information remains in effect for one full year or until consent is revoked by me in writing. I understand that further written disclosure of information requires me to complete an additional authorization.

This authorization applies to information about my (check the following):

☐ **Mental Health** ☐ **Substance Abuse** ☐ **HIV Status**

Client/Guardian Signature: _____ **Date:** _____

Dear Provider,

I recently saw your patient at Hillcrest Family Services' Mental Health Center. I have diagnosed your client with:

_____

_____

Your client has been scheduled for a Medication Intake appointment on: _____

☐ **N/A**

Because your patient has signed an authorization for us to communicate please contact me with any questions or concerns you have about this individual's care.

Sincerely,

Hillcrest Family Services' Staff: _____ **Date:** _____

This information has been disclosed to you from records protected by the federal and Iowa State Confidentiality rules CFR 42, Part 2, Iowa Chapter 228 of the Iowa Code. These rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical and other information NOT sufficient for this purpose. Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand that I may review the disclosed information by contacting the Director of Clinical Services at the address above. Hillcrest Family Services will not make the signing of the Release of Information a condition of treatment, enrollment or eligibility for services.

HILLCREST FAMILY SERVICES
FEE AGREEMENT

As the client and/or parent/guardian, I agree to give complete and accurate income and insurance information to Hillcrest Family Services. I may be eligible for an adjusted fee, if I am legally settled in an Iowa County or qualify for the State Payment Program (SPP), providing I meet the income and resource guidelines, based on my deductible dependents residing with me. Information updates are requested annually, or at any time a changes in eligibility occurs. I am fully responsible for co-payments/coinsurance and deductibles. **I am expected to pay the fee that has been agreed upon at the time of service.**

Charges are based on the time the provider spends on your behalf, including face to face contact; record processing, report writing or interpreting tests. **Your first appointment (intake) generally takes about an hour and will be billed accordingly.** Any payments made by your insurance are assigned to Hillcrest Family Services as payment towards your account balance. If Hillcrest changes its fees or your income/resource status changes, you are required to sign a new Fee Agreement; otherwise this agreement will be updated annually. **PLEASE ASK ANY QUESTIONS REGARDING YOUR FEE**.

I agree to pay for services provided to _____.
(Patients Name)

- I understand and agree that if I fail to provide insurance and income information to Hillcrest Family Services, I will be charged and responsible for the full fee of services received.
- I have been informed by Hillcrest Family Services that if I receive more than one billable service on the same day, I will be responsible for the cost of any services denied for this reason.
- I give permission for Hillcrest Family Services to contact my insurance carrier(s) listed below and to bill my insurance for services rendered. I understand that any payments received from my insurance are to be assigned as payment on my account balance.
- I understand that it is my responsibility for keeping my appointments, or notifying the clinic in advance, whether or not a courtesy reminder call was received. (Repeated no-shows or short notice cancellations may also result in future scheduling restrictions such as “same day only” appointment status.)
- I authorize the release of diagnostic and treatment information necessary to process billing of claims to appropriate entities such as insurance companies or other agencies for payment. This includes release of my identifying information to a collection agency in pursuit of any unpaid balance after ninety (90) days.
- If I am eligible for funding available through Medicaid, my county of legal settlement, or State of Iowa Payment Program and fail to comply with application procedures I will be responsible for the full fee, with a minimum of 50% due at the time of service.
- By signing below I take full responsibility for any deductibles, co-payments/coinsurance or denied charges for my services, or for any individual for which I have financial responsibility, and agree to pay those costs.

My insurance carrier(s) is/are: _____
(Name of Insurance Carrier)

I understand that it is ultimately my responsibility to secure payment for my services, or those of my dependent. Any portion not authorized or not paid on my behalf will be my responsibility. For minors (under age 18): I am affirming that I am this child’s custodial parent or legal guardian.

_____ _____ _____ _____
Client/Guardian Signature Date Witness’ Signature Date

HILLCREST FAMILY SERVICES
CLIENT GRIEVANCE PROCEDURE

As stated in the *Client Rights and Responsibilities and Consent for Treatment* policy, a client has the right to express comments or complaints about any aspect of the care, treatment and service process without being subjected to coercion, discrimination, reprisal or unreasonable interruption of care, treatment or services. The client may express concerns through informal discussions or through the formal grievance procedure. Families and legal guardians have the right to file a grievance as well. Therefore, in this procedure, the term *"client"* may represent a person receiving services, families or legal guardians. The grievance procedure has been designed to ensure the objective receipt, processing, and response to client comments or complaints.

STEP 1: If possible and appropriate, the client verbally expresses the comment/complaint with the appropriate staff member.

- ♦ For treatment/programming issues, the client should contact a staff from that particular program.
- ♦ For staff issues, the client should contact the particular staff with whom they have the concern.

If the issue is resolved through a discussion at this level, then the process concludes. If the client is not satisfied, they have the option of moving to the next step.

STEP 2: If the client is unable to resolve the issue through the above process, the client has a right to a meeting with the program supervisor/coordinator. This should be done in writing by listing the facts and evidence relative to that grievance. The program supervisor/coordinator shall convene a hearing with the client and their parent or advocate, when requested, within five working days. A written response must be given within another five working days. All documentation will become a part of the client's record.

STEP 3 *(Adolescent Residential Treatment Only)*: If not pleased with the decision in the above level, the client may grieve the decision using the same procedure and time frames as above to the supervisor of Residential Youth Services. The supervisor of Residential Youth Services must also follow the procedures as stated in "Step 2."

STEP 4: If not pleased with the decision in "Step 2" or "Step 3," the client may grieve the decision using the same procedure and time frame as above to the division director. The division director must also follow the procedures as stated in "Step 2."

STEP 5: If not pleased with the decision of the division director, the client may grieve the decision using the same procedure and time frames as above to the assistant executive director. The assistant executive director must also follow the procedures as stated in "Step 2."

STEP 6: If not pleased with the decision of the assistant executive director, the client may grieve the decision using the same procedure and time frame as above to the executive director. The executive director must also follow the procedures as stated in "Step 2."

Clients also have the right to pursue other channels of due process such as legal representation, state ombudsman, and other advocacy groups. As a general practice, the Quality Council will review all formal grievances (starting with "Step 2") in order to monitor services. Identified problems will be addressed through the appropriate division director.

*****The above items have been fully discussed with me.*****

Client/Guardian Signature _____ Date _____ Birth Date _____ Medicaid # _____

Witness Signature (staff member) _____ Date _____

Hillcrest Family Services
Client Insurance Form

Client Name:_____ **Date:**_____

Primary Insurance:

Insurance Name:_____ **Policy Number:**_____

Insurance Phone #:_____

Group Number:_____ **Name:**_____

Policy Holder Information **If self, please indicate and skip rest of section*

Relationship to Insured:_____ **Name:**_____

Address:_____

City/State/Zip:_____

Date of Birth:_____ **Sex:**_____

Secondary Insurance: *(If applicable)*

Insurance Name:_____ **Policy Number:**_____

Insurance Phone #:_____

Group Number:_____ **Name:**_____

Policy Holder Information **If self, please indicate and skip rest of section*

Relationship to Insured:_____ **Name:**_____

Address:_____

City/State/Zip:_____

Date of Birth:_____ **Sex:**_____

I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical and/or government benefits either to myself or to the party who accepts assignment below.

Signed:_____ **Date:**_____

HILLCREST FAMILY SERVICES
Adult/Child Checklist

Adult Checklist - Please check all that apply to you:

- ☐ agitation
- ☐ change in appetite
- ☐ crying spells
- ☐ depressed/sad
- ☐ difficulty coping
- ☐ discouraged
- ☐ helplessness
- ☐ hopelessness
- ☐ irritable
- ☐ loss of concentration
- ☐ loss of energy
- ☐ loss of interest
- ☐ loss of motivation
- ☐ sense of guilt
- ☐ sleep difficulty
- ☐ thinking slowed
- ☐ weight gain/loss
- ☐ worthlessness
- ☐ suicidal ideation
- ☐ avoidant
- ☐ flashbacks
- ☐ insomnia
- ☐ nightmares
- ☐ chest tightness
- ☐ dizziness
- ☐ shortness of breath
- ☐ headaches
- ☐ irritable
- ☐ heart racing
- ☐ poor sleep
- ☐ restless
- ☐ tense nervous
- ☐ tiredness/fatigue
- ☐ trembling
- ☐ worry
- ☐ purges
- ☐ agitation
- ☐ dizzy
- ☐ excessiveness
- ☐ grandiose
- ☐ minimal sleep
- ☐ racing thoughts
- ☐ binges
- ☐ body image distortion
- ☐ fear of weight gain
- ☐ loss of menstrual cycle
- ☐ aggression
- ☐ cruelty
- ☐ destructive
- ☐ fights
- ☐ fire setting
- ☐ run away/truant
- ☐ theft
- ☐ compulsions
- ☐ obsessions
- ☐ angry
- ☐ argues
- ☐ blames others
- ☐ defiant
- ☐ agoraphobia
- ☐ chest pain
- ☐ de-realization
- ☐ heart racing
- ☐ shakes/trembles
- ☐ short of breath
- ☐ sweats
- ☐ nausea
- ☐ fear of dying
- ☐ vigilante
- ☐ distractible
- ☐ easily frustrated
- ☐ fails to complete tasks
- ☐ fidgety
- ☐ forgetful
- ☐ hyperactive
- ☐ impatient
- ☐ impulsive
- ☐ poor concentration
- ☐ poorly organized
- ☐ procrastinates
- ☐ reactive
- ☐ short attention span
- ☐ working below capacity
- ☐ startles
- ☐ trauma
- ☐ other

What primary concerns brought you here today? _____

_____

Child Checklist - Please check all characteristics that apply to your child:

- ☐ Abnormal thoughts/perceptions
- ☐ Anger outbursts
- ☐ Anxiety/nervousness
- ☐ Bedwetting
- ☐ Change in friends
- ☐ Concerns with sexual activity
- ☐ Crying spells
- ☐ Decreased energy & motivation
- ☐ Depressed
- ☐ Difficulty making decisions
- ☐ Doesn't follow directions
- ☐ Drinking/drug use
- ☐ Easily frustrated
- ☐ Fatigue
- ☐ Feelings of hopelessness
- ☐ Feelings of inferiority
- ☐ Flashbacks
- ☐ Headaches
- ☐ Hyperactive
- ☐ increased aggression
- ☐ Interest in setting fires
- ☐ Irritable
- ☐ Memory problems
- ☐ Nightmares
- ☐ No appetite
- ☐ Obsessions/compulsions
- ☐ Oppositional
- ☐ Perfectionist
- ☐ Physical abuse history
- ☐ Poor self-control
- ☐ Problems with concentration
- ☐ Problems with eating
- ☐ Runs away
- ☐ School problems
- ☐ Sexual abuse history
- ☐ Sleep difficulties
- ☐ Stomach trouble
- ☐ Temper tantrums
- ☐ Thoughts of hurting others
- ☐ Thoughts of hurting self
- ☐ Traumatic experience
- ☐ Tremors
- ☐ Trouble making or keeping friends
- ☐ Unable to relax
- ☐ Withdrawn
- ☐ Other

What primary concerns brought you here today? _____

_____

HILLCREST FAMILY SERVICES
ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)
MEDICARE CLIENTS ONLY

Patient Name: Medicare HIC Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for excessive visits, provider type & 2 services in the same day as listed below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the excessive visits, provider type & 2 services in the same day.

Services	Reason Medicare May Not Pay:	Estimated Cost
Sessions beyond 20 per year Sessions provided by an LMHC, MA, LMSW, MSW 2 Services provided on the same day	Policy limits frequency of services Providers of care	$140.00 $140.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the services listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ OPTION 2. I want the services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ OPTION 3. I don't want the services listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:

Hillcrest Family Services

Notice of Privacy Practices

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact our Privacy Officer at (563) 583-7357 or toll free at (877) 437-6333

WHO WILL FOLLOW THIS NOTICE

This notice describes our agency's practices and that of:

- Any health care professional authorized to enter or review information into your treatment record.
- All programs of Hillcrest Family Services, except Hillcrest schools, Adoption Program, WIC, and Big Brothers Big Sisters of Dubuque County.
- Any member of a volunteer group we allow to help you while you are being helped by Hillcrest staff.
- All employees, staff, students, and other Hillcrest personnel.
- Hillcrest sites and programs follow the terms of this notice except those listed above. In addition, these sites and programs may share health information with each other for treatment, payment or agency operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that health, including mental health, information about you is personal. We are committed to protecting your health information. We create a record of the care and services you receive at Hillcrest. We need this record to provide you with quality care and to follow certain legal requirements. This notice applies to all of the records of your care created by Hillcrest.

This notice will tell you about the ways in which we may use and give out health information about you. We also explain your rights and the responsibilities we have regarding the use and giving out of health information.

We are required by law to:

- make sure health information that identifies you is kept private;
- give you this notice of our legal responsibilities with respect to your health information and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND GIVE OUT HEALTH INFORMATION ABOUT YOU

The following list describes different ways we use and give out health information. We provide examples to explain each way that health information could be used or given out. Not every use or disclosure in a category will be listed. However, all the ways we are allowed to use and give out information will fall within this list.

- **For Treatment**. We may use health information about you to provide you with health care, treatment or services. We may give out the minimum necessary health information about you to doctors, nurses, technicians, health care interns or students, clergy, social workers, counselors, direct care staff, pharmacists or others who are involved in your care. For example, clinicians providing you a service need to be aware of those events in your past, which have caused you emotional or psychological harm. Different departments of this agency also may share health information about you in order to coordinate your medical or mental health treatment. Counselors, therapists, mental health technicians may disclose health information about you to their supervisor or the Clinical Director during a case consultation with the intent of improving current services and preparing for aftercare.
- **For Payment**. We may use and give out health information about you so that the treatment and services you receive from Hillcrest Family Services may be billed to and payment may be collected from you, an insurance company or a third party such as a county. For example, we may need to give your insurance plan information about the services you received at Hillcrest so your health plan will pay us for the service. We may also tell your health plan about a treatment you are going to receive in order to get prior approval or to determine whether your plan will cover the treatment.
- **For Health Care Operations**. We may use and give out health information about you for agency operations. These uses and disclosures are necessary to run the agency and make sure that all of the individuals being served receive quality care. For example, we may use health information to send satisfaction surveys or gather data to improve our programs here at Hillcrest. Personal health information will be taken out unless it is

necessary for state staff or other persons to review our work.

Individual's records will be handled by authorized people and stored in a designated secured area. Only authorized people will have access to both open and closed files.

During a meeting with a supervisor, health information may be shared when discussing your treatment needs. Individuals involved during a supervision meeting may include the Clinical Director, the therapist you work with, referring worker, a nurse, family/support individual, a psychologist or psychiatrist or direct care staff such as a youth care worker.

- **Appointment Reminders**. We may use and give out health information to contact you as a reminder that you have an appointment for services at Hillcrest, except for the Hillcrest Health Clinic.

- **Business Associates**. There are some services provided in our organization through contracts with business associates. Examples include financial audits, computer software vendors, etc. We may disclose your health information to our business associates so they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.

- **Treatment Alternatives**. We may use and give out health information to tell you about possible treatment options that may be of interest to you.

- **Health-Related Benefits and Services**. We may use and give out information to tell you about health-related benefits, health services or health education classes that may be of interest to you.

- **Fundraising Activities**. We may use certain information (name, address, telephone numbers, dates of services, age and gender) to contact you in the future to raise money for Hillcrest to improve the programs we provide to the community. You have the right to opt out of receiving fundraising communications. If you do not want Hillcrest to contract you for fundraising, you must notify the Privacy Officer at _____ .

- **Hillcrest Directory of Persons Served**. Hillcrest keeps a list of persons we have served or are serving. The information on the list includes name, program, date of admission, and discharge, general condition and religious affiliation. This information is used primarily for the receptionist to get phone calls and mail to you in the correct program. This information, except for your religious affiliation may be released to people who ask for you by name. Your religious affiliation may be given to members of clergy, such as a minister, priest or rabbi. We may also give out health information about you to the Red Cross or other agencies, helping with a disaster relief effort (fire, tornado) so that your family can be told about your location and condition. If you do not want to be included in the directory, or you want to restrict the information we include in the directory, you much notify the Privacy Officer at _____ of your objection.

- **Individuals Involved in Your Care or Payment for Your Care**. We may release health information about you to a caregiver that may be a friend or family member who is involved in your care. We will release only that information that is directly relevant to that person's involvement in your care. We may also give information to someone who helps pay for your care. If there is a family member, or other relative, or close personal friend that you do not want to receive health information about you, please notify the Privacy Officer at or tell our staff member who is providing care to you.

- **Research**. Sometimes, with your written permission, we may use and give out health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all individuals who have received one type of treatment to those who have received another, for the same condition. All research projects, however, are subject to a special approval process. We will ask for your specific permission if the researcher will have access to your name, address or other types of information.

- **As Required By Law**. We will give out health information about you when required to do so by federal, state or local law.

SPECIAL SITUATIONS

- **Military**. If you are a member of the armed forces, we may give out health information about you as required by military authorities. We may also give out health information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation**. We may give out health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks (Health and Safety to you and/or others)**. We may give out health information about you for public health activities. We may use and give out health information about you to agencies when necessary to prevent a serious threat to your health and

safety or the health and safety of the public or another person. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child or dependent adult abuse or neglect
- to report reactions to medications, medication errors or problems with products;
- to let people know about recalls of products they may be using;
- to let a person know who may have been exposed to a disease or may be at risk for catching or spreading a disease or condition;
- to let the appropriate government authority know if we believe an individual has been the victim of abuse, neglect or domestic violence. We will only make this known when required or authorized by law.

- **Health Oversight Activities**. We may give out health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to oversee the healthcare system, government programs and follow civil rights laws.

- **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may give out health information about you in response to a court or administrative order. We may also give out health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

- **Law Enforcement**. We may give out health information if asked to do so by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness or missing person;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - About a death we believe may be the result of a criminal act;
  - About criminal conduct in a Hillcrest program, and
  - 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.

- **Coroners, Medical Examiners and Funeral Directors**. We may give out health information to a coroner or medical examiner. This may be necessary, for example, to identify the person who died or find the cause of death. We may also give out health information about patients of the agency to funeral directors as necessary to carry out their duties.

- **National Security and Intelligence Activities**. We may give out health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

- **Protective Services for the President and Others**. We may give out health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations for their protection.

- **Inmates**. If you are an inmate of a jail or prison or under the custody of a law enforcement official, we may give out health information about you to the jail, prison or law enforcement official. This release would be necessary (1) for the jail or prison to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Certain Uses and Disclosures that Require Your Written Authorization

- **Psychotherapy Notes**. Your authorization is required before we may use or disclose psychotherapy notes unless the use or disclosure is: (a) by the originator of the psychotherapy notes for treatment; (b) for our own training programs for students, trainees, or practitioners in mental health; (c) to defend ourselves in a legal action or other proceeding brought by you; (d) when required by law; or (e) permitted by law for oversight of the originator of the psychotherapy notes.

- **Marketing**. We may use and disclose medical information about you to communicate with you about a product or service to encourage you to purchase the product or service. Generally, this may occur without your authorization. However, your authorization is

required if: (a) the communication is to provide refill reminders or otherwise communicate about a drug or biologic that is, at the time, being prescribed for you and we receive any financial remuneration in exchange for making the communication which is not reasonably related to our cost in making the communication; or, (b) except as stated in (a), we use or disclose your health information for marketing purposes and we receive direct or indirect financial remuneration from a third party for doing so. When an authorization is required to communicate with you about a product or service, the authorization will state that financial remuneration to Hillcrest is involved.

- **Sale of Information**. Your authorization is required for any disclosure of your health information when the disclosure is in exchange for direct or indirect remuneration from or on behalf of the recipient of the health information. However, your authorization may not be required under certain condition if the disclosure is: (a) for public health purposes; (b) for research purposes; (c) for treatment and payment; (d) if we are being sold, transferred, merged or consolidated; (e) to a business associate of ours for activities undertaken on our behalf; (f) to you when requested by your; (g) required by law; (h) when permitted by applicable law where the only remuneration received by us a fee permitted by law.

- **Other Uses and Disclosures**. Other uses and disclosures will be made only with your written authorization. You may revoke such an authorization at any time by notifying the Privacy Officer in writing of your desire to revoke it. However if you revoke such an authorization, it will not have any effect on action taken in reliance on the prior authorization.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we collect about you:

- **Right to Inspect and Copy**. You have the right to look at and copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

  To look at and copy health information that may be used to make decisions about you, contact the person managing your care. If you ask for a copy of the information, we will charge a fee for the costs of copying, mailing or other supplies in order to give you your copies.

  We may deny your request to inspect and copy in certain very limited circumstances: psychotherapy notes, and information compiled in anticipation of, or use in, a civil, criminal or administrative action or proceeding. If you are denied access to health information, you may ask that the denial be reviewed. The Clinical Director will review the denial. We will accept the outcome of the review.

- **Right to Amend**. If you feel that health information we have about you is incorrect or incomplete, you may ask us to correct the information. You have the right to request a correction for as long as the information is kept by or for Hillcrest.

  - To ask for a correction, you must do so in writing and give it to the Privacy Officer. In addition, you must have a reason that supports your request.

  - We may deny your request for correction if it is not in writing or does not include a valid reason to support the request. In addition, we may deny your request if you ask us to change information that:

  - Was not created by us or the person or entity that created the information is no longer available to make the correction;

  - Is not part of the health information kept by or for Hillcrest;

  - Is not part of the information which you would be allowed to inspect and copy, or

  - Is already accurate and complete.

  If we deny your request we will inform you of the basis for the denial. You will have the right to submit a statement disagreeing with our denial. We may prepare a rebuttal statement. Your request for amendment, our denial, your statement of disagreement, if any, and our rebuttal, if any, will be included with any subsequent disclosure of the health information, or at our election, we may include a summary of the request and denial. If you do not submit a statement of disagreement, you may ask that we include your request for amendment and our denial with any future disclosures of the information.

- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This is a list of the times we gave out health information about you to others except for purposes of treatment, payment and operations identified above. Certain types of disclosures are not included in such an accounting such as: (a) Disclosures to carry out treatment, payment and health care operations; (b) Disclosure of health

information made to you; (c) Disclosures incident to another use or disclosure; (d) Disclosures that you have authorized; (e) Disclosures for our facility directory or to persons involved in your care; (f) Disclosures for disaster relief; (g) Disclosures for national security or intelligence purposes; (h) Disclosures to correctional institutions or law enforcement officials having custody of you; (i) Disclosures that are part of a limited data set for purposes of research, public health or health care operations; and (j) Disclosures made prior to April 14, 2003.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should tell us in what form you want the list (for example, on paper or electronically). You may ask for one free list in a 12-month time period. For additional lists, we may charge you for the costs of providing the list. We will tell you the cost and you may choose to change your request at that time before any costs are added.

- **Right to Request Restrictions**. You have the right to ask for a limitation on the health information we use or give out about you for treatment, payment or health care operations. You also have the right to ask for a limit on the health information we give out about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, if you are a patient of the Hillcrest Clinic, you could ask that we not use or give out information about your care.

  We are not required to agree to your request. If we do agree, we will accept your request unless the information is needed to provide you emergency treatment. The foregoing notwithstanding, we will always agree to a request to restrict disclosures to a health plan if the information relates solely to a health care item or service for which you, or someone on your behalf (other than the health plan) have paid us in full.

  To ask for restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit the use or giving out of health information or both or (3) to whom you want the limits to apply, for example, giving out information to your wife or husband.

  You may write to us at:
  Privacy Officer
  Hillcrest Family Services
  2005 Asbury Road
  Dubuque, Iowa 52001

- **Right to Request Confidential Communications**. You have the right to ask that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work, home or by mail.

  To ask for confidential communications, you must make your request in writing to the Privacy Officer. We will not ask you the reason for your request. We will accept all reasonable requests. Your request must tell us how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this privacy notice. You may ask us to give you a copy of this privacy notice at any time by requesting a copy from any Hillcrest staff member. You may obtain a copy of our Notice of Privacy Practices over the internet at our web site www.hillcrest-fs.org

CHANGES TO THIS NOTICE

- We have the right to change this notice. We have the right to make the changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at each Hillcrest office. The notice will contain on the first page, at the top of the page, the effective date. In addition, each time you are admitted to Hillcrest for treatment or health care services, we will offer you a copy of the current notice.

COMPLAINTS

If you believe your privacy rights have been violated, you may contact or submit your complaint in writing to the Privacy Officer at Hillcrest. If we cannot settle your concern, you also have the right to file a written complaint with the Secretary of the Department of Health and Human Services , 200 Independence Avenue SW, Washington DC 20201 or online at http://www.hhs.gov/ocr

The quality of your care will not depend on nor will you be penalized for filing a complaint.