Easterseals Iowa Brain Health
Demographic Information

Information about the person coming for Brain Health Services at Easterseals		
First Name	Middle Name	Last Name
Gender	Date of Birth	Preferred Pronouns
Street Address	City and State	Zip Code
Preferred Phone Number	Email address	Marriage status
Race	Religion	
Employer or School	Legal Guardian or Parent	Guardian or parent phone number
Guardian/parent address	Guardian or parent City and State	Guardian/parent Zip Code
Emergency contact name (not a child's parents, someone if we can't reach the parent)	Emergency contact relationship to you	Emergency contact phone
Phone number to leave voicemail messages	Phone number text reminders can be sent to	Check below if you prefer we don't leave messages
		☐ Text Messages ☐ Voicemail messages

Insurance information		
Primary insurance	Policy number (may be called identification number)	Subscriber's name (person whose employer provides insurance)
Subscriber's Date of Birth	Copay or co-insurance	Deductible (if you know)
Secondary insurance	Policy number (may be called identification number)	Subscriber's name (person whose employer provides insurance)
Subscriber's Date of Birth	Copay or co-insurance	Deductible (if you know)
Tertiary (third) insurance	Policy number (may be called identification number)	Subscriber's name (person whose employer provides insurance)
Subscriber's Date of Birth	Copay or co-insurance	Deductible (if you know)
Place an X in this box if you, or a child's adult(s) living in their home, are responsible for payment of any cost for this service, if not please fill out the boxes below ☐		
Person responsible for payment and relationship	Address for person responsible for payment	Phone number of person responsible for payment

Easterseals Iowa
RELEASE OF INFORMATION

☐PO Box 5168, Des Moines, IA 50305/ Phone:515.289.1933 ☒401 NE 66th Avenue, Des Moines, IA 50313/Phone: 515.289.1933

Client: **SSN/Medicaid ID:** **DOB:**

I, the undersigned, hereby authorize Easterseals Iowa team members to release and/or obtain the information indicated below, regarding the above-named client, with:

Name of Person or Agency: Primary Care Physician:

Complete Mailing Address:

INFORMATION BEING RELEASED WILL BE USED FOR THE FOLLOWING PURPOSES:
☐ Planning and implementation of my Individual Comprehensive Plan
☒ Coordination of services
☐ Monitoring of services
☐ Referral for new services
☐ Other (specify):

INFORMATION TO BE RELEASED FROM EASTERSEALS IOWA:

Yes	No	
☐	☒	Social History
☐	☒	Progress Summary Report
☐	☒	Individual Comprehensive Plan
☐	☒	Annual Review
☐	☒	Discharge Summary
☒	☐	Other (specify): **Inform PCP client is participating in Brain Health Services, diagnosis, treatment plan, and exchange information if needed**

INFORMATION TO BE OBTAINED FROM THE PERSON OR AGENCY INDICATED ABOVE:

Yes	No	
☐	☒	Social History
☐	☒	Educational/Vocational Plans
☒	☐	Progress Summary
☐	☒	Psychological Evaluations/Reports
☐	☒	Psychiatric Assessment/Reports
☒	☐	Medical History
☒	☐	Treatment Plan
☐	☒	Discharge Summary
☐	☒	Other (specify):

This authorization shall expire after one year from signature date. At that time, no express revocation shall be needed to terminate my consent, but I understand that I may revoke this consent at any time by sending a written notice to the recipient named and to Easterseals Iowa. I understand that any information released prior to the revocation may be used for the purposes listed above and does not constitute a breach of my rights to confidentiality. I understand that if the person or entity that receives the information requested is not covered by federal or state privacy regulations or if a release and/or redisclosure of the information is not otherwise prohibited by law the information released may be redisclosed by the person or entity receiving the information. I understand that I may review the disclosed information by contacting the recipient named, or Easterseals Iowa. I specifically authorize the release of data and information relating to Mental Health and as otherwise required by law or valid court/agency order:

If you would prefer we do not send information to your Doctor write "Decline" on the line below

Signature of Client: _____ Date: _____

Signature of Legal Guardian/Co-Guardian: _____ Date: _____

Signature of Legal Guardian/Co-Guardian: _____ Date: _____

I specifically authorize the release of date and information relating to:
☐ Substance Abuse ☐ HIV-Related Information

Signature of Client: _____ Date: _____

Signature of Legal Guardian/Co-Guardian: _____ Date: _____

Signature of Legal Guardian/Co-Guardian: _____ Date: _____

Copies Given to Client/Guardian on:

Revised January 2011

EASTERSEALS IOWA
Creating solutions, changing lives.

WAIVER OF LIABILITY

The undersigned, individually or as a parent or natural guardian, in partial recognition of services rendered and benefits conferred by the Easter Seal Society of Iowa, Inc., hereby releases and forever discharges the Easter Seal Society of Iowa, Inc., its agents and assigns, from any and all claims, demands, or actions, causes of action or suits of whatsoever kind or nature for damages sustained by the participant identified below or accruing to the undersigned in consequence of any accident or occurrence resulting from the participation in any activity or program of the Easter Seal Society of Iowa, Inc. and when the participant identified below is not on the premises of said Easter Seal Society of Iowa, Inc., and is engaged in any venture or activity solely in his or her own behalf.

Name of Participant _____
(Please Print)

Signature _____ Date _____
(Participant)

Signature _____ Date _____
(Guardian)

Signature _____ Date _____
(Easter Seals Representative)

Easterseals Iowa Brain Health
Signature Page and Payment Agreement

Documents I have received or been offered:

- Rights and Responsibilities
- Informed Consent/Consent to Treat
- Notice of Privacy Practices
- Description of Easterseals Services
- Client Grievance and Appeal Process

Payment agreement and assignment of benefits:

I understand that if I owe anything like a copay or other payment for brain health services at Easterseals I will pay it at each session, unless an alternative arrangement is written below.

I also authorize the release of any medical or other information necessary to process claims. I request payment of benefits (i.e. Medicare, Medicaid, or other insurance benefits) to Easter Seals Society of Iowa who accepts assignment. I authorize payment of medical benefits to Easter Seals Society of Iowa for services described in claims.

Session attendance:
Where allowed by law, I understand that I may be charged a no-show fee of $50 if I do not notify the provider at least 12 hours before the appointment via phone or email. If I chronically miss my appointments I may lose my appointment time, or my therapist and the director may decide to stop scheduling sessions with me.

Alternative Payment Agreement, to be completed by therapist:

I am requesting an alternative payment agreement as outlined here: _____

_____

_____

_____

_____ _____ _____ _____

Client Signature Date Parent/Guardian signature Date

_____ _____

Provider Signature Date

_____ _____

Director approval of alternative payment agreement Date