3501 W. Elder St. Boise, ID 83705
Phone #: 208-286-1529
Fax #: 208-445-2285

CLIENT INFORMATION SHEET

Client Name: _____

Preferred Name: _____

Client's Legal Gender: _____

Preferred Pronouns: _____

Age: _____ DOB: _____ Today's Date: _____

Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Divorced

( ) Separated ( ) Partnership ( ) Other:_____

Parent/Legal Guardian Name: _____

Address: _____

Street Number City State Zip Code

Phone number: (__)_____

Preferred phone number for appointments/contacting: (__)_____

E-Mail: _____

Employer/School: _____

Referral Source: _____

Emergency Contact Information #1:

Name: _____

Phone Number: _____

Relationship to client: _____

Emergency Contact Information #2:

Name: _____

Phone Number: _____

Relationship to client: _____

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Financial Information:

Name of Financially Responsible Person: _____

DOB: _____

Address: _____
Street Number City State Zip Code

Phone Number: _____

Relationship to Client: _____

I understand that I am responsible for any fees charged for services and agree to pay

SIGNATURE: _____

Medicaid Yes or No: _____

Medicaid Policy Number: _____

IF MEDICAID IS YOUR ONLY INSURANCE PROVIDER PLEASE SKIP TO SIGNATURE LINE AT THE BOTTOM OF THIS PAGE. IF MEDICAID IS NOT YOUR ONLY INSURANCE PROVIDER, PROOF OF VALID PRIMARY INSURANCE COVERAGE IS REQUIRED BEFORE COUNSELING SERVICES WILL BE PROVIDED

PRIMARY INSURANCE INFORMATION:

PROOF OF VALID PRIMARY INSURANCE CARD: *Please upload a copy of your valid primary insurance card or present a copy of your insurance card to the front office at time of first counseling appointment. This is required.*

Name of Primary Insurance Provider: _____

Policy Holder Name: _____

Policy Holder DOB: _____

Name of Employer: _____

Policy Holder SSN Number: _____

Policy Number: _____

ID Number: _____

Group Number: _____

Co-Pay: _____

Federal regulations allow me to use or disclose Protected Health Information from your record to provide treatment, obtain payment for the services I provide and operate my practice. Nevertheless, I ask your consent to make your permission explicit. My Notice of Privacy Practices describes these disclosures in greater detail which you have the right to review before signing this consent.

I hereby authorize the provider of service to furnish information requested by my Insurance Carrier and I hereby assign to the provider all payments rendered to myself or my dependents. I understand it is my responsibility to pay for any deductible amount, co-payment or other allowable balance not paid for my insurance.

Client/Parent/Legal Guardian Signature: _____

Date: _____

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FINANCIAL POLICY

Thank you for choosing Noble Intent as your Mental Health clinic. We are committed to building a successful clinicians-client relationship with you and your family. Please understand that payment for services and a clear understanding of our Client Financial Policy is a part of that relationship. It is your responsibility to notify our office of any client information changes. (i.e., address, name, insurance information, marital status, personal representatives, etc.)

Insurance

It is the client's responsibility to know if our office is participating with their insurance plan. If we are not a participating therapist in your insurance plan, you will be responsible for payment in full at time of service. If there is a discrepancy with our information, the client will be considered self-pay until coverage is determined. However, as a courtesy, we will file your initial insurance claim.

To bill your insurance, we must receive a copy of your insurance card and a valid government photo ID.

Co-pays and Co-Insurance

- All co-payments and past due balances are due at time of check-in unless previous arrangements have been made.
- Co-pays are a requirement of your insurance plan, but it does not affect your obligation to pay our bill.
- We accept cash, check or credit cards; Absolutely no post-dated checks will be accepted.

Deductibles

Most insurance plans require that clients pay a predetermined dollar amount each year prior to services being covered. If you have not met your deductible, you will be asked to pay in full at the time of your session visit.

Self-Pay

Self-pay accounts ***must*** be paid in full at time of service unless prior arrangements have been made. You are self-pay if you are:

- A client without insurance coverage
- A client covered by insurance plans in which Nobble Intent does not participate.
- A client without an insurance card on file with us

Noncovered Sessions

Insurance does not cover Family Therapy and Individual Therapy within the same day. It will be the client's full responsibility to cover the Family Therapy of $125 if both sessions are done on the same day.

Fees

NO SHOW, LATE AND CANCELATION POLICY

When an appointment is scheduled, we are unable to use this time for another client. Therefore, it is so important that you show up to your scheduled appointment and that you are on time. We understand things come up and there will be times you may have to cancel your appointment. We request that you cancel your appointment **24 HOURS AHEAD OF TIME**. If you do not give notice 24 hours prior to your appointment, you will be noted as a "no show" and charged a fee. If it happens more than twice you will be at risk of being removed from re-occurring appointments and will need to schedule your appointment each week. We understand there may be emergencies or illness and we may have to make exceptions.

Please read and agree to the terms below:

- I understand that I will be charged a **LATE CANCELATION FEE OF $125** if I fail to cancel my appointment 24 hours prior to the scheduled time. Exceptions will be made in the case of an emergency or illness but not on a regular basis.

- I understand that I will be charged a **NO-SHOW FEE OF $125** if I fail to show up for my appointment with no notice.
- I understand that if I am late to the appointment, I will have to end the session at the allotted time.
- I understand that if I have more than two late cancelations and/or no shows that I will be at risk of being removed from re-occurring appointments and will need to schedule my appointment each week.

Noble Intent sends appointment reminders via text messaging.

Returned Checks
Returned check fee is $25, payable by cash or credit card. This will be applied to your account in addition to the insufficient funds amount. Following a returned check, we may choose to place you on a cash only basis.

Collections
If your account gets turned over to collections, there could be a collection fee added to your balance, billed through the collection agency. Client agrees to be responsible for any interest charges, court costs, and/or attorney fees if balance goes to collections.
I understand if I have an unpaid balance to Noble Intent and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of the fee of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts.

In order for Noble Intent or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Noble Intent and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable. Furthermore, I consent the designated external collection agency to share personal contact and account related information with third party vendors to communicate account related information via telephone, text, e-mail, and mail notification.

Session Hold
There will be a $75 holding fee for any requested time slots with your counselor. Payment is required to be paid up front at the time of the request.

Payment
Prior to providing additional services to you, payment in full of total outstanding balances is required. All balances after 90 days will be charged an 18% finance charge. Payment is expected at the time of your appointment unless other arrangements have been discussed and agreed upon in advance. Your health insurance company may reimburse us for services. However, you are still responsible for any deductible, co-payment, or balance applicable to your individual policy. Noble Intent asks all clients to submit a credit card authorization sheet. Noble Intent will charge your card after each service and will send you a receipt via email. Regardless of any personal arrangements that a client might have outside of our office, if you are over 18 years of age and receiving counseling, you are ultimately responsible for payment of the session. Our office will not bill any other personal party.
Payment is expected at the time of your session. We accept cash, debit, or credit card. Payment will include any unmet deductible, coinsurance, co-payment amount, prior balance, or non-covered charges.

Payment Plan
Extended payment arrangements are available if needed. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our clients, only to provide them with the best care possible and the least amount of stress. A payment plan is not active until a Payment Plan Consent form has been signed.

Past Due Balances
Due to the high cost of rendering care and the low reimbursements by many insurers, we simply cannot afford to carry large account balances.
- Balances not paid within 90 days will be considered past due and will begin to incur 18% interest.
- For past due accounts, a single phone call will be made to try to make payment arrangements.

- Clients with accounts sent to collection face termination from the clinic and will need to find another therapist.
- Noble Intent has the right to refer a client to another Mental Health clinic for any outstanding balances of $250 or more if no payment arrangements have been made.

Accounts sent to collection incur additional fees including but not limited to late fees, collection agency fees, interest, and attorney fees. The person financially responsible for the account will be responsible for all outstanding balances and collection costs. Client agrees to be responsible for any interest charges, court costs, and/or attorney fees if balance goes to collections.

Please direct questions regarding payment to:
Noble Intent Billing Department
(208) 286-1529

It has become increasingly expensive to collect fees rightfully due to the provider for services rendered in good faith to clients. Therefore, we have found it necessary to be very explicit in the financial policies of this practice. Non-payment by some affects the cost of mental health to all our clients. If you do not present a form of payment to meet your obligations to your insurance provider and to your mental health therapist, we cannot accept you as a client or continue to schedule you for sessions.

Thank you for taking time to review our Financial Policy. This policy helps our client provide quality care to our valued clients. If you have any questions or need clarification of any of the above, please feel free to ask.

This financial policy is effective immediately as of the date signed below and will replace any prior policies.

By signing Noble Intent's Financial Policy, I acknowledge that I have read, understand, and agree to the above terms and conditions, and agree to ultimately accept sole responsibility for payment of my account in full.

_____
Printed Name of Client or Legally Responsible Person

_____
Signature of Client or Legally Responsible Person

_____
Date

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CREDIT CARD AUTHORIZATION FROM

Will charge card after each service (will include fees for service and any cancelation fees that have been applied).

If you want Noble Intent to bill your card after the session/service, sign here.

Name (As shown on card): _____

Client Name: _____

Type of Card: _____

Credit Card #: _____

Expiration Date: _____

3- or 4-Digit Security Code on Back of Card: _____

Zip Code (where bill is mailed to): _____

If your credit card changes, please let us know. Thank you.

If we are unable to charge your card for any unpaid balances held over 60 days, we will have to submit your bill to a collection's agency. You will also be responsible for any collections, attorney, or court fees resulting from your account being sent to collections.

Please sign below stating you have read and agree to all these terms.

_____ _____

Signature of Financially Responsible Person Date:

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Mental Health Intake Form

All information on this form in strictly confidential. Please fill out the form to the best of your ability. If you would like assistance completing this form, please let our office know.

Patient First Name:	**Patient Last Name:**
Date Completed:	**Patient Date of Birth:**
Primary Care Physician:	**Physician Phone #:**

Gender Identification: Which of this best describes your current gender identity? (Please check all that apply)

☐Male ☐Female ☐Genderqueer

☐Female-to-male (FTM)/transgender male/trans man ☐Male-to-female (MTF)/transgender female/trans woman

☐Other, please specify_____ ☐Choose not to disclose.

Sexual Orientation: Which of this best describes your current sexual orientation? (Please check all that apply)

☐Asexual ☐Bisexual ☐Gay/Lesbian ☐Heterosexual/Straight ☐Pansexual

☐Queer ☐Other, please specify_____ ☐Choose not to disclose.

Symptoms: Please check all that apply

☐Depressed moods	☐Racing Thoughts	☐Anxiety attacks.
☐Unable to enjoy activities	☐Impulsivity	☐Avoidance.
☐Loss of interest	☐Increased irritability	☐Hallucinations.
☐Concentration/forgetfulness	☐Crying Spells	☐Paranoia.
☐Fatigue	☐Excessive worry	☐Excessive guilt

Comments:

Emotional/Psychiatric History:

Prior Outpatient Treatment? ☐ Yes, please describe ☐ No

Reason:	Dates Treated:	By Whom:

Prior Inpatient Treatment (psychiatric, emotional, or substance abuse disorder? ☐ Yes, please describe ☐ No

Reason:	Date Hospitalized:	Where:

Family Mental Illness History: Has anyone in your family ever been treated for a mental illness?

☐ Yes, please describe ☐ No ☐ Unknown.

Family Member:	Diagnosed Mental Illness:

Current Medications: Please list current medications and dosage. ☐ Yes, please describe ☐ No

Medication:	Dosage:

Developmental History/Milestone:

Met typical developing milestone? ☐ Yes ☐ No, please describe ☐Unknown.

Delayed Developmental Milestone:	Intervention/Treatment:
Gross Motor	
Fine Motor	
Language	
Toileting	
Social	

Socio-Economic Information: Please describe the following:

Current living situation: _____

Support System: _____

Legal History: ☐ No ☐ Choose not to disclose ☐ Yes, please describe _____

Cultural/Spiritual preferences: _____

Strengths: _____

Goals For Treatment:

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RELEASE OF INFORMATION

Client Name: _____ DOB: _____

Agency requesting or needing information: **Noble Intent**

I authorize the following person or business to release or disclose confidential information about me:

Primary Care Doctor: _____

Primary Care Office Address: _____

Primary Care Phone Number: _____

Purpose of Disclosure: *Coordination of Care*

Type of information requested: *Written & Verbal Records Please check all that apply:*

Assessment	☐ Educational Information
Diagnosis	☐ Discharge/Transfer Summary
Psychosocial Evaluation	☐ Continuing Care Plan

- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Treatment Plan or Summary
- ☐ Current Treatment Update
- ☐ Presence/Participation in Treatment
- ☐ Progress in Treatment
- ☐ Demographic Information
- ☐ Psychotherapy Notes
- ☐ Management Information
- ☐ Nursing/Medical Information
- ☐ Other _____

This authorization is good until 1 Year.

I understand that this information may be exchanged by fax, email, or telephone.

I understand that I am under no obligation to sign this form and the person and/or organization listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for healthcare benefits or my decision to sign this authorization. I understand that if the person and/or organization listed above are not healthcare providers, health plans, or healthcare clearinghouses that must follow the federal privacy standards that the health information disclosed because of this authorization my no longer be protected by the federal privacy standards and my health information could be re-disclosed without my authorization.

I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization. I understand that I have a right to receive a copy of this authorization.

I release the person/agency disclosing this information from any liability arising from the release of information to the agency or person designated above. Federal rules prohibit further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains.

Client/Parent/Legal Guardian Signature: _____

Date: _____

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RELEASE OF INFORMATION

Client Name: _____ DOB: _____

Agency requesting or needing information: **Noble Intent**

I authorize the following person or business to release or disclose confidential information about me:

School Name: _____

School Address: _____

School Phone Number: _____

Purpose of Disclosure: *Coordination of Care*

Type of information requested: *Written & Verbal Records*

- ☐ Assessment
- ☐ Diagnosis
- ☐ Psychosocial Evaluation
- ☐ Psychological Evaluation
- ☐ Educational Information
- ☐ Discharge/Transfer Summary
- ☐ Continuing Care Plan
- ☐ Progress in Treatment

- ☐ Psychiatric Evaluation
- ☐ Treatment Plan or Summary
- ☐ Current Treatment Update
- ☐ Presence/Participation in Treatment
- ☐ Demographic Information
- ☐ Psychotherapy Notes
- ☐ Management Information
- ☐ Nursing/Medical Information
- ☐ Other _____

This authorization is good until 1 Year

I understand that this information may be exchanged by fax, email, or telephone.

I understand that I am under no obligation to sign this form and the person and/or organization listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for healthcare benefits or my decision to sign this authorization. I understand that if the person and/or organization listed above are not healthcare providers, health plans, or healthcare clearinghouses that must follow the federal privacy standards that the health information disclosed because of this authorization my no longer be protected by the federal privacy standards and my health information could be re-disclosed without my authorization.

I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization. I understand that I have a right to receive a copy of this authorization.

I release the person/agency disclosing this information from any liability arising from the release of information to the agency or person designated above. Federal rules prohibit further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains.

Client/Parent/Legal Guardian Signature: _____

Date: _____

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RELEASE OF INFORMATION

Client Name: _____ DOB: _____

Agency requesting or needing information: **Noble Intent**

I authorize the following person or business to release or disclose confidential information about me:

Past Mental Health Treatment Provider: _____

Past Mental Health Treatment Provider Address: _____

Past Mental Health Treatment Provider Phone Number: _____

Purpose of Disclosure: *Coordination of Care*

Type of information requested: *Written & Verbal Records*

- ☐ Assessment
- ☐ Diagnosis
- ☐ Psychosocial Evaluation
- ☐ Psychological Evaluation
- ☐ Educational Information
- ☐ Discharge/Transfer Summary
- ☐ Continuing Care Plan
- ☐ Progress in Treatment

- ☐ Psychiatric Evaluation
- ☐ Treatment Plan or Summary
- ☐ Current Treatment Update
- ☐ Presence/Participation in Treatment
- ☐ Demographic Information
- ☐ Psychotherapy Notes
- ☐ Management Information
- ☐ Nursing/Medical Information
- ☐ Other _____

This authorization is good until 1 Year

I understand that this information may be exchanged by fax, email, or telephone.

I understand that I am under no obligation to sign this form and the person and/or organization listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for healthcare benefits or my decision to sign this authorization. I understand that if the person and/or organization listed above are not healthcare providers, health plans, or healthcare clearinghouses that must follow the federal privacy standards that the health information disclosed because of this authorization my no longer be protected by the federal privacy standards and my health information could be re-disclosed without my authorization.

I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization. I understand that I have a right to receive a copy of this authorization.

I release the person/agency disclosing this information from any liability arising from the release of information to the agency or person designated above. Federal rules prohibit further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains.

Client/Parent/Legal Guardian Signature: _____

Date: _____

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RIGHTS, RESPONSIBILITIES, AND ETHICS: CLIENT RIGHTS AND RESPONSIBILITIES

Client Name: _____ DOB: _____

Thank you for choosing Noble Intent for your therapy services. Starting therapy is a major decision and you may have many questions. This document is intended to inform you about your rights as a client, and what to expect from the therapeutic relationship. Please read the following information and express any concerns or questions you may have.

As a client you have the following rights:

- To receive information about your therapist's credentials, licensure, experience, education, and training, and therapeutic orientation
- To receive information about the methods of therapy, the techniques used, the duration of therapy (if known), the benefits and risks of therapy, costs of treatment, and alternative treatment procedures that are available, if any
- To have a choice of treatment providers. You are an active participant, and it is important to work with a provider and treatment modality that meet your needs.
- To refuse services offered to you unless an emergency exists, or a court order is in effect.
- To terminate therapy at any time, unless prevented by law. Noble Intent also retains the right to terminate providing services to you.
- To have treatment and medical records kept confidential, except as required by law. These exceptions include: 1) Reporting suspected child abuse or neglect; 2) Reporting threat of harm to self or others, as in the case of suicide, homicide, or grave disability; 3) Reporting information required by court order; 4) Disclosing necessary information to a client's insurance company for reimbursement; 5) Disclosing information necessary for consultation or supervision; 6) Disclosing information as authorized by the client or legal guardian in writing. Your right to confidentiality may also be waived in the case of non-payment, for your name to be released to a collection agency.
- To see your records or have them shown to any person that you designate in writing according to Idaho law. If you are denied access to your records, you have the right to know why and the right to appeal the decision.
- The practice of mental health is regulated by the Idaho Bureau of Occupational Licenses, Board of Professional Counselors and Marriage and Family Therapists. Contact information is 1109 Main Street, Suite 220, Boise, ID 83702-5642, Phone: 208/334-3233. You are entitled to report complaints to the Board, and you cannot be retaliated against for making such complaints. Please also understand that licensure of an individual by the Board does not imply endorsement by the Board or imply effectiveness of treatment.

As a client of Noble Intent, you have the following responsibilities:

- To respect the rights and property of other clients, staff, and the building
- To be on time for appointments, and to make cancellations at least 24 hours in advance by calling Noble Intent at 208-286-1529. Please understand that should you fail to cancel your appointment or fail to give proper notice; you may be charged a no show/late cancel fee. In addition, repeated no shows/late

cancels may be cause for termination of services.

- To be responsible for the financial obligations incurred while participating as a client at our agency
- We will create a treatment plan together to guide your treatment. It is your responsibility to let your therapist know if you are unhappy with the treatment plan or wish to adjust it. Your therapist is here to help you reach your goals in therapy; however, it is your responsibility to follow the agreed upon treatment plan. If, at any time, you refuse to follow the treatment plan this may be cause for termination of services, as it is unethical to maintain a therapeutic relationship that is non-beneficial to the client.

Ethical Obligations:

- To be treated with respect and dignity
- To impartial access to treatment, regardless of race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity; an inability to pay; or whether payment for services would be made under Medicare, Medicaid, or CHIP
- To receive services which are suited to individual needs, in the least restrictive setting in keeping with the available resources
- Noble Intent will not render services or practice outside our scope of services. Clients will be entitled to receive an appropriate referral to another agency or provider who specialize in the services determined to be most beneficial and appropriate.
- We will build and maintain ethical and professional boundaries with clients.
- Noble Intent will continuously re-evaluate our strengths, limitations, biases, and effectiveness.
- We adhere to all governing agencies and maintain and update our policies and procedures when necessary to adhere to best practice and maintain evidenced-based treatment.

Violation of Rights or Filing Grievance:

If you believe your client rights have been violated, the protocol is to speak in person or by phone with the owner of the agency, who will obtain additional information from you regarding the alleged violation. The owner of the agency will promptly investigate any alleged breach of your rights, contact the appropriate agencies if necessary, and address any concerns as appropriate.

General Information:

- Please understand that the practice of psychotherapy is not an exact science, and treatment outcomes cannot be guaranteed. Psychotherapy can have benefits and risks. Since psychotherapy often involves discussing unpleasant aspects of your life, you may feel uncomfortable feelings. Conversely, psychotherapy has also been shown to have many benefits. Psychotherapy often leads to increased self-awareness and confidence, improved relationships, solutions to specific problems, and significant reductions in feelings of distress or other symptoms.
- Your treatment provider cannot always guarantee availability during a crisis. If an emergency arises outside of normal business hours or if your treatment provider is not available by phone during an emergency, you should call 911, or go to the nearest hospital emergency room for assistance.
- If you are a private pay client and your account balance is two or more sessions in arrears, you will be required to sign a Payment Agreement Plan, which will serve as a specific contract between you and your provider, enforcing an individual payment plan to bring your unpaid balance to zero. Failure to abide by the Payment Agreement Plan will be considered noncompliance with treatment, and as such, may be cause for discharge from services.
- If services are terminated by your therapist for any reason (for example, noncompliance with treatment, non-payment, repeated no shows/late cancellations, etc.) referrals to alternate treatment providers will be given.

My signature below indicates that I have read, and if requested, received a copy of the preceding information; that I understand my rights and responsibilities as a client, and that I consent to treatment with Noble Intent. Any questions related to this document have been answered to my satisfaction.

_____ _____

Client Signature: Date:

_____ _____

Parent/Guardian Signature (if underage of 18): Date:

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Fax #: 208-445-2285

RIGHTS, RESPONSIBILITIES, AND ETHICS: GRIEVANCE PROCEDURE

You have the right to have your concerns/grievances heard and addressed appropriately. Noble Intent has an open-door policy and desires to help you resolve any concerns to ensure that your experience here is positive. Additionally, there are protection, advocacy and legal services available to help you including, but not limited to, the Idaho Mental Health Coalition (208) 658-2000, the National Alliance for The Mentally Ill (208) 673-6672, the Idaho Volunteer Lawyers (800) 221-3295. Last, as a client, you have the right to make complaints regarding ethical concerns of a service provider to the Bureau of Occupational Licenses at (208) 334-3233.

If the complaint is a general issue regarding the building, lobby, or other issue outside of the therapeutic process, you may inform your counselor or service provider, or any office staff. If the complaint or problem, is with your counselor or other service provider, we ask you to first inform them of the concern and attempt to address it with them. However, if you are unable to resolve your concern, or do not feel safe to approach your counselor or other service provider with your concern, you may notify the clinical director. This can be done by telling one of the administrative assistants that you have a concern that you would like to address with the clinical director. The clinical director will help you mediate a solution to your concern or will provide alternative services/providers to meet your needs.

In signing this I am acknowledging my understanding of this policy as a recipient of services through Noble Intent.

_____ _____

Client Signature: Date:

_____ _____

Parent/Guardian Signature (if underage of 18): Date:

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RIGHTS, RESPONSIBILITIES AND ETHICS: INFORMED CONSENT

Client Name: _____ DOB: _____

All clients must provide informed consent prior to receiving any treatment. Each client also has the right to be actively involved in their treatment and care decisions. As such, the following procedures will be followed to ensure that all consent is given freely:

1. When any treatment is proposed or executed, the client has the right to refuse to participate. Clients shall not be required to perform any task or be involved with any treatment that s/he does not consent to.
2. When performing a Comprehensive Diagnostic Assessment (CDA), the therapist will explain the purpose of the assessment and how the information obtained will be used. The therapist will explain HIPAA requirements and patient rights before beginning the assessment. The therapist will also obtain consent from the client to perform the Diagnostic Assessment.
3. When an Individualized Treatment Plan is being implemented, the client and the client's guardian (if client is a minor) shall be actively involved in creating the Treatment Plan. While each client's ability to be involved will vary, the clinician and treatment team will involve the client and/or guardian to the extent possible when taking the client's circumstances into account.
4. Before an Individualized Treatment Plan or Case Management Plan is implemented, the treatment provider will fully explain the content, goals, and objective measurements of the plan to the client or the client's parent/guardian. The provider will adequately answer all questions the client may have so informed consent can be given. The provider will obtain a signed copy of the client or guardian's consent prior to beginning any treatment.
5. Any updates to a treatment plan will be fully explained to the client or a guardian. If a valid consent to treatment is in the client's file, then a verbal consent will suffice for the necessary changes, unless the changes involve a change in level of care, in which case a new consent to treatment must be signed and placed in the client's file.
6. The consent to treatment may be revoked at any time by a client submitting a written statement revoking such consent. Any revocation of consent is to be placed in the client's file and kept on record. The consent to treat expires one year from the date on which such consent was given, and providers will ensure that a valid consent form is always in the client's file.
7. I understand that there is a potential emotional risk to therapy. I understand that there is a potential emotional risk to therapy. I understand that at time I may experience extremely difficult emotions. I know that I can ask questions about anything that happens in therapy. I know that I can reuse any request or suggestion made by Noble Intent. I acknowledge that it is my choice to participate in mental health treatment (or have my child participate). I will take responsibility for my treatment and will be prepared and

ready for each session. I have also had time to read and understand ALL policies and am agreeing to follow them.

_____ _____

Client Signature: Date:

_____ _____

Parent/Guardian Signature (if underage of 18): Date:

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Phone #: 208-286-1529
Fax #: 208-445-2285

RIGHTS, RESPONSIBILITIES AND ETHICS:
CONFIDENTIALITY OF CLIENT HEALTH INFORMATION (HIPAA)

Client Name: _____ DOB: _____

Noble Intent will adhere to and enforce strict confidentiality and privacy regarding client's medical information. As a mental health agency, Noble Intent, and its employees are subject to the rules established by the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA imposes strict confidentiality requirements with respect to client health information, which all employees must follow.

- HIPAA confidentiality rules protect from disclosure of all "individually identifiable health information" held or transmitted, in any form or media, whether electronic, paper, or verbally, involving client health information.

- "Individually identifiable health information" is information, including demographic data, that relates to the individual's past, present or future physical or mental health or condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number) and documents contained in the treatment record.

- Individually identifiable health information may only be disclosed on a need-to-know basis. If an individual including any employee does not need to know some aspect of a client's health information to render appropriate care, then that individual is not allowed to share the information with that person or employee.

- As a condition of employment, all employees are responsible for knowing and following HIPAA's confidentiality rules, which can be accessed here: https://www.hhs.gov/hipaa/forhttps://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/combined-regulation-text/index.htmlprofessionals/privacy/laws-regulations/combined-regulation-text/index.html

To ensure strict client privacy, employees must always observe the following procedures:

1. Noble Intent will ensure that all approved employees have access to the client records after they have received training on the importance of HIPAA regulations.

2. Every employee shall receive training on the privacy requirements imposed by HIPAA, applicable state law, and related Noble Intent's policies and procedures.

3. Every employee must sign a training form, indicating they have successfully completed topics on: a) privacy rules and procedures, b) that they understand the applicable rules and procedures, and c) they agree to follow all privacy rules and procedures.

4. Noble Intent will have an approved list of employees who are authorized to have access to printed client files.

5. Unless compelled by law or emergency, no client health information may be disclosed without first obtaining a Consent to Release Form signed by the client. Disclosure is only authorized to the extent permitted in the signed Consent to Release Form. The client's refusal to sign such form must be documented in the client's record, and the client must be advised of foreseeable consequences of their refusal.

6. Noble Intent utilizes electronic health records whenever possible. Access is restricted to designated personnel who must first obtain clearance before they can or may view client records.

7. Employees may not view electronic health records on a screen or device that can be seen by other people. Computer screen locations must not violate confidentiality. Noble Intent may provide monitor screens if computer is in a more visible location.

8. Client records may only be accessed by a Clinical Supervisor, Owner, and the assigned therapist when necessary for updating records, reassessments, or conducting other legitimate agency business.

9. Any mobile phone or laptop computer used by an employee to communicate with a client, view, or download any client information must be password protected. No password or any other client information may be shared with any person without prior authorization.

10. Physical client records must be kept in a locked filing cabinet within a secured room at the office except when being actively used by personnel in the course of their employment. Employees must actively prevent unauthorized employees or clients from viewing the records. Employees will be required to file all client documentation before leaving the office and ensure that files are locked in a secure location. Employees will not leave confidential client material on any printer or other electronic device where others may walk by and see, and/or pick up.

11. If client records must be transported offsite, the employee must follow the procedures contained in the **Record Transportation Policy**.

12. Employees are strictly prohibited from disclosing client names, addresses, or any other personal identifiable information to any person not employed by Noble Intent, or any person not expressly authorized in the client's signed Consent to Release Form.

13. Any person who becomes aware or reasonably suspects that the privacy rules and procedures were violated must immediately report the violation to a supervisor. The supervisor will investigate and draft a written report detailing the facts surrounding the violation, and inform Optum Idaho and Idaho Health and Welfare, if necessary.

14. Clients or their designated representatives must always sign a Consent to Release Information Form prior to any disclosure. The scope of any authorized disclosure and its recipient(s) is strictly limited to the records and persons expressly identified in the signed Consent to Release Information Form.

I HAVE READ AND UNDERSTAND THE PRIVACY NOTICE AND MY RIGHTS CONCERNING USE AND DISCLOSURE OF PROTECTED HEALTHCARE INFORMATION.

Client/Parent/Legal Guardian Signature: __ **Date:**

3501 W. Elder St. Boise, ID 83705
Phone #: 208-286-1529
Fax #: 208-445-2285

RIGHTS, RESPONSIBILITIES AND ETHICS:
USE OF PORTABLE ELECTRONIC MEDIA TO COMMUNICATE WITH CLIENTS

Any mobile phone or laptop computer used by an employee to communicate with a client, view, or download any client information must be password protected. No password or any other client information may be shared with any person without prior authorization.

Noble Intent will ensure that all providers use applications that are encrypted and fall under the purview of HIPAA and meet applicable standards.

Informed Consent Providers of technology-assisted services are bound by the same legal and ethical requirements and standards of practice that apply to in-person service delivery; however, technology introduces some additional risks and benefits that should be covered with clients in technology-assisted services. The risks and considerations vary by type of technology used, as well as the type of service delivered.

The following key principles guide Noble Intent in the behavioral health arena:

- Clinical judgment is fundamental and should drive decisions regarding the use of technology.
- Clinical judgment, and not merely the existence of a given technology, should guide the application of said technology in clinical contexts.
- Practitioners should use technological solutions only within their realm of professional competence and scope of practice.
- The way technology-based tools are used may differ across populations and settings.
- Clinicians and clients should thoughtfully consider and discuss the risks and benefits of technology-based tools as part of the therapeutic process.
- Technology can offer value for individuals and their families along the entire spectrum of behavioral health services. This may include screening, assessment, prevention, treatment, recovery management, and continuing care.
- Maintaining security and confidentiality at Noble Intent is the responsibility of all parties engaged in such care.
- Therapists and other providers, clients, and other stakeholders should continually work together to shape, maintain, and refine models for the adoption and use of technology-based therapeutic tools in treatment.

Client/Parent/Legal Guardian Signature: _____Date:

3501 W. Elder St. Boise, ID 83705
Phone #: 208-286-1529
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PROFESSIONAL COURT TESTIMONY

To protect the therapeutic relationship, the professionals at Noble Intent have with their clients and the effectiveness of treatment, professionals at Noble Intent DO NOT participate court hearings, address the court in a letter, or testify on behalf of anyone. It is also not the role of Noble Intent professionals to give custody recommendations. If employees are forced against their will to participate in court via a subpoena, the charge is $3,000.

If you have questions about this you may speak with the owner of Noble Intent, Jena Schildhauer.

If you have read and understand this policy, please sign below.

Client/Parent/Legal Guardian Signature: _____

Date: _____

ICANS Informed Consent

I, _____*(parent's name)*, am the parent or legal guardian of

_____*(minor client's name)*.

I have received a brochure explaining how ICANS is a secure electronic health system used to administer the ICANS assessment and make the results available to providers who participate in the ICANS system.

I authorize the following Agency Noble Intent (*name of provider/agency/ organization)* to release, use, receive, mutually exchange, communicate with, and disclose information to the ICANS system, and with Agencies/Authorized Users with access to ICANS.

WHO MAY DISCLOSE INFORMATION. The agency I have named at the top of this form may disclose protected health information to ICANS.

WHAT MAY BE DISCLOSED. By signing this consent, I specifically understand that protected health information or records will be released, used, disclosed, received, mutually exchanged, or communicated to, by, among, or between any person, entity, or agency named in this authorization. I understand this information may include material protected under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164; and the Medicaid Act, 42 CFR Part 431, Subpart F. Federal rules restrict any use of the information to criminally investigate or prosecute and to redisclose records relating to any alcohol or drug abuse patient.

PURPOSES.
I understand this authorization will allow my treatment team to plan and coordinate services I need and allows any person, entity, or agency named in this authorization to be actively involved in my case coordination, evaluation, treatment, planning, or legal proceedings. I hereby request and give my permission for an open exchange of information to, by, among, or between, any person, entity, or agency named in this authorization.

REVOCATION.
I also understand that I may revoke this Informed Consent at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization expires automatically as indicated with each disclosure item identified above. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as this original.

EXPIRATION
This authorization shall expire one (1) year from the date the Minor Client and Parent or Legal Guardian signs below.

CONSENT.
I understand that my information cannot be disclosed without my written consent, except as otherwise provided by law, and that federal and Idaho law will be followed for using and disclosing my ICANS information.

By signing this form, I am authorizing providers assessing or treating my child/ward to provide my child/ward's information to ICANS. I understand that failure to sign this authorization may limit determine of eligibility, enrollment, or treatment for my child/ward.

I have read this Informed Consent/had this Informed Consent read/explained to me and I acknowledge an understanding of the purpose for the release of information. I am signing this authorization of my own free will.

Full Legal Signature of Minor or Authorized Personal Representative	**Relationship to Client**	**Date**
Full Legal Signature of Parent or Legal Guardian – ***Required if Client is under 16 years of age, but only after signed by client.***	**Relationship to Client**	**Date**
Full Legal Signature of Witness (Agency Employee)	**Initiating Agency Name**	**Date**