Client Name: Medicaid No.

YOUTH REGISTRATION			
Client Information			
Date		Medicaid No.	
Full Name		Is Medicaid Your Primary Insurance ☐ Y ☐ N	
Social Security No.		DOB	Age
Street Address		City/State/Zip	
Home Phone	Cell Phone	Email Address	
Sex: ◯ M ◯ F ◯ Other			
May we contact you for appointment reminders? ☐ YES ☐ NO			
EMERGENCY CONTACT INFO			
Emergency contact name	Phone No.	Relationship	
Cultural Orientation Information			
Preferred Language ◯ English ◯ Spanish ◯ French ◯ Other:			
Relationship Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Domestic Partner ◯ Other:			
Race ◯ Caucasian ◯ African American ◯ Asian ◯ Native American ◯ Other:			
Ethnicity ◯ Hispanic/Latino ◯ Non- Hispanic/Non- Latino ◯ Other:			

Youth Information	
Reason for referral or visit: What are your primary concerns?	
Primary Physician (list all that apply)	**Phone No.**
Managed care organizations require that we have interaction with client's physician to coordinate care. Do you give us consent to discuss your care with the physician(s) above? ☐ **YES** ☐ **NO**	
If you answered no please explain:	

Current Medications			
Medication	**Dosage/Freq**	**Start Date**	**Purpose**
1)			
2)			
3)			
4)			

Has your child ever been hospitalized for medical or psychiatric reasons? ☐ YES ☐ NO		
Hospital	**Mo/Yr.**	**Reason**
1)		
2)		
3)		

Do you currently see a specialist for any reason? ☐ YES ☐ NO	
Specialist Type	**Reason**

Have you previously been seen by a specialist for any medical reason with in the past year? ☐ YES ☐ NO		
Specialist Type	**Reason**	**Last Visit**

Have you used any of the following substances in the past 12 months?				
Drug Type			**Last Date Used**	**How Often**
Alcohol	◯ Yes	◯ No		
Tobacco (Cigarettes, Dipping/Chew, Vaping)	◯ Yes	◯ No		
IV Drug use	◯ Yes	◯ No		
Other (specify):	◯ Yes	◯ No		

Does your child frequently complain of or have any [problems with (check all that apply)

Headache ❑ Dizziness ❑ Stomach Aches ❑ Weakness ❑ Nausea ❑ Diarrhea ❑ Fatigue ❑ Wetting/soiling Accidents ❑ Muscle Tension

Please list any significant medical problems that may be relevant to your child's treatment:

Family Medical History: Has anyone in your child's immediate family had any of the following?			
	YES	**WHO**	**Explain**
Neurological Disease			
Seizures			
Psychiatric Problems			
Alcoholism			
Hyperactivity			
Learning Problems			
Autism Spectrum Disorder			

School and Family History

Does your child experience any developmental, academic, or behavior problems as a child or while in school, with peers or teachers? ☐ YES ☐ NO

If yes, please explain:

Grade in School (or last grade completed if not currently in school):

What school does your child attend?

Please check all that apply to your child's biological parents

Mother	Father
❑ Living ❑ Deceased ❑ Married ❑ Divorced ❑ Remarried	❑ Living ❑ Deceased ❑ Married ❑ Divorced ❑ Remarried

With whom does your child live:

_____

What custody and/or visitation orders are in place?

_____

Who has legal custody?

_____

Does your child consider anyone else to be a "parent" in his/her life? ◯Yes ◯No If so, whom? _____

List first names and ages of your child's brothers and sisters:

Name	Age	Relationship (Biological/Step)	Lives with

CONSENT FOR TREATMENT OF A MINOR

- We/I, _____ the parent(s) and/or guardian(s) of a minor child _____DOB:_____, give you full and unconditional authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me/us as parent(s) and/or guardian(s) of said child. We/I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child. It is clearly understood that you are hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that your duties are performed with standard care and responsibility to the best of your professional ability.
- Financial arrangements between divorced parents must be handled independently of Healthwise Behavioral Health & Wellness. Although court orders may assign responsibility for a child's healthcare expenses to one parent or another, we, as mental health providers, are not bound by the terms of such court orders. In cases of divorce, the parent seeking service is responsible for the account. If the other parent holds the insurance, they must complete the appropriate consent and acknowledgement forms to give us permission to bill the health insurance. Fees due on the day of an appointment must be collected at every visit regardless of who brings a child to the appointment.

Signature of Parent/Guardian: Date:

Parent/Guardian Name (Please Print):

Date:

Signature of Parent/Guardian:

Parent/Guardian Name (Please Print):

Client Name: Medicaid No.

PHONE: 337.534.0770 FAX: 337.534.4370 www.InsightGuidanceGroup.com

NOTICE OF PRIVACY PRACTICES

In Accordance with HIPPA

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your health record contains personal information about you and your health. This information, which may identify you and relates your past, present, or future physical or mental health or condition and related health care services, is referred to as Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy our on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to quality assessment activities, employee review activities, remind you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	Judicial & Administrative Proceedings
Emergencies	Law Enforcement
National Security	Public Safety (Duty to Warn)

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures are not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Client Name: Medicaid No.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to Insight Guidance Group.

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

Breach Notification. If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

Right to a Copy of this Notice. You have the right to a copy of this notice.

Notice of Privacy Practices Receipt and Acknowledgment of Notice

PLEASE REVIEW CAREFULLY

The Notice of Privacy Practices tells you how the Louisiana Department of Health uses and discloses information about you. Not all situations will be described. We are required to give you a notice of our privacy practices for the information we collect and keep about you.

I, _____, have been given a copy of the

Insight Guidance Group's Notice of Privacy Practices.

Signature of Client: Date:

Signature of Parent, Guardian or Personal Representative: Date:

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, parent, etc.) Please print name and authority.

Client Name: Medicaid No.

COUNSELING POLICIES

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

CONSENT TO TREATMENT

- Psychological services include consultation services regarding behavioral, developmental, or emotional concerns; which provides diagnostic clarification and treatment recommendations, and psychotherapy; which has been shown to have benefits in the reduction of feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. There are no guarantees or assurances of what you will experience.
- Providers are often not immediately available by telephone. A message may be left with the front desk or on the provider's confidential voicemail. Every effort to return your call within a reasonable time is made during business hours. In the event of an emergency, contact you may contact your family physician, call 9-1-1, or proceed to the nearest emergency room. Insight Guidance Group provides a 24/HR crisis line:

ACKNOWLEDGEMENT OF 24 HOUR ON CALL SERVICE

I HAVE BEEN INFORMED THAT IGG PROVIDES THE FOLLOWING 24 HOUR, 7 DAYS A WEEK EMERGENCY TELEPHONENUMBER

(337) 281-1829

This telephone number is for the use of recipients or family members in a CRISIS SITUATION. The individual answering the phone number will be the on-call staff member: MHP to provide crisis intervention up to and including face to face services. Furthermore, I have been given this number and encouraged to post it for EMERGENCY ACCESSIBILITY when needed.

Recipient/Guardian Signature: _____

- Insurance companies require a formal diagnosis with their claims. Diagnoses are technical terms that describe presenting concerns.
- Insight Guidance Group will bill your insurance company for your appointments. If you have a change in insurance please let us know at least 15 days prior to

Emergency Care Consent

I hereby authorize Insight Guidance Group to obtain emergency medical care if the need arises. Every attempt will be made to contact the recipient's emergency contact as listed in the intake form and if the recipient is a minor the parent/guardian before obtaining emergency medical care unless it is a life-threatening circumstance.

Recipient/Guardian Signature: _____

CONFIDENTIALITY

- Insight Guidance Group follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.
- Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all person mandated by law and with the agency that referred you and the insurance carrier responsible

for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentially that may result.

- Insight Guidance Group is a group practice and may share responsibility for and information about clients only within the practice. However, we do not share any personal or clinical information with outside parties without proper consent of the client. Confidentiality is taken very seriously and strictly adhered to at Insight Guidance Group. We ask that you also protect the privacy of other clients you may encounter in the waiting room or in a group therapy setting.

Release of Liability

In exchange for participating in the activity of transportation in ANY EMPLOYEES vehicle organized by Insight Guidance Group and/or use of property, facilities and services, I agree for myself and (if applicable) my child and members of my family to the following:

1. I agree to observe and obey ALL posted rules and regulations. I further agree to follow any oral instructions or directions given by IGG, its employees, or representatives,
2. I recognize that there are certain inherent risks associated with the above described activity and I assume FULL RESPONSIBILITY for personal injury to myself and)if applicable), my family member and further release and discharge IGG for injury, loss or damage arising out of my family's use and other litigations costs, which may in any way arise from me or my family's use of or presence upon the facilities of IGG.
3. I agree to pay for all damages to the facilities of IGG caused by me or my family's negligent, reckless, or willful actions.
4. In the event that I or my family is injured during activities at the IGG facility, I give my permission to the agency and its representatives to arrange necessary medical treatment for which I WILL BE FINANCIALLY RESPONSIBLE.

IGG SHALL HAVE THE FOLLOWING POWERS:

a. The power to seek appropriate medical treatment or attention on behalf of myself/my children and or family member as may be required by the circumstance, including without limitation, that of a licensed medical physician and/or hospital.
b. The power to authorize treatment or medical procedures in and emergency situation, and
c. The power to make appropriate decisions regarding clothing, bodily nourishment and shelter.

Any legal or equitable claims that may arise from participation in the above shall be resolved under Louisiana law. I HAVEREAD THIS DOCUMENT AND UNDERSTAND IT, FURTHER, I UNDERSTAND THAT BY SIGNING THIS RELEASE, I SURRENDER CERTAIN LEGAL RIGHTS.

RECIPIENT/GUARDIAN SIGNATURE: _____

MISSED APPOINTMENTS & CANCELLATION POLICY

- 24-hour cancelation notice is required

This policy is designed to protect our providers' time, not to penalize our clients financially. When an appointment is made with one of our providers, that time is booked and is no longer available for scheduling. Late cancellation and no-show appointments are rarely filled due to lack of advance notice and result in a loss of our providers' time.
Insight Guidance Group reserves the right to terminate services after 3 late cancel/no show missed appointments. Should scheduling @ Insight Guidance Group be discontinued your provider will provide you with outside referral sources.

UNATTENDED CHILDREN: We are unable to provide supervision for children in the waiting room and cannot accept responsibility for their safety if left unattended. For the safety and welfare of the children and out of consideration for others, please make arrangements for childcare during therapy sessions, or provide adult supervision for children while waiting in the waiting room. Parents will be held responsible for any property damage caused by their child.

Recipient Orientation

Acknowledgement upon admission of the materials regarding:

- **Recipient Rights;**
- **Grievances and appeal procedures**
- **An explanation of the agency's:**
  - Services and activities;
  - Expectations;
  - Hours of operation;
  - Access to after-hours services;
  - Code of ethics;
  - Confidentiality policy;
  - Recipients Orientation Manual
  - Requirements for follow up for the mandated person served regardless of discharge outcome;
  - Use of restraint;
  - No smoking policy;
  - No drug usage on premises policy;
  - Abuse and neglect policy;
  - Individual Service Plan;
  - Admission/Discharge Criteria; and
  - Emergency plan including fire, first aid, disaster and evacuation procedures

Client Name: Medicaid No.

Consent to Email or Text Usage for Appointment Reminders

Persons served by Insight Guidance Group (IGG) may be contacted via email and/or text messaging to be reminded of an appointment(s), to obtain feedback on services received, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email address or text number from IGG.

1. How we will use email and text messaging: We use these methods to communicate only about non-sensitive and non-urgent issues. All communications to or from you may be made a part of your medical record. You have the same right of access to such communications as you do to the remainder of your medical record. Your email and text messages may be forwarded to another IGG staff member as necessary for appropriate handling. We will not disclose your emails or text messages to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information concerning permitted uses of your health information and your rights regarding privacy matters.

2. Risk of using email and text messages: The use of email and text message has a number of risks that you should consider. These risks include, but are not limited to, the following:

a. Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b. Senders can easily misaddress an email or text and send the information to an undesired recipient.
c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
d. Employers and on-line services have a right to inspect emails and texts sent through their company systems.
e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
f. Emails and texts can be used as evidence in court.
g. Email and text messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.

3. Conditions for the use of email and text messages: IGG cannot guarantee but will use reasonable means to maintain security and confidentiality of email/text information sent and received. You must acknowledge and consent to the following conditions:

a. IN A MEDICAL EMERGENCY, DO NOT USE EMAIL, CALL 911. Do not email for urgent problems. If you have an urgent problem during regular business hours, please call the clinic. Urgent messages or needs should be relayed to us by using regular telephone communication.
b. Emails should not be time-sensitive. While we try to respond to email messages daily, we cannot guarantee that any particular email will be read and responded to within any particular period of time.
c. You should speak with your staff person to discuss complex and/or sensitive situations rather than send email or text messages regarding such situations.
d. Email and text messages may be filed electronically into your medical record.
e. Clinical staff will not forward your identifiable email/texts to outside parties without your written consent, except as authorized by law.
f. You should use your best judgment when considering the use of email or text messages for communication of sensitive medical information. Clinical staff are not responsible for the content of messages.
g. IGG is not liable for breaches of confidentiality caused by you or any third party.
h. It is your responsibility to follow up with your staff person if warranted.

IGG does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Person served or guardian shall indicate and sign the Informed Consent at Intake for consent or denial for the above information.

Assignment of Benefits; Release of Medical Information; and Authorization to Use Social Security Number

Assignment of Benefits

I understand that in order for anyone to bill Medicare, Medicaid, or other insurance carriers for any inpatient/outpatient medical care, I must give permission.

I hereby assign, transfer, and set over unto Insight Guidance Group Authority, as its interest may appear, all medical benefits now due or becoming due to me under the terms of any third party insurance coverage that I currently am entitled to or that I become entitled to in the future under the terms of the described policy. I hereby direct any third-party insurance entity whose benefits are now due or become due to me, including Medicare, Medicaid, or commercial insurance companies, to pay such benefits directly to the above-named agency for services provided.

I understand that I am responsible for payment of any services provided that are not covered by my insurance carrier(s) (amount determined upon receipt of proof of income). I understand that I am responsible for payment for any required deductibles and for any portion of the final bill that was not paid by my insurance carrier(s).

Release of Medical Information

I understand that the information contained in a medical record is confidential. However, I specifically give consent for Insight Guidance Group authority to release medical information to Medicare (Health Care Financing Administration and its agents), Medicaid, other insurance carriers, or third-party websites in order to obtain prior authorization for medication or services on my behalf.

Medical information is to be disclosed for the purpose of monetary reimbursement and prior authorization for medication or services. This consent is subject to written revocation at any time except to the extent that action has already been taken upon this consent.

Client Name: Medicaid No.

Authorization to Use Social Security Number

I hereby consent to Insight Guidance Group to verify and use my social security number as identification for record-keeping purposes.

Person served shall sign the Informed Consent at Intake indicating consent or denial for the above information

Behavioral Health Services Authorization for Assessment; Treatment; Contact by Phone; and Photograph

Authorization for Assessment and Treatment

I understand that my (or my child's) assessment and/or treatment is voluntary. I understand and accept the requirements of treatment as explained to me. I understand that I am free to accept or reject any special type of treatment that members of the clinic staff have recommended for me. I understand that lab work may be required as a condition of treatment. I understand that if I am prescribed controlled substances from this clinic or elsewhere or if this is suspected, queries will be made to the Louisiana Prescription Monitoring Program and any controlled substances prescribed to me will be reviewed and discussed as part of the management of my treatment. I also understand that choosing not to fulfill my obligations of my treatment plan may result in discharge from the clinic. I also understand that services shall be provided without regard to race, creed, national origin, sex, disabling condition, and/or other condition. I have read the above statements and understand them.

Authorization for Photograph

I hereby consent for my photograph or photo identification to be used for identification and chart use only. I understand that this will not be used for publication.

Authorization to Contact by Phone

I understand that my permission is needed for staff to call my contact number and remind me, or if I am not available, whoever answers the phone (or if no one answers the phone, permission is given to leave a message on my answering machine) regarding the day, date, and time of my (or my child's) next appointment.

Person served shall sign the Informed Consent at Intake indicating consent or denial for the above information.

IMPORTANT SIGNATURES

I Authorize Insight Guidance Group to conduct/provide: Assessment; Treatment; Contact by Phone; and Photograph.

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

I have reviewed and understand the Recipient Rights and Orientation Materials.

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

I authorize the use of my email/phone number for contact related to appointment reminders.

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

I authorize the payment of medical benefits to the provider of services.

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

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

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

Insight Guidance Group
113 W. Convent Street, Lafayette, La 70501
Phone:337-534-0770 Fax:337-534-4370
Email: admin@insightguidancegroup.com

School Visitation Permission

CONSENT TO VISIT BELOW SAID MINOR FOR THE PURPOSE OF BEHAVIORIAL HEALTH SERVICES

I, _____as the legal parent and/or guardian, give Insight Guidance Group Staff permission to visit _____ at his/her school.

School Name: _____

School Address: _____

School Phone: _____

Parent Signature: _____Date: _____

IGG Employee Witness: _____Date: _____