NORTHWEST IOWA COUNSELING ASSOCIATES

PATIENT INFORMATION

Name__________________________ Gender ☐Male ☐Female
Address__________________________
City__________________________ State________ Zip ____________
Phone__________________ Work Phone____________ Ext.________ Cell Phone______________
Date of Birth____________ Social Security Number______________ Marital Status__________
Employer or School__________________________ Employment Status______________
Who referred you to our office?__________________________
How would you prefer we contact you: ☐ Home ☐ Cell ☐ Email OK to leave message? ☐ Yes ☐ No
My email address is__________________________

PRIMARY INSURANCE INFORMATION

Insurance Co Name__________________________ID#__________________
Policy/Group #__________________ Relationship of patient to insured:__________________
Insured's Name__________________________ Gender ☐Male ☐Female
Address__________________________
City__________________________ State________ Zip ____________
Phone__________________ Work Phone____________ Ext.________ Cell Phone______________
Date of Birth____________ Social Security Number______________ Marital Status__________
Employer or School__________________________ Employment Status______________

SECONDARY INSURANCE INFORMATION

Insurance Co Name__________________________ID#__________________
Policy/Group #__________________ Relationship of patient to insured:__________________
Insured's Name__________________________ Gender ☐Male ☐Female
Address__________________________
City__________________________ State________ Zip ____________
Phone__________________ Work Phone____________ Ext.________ Cell Phone______________
Date of Birth____________ Social Security Number______________ Marital Status__________
Employer or School__________________________ Employment Status______________

RESPONSIBLE PARTY INFORMATION

Who is responsible for charges for this patient ☐Patient – Please continue to back, if applicable.
☐Other–Please complete the following.

Name__________________________ Relationship to patient:__________________
Address__________________________
City__________________________ State________ Zip ____________
Phone__________________ Work Phone____________ Ext.________ Cell Phone______________
Date of Birth____________ Social Security Number______________ Marital Status__________
Employer or School__________________________ Employment Status______________

NORTHWEST IOWA
COUNSELING ASSOCIATES
20 West 4th Street, Spencer, IA 51301
Phone: 712-262-6111 • Fax: 712-262-6180
www.northwestiowacounseling.com

Gary Zeutenhorst, ACSW, LISW
Rhonda Jager-Pippy, LISW
Terry Huisman, LMHC
Rachel Wassenaar, LISW

Assignment & Release

I authorize Northwest Iowa Counseling Associates, P.C. to release to the Health Care Financing Administration and its agents any information needed to determine benefits. I understand that my signature below requests payment be made to Northwest Iowa Counseling Associates, P.C. authorizes release of medical information necessary to pay claims. If information regarding supplemental insurance is supplied, I also authorize release of information to that insurer or agency. Because Northwest Iowa Counseling Associates, P.C. accepts Medicare assignment, our providers agree to accept the charge determined by Medicare to be the full charge, and the patient agrees to be personally responsible for deductible, coinsurance and any non-covered services.

_______________________________ _______________________

Signature of Insured/Guardian Date

Emergency Contact

The following person(s) will be contacted to assist in the event of:

1. You are a danger to yourself or others.
2. In the case of a medical emergency.

Name	Phone

Name of Primary Care Physician:_______________________________

Address:_______________________________

Phone:____________________

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CONSENT FOR BEHAVIORAL HEALTH EVALUATION AND/OR TREATMENT

Nature of Services:
I do hereby express my understanding that ______________________________ is to receive behavioral health services by Northwest Iowa Counseling Associates, P.C. staff and that the services to be provided will be:

- ☐ Evaluation, testing, and/or treatment planning
- ☒ Psychological therapy/treatment
- ☐ EAP assessment
- ☐ Child custody evaluation
- ☐ Other______________________________

I understand the purpose of the service to be:

- ☒ Evaluation/diagnosis or treatment planning
- ☐ Consultation with medical care provider
- ☐ Consultation with legal counsel
- ☐ Compliance with court orders
- ☐ Consultation with employer regarding employment, performance, or promotion considerations
- ☐ Other______________________________

and I understand that I have the option to decline the evaluation and/or treatment and to request a referral to a different service provider.

LIMITS OF EVALUATION/TREATMENT
I understand that behavioral health services are inexact sciences and that no guarantees are being made as to the outcome or results of the evaluation, testing or treatment. I further understand that evaluation and/or treatment results may not be what I hope they may be or wish they may be, and that Northwest Iowa Counseling Associates, P.C. will evaluate the data made available to them as objectively as possible to formulate an accurate assessment and make recommendations.

LIMITS OF CONFIDENTIALITY
I further understand that my privilege of confidential communication will be maintained by Northwest Iowa Counseling Associates, P.C. with the following exceptions:

- Should there be an allegation or suspicion of child or elder abuse or neglect, Northwest Iowa Counseling Associates, P.C. have a legal obligation to report any pertinent information to the proper authorities, and may be asked to testify in court regarding that information, and will, if subpoenaed, do so.
- Should there be any expressed intention to harm another or oneself, Northwest Iowa Counseling Associates, P.C. have a legal obligation to report this information to the appropriate authorities and to make a reasonable effort to contact authorities to prevent such action and will do so.
- Should written request for, or permission for the release of evaluation or treatment information be provided by you, such information will be released to the professional individual, agency, or corporation as requested and as provided by law.

I have read this Consent for Behavioral Evaluation, Testing, and/or Treatment. I understand it fully, and voluntarily sign:

______________________________ ______________________________
Client, Parent or Managing Conservator Date