Client Demographics

Client First Name:	Client Last Name:	Preferred Name:
Client Gender Identity:	Client Pronouns:	Client Phone:
Client Address:	City:	State: Zip:
Emergency Contact (EC) Name:	EC Phone:	EC Relationship to Client:

Primary Insurance Information:

Insurance Carrier Name:
Insurance Policy Number:
Insurance Group Number:
Insurance Policy Holder Name (if different than client):
Insurance Policy Holder Date of Birth:
Insurance Policy Holder Address:
Insurance Policy Holder Relationship to Client:

Do you have secondary insurance? Yes No

Secondary Insurance Information (if applicable):

Insurance Carrier Name:
Insurance Policy Number:
Insurance Group Number:
Insurance Policy Holder Name (if different than client)
Insurance Policy Holder Date of Birth:
Insurance Policy Holder Address:
Insurance Policy Holder Relationship to Client:

Briefly state what the client is being seen for (challenges experienced, for how long, how impacting functioning)

Brief Policy Overview

Practice Name	Practice Address	Practice Phone	Practice Fax
Rooted Insights	2570 106th St. Ste E Urbandale IA 50322	515.446.7284	515.349.7195

Initial Here	Policy Topic	Brief Summary/Overview
	Late Cancellations	We request 24 hours for notification you are unable to attend appointments. Please call or text us at 515.446.7284. There is a late cancel fee of $25 for cancellations with less than 24 hours notice
	Missed Appointments	There is a $150 fee for appointments which were not attended and no notice was provided to our offices that you were unable to make the appointment.
	Telehealth Access	All Telehealth appointments are completed through the Spruce Platform or App. You can sign up with Spruce using this link. https://spruce.care/RootedInsightsPLC. Your provider will initiate a video call at the time of your appointment.
	Telehealth Troubleshooting	Services without audio and visual may not be covered by your insurance. If you are unable to utilize the telehealth technology provided, we recommend scheduling in person appointments.
	COVID/Illness	We request that you do not attend in person appointments if you have been exposed to or have symptoms of COVID or other illness. We will happily change your in-person appointment to telehealth to reduce the spread of illness.
	Emergencies	We are not an emergency provider and do not provide on call services. We request two business days to return all correspondence due to our small practice size. For emergencies please go to your nearest Urgent Care, Emergency Department, or call 911 or 988).
	Card on File Policy	Due to our small practice size, we have a zero balance policy and request that all patients keep a card on file which we charge for co-pays, co-insurance, deductible and fees not covered by insurance. Your card information is masked in our system and protected. You will receive a receipt uploaded to your client portal when your card on file is charged.
	Refills	Due to our small practice, we request at least seven business days notice for all refill requests. For controlled substances, you may have to call to speak to a pharmacist in order for them to process a refill on that is on file.

Client/Guardian Signature:
Client/Guardian Typed Name:
Date Signed:

ROOTED INSIGHTS PRACTICE POLICIES AND CONSENT FOR TREATMENT

Welcome to Rooted Insights, PLC (referred to as Rooted Insights forward). Please read this document carefully, it will provide information on our office policies and your rights as a client. Should you have questions or concerns, please feel free to address with your provider in session or one of our administrative staff prior to your session.

OUR PRACTICE

At Rooted Insights, we want you to know what to expect as you participate in treatment with our providers. We are pleased to offer both medication management and counseling services for the treatment of psychiatric and psychological difficulties. We offer both in-person and telehealth services in Urbandale, Iowa.

CANCELLATIONS/MISSED APPOINTMENTS

Late Cancel Fee: $25 (less than 24 hours notice)
Missed appointment/No Show: $150 (no call to cancel appointment, client did not present to appointment)

At Rooted Insights we will attempt to remind you of your scheduled appointments. Reminders are not fool proof and should not be relied on to remember appointments. It is ultimately your responsibility to keep track of scheduled appointments. **Rooted Insights is not responsible for missed appointment fees should a reminder system implemented by Rooted Insights fail.**

Scheduled appointments can be viewed through the client portal and confirmed by contacting our offices at 515.446.7284. Rooted Insights requests 24 hours' notice to cancel/reschedule an appointment. If 24 hours notice is not provided, there will be a $25 late cancel fee charged to your card on file as per our card on file policy. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, your appointment will not be extended beyond the scheduled time frame. If you are over 10 minutes late for a visit, your provider will assume the appointment is missed and the $150 missed appointment fee will be applied.

Because the therapeutic relationship depends upon the client's commitment as well as the provider's, should you frequently cancel your appointments or miss more than two (2) appointments in one year without reasonable explanation, Rooted Insights reserve the right to terminate the provider/client relationship.

EMERGENCIES

Rooted Insights, PLC is not an emergency provider. Our administrative staff will respond to requests within two business days of receipt or requests and voicemail, email, and secure messages are checked at least once during normal business hours. We do not offer on call services. If your crisis becomes unmanageable or you or someone else is in imminent risk of harm, please go to the nearest emergency room or dial 911 or 988.

*******We are not an emergency service provider and do not provide on call services. ********

If an emergency situation arises, please call 911 or any local emergency room. If you need to contact your provider between sessions, Rooted Insights recommends utilizing the Spruce app or by texting or calling 515.446.7284. We are often not immediately available as we are all practicing clinicians; however, we will attempt to return your call/message within two business days. If you send a message via email, please do not send personal information as not all email is secure. Again, the best and most secure way to contact Rooted Insights would be through the secure client portal or Spruce App.

CLIENT PORTALS/SCHEDULING

Rooted Insights utilizes a HIPAA compliant, secure portal through Valant for all of our scheduling and billing services. Upon scheduling or contact, you will be provided access to this portal to which you can send billing/scheduling questions, request/cancel appointments, and pay fees. We also utilize a HIPAA compliant, secure service for managing phone calls, texts, video appointments, and other communications such as fax through Spruce Health. Your provider may invite you to utilize the Spruce Health Application to provide an alternative way to communicate cancellations as well as sending homework and other paperwork following your initial intake, should you meet with your provider via Telehealth. Please inquire with questions or concerns regarding either of these portals.

BILLING/PAYMENT FOR SERVICES

Clients are ultimately responsible for payment of services and understanding their insurance coverage and benefits. Clients are responsible to notify Rooted Insights of any changes in health care plans immediately. Rooted Insights will not be held responsible for denials of coverage due to client's non-admission of changes in insurance policy or other primary coverages. At Rooted Insights, we bill your in-network plan following your visit. Rooted Insights recommends verifying in-network coverage with your insurance provider.

If you choose to be seen and have an out of network insurance, Rooted Insights requires payment for services rendered at the time of service. Rooted Insights will provide you with an invoice which you may submit to your insurance for ***possible*** out of network reimbursement, which you are responsible for submitting to your insurer to obtain reimbursement. Please note that there is no guarantee your insurance will reimburse for out of network providers. Please contact your insurance prior to scheduling to determine whether your policy covers or will provide reimbursement for our services. As required by the No Surprises Act of 2022, Rooted Insights will provide all self-pay clients with an estimate of out-of-pocket cost prior to services being rendered.

At Rooted Insights, we have a zero-balance policy and require a credit card on file for out-of-pocket expenses. Please see our card on file policy for more information and contact our office should you have any questions.

Please note, we are not in network with Iowa Medicaid plans. Should you have this plan and choose to be seen as out-of-network. You will be responsible for this out-of-pocket expense. Please see Good Faith Estimate provided in this document for estimated costs. If you have Medicaid as a secondary plan, you will be responsible for any balances not covered by your primary insurance (denied charges, deductible, co-insurance, co-pays, late cancel and missed appointment fees).

FEES

A $35.00 service charge will be charged for any checks returned for any reason for special handling.

Should a court appearance be required, services may be billed at the provider's full hourly rate for prep time, travel time, and court appearance time billed at a minimum of $2000 per day. There may be a fee for medical record requests based on hourly rate. (See also "Litigation" section below)

There may be a fee of $30 for completion of paperwork which involves extended time for our providers (multiple requests per year, several edits).

Late cancel (less than 24 hours notice) $25
Missed Appointment (no call/did not present): $150

TELEPHONE/EMAIL ACCESSIBILITY

Rooted Insights is a small group practice and we are not immediately available by telephone, secure messaging, or email. We have administrative office hours where we return calls and other administrative inquiries. We are dedicated to serving our clients and prospective clients and endeavor to return inquiries and calls within two business days.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, our providers do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our providers' respective privacy. It may also blur the boundaries of the therapeutic relationship. If you have questions about this, please bring them up with your provider. Our providers will not respond to messages sent through Social Networking sites or reviews posted online(WhatsApp, Messenger, etc.).

Our practice welcomes your feedback. If you have a concern regarding our practice or feedback you would like to offer, please email us at info@rootedinsights.org or call 515.446.7284. We are happy to address any concerns regarding care you may have received directly. Please note, due to confidentiality concerns, we will not respond to any public reviews posted on internet platforms.

AUDIO OR VISUAL RECORDING

Unless otherwise agreed to by all parties beforehand, audio or video recording of sessions, phone calls, or any other services provided by any providers at Rooted Insights is strictly prohibited.

INTERNET SEARCHES

As a general practice, we do not use search engines to look up information about clients. In extreme situations that involve the well-being and safety of the client, such as when we have reason to suspect that a client might be in a crisis or if a client has not shown up to an appointment or provided notice to their provider that they will not be attending an appointment, exceptions might be made. In these cases, searching the internet for pertinent information about the client or attempting to find alternative ways to contact the client might be necessary to ensure their welfare. These extraordinary incidents would be fully documented and discussed with the client when and as soon as possible.

MINORS

Rooted Insights requires the consent of a legal guardian in order to treat a minor. A parent or guardian is expected to attend appointments with minors unless alternative arrangements have been agreed upon. We request that clients do not leave minors unattended in the waiting room of our practice. We are not responsible for the supervision of unattended minors and recommend securing childcare for your appointments.

LITIGATION

Sometimes clients become involved in litigation while they are in mental health services or after mental health services have been completed. Sometimes clients (or the opposing attorney, in a legal case) want the records disclosed to the legal system. Due to the nature of the psychotherapeutic and mental health care process and the fact that it often involves making a full disclosure with regard to many matters, clients' records are generally confidential and private in nature.

Clients should know that very serious consequences can result from disclosing therapy records to the legal system. Such disclosures may negatively affect the outcome of custody disputes or other legal matters and may negatively affect the therapeutic relationship. If you or the opposing party/attorney are considering requesting Rooted Insights' disclosure of records, we will do our best to discuss with you the risks and benefits of doing so. As noted in this document, you have the right to review your own records anytime. Please note that, should records be subpoenaed, all email and communications will be subject to disclosure under such subpoena. We reserve the right to charge our providers full hourly rate for any court related appearance costs with a minimum rate of $2000/day per court appearance.

DUAL RELATIONSHIPS

Despite a common misconception, not all dual relationships are unethical or avoidable. Therapy and other health care related services never involve sexual or any other dual relationship that impairs the therapist's objectivity, clinical judgment, or therapeutic effectiveness. Your provider is ethically required to assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. It is important to realize that in some communities, particularly small towns, small communities, military bases, university campuses, spiritual and rehabilitation communities, etc., multiple relationships are either unavoidable or expected. Your provider will never acknowledge working with anyone without their written permission. Dual or multiple relationships can enhance therapeutic effectiveness but can also detract from it and often it is impossible to know which result will occur ahead of time. Your provider will discontinue the dual relationship if they find it is interfering with the effectiveness of the therapeutic process or your welfare and, of course, you can do the same at any time. If you have questions regarding dual relationships, please feel free to bring up in your visit.

COUNSELING AND THE THERAPEUTIC PROCESS

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how the relationship will work, and what can be expected in the therapeutic process. This consent will provide a clear framework for your work with your mental health provider. Feel free to discuss any of the following with your mental health provider.

You have the right to consent to treatment and terminate care at any time through the course of your treatment.

You have taken a very positive step by deciding to seek mental health care. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort.
Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. Our providers cannot promise that your behavior or circumstance(s) will change. We can promise to support you and do our very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself. There are times when the recommended treatment for your condition might be outside of your provider's scope of practice. Should this occur, your provider is ethically bound to provide a referral to an alternative provider. This will be discussed with you and a plan of care for continuity of care through this process will be made with your participation and input.

MEDICATION MANAGEMENT

If you see a provider that can prescribe medications, they may prescribe medication(s) to you for the treatment of your symptoms. This is something that you and your provider will discuss and decide together. For treatment to be effective, medications must be taken as prescribed. With any medication, there are always risks of side effects that you and your provider will discuss. Results cannot be guaranteed for everyone; however, with patients in continued care, excellent results are often achieved.

PRESCRIPTION REFILLS

Please ensure you attend appointments for prescription refills in order to receive your refill in a timely manner. Refills for prescriptions are written at the time of your appointment. We are not an emergency provider and are not able to provide same day refills in most cases. **We will not be available to process refill requests on federal holidays, days where our provider's might be ill, or on vacation.**

We require seven business days advance notice to call in prescriptions with no refills remaining and for writing scripts for controlled substances. Please allow a week for a refill request to completely process. If you have refills on file, please contact your pharmacy to request a refill. Refills are not considered an emergency. It is the patient's responsibility to maintain scheduled appointments as recommended by their healthcare provider to ensure refills are processed efficiently. Our provider's reserve the right to withhold filling refill requests without an appointment.

DURATION OF APPOINTMENTS

The standard meeting time for psychotherapy is around 55 minutes. Duration of treatment varies, depending upon goals and circumstances. In general, therapy begins with weekly meetings and may transition to bi-weekly or longer intervals in between. Duration of medication management appointments vary and can range between fifteen minutes to one hour.

PET ASSISTED THERAPY

At Rooted Insights, some of our providers offer pet assisted therapy. There are certain risks to this which include but are not limited to:

1. Possible unintentional scratch to the client (shaking, getting on couch)
2. Risk of dog bite. Our dogs are AKC Good Citizen Certified and have no bite history. However, with any animal, there is this risk.
3. Allergies may be aggravated. If you are or think you may be allergic to dogs, pet assisted therapy is not recommended.
4. If you have an aversion to dogs, an alternative provider would be suggested.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to create and understand a termination process to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. Your provider may terminate treatment after appropriate discussion with you and a termination process if it is determined that the psychotherapy is not being effectively used or if you are in default on payment or not following treatment recommendations. Your provider will not terminate the therapeutic relationship without first attempting to discuss and explore the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, we will provide you with a list of qualified mental health counselors to provide care. You may also choose someone on your own or from another referral source.

Should you have two missed appointments or frequent cancellations without adequate notice, termination may be necessary. Ideally, we would discuss this with you in session before terminating the relationship. However, if we are unable to reach you, you will receive a notice of termination via the secure portal and, if you request them, referral options will be provided. This is to ensure that those clients who can attend appointments are able to be seen in a timely manner. Please note, attending therapy on a consistent basis has been shown to have the most benefit. If you have not been seen for over three months, we will assume you are no longer choosing to engage in care with Rooted Insights, and we will close your chart unless alternative arrangements have been made (ie maintenance sessions). Please note, should you receive a chart closing letter, this does not mean you cannot return to our practice, it is to indicate that we are no longer actively following you as a client and you may have to complete paperwork again upon your return to our practice.

TELEHEALTH AND VIDEO APPOINTMENTS

Iowa Law defines Telehealth as the delivery of health care services through the use of interactive audio and video. On March 28, 2018, the governor signed House File 2305, an Act which relates to "insurance coverage for healthcare services delivered by Telehealth, and including applicability provisions." If you and your provider chose to use information technology for some or all of your treatment, you need to understand that:

1. You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
2. All existing confidentiality protections are equally applicable.
3. Your access to all medical information transmitted during a Telehealth appointment is guaranteed, and copies of this information are available for a reasonable fee.
4. Dissemination of any of your identifiable images or information from the Telehealth interaction to researchers
5. There are potential risks, consequences, and benefits of Telehealth. Potential benefits include, but are not limited to, improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs.
6. While many plans cover telehealth services, there are still some self-insured groups that do not. It is ultimately your responsibility to verify coverage and discuss benefit concerns with your provider.
7. If you are unable to utilize the Spruce Platform in order to hold an audio/video appointment, services will not be covered by insurance and we recommend attending in person sessions.

Effective mental health care is often facilitated when the provider gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Providers may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in mental health services, potential risks include, but are not limited to the provider's inability to make visual and olfactory observations of clinically or therapeutically

potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the provider not being aware of what they would consider important information, that you may not recognize as significant to present verbally the provider.

CONFIDENTIALITY

The session content and all materials relevant to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist that may permit Rooted Insights to disclose confidential information, as follows:

1. If a client threatens or attempts to commit suicide or otherwise conducts him-/herself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the provider has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years.
4. If the provider has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of an elderly person.
5. If the provider has a reasonable suspicion that a client is neglecting children under the age of 18 years or elderly persons.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally, your provider may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name or identifying information.

If you see your provider in public outside of the therapy office, your provider will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to us, and we do not wish to jeopardize your privacy. However, if you acknowledge your provider first, they may acknowledge you and exchange pleasantries. Please remember that it is not appropriate for your provider to engage in any lengthy discussions with you in public or outside of the therapy office.

MY ELECTRONIC OR WRITTEN SIGNATURE INDICATES THAT I AM AGREEING THAT I HAVE READ, UNDERSTAND, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client or Guardian/Parent Printed Name:
Client or Guardian/Parent Signature:
Date Signed:

CREDIT CARD POLICY AND AUTHORIZATION FORM
(ZERO BALANCE/CARD ON FILE POLICY)

Thank you for choosing Rooted Insights practice for your behavioral health needs. We are committed to providing you with exceptional care while also keeping the billing process as smooth as possible.

Due to changes in the healthcare industry, many insurance plans now have co-pays or deductibles in amounts which our offices may not be aware of when providing services. To streamline billing and payment as well as ensure convenience in billing and payments for our clients, we request all clients keep a credit card on file for billing purposes.

Circumstances when your card would be charge include but are not limited to:

- Missed or cancelled sessions without 24 hours notice (charged at time of late cancel ($25) or missed appointment ($150)
- Missed co-payments, deductibles and co-insurance, any non- covered services and/or denial of services
- Co-pays are charged up front at time of service, once co-pay amount has been determined.
- Deductibles and co-insurance are charged following insurance determination of benefits
- Non-covered or denied services
- Services billed as self-pay (not billed to insurance)

As a courtesy, Rooted Insights will bill in-network insurance providers following your visit. Once insurance has processed your claims, they will send both you and Rooted Insights an explanation of benefits (EOB). Please review for errors and notify Rooted Insights immediately should there be concerns regarding your responsibility. Upon receipt of EOB or once we know your out of pocket, your card on file will be charged the amount shown as client responsibility.

We do not have access to view your credit card information as it is blinded in our system for both your and our protection. If there is a problem with your bill/claim and it is brought to our attention after your credit card payment processes, Rooted Insights will investigate and refund monies owed in a timely manner. We understand that there are legitimate reasons that you may not have a credit card. If this is the case, please discuss billing/payment options with your clinician at time of service as payment will be due at time of service.

Please feel free to bring any concerns or questions regarding this policy to your appointment to be addressed or send via secure portal message.

Your responsibilities:

1. Ensure card on file is up to date.
   a. If the credit card have on file for you changes, please update via the secure portal IMMEDIATELY. It is not uncommon for people to change or cancel their credit cards for various reasons, including when a credit card expires. That is quite understandable. If our offices run your credit card and it is denied for any reason, we reserve the right to charge an additional $25 declined card fee if we are unable to run a new credit card within 7 days of declined charge.
2. If you have an HSA or FSA account you are using, we also require a card which is non- HSA/FSA on file as these accounts do not cover services which are not covered by insurance such as missed appointments or late cancellation fees
3. If you are not the owner of the card and will not be responsible for billing matters, we request a release of information for the card holder in order to review and sign this form and also to discuss any billing related concerns

CREDIT CARD AUTHORIZATION (ENROLL IN AUTO PAY)

Credit Card Authorization (Enroll in Auto Pay)

You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled. Please discuss with your provider if you need to cancel as our offices require a card on file to bill for missed/late cancelled appointment as well as non-covered insurance balances.

My electronic signature below indicates I have read and understand above policy and authorize my provider to charge my card for missed appointments, late cancelled appointments, co-pays, deductibles, self-pay balances, and non-covered insurance charges. I understand that my information will be saved to file for future transactions on my account.

Client Name:
Client or Guardian/Parent Signature:
Guardian/Parent Name (if applicable):
Date Signed:

GOOD FAITH ESTIMATE

As of January 1, 2022, with the implementation of the No Surprises Act, federal law requires healthcare providers to provide all clients who are either not using insurance (due to out of network or personal reasons) or do not have insurance an estimate of costs. At Rooted Insights, we have made the decision to provide this document to all of our clients as we are often unaware of insurance loss of coverage or other changes of insurance which may lead to a requirement for this document. This is not a bill or request for payment, and your out of pocket expense may be variable, especially if you have in-network insurance which we will bill for services. Please see attached form for FAQ regarding this law.

In the mental healthcare field, there are many aspects of the dynamics of these costs which make it challenging to provide a completely accurate picture of estimated costs. These factors include but are not limited to variable amounts of time a client may need for various treatment modalities, changing symptom presentation which might lead to a reduction or increase in need for services, which is often unpredictable in the mental health field, and some clients choose to partake in therapy on a weekly basis, while others may only need monthly or more extended frequency of appointments. At Rooted Insights, we will be unaware of your diagnosis until after your first appointment. We have provided a short list of codes we commonly treat for your reference. Your billed charges do not tend to change with changes in diagnosis and this is not a comprehensive list.

Common diagnosis codes we treat at Rooted Insights follow:

- Adjustment Disorder (F43.23)
- Anxiety (F41.1)
- Attention Deficit Disorder (F90.9)
- Bipolar Disorder (F31.9)
- Depression (F32.9)
- Insomnia Disorder (F51.01)
- Obsessive Compulsive Disorder (OCD) (F42.2)
- Oppositional Defiant Disorder (ODD) (F91.3)
- PTSD/Post Traumatic Stress Disorder (F43.10)

Treatment Frequency/Duration: Every psychological care treatment plan is unique and can be influenced by several factors.

- Client/Client Schedule/Availability
- Provider Availability
- Changing life circumstances
- Changing symptom presentation
- Stability of symptoms

In general, at the start of the counseling journey, clients are recommended to be seen on a weekly basis in order to build rapport and develop and begin treatment planning. Frequency of medication management appointments can vary from weekly, every two weeks, monthly, or at various monthly frequencies

Since we are not able to provide a range of costs and have to provide as close an estimate as possible, we prefer to provide what the costs might look like for the potentially highest frequency of care which will likely be a high estimate. We have provided a list of our regularly billed codes, with the fee, as well as the expense for various levels of care/frequency of appointments in order to provide as comprehensive and transparent information as possible regarding our fees. If you have questions regarding these fees, please do not hesitate to reach out to our administrators at 515.446.7284.

Our Providers

Provider Name	Provider Role	NPI
Isaiah Fogle, Admin/Co-founder	Mental Health Counselor	1265094577
Carmen Tillman, Admin/Co-founder	Mental Health Counselor	1558979237
Ellie Van Dam	Licensed Independent Social Worker	1699391920
Brooke Thielking	Psychiatric Nurse Practitioner	1942441423
Kira Conard	Licensed Independent Social Worker	1205410966
Ashley Harvey	Licensed Master's Level Social Worker	1508741315
Brenna McConnell	tLMHC, Mental Health Counselor	1598640302

GOOD FAITH ESTIMATE CONTINUED

Our Location

Practice Location Name	Practice Address	Practice Phone	Practice NPI/Tax ID
Rooted Insights, Urbandale	2570 106th St. Ste E Urbandale, IA 50322	515.446.7284	1073265633/874172947

Counseling/Therapy Fees

Description	Code	Frequency Billed	Fee	Yearly Estimate Total
Counseling Intake	90791	1x/year	$250	$250
Counseling (55 min)	90837	Weekly 52 appt max/year	$200	$10,400
Estimated Yearly	One intake +51 counseling			**$10,450**

Medication/Psychiatry Fees

Description	Code	Estimated Frequency	Fee	Yearly Estimate Total
New Patient	99205	One time	$475	$475
Established (30 min)	99214	Weekly to every three months	$250	$13000
Psychotherapy with E/M Services (billed at follow up appointments often)	90833	Weekly to every three months	$130	$6760
Behavioral Health Assessment	96127	Variable – Every Three Months	$25	$100
Estimated Yearly Total	One intake, weekly follow up sessions w/psychotherapy	99205 (1x) 99214, 90833 (51x)		$18,855

Other Potential Expenses not Covered by Insurance

Description	Code	Estimated Frequency	Fee	Yearly Estimate Total
Late Cancel	NA	**Variable**	$25	Varies
Missed appointment	NA	**Variable**	$150	Varies
Paperwork	NA	**Variable**	$30	
Legal/Court Appearance	NA	**Variable- $2000 per day court appearance minimum**	$2000/day/appearance minimum	Variable
Legal/Court Prep (paperwork, phone calls, provider time spent)	NA	**Hourly Rate**	$200/hour for legal prep time	Variable

Please note: This is not a bill and just is an estimate of potential fees. If you would like a specific estimate once you and your provider meet to establish a plan moving forward, please do not hesitate to request from your provider or one of our administrative staff.

Disclaimer:
This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill. If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call HHS at (800) 368-1019. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call (800) 368-1019. Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

Client Name:
Client/Guardian Signature:
Date Signed:

CONSENT FOR TELEHEALTH

CONSENT FOR TELEHEALTH AND TELEHEALTH EMERGENCY CONTACT

1. I understand that my health care provider wishes me to engage in a Telehealth services.
2. I understand that my insurance may not cover audio only appointments, and that is my responsibility to understand my insurance coverage for telehealth (audio and video appointments)
3. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
4. I understand that a Telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
5. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the Telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
6. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
7. I agree to treat Telehealth appointments as similar to as possible as a service provided in person. This means I will wear proper attire, not be under the influence of substances, and secure a confidential uninterrupted space for the appointment. If I am unable to do so, I agree to notify my provider with 24 hours notice prior to the appointment so that accommodations may be made or appointment may be rescheduled. **I understand that should these requirements not be made, my provider may cancel the appointment subject to the $50 late cancel fee.**

CONSENT TO USE THE TELEHEALTH BY SPRUCE OR BACK UP SYSTEMS

Telehealth by Spruce is the technology service we will use to conduct Telehealth videoconferencing appointments. By signing this document, I acknowledge:

1. Telehealth services through Spruce or other means is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither Spruce nor other Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by Spruce facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth through Spruce – or that such information is current, accurate or up-to-date.
5. To maintain confidentiality, I will not share my Telehealth appointment information with anyone unauthorized to attend the appointment.

IN CASE OF EMERGENCY - TELEHEALTH

If you have a mental health emergency do not wait for communication back from our offices, but do one or more of the following:

- Call the National Suicide Hotline at 988
- Call Suicide Prevention Helpline (800) 273-TALK
- Call Iowa HelpLine at (855) 800-1239
- Call Foundation 2 at (800) 332-4224
- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Crisis Chat Line (855) 325-4296
- Call 911
- Go to the emergency room of your choice

TELEHEALTH CONSENT (CONTINUED)

Emergency procedures specific to Telehealth services

There are additional procedures that we need to have in place specific to Telehealth services. These are for your safety in case of an emergency and are as follows:

You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, we may determine that you need a higher level of care and Telehealth services are not appropriate.

We require an Emergency Contact Person (ECP) whom we may contact on your behalf in a life- threatening emergency only. Either you or your clinician will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or your clinician determine necessary, the ECP agrees take you to a hospital**. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.**

You agree to inform your clinician of the address where you are at the beginning of every session.

You agree to inform your clinician of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency.

You agree to inform your clinician of the nearest police department to your primary location that you prefer to go to in the event of an emergency.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Client or Guardian Name:
Client or Guardian Signature:
Date Signed:

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: 07.24.2022

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.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. **Request to receive communications of protected health information in confidence**.
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A reasonable copying/labor charge may apply.
5. **Request an amendment to your protected health information**. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
   - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
   - is not part of your medical or billing records;
   - is not available for inspection as set forth above; or
   - is accurate and complete.

   In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:
   - to carry out treatment, payment and health care operations as provided above;
   - to persons involved in your care or for other notification purposes as provided by law;
   - to correctional institutions or law enforcement officials as provided by law;
   - for national security or intelligence purposes;
   - that occurred prior to the date of compliance with privacy standards (April 14, 2003);
   - incidental to other permissible uses or disclosures;
   - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
   - made to patient or their personal representatives;
   - for which a written authorization form from the patient has been received
7. **Revoke your authorization to use or disclose health information** except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
8. **Receive notification if affected by a breach of unsecured PHI**

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.

Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you

Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death

Business Associates: There may be some services provided in our organization through contracts with Business Associates.
Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.

Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example, in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Fund raising: Unless you notify us you object, we may contact you as part of a fund-raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fund-raising material you receive.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Research (inpatient): We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

OUR RESPONSIBILTIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site.

Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) most uses and disclosures of psychotherapy notes (ii) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of your health information; and (iv) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMAITON OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer, Isaiah Fogle, at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at Rooted Insights, PLC or with the Secretary of the Department of Health and Human Services. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

U.S. Department of Health and Human Services Office of the Secretary 200 Independence Avenue, S.W. Washington, D.C. 20201 Tel: (202) 619-0257 Toll Free: 1-877-696-6775 http://www.hhs.gov/contacts	**Rooted Insights, PLC** Isaiah Fogle Privacy Officer 2570 106th St. Ste E Urbandale, Iowa, 50322 Tel: 515.446.7284 Fax: 515.349.7195

NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be provided with a hard copy or an electronic copy via your client portal prior to or at the time we first deliver services to you. Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's Web site for downloading.

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:	**Patient Date of Birth:**

I hereby acknowledge that I have received a copy of Rooted Insights, PLC 's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgment if I so choose.

Signature of Patient or Legal Representative:	**Date:**
Printed Name of Patient or Legal Representative:	**Relationship to Patient:**

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule providers individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to an individual's office instead of the individual's home.

Our electronic health record (EHR) through Valant is able to send appointment reminders and we utilize a secure, HIPAA compliant platform for our telephone/texting/fax services through Spruce. You may be invited to the Spruce App for electronic communications. You may also receive direct text (SMS) messages from our practice.

Rooted Insights reserves the right to contact you using an unpreferred method of contact in the event that we need to obtain or relay information more quickly.

Please indicate if you would like to OPT OUT (not receive communications by specific means).

I DO NOT wish to be contacted by the following means (statements may be sent via mail even if box is checked):

- ☐ Phone call to primary listed phone
- ☐ Text message
- ☐ Email
- ☐ Mail

I wish to receive appointment reminders via

- ☐ Home Email
  or
- ☐ Work Email

- ☐ Phone call to primary phone
  or
- ☐ Text message to primary phone

I approve statements and billing related information being sent to my email address:

- ☐ Yes

- ☐ No

**As a client or guardian of Rooted Insights, PLC, I acknowledge by signing this document that if I choose to communicate with Rooted Insights in any capacity via email or text message, there is a risk my private health information could be violated. I accept this risk and agree to hold Rooted Insights blameless in the event this would occur. I also acknowledge and am aware of the fact that Rooted Insights and its providers will continue to do everything in their power to keep my confidential information safe, including maintaining secure email and text messaging on their side of the practice. Risk of confidential information being unsecured may come on the end of my own email/text messaging platform and I am aware of this and accept it by choosing to communicate via email or text message with my provider. My signature below serves as indefinite consent to this policy unless I revoke it in writing.

Client/Guardian Name:
Client/Guardian Signature:
Date Signed:

CONSENT TO TREAT MINOR

Is this client a minor? **Yes** **No**

Minor Guardian/Parent Information (if applicable):

Parent/Guardian Name:	Parent/Guardian Name:
Parent/Guardian Phone:	Parent/Guardian Phone:
Parent/Guardian Email:	Parent/Guardian Email:
Parent/Guardian/Address:	Parent/Guardian/Address:
Parent/Guardian DOB:	Parent/Guardian DOB:
Relationship to Client:	Relationship to Client:
Is this person responsible for payment on account? Yes No	Is this person responsible for payment on account? Yes No

Your signature indicates that you are the patient's parent or legal guardian and consent to the minor patient's treatment at Rooted Insights, PLC.

Minor Patient Name: _____ **Minor Date of Birth:** _____

Patient/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Date of Signature: _____

I consent for the following people (non-parent/guardians) to bring the minor to appointments. I understand that should I want the individual to participate in the appointment, additional authorization might be required.

Name/Age _____ Relationship to patient _____ Phone _____

Name/Age _____ Relationship to patient _____ Phone _____

Name/Age _____ Relationship to patient _____ Phone _____

Name/Age _____ Relationship to patient _____ Phone _____

Name/Age _____ Relationship to patient _____ Phone _____

I am consenting for Rooted Insights to provide psychiatric and counseling services and bill my in-network insurance.

MY ELECTRONIC OR WRITTEN SIGNATURE INDICATES THAT I AM AGREEING THAT I HAVE READ, UNDERSTAND, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Patient Name:
Patient DOB:
Parent or Guardian Name (if applicable):
Patient/Parent Guardian Signature:
Date Signed: