Southwest Iowa Families, Inc.
215 E. Washington St., Clarinda, IA 51632
Phone: (712) 542-3501 Fax: (712) 542-4725

BHIS Consent for Services

Name:	**Client's DOB:**	**Title 19#:**	
Client Address	**Street:**		
	City:	**State:**	**Zip Code:**
Phone	**Home: ( )** ☐Yes, may leave message	**Cell: ( )** ☐Yes, may leave message	**Work: ( )** ☐Yes, may leave message

EMERGENCY CONTACT:_____
Relationship: _____
Home: ( ) **Cell: ( )** **Work: ( )**
☐Yes, may leave message ☐Yes, may leave message ☐Yes, may leave message

Billing Authorization

☐Title 19 to be billed
☐ I understand and agree to pay the amount of $ _____ at the beginning of each session, which is the fee based on the established sliding fee scale, if applicable.

- I understand that Southwest Iowa Families and my health plan representatives may exchange any and all information pertaining to my BHIS services to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance, and/or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent. I understand that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

PLEASE INITIAL BELOW to confirm that you were notified of & offered a copy of the written materials regarding

_____Client Rights & Responsibilities
_____Grievance policy included in the Client Rights & Responsibilities.
_____ Notice of Privacy Practices (HIPAA) including Limits of Confidentiality and Access to Records.
_____Description of BHIS and its possible risks, benefits, and alternatives
_____I agree to pay for services not covered by my health plan & understand what will be shared for billing purposes.

My signature indicates my Consent for BHIS Services based on my opportunity to review the above information and acknowledges that a copy of all of these documents were offered to me and can be requested at any time.

_____ _____ _____
Client's Signature Printed Name Date

_____ _____ _____
Legal Guardian's signature & relationship Printed Name Date

Is there anyone else who is able to legally sign for this individual? Yes No

Name _____ Relationship _____ Date _____

Witness _____ Date _____

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BHIS Consent to Transport

I hereby authorize that Southwest Iowa Families' staff may transport myself/child/adult (guardian):

Name_____
Date of Birth _____

Signature of Client(s) or Legal
Guardian_____Date_____
Witness_____
_____Date_____