Providence Place
CLIENT HANDBOOK

DESCRIPTION OF SERVICES

Outpatient Assessment, Counseling and Referral Services

Outpatient assessment and counseling services with staff at Providence Place are based upon developing a trusted relationship between the client and staff member. This process begins with a complete assessment to accurately determine the therapeutic needs of the client. Together, the client and therapist develop a treatment plan to meet the therapeutic needs of the individual. With consent of the client, other involved persons may be asked to participate in treatment. These services are provided to individuals, families and groups within the confidential office or school setting. We are committed to working collaboratively with parents, school staff and any other professionals to surround the child with quality care.

Emergency Services

These services are available during regular office and school hours.

IF YOU ARE IN A CRISIS AND CANNOT REACH A STAFF MEMBER of PROVIDENCE PLACE - CALL 911 OR GO TO YOUR NEAREST HOSPITAL EMERGENCY ROOM

Emergency or crisis service is intended for rapid stabilization of acute symptoms of mental illness or emotional distress during school or office hours. Emergency services include assessing suicidal risk and evaluating the need for higher levels of care, crisis intervention and de-escalation.

Consultation

Consultation services are those services which provide professional assistance and information about mental health or mental illness to individuals, agencies, groups, or organizations. The consultation may be case, program or community oriented.

Education

Education services are those activities which provide information and training regarding the availability of services, the promotion of mental health and the prevention of mental illness. This service is provided to community leaders, organizations, other human service providers and the general public. Providence Place education services focus on the importance of mental health services and to increase the community's knowledge, understanding and acceptance of emotional/mental illness.

Groups

STEPPS and STAIRWAYS

These two groups are an approach to treatment of individuals with Borderline Personality Disorder (BPD) originally developed by Bartels and Crotty (1992). That program has subsequently been adapted and revised by Blum, St. John, and Pfohl (2002). The current program includes two phases—a 20 week Basic Skills group identified by the acronym **STEPPS** and a one-year, twice monthly advanced aftercare group program called

STAIRWAYS. The combined program is identified as the **Systems Training for Emotionally Predictability and Problem Solving.**

In this cognitive-behavioral, skills training approach, Borderline Personality Disorder (BPD) is characterized as a disorder of emotion and behavior regulation. The goal is to provide the person with BPD, other professionals treating them, and closely allied friends and family members with common language to communicate clearly about the disorder and skills used to manage it.

Other groups will be developed as the needs are identified, or groups are requested, and qualified staff are available.

CLIENTS' RIGHTS and RESPONSIBILITIES

As you receive services from Providence Place, you have certain rights that we hope to maintain. As a fully trained, licensed and a highly competent mental health professional. It is our goal to provide quality services and follow standards set by federal and state program guidelines, Iowa State licensing boards and other professional organizations. In addition to the above assurances, you have the following basic rights as a client of Providence Place:

1. To be treated with consideration, respect and dignity
2. To receive treatment in the least restrictive setting
3. To be informed of the services offered by Providence Place and the charge for these services.
4. To be fully informed about your condition and recommended treatment
5. To participate in the development, implementation and evaluation of your treatment plan.
6. To make choices about your participation in treatment and research conducted by Providence Place staff.
7. The right to privacy, including the right to private conversations and confidentiality
8. The right to appeal the application of policies, procedures or any staff action that affects you

You have the following basic responsibilities as a client of Providence Place:

1. Treat those giving you care with dignity and respect.
2. Give provide information that is needed. So we, as providers can deliver the best possible care.
3. Ask questions about your care. This is to help you understand your care.
4. Follow the treatment plan. The plan of care is to be agreed upon by the client and staff member.
5. Follow the agreed upon medication plan, when medication is prescribed by your physician or other health care provider.
6. Tell this provider and primary care physician about medication changes, including medications given to you by others.
7. Keep your appointments. Clients should call as soon as they know that they need to cancel visits.
8. Let us know when the treatment plan isn't working for them.
9. Let us know about problems with paying fees.
10. Report abuse and fraud.
11. Openly report concerns about the quality of care you receive.

APPEALS and GRIEVANCES

Policy: All efforts shall be made to make the experience at Providence Place a positive one for all individuals we serve. This appeals and grievance procedure shall be given to all individuals at the time of intake

Procedure:

1. Should an individual served by Providence Place become dissatisfied with any service provided by staff they should first discuss the grievance with the staff in person.
2. If the issue is not resolved and the individual continues to feel dissatisfied, the person may obtain a grievance form from a staff person at 515-986-7255. The individual will be asked to indicate the nature of the complaint and return the completed form to the administrative assistant. A copy of the completed form will be provided to the individual.
3. Within 5 business days of receipt of the completed client grievance form, staff will address corrective action of the complaint and within 10 working days staff will meet with the client for the purpose of resolving the conflict.
4. Should the individual continue to be dissatisfied, they should contact: Secretary of Health and Human Services at 200 Independence Avenue S.W., Washington D.C. 20201 or by calling (202) 619-0257.
5. All written grievances with clients or contract providers and employees shall be kept on file with Providence Place indefinitely.

This policy is part of the consumer handbook to assist individuals in being aware of the course of action to take in a grievance or appeal.

CONFIDENTIALITY/NOTICE OF PRIVACY PRACTICES

***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 records contain personal information about you and your health. This information about you that may identify you and that relates to 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 Confidentiality/Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *ACA Code of Ethics.* 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 Confidentiality/Notice of Privacy Practices. We reserve the right to change the terms of our Confidentiality/Notice of Privacy Practices at any time. Any new Confidentiality/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, sending a copy to you in the mail upon request or providing one to you at your next appointment.

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 consultation only with your authorization.

For Payment: We may use and 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 processed due to lack of payment for services, we will only disclose the minimum about 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, licensing, and conducting or arranging for other business.

Child/Dependent Adult Abuse: Staff at Providence Place as professionals are required by state law to report suspected abuse and neglect to the appropriate authorities.

COST OF SERVICE

Our cost of services is subject to change without notice
The following is an estimate cost of standard visit for the counseling services that Providence Place provides. The charges you are actually billed reflect the amount of time spent in each session, whether you have third party payer, or whether you have reduced fee.

1. Assessment - $200
2. Therapist – 1 hr - $160 and 50 min. - $150
3. Third party payers (Insurance) will be charged the contracted fee. The client is responsible for payment per their policy benefits, including all deductibles and co-payments/co-insurance.)
4. All service fees are payable at the time of service.

Appointments: We set aside a time especially for you. This is time that has been scheduled for you to meet your Therapist or Caseworker. We expect that you will keep your appointment as scheduled. However, if you **do** need to cancel, **we require at least 24 hours notice.** If you do not give us 24 hours notice, you may be charged for that appointment.
No Shows: A "no show" is a missed appointment without any notice given.

We reserve the right to charge for "no show" appointments.

If you frequently cancel or have two "no shows," we will place you on a "walk-in" status. You will not be able to schedule appointments in advance. You will be required to call the day you wish to be seen. An appointment will occur only if the therapist and/or worker have available time that day. If you consistently keep your walk-in appointments, you will be removed from "walk-in" status.

REQUEST FOR RECORDS

Any copies of records sent to other facilities, providers, third parties or insurance companies regarding client's treatment or progress will be at a minimum charge of $25.

RECEIPT OF CLIENT HANDBOOK and Consent for Treatment

Description of services: My signature below verifies that I have received the Providence Place handbook. Included in the handbook is a description of the services, client's right and responsibilities, appeals process, confidentiality and explanation of the cost for services.

Client Rights and Responsibilities: I have received information outlining my rights and responsibilities as a client of Providence Place. I understand that it is my right to ask questions if I need clarifications or have concerns.

Appeals Process: I have received the information about appeals and grievances. I understand I may ask for help in this process if needed.

Confidentiality: I understand that what I share in the course of treatment at Providence Place with my therapist and/or worker is private and confidential and my records are protected under state and federal regulations governing confidentiality. My records cannot be disclosed without written consent, unless otherwise provided for in the regulations, or signed release. I understand that information regarding my care may be shared internally with other professional workers that are housed at Providence Place to assure effective treatment. Information regarding my care will also be provided to our support staff to maintain my records.

Acknowledgement of Child and Dependent Adult Abuse/Neglect Reporting Requirements: I understand that all health and human service providers are required by state law to report suspected abuse or neglect to the appropriate authorities. (If you have any questions about this, please feel free to ask for a better understanding before you sign.) My signature below acknowledges my understanding.

Consent for Services: I authorize Providence Place therapists to perform diagnostic and/or therapeutic treatment services for (please check one of the following and provide full name of the individual for whom you are authorizing services if other than yourself):

_☐_ Myself
_☐_ My Child: _____
_☐_ Person for whom I am legal guardian/custodian: _____

Service Outcome: I understand that the person who provides my clinical services is not responsible for the outcome of the services.

Authorizing Signature: I understand that I have the right to revoke this consent, in writing, at any time except to the extent that my provider has taken action in reliance upon this consent.

_____ _____
Signature of Client/Legally Responsible Person Date

_____
Witness