



Therapist: _____
Diagnosis: _____
Acct. Type: _____
*For Office Use Only

CLIENT INFORMATION FORM

Full Name _____ Today's Date _____

Birth date _____ Soc Sec # _____ Address _____

City _____ State _____ Zip _____ Sex: M F Marital Status: M S D Sep

Home phone _____ Work phone _____ Cell phone _____

Fax _____ Email Address _____ Would you like to receive the WFT newsletter? Yes No

Employer _____ Employer Address _____

Occupation _____

Responsible Party Information

Full Name _____ Relationship to Client _____ Birth date _____

Soc Sec # _____ Address _____ City _____

State _____ Zip _____ Home phone _____ Work phone _____

Cell phone _____ Fax _____ Email address _____

Sex: M F Marital Status M S D Separated Employer _____

Employer Address _____ Employer Phone _____

Referral Source

How did you hear about us? _____ If the internet, which site? _____

Referral Sources' Address & Phone # _____

Presenting Problem

Reason for seeking therapy? _____

What do you hope to gain from therapy? _____

Medical History

Primary Care Physician _____ PCP Phone _____ Fax _____

Physician's Address _____

List any health concerns _____ List Medications _____

Therapy History

Have you received therapy before? Name _____ Address _____

Phone _____ Fax _____ Was this helpful? _____

Have you ever seen a psychiatrist? Name _____ Phone _____

Address _____ Fax _____

Are you currently seeing a psychiatrist? Name _____ Phone _____

Address _____ Fax _____

Are you currently taking psychotropic medication? Please list _____

Emergency Contact

Name _____ Relationship to Client _____

Home Phone _____ Work Phone _____ Cell Phone _____

Informed Consent

I have received a copy & read WFT HIPPA Privacy Policy.
I have received a copy of, understand, & I agree to WFT Service Agreement.
I consent to psychotherapy treatment at Wasatch Family Therapy, LLC

Signature _____ Date _____



Professional Service Agreement

Thank you for coming to Wasatch Family Therapy, LLC for mental health therapy services. We look forward to working with you to improve your life and your relationships. This agreement is to clarify the business aspects of our relationship, and to help our therapeutic relationship go smoothly.

Fees & Billing

- | | | | | | |
|----------------------------------|-------|-------|--|------|------|
| • Initial Assessment | \$125 | \$150 | • Group Therapy (90 min) | \$50 | \$50 |
| • Individual Therapy (45-50 min) | \$100 | \$125 | • <u>Payment is due in full at the beginning of each session by cash, check or credit card.</u> Included in the above fees are brief phone calls (under 15 min) and routine paperwork. | | |
| • Individual Therapy (25 min) | \$ 50 | \$ 65 | • <u>There will be a \$25 fee for any cancelled check or declined credit card transactions.</u> | | |
| • Couples Therapy (45-50 min) | \$100 | \$125 | | | |
| • Family Therapy (45-50 min) | \$110 | \$140 | | | |

Health Insurance Coverage

While we don't work directly with insurance companies, we can provide you with comprehensive receipts to submit to your insurance company for reimbursement of any mental health therapy fees they will cover. Call your insurance company to find out if you have out-of-network mental health benefits.

Confidentiality

- The information you share will be kept confidential. We will ask you to *sign a release-of-information* form before discussing your treatment, or sending records about you to anyone else.
- Your confidentiality/privacy is protected by state law and by the rules of our profession, except in the following circumstances. The limits of confidentiality are:

1. If you were sent to me by a court or an employer for evaluation or treatment, the court or employer expects a report from me. You have a right to disclose only what you are comfortable with telling.
2. If you are involved in a law suit, and you tell the court that you are in therapy, we may then be ordered to show the court my records. Please consult your lawyer about these issues.
3. If you make a serious threat to harm yourself or another person, the law requires the therapist to try to protect you or that other person.
4. If I believe a child, or a dependent adult, has been or will be abused or neglected, we are legally required to report this to the authorities.
5. If you send a health insurance claim form to your insurance for reimbursement, it will have a mental health diagnosis listed and it will become part of your permanent medical record.
6. In order to provide you with the best treatment we may consult with other mental health professionals about your case.

Late Cancellation/No Show Policy

If you are unable to make your scheduled appointment, please cancel at least 24 hrs. in advance so another client can be scheduled during that time. If 24 hrs. notice is not given, you will be charged the full session amount. We reserve the right to charge credit cards that are kept on file for no shows and late cancellations.

If Case of Emergency

If you have an emotional, behavioral, or medical crisis call the University of Utah Neuropsychiatry Institute at 801-583-2500, call 911, or go to the nearest emergency room. Wasatch Family Therapy does not provide 24 hour crisis services.

I understand, and agree to, the policies as stated above, and I give consent for treatment at Wasatch Family Therapy, LLC.

Client's Name _____ Date _____

Client's (or Responsible Party's) Signature _____ Relationship to Client _____ Date _____



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NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW HEALTH 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 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". This Notice of Privacy Practices describes how I may use and disclose your protected health information in accordance with applicable law and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your protected health information. As part of your protected health information I keep some specific information in what are called "psychotherapy notes". These notes are kept separate from your health record and are given much higher privacy protection. They contain my impressions about you and details of the psychotherapy conversation I consider to be inappropriate for the health record. They contain information pertinent only to my future work with you. They are not available for your review, nor to insurance and managed care companies.

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

How I May Use And Disclose Health Information about You

For Treatment : Your protected health information 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.

For Payment : I may use and disclose protected health information so that I 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, I will only disclose the minimum amount of protected health information necessary for purposes of collection.

For Health Care Operations : I may use or disclose, as needed, your protected health information in order to support my business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your protected health information with third parties that perform various business activities (e.g., billing or typing services). This is allowed only if I have a written contract which requires that business to safeguard the privacy of your protected health information.

Required by Law : There are occasions which require me under law to disclose your protected health information with or without your authorization. Some examples are:

- If you are in imminent danger of committing suicide I am legally and ethically bound to intervene in anyway necessary to prevent that including contacting family members and the police.
- To the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the Federal privacy requirements.
- If you are at risk of being a serious and imminent threat to the health or safety of a person or the public, I will disclose information to prevent or lessen that serious threat. I will disclose it to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- If you are in imminent danger of committing suicide I am legally and ethically bound to intervene in anyway necessary to prevent that including contacting family members and the police.
- If there is suspicion of neglect or abuse of a child in the past, present or future I am required by law to report that to the Utah Division of Child and Family Services or the police.
- If I have reason to believe that a vulnerable adult is suffering from abuse, neglect, abandonment or exploitation, I am required by law to make a report to either the Utah Adult Protective Services or the nearest law enforcement agency as soon as I become aware of the situation.
- Utah law requires that I report the names of any individuals having communicable diseases to the Health Department.
- I may disclose your personal health information in accordance with workers compensation laws.
- If you become involved in the court system a judge can order that I provide information on you. Two examples of this are child custody cases and cases in which clients bring action against therapists.

With Your Verbal Permission: I can share some information about you with your family or close others. I will only share information with those involved in your care and anyone else you choose such as close friends or clergy. I will ask you about who you want us to tell what information about your condition or treatment. You can tell us what you want and we will honor your wishes as long as it is not against the law.

If it is an emergency - so I cannot ask if you disagree - I can share information if I believe that it is what you would have wanted and if I believe it will help you if I do share it. If I do share information, in an emergency, I will tell you as soon as I can. If you don't approve I will stop, as long as it is not against the law.

With Your Written Authorization: Uses and disclosures not specifically permitted by the circumstances described above will be made only with your written authorization, which may be revoked.

Your Rights Regarding Your Protected Health Information

You have the following rights regarding protected health information I maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer, (Julie A. Hanks, LCSW, 7084 South 2300 East #120 Salt Lake City UT, 84121, (801) 550-2741).

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy protected health information that may be used to make decisions about your care. Your right to inspect and copy protected health information will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the protected health information I have about you is incorrect or incomplete, you may ask me to amend the information although I am 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 I make of your protected health information. I 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 protected health information for treatment, payment, or health care operations. I am not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about health matters in a certain way or at a certain location. For instance, you can ask me to avoid calling you on selected phone numbers or ask that I send bills to an alternate address.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Complaints

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, (Julie A. Hanks, 7084 So.2300 E.#120 SLC, UT 84121) or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. I will not retaliate against you for filing a complaint.

Effective Date The effective date of this Notice is April 14, 2003.



7084 South 2300 East Suite 120
Salt Lake City, UT 84121
Phone 801-944-4555

Consent to Release Protected Health Information

Patient Name _____ Date of Birth _____

I, _____, hereby authorize

_____ to release and receive information
(name of therapist)

to the agencies/providers listed below for the purposes of: (check all that apply)

_____ Coordination of Treatment

_____ Consultation

Information to be released/received includes:

_____ Assessment and Diagnosis

_____ Treatment Summary and Recommendations

_____ Psychological/Psychiatric Assessments

_____ Medical Records/labs

_____ Other _____

Agencies/Individual Providers	Address	Phone	Fax
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

This authorization for release of protected health information is specifically limited to the information specified above and is made in accordance with the Health Insurance Portability and Accountability Act (HIPPA). State and federal laws prevent disclosure of your protected health information without your consent. This release shall remain in effect until 90 days after discharge from treatment.

Client signature

Parent/Legal Guardian Signature (if client is a minor)

Date

Witness