Center For Hope, LLC

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

Today's Date: _____

CLIENT INFORMATION FORM

Personal Information

Full Name: _____ Sex: M F

Marital Status: M S D Sep

Birth date: _____ Soc Sec #: _____

Email Address: _____

Cell Phone: _____ Other Phone: _____

May we send you Text messages: Y / N

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Employer: _____

Preferred Primary Contact Method (circle):

Home Phone
Cell Phone
Work Phone
Email

Responsible Party Information

Full Name: _____

Relationship to Client: _____

Birth date: _____ Soc Sec #: _____ Sex: M F

Marital Status: M S D Sep

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Other Phone Number: _____

May we send you Text messages: Y / N

Email Address: _____

Occupation: _____

Employer: _____

Emergency Contact

Full Name: _____ Relationship to Client: _____

Phone Number(s): _____ _____

Referral Source

How did you hear about us? _____

If the internet, which site? _____

Presenting Problem

Reason for seeking therapy?

_____

_____

_____

_____

What do you hope to gain from therapy? (You can write more on the back if you need more space)

_____

_____

_____

_____

_____

Medical History

Primary Care Physician: _____

PCP Phone: _____

List health concerns: _____

List Medications: _____

Therapy History

Have you received therapy before? Yes No Was this helpful? Yes No

Explain:

_____

_____

_____

Name of therapist: _____ Location: _____

Phone: _____

Have you seen a psychiatrist? Yes No

Name of psychiatrist: _____ Location: _____

Phone: _____

Are you currently seeing a psychiatrist? Yes No

Name of psychiatrist: _____ Location: _____

Phone: _____

Are you currently taking any psychotropic medication? If so, please list:

_____

_____

_____

Informed Consent

I have received and read a copy of the **Center For Hope Notice of Privacy Practices (HIPPA).**
I have a received a copy of, understand, and agree to the **Center For Hope Professional Service Agreement.**

I consent to psychotherapy treatment at Center For Hope, LLC.

Signature: _____

Date: _____

Professional Service Agreement

Welcome to Center for Hope, LLC. We are looking forward to getting to know you and teaming up with you to create healing, growth, and greater happiness in your life. This agreement is to clarify the business aspects of our relationship and to help our therapeutic relationship go smoothly.

Fees & Billing

• Initial Assessment $215/ $185(if paid at time of service)
• Therapy Session (45-50 minutes) $145 if you want me to bill you, $125 if you pay at time of service or have your credit card on file.

- Payment is due in full at the beginning of each session by cash, check or credit card. Included in the above fees are brief phone calls (under 10 min) and routine paperwork.
- We will be unable to continue therapy if your balance due exceeds $500 until that balance is paid.
- There will be a $25 fee for any cancelled check or declined credit card transactions
- Any and all fees related to the collection of delinquent accounts(i.e. attorney's fees, court fees) will be the sole responsibility of the client or responsible parties indicated in this agreement.
- No-shows and late cancellations: If 24 hrs. cancellation notice is not given, you will be charged the full session amount. We reserve the right to bill credit cards on file for scheduled sessions.

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 or an EAP (Employee Assistance Plan) that pays the cost of some therapy.

Insurance Information

Insurance company name:_____
Policyholder's Name:_____

Policyholder's date of birth:_____
Applicant's relationship to policyholder (Circle one) Self Spouse Child Other
Insurance company Address:_____
City_____ State_____ Zip_____
Phone_____
Policy #:_____ Co-payment amount:_____
Group #:_____

Third Party Payer:

Name_____ Relationship _____
Phone Number_____
Email_____
Address_____

I understand, and agree to, the policies as stated above I understand that I am responsible for the cost of therapy and I will take responsibility for seeking reimbursement from any third party payer (ie Insurance, Bishop, etc).

Name_____ Date_____
Signature (or Responsible Party) _____

Client-Therapist Service Agreement

Welcome to Center For Hope! We're excited to help you improve your life. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in therapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Goals of Therapy

At Center for Change we will work with you to develop your own goals for therapy. There can be many goals for the therapy relationship. Some of these will be long term goals such as improving the quality of your life and relationships. Others may be more immediate goals such as decreasing anxiety and depression symptoms, changing behavior or decreasing/ending drug use.

Risks/Benefits of Therapy

Therapy is an intensely personal process, which can bring unpleasant memories or emotions to the surface. There are no guarantees that therapy will work for you. Clients can sometimes make improvements only to go backwards after a time. Progress may happen slowly. Therapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

However, there are many benefits to therapy. Research and our personal experience show that most people experience positive change through therapy. Therapy can help you develop coping skills, make behavioral changes, reduce symptoms of mental health disorders, improve the quality of your life, learn to manage anger, learn to live in the present and many other advantages.

Appointments

Appointments will ordinarily be 50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, please give 24 hours' notice. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

Confidentiality

Your therapist will make every effort to keep your personal information private. Your confidentiality/privacy is protected by state law and by the rules of our profession. If you wish to have information released, we will ask you to sign a *release-of-information* form before discussing your treatment, or sending records about you to anyone else. There are some limitations to confidentiality to which you need to be aware.

Therapists are required by law to release information:

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, this will not include identifying information like full names.

Confidentiality and Group Therapy
The nature of group therapy makes it difficult to maintain confidentiality. If you choose to participate in group therapy, be aware that your therapist cannot guarantee that other group members will maintain your confidentiality. However, your therapist will make every effort to maintain your confidentiality by reminding group members frequently of the importance of keeping what is said in group confidential. Your therapist also has the right to remove any group member from the group should she discover that a group member has violated the confidentiality rule.

Confidentiality and Technology
Some clients may choose to use technology in their therapy sessions. This includes but is not limited to online therapy via Skype, telephone, email, text or chat. Due to the nature of online therapy, there is always the possibility that unauthorized persons may attempt to discover your personal information. Your therapist will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communications could not occur.

Facebook
At Center for Hope we have a policy of not being Facebook "Friends" with clients. This helps us keep the relationship warm, clear and focused on growth and change.

Record Keeping
Your therapist will keep records of your therapy sessions and a treatment plan which includes goals for your therapy. These records are kept to ensure a direction to your sessions and continuity in service. They will not be shared except with respect to the limits to confidentiality discussed in the Confidentiality section. Should the client wish to have their records released, they are required to sign a release of information which specifies what information is to be released and to whom. Records will be kept for at least 7 years but may be kept for longer. Records will be kept either electronically on a USB flash drive or in a paper file and stored in a locked cabinet in the therapist's office.

Contacting Me
Your therapist is often not immediately available by telephone. He/She does not answer the phone when they are with clients or otherwise unavailable. At these times, you may leave a message on confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters.

If Case of Emergency
Center for Hope does not provide 24 hour crisis services. 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.

Termination/Transfer

In the rare situation that it is determined that your case is not a good fit for our practice, we will provide you with the contact information for other therapists who may be better suited to serve your particular needs. If we have not seen you for 6 weeks, we will consider therapy terminated, however we will be happy to continue therapy if/when you decide to return.

Email

Therapist may request client's email address. Client has the right to refuse to divulge email address. Therapist may use email addresses to periodically check in with clients who have ended therapy suddenly. Therapist may also use email addresses to send newsletters with valuable therapeutic information such as tips for depression or relaxation techniques.

Consent to Therapy

Your signature below indicates that you have read this Agreement and agree to its terms.

Client Signature _____
Date_____

Signature of Parent of Guardian (if under 18)_____Date_____

Center for Hope, LLC
Notice of Privacy Practices(HIPPA)

CLIENT COPY

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, (Monica L. Blume, LCSW, 1220 North Main Street #7 Springville UT, 84663, (801) 361-0982).

• **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 are 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 we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, (Monica L. Blume, LCSW, 1220 North Main Street #7 Springville UT, 84663, (801) 361-

0982). 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 July 30, 2012.