

Circle of Life Counseling Center

3375 Mayflower Ave, Suite A, Lehi, UT 84043
Phone: 801.331.6775 * Fax: 801.766.2010



CONFIDENTIAL **ADULT** WELCOME PACKET
Updated: 7/1/17

Office Use Only: DATE: _____

CLINICIAN: _____

Client Information

Name: _____

DOB: _____

Gender: Male Female

Marital Status: Single Married Divorced Widowed

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Work Phone: _____

Mobile Phone: _____ Home Phone: _____

Spouse Information

Name: _____

DOB: _____ Phone: _____

Mailing Address (if different than above): _____

City: _____ State: _____ Zip: _____

Primary Insurance Information

Patient's relationship to insured: Self Spouse Child Other

Name of insured: _____ DOB: _____

Mailing Address (if different than above): _____ City: _____

State: _____ Zip: _____ Insurance Company: _____

Insurance Member ID #: _____ Group #: _____

Employer Name: _____

PRIMARY CARE PHYSICIAN: _____

Secondary Insurance Information

Patient's relationship to insured: Self Spouse Child Other

Name of insured: _____ DOB: _____

Mailing Address (if different than above): _____ City: _____

State: _____ Zip: _____ Insurance Company: _____

Insurance Member ID #: _____ Group #: _____

Emergency Contact

Name: _____ Relationship to client: _____

Work Phone: _____ Mobile Phone: _____

Home Phone: _____

Credit Card Authorization Form

Circle of Life requires a credit card on file before any appointments will be scheduled regardless of your insurance benefits and regardless of Bishop pay or Third-Party pay clients.

Credit Card / Debit Card Information (confidential)

Card Type: Visa MasterCard Discover Amex

Name on the Card: _____

Card Number: _____

Expiration Date: _____ **Security Code:** _____

Card Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Email Address (to email receipts): _____

I authorize Circle of Life Counseling Center to use the above payment method as my preferred method of payment for all services. I agree to pay the stated amount for services. I authorize Circle of Life Counseling Center to automatically charge any and all co-pays and/or co-insurance via a credit/debit card on file at the time of service. A \$50 or \$85 fee for no-shows or appointments cancelled without a 24-hour notice may also be charged to the above credit card.

By signing below, I am authorizing *Circle of Life Counseling Center* to use my credit card information to charge my credit card for a scheduled therapy session, in the event that I do not notify the office of my inability to attend a scheduled therapy appointment, do not cancel my appointment at least 24-hours in advance, or if a check is returned for any reason as agreed to in the Appointment and Professional Fees /Payment Arrangement policies stated in the signed Client Agreement and Therapeutic Policies Form that I have reviewed and signed. This card may be charged for scheduled appointments, no-shows, and late cancellations.

Card Holder Signature X _____ **Date:** _____

Notes: _____

If a Bishop or a Third party is going to pay for any portion of your therapy, a Bishop Authorization Form or Third Party Authorization Form is required *in addition* to your credit or debit card information, before any services are rendered. Please ask for these forms to be emailed to you or pick them up in person before your scheduled appointment.

Client Agreement and Therapeutic Policies

This agreement is intended to provide clients with important information regarding our professional services & business policies. This consent form will provide a clear framework for our work together & will facilitate the therapeutic relationship. Any questions or concerns regarding the contents of this agreement should be discussed with your Therapist / Circle of Life Staff prior to signing it.

Part I: Authorization and Consent

Welcome to Circle of Life Counseling Center! The next few pages contain our office policies/procedure including authorization and consent to treat. If you have any questions or concerns, your therapist or the receptionist will gladly discuss them with you. Please initial under each section to indicate that you have read and understand each consent and/or policy.

I consent to treatment as necessary and desirable as the named client.

I understand that regardless of insurance coverage, I will provide a credit or debit card to be kept on file to use for charges incurred. I understand that I am responsible for all charges for treatment, no-show or late cancellation fees, or services including additional legal and collection fees required as a result of non-payment. I agree to pay for treatment or services in full at the time of service. Circle of Life Counseling Center will not carry a balance over \$50.00 on any account.

I understand that if insurance is billed, my insurance company may ask my clinician to provide certain information obtained during my session or treatment (mostly common diagnosis, treatment plans, or treatment methods, though it can be more involved in some instances). I authorize Circle of Life Counseling Center to release any medical or other information necessary to process claims.

I agree to notify this office immediately of changes in my insurance coverage. If not, I agree to be responsible for fees associated with non-authorized services. I also agree to notify this office of changes in addresses, employment, etc.

Part II: Therapist Information

Professional Orientation:

We provide individual therapy for adults, adolescents, and children over the age of 10. We also provide couples therapy, family therapy, pre-marital therapy, group therapy, and parental training for clients in need of these services. Depression, Anxiety, Post-Traumatic Stress Disorder, self-mutilation, addictions, behavioral issues, self-confidence building, and relationship improvements are some of the issues that we treat in our practice.

The Circle of Life Counseling Center scope of expertise does NOT include: Play Therapy, Treatment for Criminal or Violent Offenders, Juvenile Sex Offenders, Adult Sex Offenders, Court Ordered Domestic Violence, Court Ordered Substance Abuse, Intensive Outpatient Treatment or those who in our professional assessment require a higher level of care or would be better served elsewhere— We reserve the right to refuse treatment for any reason.

Educational/ Training Background:

Each therapist who practices at the Circle of Life Counseling Center hold one or more Master's degrees and is either a Clinical Mental Health Counselor (CMHC) or a Licensed Clinical Social Worker (LCSW) in the State of Utah.

Part III: The Therapeutic Process

Benefits and Risks of Therapy:

Psychotherapy is a process in which you and your therapist discuss a variety of issues, events and experiences for the purpose of creating positive change so you can experience your life more fully. Participating in therapy may result in a number of benefits to you, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. The issues presented by you may result in unintended outcomes, including changes in personal relationships. During the therapeutic process, many

clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Please address any concerns you have regarding your progress in a therapy session with your therapist.

Communication with Your Therapist Outside of a Scheduled Appointment via E-Mail, Cell Phones, Texting, Computers and Faxes:

Telephone Calls

Please know that every call is important to us and we do our best to answer each call. If we are not able to answer your call immediately, please leave a voicemail or message with your name, number, and nature of the call, and we will return your call within the next business day. If you have an emergency or are in crisis, please call 911 or a crisis hotline:

Crisis Line of Utah County 24 hours / 7 days (801) 226-4433

Crisis Line of Salt Lake County 24 hours / 7 days (801) 261-1442

To ensure the safety and professional boundaries of the Therapeutic relationship between Client and Therapist:

1. Texting between Client and Therapist is **strictly prohibited**;
2. Chatroom and Blog interactions between Client and Therapist are **strictly prohibited**;
3. Social Media interactions between Client and Therapist are **strictly prohibited**. Please do not 'friend request' any therapist at the Circle of Life Counseling Center for they are REQUIRED to DENY any and ALL such requests unless such a request is made through a Therapist's Professional Page;
4. Unscheduled Phone Calls are **prohibited**;
5. Emailing between Client and Therapist is **prohibited**, without written agreement outlining the parameters of such emails

It is very important to be aware that computers, E-mail, fax and cell phone communication can be relatively easily accessed by unauthorized people and, hence, can compromise the privacy and confidentiality of such communication. Although we only use computers that are equipped with a firewall, a virus protection and a password, E-mails are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Additionally, the emails sent by Circle of Life Therapists are not encrypted and Emails as well as faxes can easily be sent erroneously to the wrong address or recipient.

Part IV: Client(s) Rights

1. You have the right to ask questions about any procedures used during therapy. If you wish, your therapist will explain his/her approach and methods to you.
2. You have the right to decide not to receive therapeutic assistance from us; if you wish, we will provide you with the names of other qualified professionals whose services you might prefer.
3. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those *already* accrued. We ask you have a discussion with your therapist before you make such a decision.
4. You have the right to expect that your therapist will maintain professional and ethical boundaries by not entering into other personal, financial, online, or professional relationships with you, all of which would greatly compromise the therapeutic relationship.
5. Therapy involves a partnership between therapist and client. Your therapist will contribute knowledge, skills and a willingness to do their best, while you as a client must adhere to the boundaries set by the therapist, comply with the treatment plan and therapeutic interventions and commit to doing *your* best.
6. One of the most important rights involves confidentiality: within the limits of the law, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission.
7. Your therapist, is legally prohibited from revealing to another person that you are in therapy nor can he/she reveal what you have said in any way that identifies you without your written permission. However, in the following instances, your right to confidentiality must be set aside as required by law or my professional standards.

Limits of Confidentiality:

- a) Instances of actual or suspected physical or sexual abuse, emotional cruelty, or neglect of a child or an elder or dependent adult must be reported to the appropriate protective services.
- b) If I have a reason to believe that a client poses an unavoidable and imminent danger of violence to another person, your therapist may warn the intended victim and notify the proper authorities.
- c) If you, as a client, reveal a serious intent to harm yourself, your therapist is ethically bound to do what he/she can to help maintain your safety, which may involve notifying others who may be of assistance.
- d) If a judge orders your therapist's testimony or, in the context of a legal proceeding, you raise your own psychological state as an issue, your therapist may be required to release your confidential information to the court.

In all of the above cases, it is incumbent upon your therapist to release only that information necessary to appropriately carry out his/her responsibilities. Your confidentiality still remains an *ethical priority*.

Minors & Parents:

Patients under 18 years of age, who are not emancipated, and their parents should be aware that the law allows parents to examine their child's treatment records unless we believe that doing so would endanger the child or we (patient, therapist, and parents) agree to do otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, at times, we will request agreements from parents that they consent to give up their access to their child's records. If the parent agrees, during treatment we will provide them only with general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Any other communication will require the child's authorization, unless we feel that the child is in danger or is a danger to someone else. If that is the case, the therapist will notify the parents of their concern. Before giving parents any information, your therapist will discuss matters with the child, if possible, and do their best to handle any of their objections.

Part V: Professional Records

1. Each therapist at the Circle of Life Counseling keeps a set of professional records, providing pertinent information regarding the contents of the session. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. Your therapist may take notes regarding treatment during the session called "psychotherapy notes". These "psychotherapy notes" are given a greater degree of protection than your general PHI (protected health information) and are kept separate from your medical record. In essence these notes are considered the property of the therapist NOT the client.
2. Your "psychotherapy notes" cannot be sent to anyone else, including insurance companies without your expressed written consent. Insurance companies cannot require this as a condition of coverage nor penalize you in any way for your refusal to provide it. (UTAH HIPAA NOTICE FORM)
3. Professional records, providing pertinent information regarding the contents of the session including the "psychotherapy notes" constitute our clinical and business records, which by law, we are required to maintain. Should you request a copy of these records, such a request must be made in writing and in most situations, you will need to schedule a time with your therapist, appear in person and pay for the session before we are able to compile, consolidate, give or send these records. We reserve the right under Utah law, to provide you with a treatment summary in lieu of actual records. We also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. If these records are used in any type of court proceedings, please see: Subpoena/Testimony/Witness on the next page.
4. If your therapist refuses your request for access to your records, you have a "right of review" (this does not apply to information provided confidentially by people other than you), which your therapist will discuss with you upon request.
5. If you require paperwork to be filled out on your behalf, such as information to support Disability or a records request, you must schedule an appointment with your therapist. Your therapist will not fill out paperwork on your behalf without your presence. Professional records requested by Disability or any other third party will require you to schedule a one-hour appointment with your therapist, appear in person and pay the cash rate (**one-hour minimum charge**) before we will compile, consolidate, give or send these records.
6. We will maintain client's records for seven years following termination of therapy. After 7 years, your records may be destroyed in a manner that preserves your confidentiality.

SUBPOENA/TESTIMONY/WITNESS

CLIENTS ARE DISCOURAGED FROM THE FOLLOWING:

1. Having a Circle of Life Therapist/Staff subpoenaed or be a witness;
2. Asking a Circle of Life Therapist/Staff to supply verbal or written testimony in any type of court proceeding, litigation, suit, mediation, or disposition;
3. Asking a Circle of Life Therapist/Staff to write a letter for any type of court proceeding, litigation, suit, mediation, or disposition;
4. Asking a Circle of Life Therapist/Staff to participate, in any way, in any type of court proceeding, litigation, suit, mediation, or disposition.

For those who fail to heed this discouragement, and/or if any legal action occurs in which a Circle of Life Therapist/Staff is requested or subpoenaed to provide written documentation or verbal testimony, including but not limited to divorce or custody cases, you will be responsible to pay Circle of Life Counseling Center a **\$1500 retainer** immediately and directly before any such written or verbal testimony is provided AND the following fees will be in effect:

1. The minimum charge for a court appearance: \$1500 per day. The retainer of \$1500 is due in advance.
2. Records Preparation: \$250/hr. (one-hour minimum charge)
3. Phone calls: \$250/hr. (one-hour minimum charge)
4. Depositions: \$250/hr. (one-hour minimum charge)
5. Time required giving testimony: \$250/hour (one-hour minimum charge)
6. Mileage: \$0.40/mile
7. Writing any letter: \$250/hour (one-hour minimum charge)
8. All attorney fees and costs incurred by the Circle of Life Therapist/Staff as a result of the legal action.
9. If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice, there will be an additional \$250 "express" charge.
10. If the case is reset with less than 72 business hours' notice, then the client will be charged \$500 (in addition to the retainer of \$1500).
11. The \$1500 fee is NOT reimbursable by a Third-Party Payer and is therefore the full legal responsibility of the client and/or the client's parent or legal guardian.

Also, be aware that even though you are responsible for the above fees, it does not mean that a Circle of Life Therapist/Staff's testimony will be solely in your favor. Your therapist can only testify to the facts of the case and to their professional opinion.

Part VI: Office Policies

Professional Fees:

Co-Pays, Co-Insurance, Service Fees and any outstanding balances are due before your therapy session begins. We ask that your account be kept current and payments be made at the beginning of each session unless we have agreed otherwise or we have obtained permission to bill an *LDS Bishop* on your behalf. We accept cash, check, Visa or MasterCard. If your check is returned, you will be responsible to pay the original amount due plus a \$25 processing fee.

We will not bill non-custodial parents or anyone else for 'their' half or 'their' portion for services, this is something you must do on your own.

The Circle of Life Counseling Center is unable to carry a balance in excess of \$50 00. Should the fees for two or more sessions not be paid, or there are fees owing, no future sessions will be scheduled until the balance is paid and/or payment arrangements have been made with the billing person. At the conclusions of treatment, all outstanding fees must be paid upon termination.

The undersigned agrees whether he/she signs as an agent/guarantor or client that in consideration of the services rendered to the client, he/she hereby individually obligates himself/herself to pay the account of the Circle of Life Counseling Center, including any late charges, in accordance with the regular rates and terms of the Circle of Life Counseling Center.

If an account is more than 90 days overdue, 37% of the amount owed will be added to the total amount due. Should collection become necessary, your signature on this document indicates your agreement to pay an additional 30% of the amount overdue as a collection fee in addition to all legal fees connected to the collection, with or without suit, including attorney's fees and court costs. All delinquent accounts, 30 days past the due date, shall bear interest at the legal rate.

In general, it is important to discuss with your therapist any issues that arise in connection with your financial arrangements, so that they do not hinder the therapeutic relationship.

CASH-RATES for all Circle of Life therapists:

Billing Code: 10900	Billing Code: 10901	Billing Code: 10902	Billing Code: 10903	Billing Code: 10904	Billing Code: 10905
Couple/Family Initial Assessment \$180.00 90 Min	Individual Initial Assessment \$155.00 75-90 Min	Individual Session \$125.00 60 Min	Couple/Family Session \$155.00 60 Min	Crisis Session \$185.00 60 Min	15 Min Add-On to Session \$45.00 15 Min

Part VII: Health Insurance:

IN-NETWORK

We are 'IN-NETWORK' contracted providers for numerous insurance companies. We will collect co-pays and/or coinsurance according to your plan before your session and we will submit claims on your behalf. If for any reason the insurance does not pay for billed services, you are solely responsible for paying the fees billed.

OUT-OF-NETWORK

We are 'OUT-OF-NETWORK' providers for several insurance companies and we are **NOT** contracted with them. Clients who have an insurance in which we are 'OUT-OF-NETWORK' are required to pay our CASH RATES and the CLIENT is responsible for paying us first and for recovering the insurance reimbursement on their own. Upon request and payment in full, we can provide you with a billing statement that you can provide to your insurance company and other third party payers. WE ARE **OUT-OF-NETWORK** WITH AND ABSOLUTELY **WILL NOT BILL** THE FOLLOWING INSURANCES:

ALTIUS/MHNet	MEDICARE	MEDICAID	MOLINA	SELECTHEALTH	UHC/UBH	UMR	OPTUM
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**This list is NOT all inclusive

We **WILL NOT BILL** the above insurance companies and we do not consider their insurance deductibles and co-payments. Clients who have any of the above insurances are required to pay our CASH RATES even if you plan to seek insurance reimbursement. Upon request and payment in full is received, we can provide you with a billing statement that you can provide to your insurance company and other third party payers.

Special Note: CNIC, CIGNA, VALUE-OPTIONS, BEACON HEALTH and TRICARE are the **only** five 'OUT-OF-NETWORK' insurance companies we will bill. We will collect your co-pay and/or coinsurance and we will submit the Health Insurance Claims for services rendered on your behalf. If for any reason the insurance does not pay for billed services, you are solely responsible for paying the fees billed.

Assignment of Insurance Benefits

The Circle of Life Counseling Center accepts many insurance plans: however, your therapist may or may not be a provider for a managed care company. If you have insurance, we will help you receive maximum benefits. We will contact your insurance company before, during or after you first visit to verify coverage and benefits. We require that you pay deductible and estimated co-payments before each session. Please allow us to make a copy of your insurance card. We file claims as a courtesy to our clients. Insurance is a contract between you and your insurance company. You are responsible for the timely payment of your

account. Circle of Life Counseling Center will not carry a balance of over \$50.00 on an account. We accept cash, checks and major credit cards.

I authorize payment of insurance benefits otherwise payable to me, to be paid directly to the Circle of Life Counseling Center for the services described on the health insurance claim form, unless other regulations apply.

The undersigned authorizes, whether he/she signs as an agent/guarantor/client, the direct payment to Circle of Life Counseling Center of any insurance or health benefits otherwise payable to or on behalf of the client for treatment of outpatient services, including emergency services, at a rate not to exceed the Circle of Life Counseling Center's regular charges.

It is agreed that payment to the Circle of Life Counseling Center pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations under the policy to the extent of such payment. In consideration services provided to the client, the undersigned hereby gives the Circle of Life Counseling Center an irrevocable assignment to any and all rights the client has in all insurance and health plan benefits payable to the patient or on his/her behalf. The undersigned directs all insurance companies, health plans and attorneys to make payments on behalf of the client directly to Circle of Life Counseling Center.

The undersigned agrees that he/she and/or the client is responsible for charges not covered by this assignment. It is understood and agreed that any conditions precedent to recovery under any insurance or other types of indemnity contracts applicable to the treatment of said client shall be the sole responsibility of the client or guarantor.

Signature on File

The undersigned authorizes, whether he/she signs as an agent/guarantor or client, Circle of Life Counseling Center to put the words "Signature on File" on claim forms submitted for payment to insurance companies. "Signature on File" will be in effect from the time of your first session at Circle of Life Counseling Center and I authorize a copy of this authorization form to be used in place of the original.

Part VIII: Scheduled Appointments:

Your appointment time is reserved especially for you. Each therapy appointment is traditionally 45-60 minutes, unless specially arranged by the therapist. Once an appointment is scheduled, it is your responsibility to keep track of the dates and times of your appointments. Regular attendance is recommended to insure continuity and to enhance the effectiveness of the therapy. If you must cancel or if you need to reschedule, please give your therapist the courtesy of cancelling your appointment as soon as you know you will not be able to make it or at least 24-48 hours before your scheduled appointment.

'Late Cancellation' / 'No-Show' Policy:

Our scheduling system sends a reminder text to you 48-hours before your scheduled appointment. PLEASE RESPOND to this text message by either confirming or cancelling your appointment. If your appointment is not confirmed via text within 24 hours of your scheduled appointment, we may put another client in that spot. Cancellations must be made at least 24-hours before your scheduled appointment to avoid the \$50 'Late Cancellation' fee.

After two 'Late Cancellations' and/or 'No-Shows' and before you can get back on the schedule, you will be required bring your account current and in addition you will be required to PRE-PAY for your next session at the CASH-RATE, regardless of your insurance.

PRIME-TIME 'Late Cancellation' / 'No-Show' Policy:

Appointments scheduled during the hours of 3:00 PM and 7:00 PM are considered 'Prime-Time' and cancellations for Prime-Time Slots must be made 48-hours before your appointment; otherwise, you are responsible for an \$85 'Late Cancellation' fee.

Our scheduling system sends a reminder text to you 48-hours before your scheduled appointment. PLEASE RESPOND to this text message by either confirming or cancelling your appointment. Cancellations for 'Prime-Time' slots must be done at least 48-hours before your scheduled appointment to avoid the \$85 'Late Cancellation' fee.

After two 'Late Cancellations' and/or 'No-Shows' for a 'Prime-Time' appointment, you will be taken off of the schedule and you will not be able to schedule another 'Prime-Time' appointment for 30 days – you may only schedule a non 'Prime-Time' appointment. Before you can get back on the schedule for a non 'Prime-Time' appointment, you will be required bring your account current and in addition you will be required to PRE-PAY for your next session at the CASH-RATE, regardless of your insurance.

Insurance companies do not pay for 'Late Cancellations' and/or 'No-Shows' appointments and the Circle of Life Counseling Center strictly adheres to this policy. We require a current credit card to be on file as insurance and we reserve the right to terminate

treatment with a client for failure to show up to two or more appointments. In cases of emergencies and/or hospitalizations, please discuss concerns with your therapist, as reducing/waiving this fee is at the discretion of the individual therapist.

Part IX: Additional Policies and Procedures

You should be aware that your therapist may practice with other mental health professionals and employs administrative staff and in most cases, there is a need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All mental health professionals are bound by the same rules of confidentiality. All staff members have been instructed about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member. *(UTAH HIPAA NOTICE FORM)* If a client threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. There are some situations where we are permitted or required to disclose information without either your consent or authorization. *(UTAH HIPAA NOTICE FORM)*

If you are involved in a court proceeding and a request is made for information concerning our professional services, such information is protected by the therapist-patient privilege law, we cannot provide any information without your written authorization, or a court order. If you are involved in, or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information. *(UTAH HIPAA NOTICE FORM)*

If a government agency is requesting the information for health oversight activities, we may be required to provide it for them. If a client files a complaint/lawsuit against us, we may disclose information from this client's record relevant to the complaint. *(UTAH HIPAA NOTICE FORM)*

If a client files a worker's compensation claim, and we are providing treatment related to the claim, we must, upon appropriate request, furnish copies of all medical reports and bills. There are some situations in which we are legally obligated to take actions, if we believe it necessary to protect someone from harm; in these rare cases, we may have to reveal some information about a client's treatment. These situations are unusual in our practice. *(UTAH HIPAA NOTICE FORM)*

If your therapist has reason to believe that a child has been abused the law requires that a report be filed with local law enforcement and/or DCFS. Once such a report is filed, we may be required to provide additional information. If your therapist has reasonable cause to believe that a disabled adult or elder person has been abused, it is required to be reported to the appropriate agency. Once such a report is filed, we may be required to provide additional information. *(UTAH HIPAA NOTICE FORM)*

If it is determined a client presents a serious danger of violence to himself/herself or another, we may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the client. If such a situation arises, your therapist will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to what is necessary. Please feel free to discuss and concerns or questions you may have about confidentiality. *(UTAH HIPAA NOTICE FORM)*

The undersigned agrees, whether he/she signs as an agent/guarantor or client that to the extent necessary to determine liability for payment and to obtain reimbursement. Circle of Life Counseling Center may disclose portions of the client's records, including his/her treatment records to any person or corporation which is or may be liable for all or any portion of the Circle of Life Counseling Center's charges including, but not limited to, insurance companies, health care services plans or Worker's Compensation carriers. *(UTAH HIPAA NOTICE FORM)*

Part X: Binding Arbitration Agreement

The arbitration agreement requires that you submit all future claims to arbitration instead of having the claim heard in court by a judge or jury. This agreement is to minimize the cost of any disputes that may arise from your contact with The Circle of Life Counseling Center, its mental health providers, staff and affiliates. You may decline to sign the arbitration agreement and still receive mental health care from The Circle of Life Counseling Center and its mental health providers. Simply write "I decline the binding arbitration agreement" above your signature below.

Your Signature below indicates that you have read this agreement and consent to treatment by our providers under these terms and conditions. This agreement also serves as an acknowledgement that you understand Utah HIPAA guidelines. If you would like a copy of this agreement, or a copy of the actual 'UTAH HIPAA NOTICE FORM' please ask the receptionist.

1. I agree BY ENTERING into therapy with Circle of Life Counseling Center, I will pay the full fee at each session. If I am late to a session, the length of the session may be shortened, and I agree to pay for a full session.

2. A 24-hour notice is required for cancellation of a scheduled session. If I do not meet this requirement, I agree to pay a \$50 or \$85 No-Show or Late Cancellation fee. I understand that this will be my responsibility, not that of a third-party payer.

3. I agree that I will keep a current credit card on file.

4. I understand that Circle of Life Counseling Center has the right to seek legal recourse to recoup any unpaid balance. In pursuing these measures, the therapist will only disclose biographical information and the amount owed, in order to ensure confidentiality.

5. I understand that I may pay for my sessions using a major credit card, personal check or cash at the time of service.

Thank you for reviewing this information and please feel free to discuss any of this information with your therapist or any Circle of Life Staff Member.

My signature on this disclosure statement indicates I have read and understood the conditions of the services outlined. I have had the opportunity to clarify any questions and agree to the terms described above before receiving services. I have been provided with a copy of this disclosure statement.

Client or Guarantor Print: X _____

Client or Guarantor Signature: X _____ Date: _____

Relationship to client: _____

Therapist or COL Staff Signature _____ Date _____

Client's History
(please print legibly and fill out completely)

Client Information

Name: _____

DOB: _____ Social Security: _____

Gender: Male Female

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Work Phone: _____

Mobile Phone: _____ Home Phone: _____

Name of Person or Agency who referred you: _____

Education Level: _____ Occupation: _____

Family Origin

Place of Birth: _____ Raised Where? _____

How many children in the family? _____ Which one were you? _____

Describe sibling relationships: _____

Describe relationship with your mother and any significant problems: _____

Describe relationship with your father and any significant problems: _____

Marital Status: Single Married Divorced Widowed If Divorced, when: _____

Describe your spouse: _____

Marital problems? _____

Children: Yes No If yes: Number of Sons: _____ Number of Daughters: _____

Child Name: _____ Gender: _____ Age: _____ DOB: _____ Relationship to Child: _____

Child Name: _____ Gender: _____ Age: _____ DOB: _____ Relationship to Child: _____

Child Name: _____ Gender: _____ Age: _____ DOB: _____ Relationship to Child: _____

Child Name: _____ Gender: _____ Age: _____ DOB: _____ Relationship to Child: _____

Medical and Mental Health History

Illness/Accident: _____ Age: _____ Length of Recovery: _____

Fever/Unconscious: _____ Treatment/Results: _____

Illness/Accident: _____ Age: _____ Length of Recovery: _____

Fever/Unconscious: _____ Treatment/Results: _____

Family Physician Name: _____ Phone Number: _____

Current Medications & dosages: _____

Current Medications & dosages: _____

Current Medications & dosages: _____

Prior therapy: Yes No

If yes: What was the diagnosis: _____

Name of Therapist: _____ Therapist Phone: _____

Address of Therapist: _____

Psychiatric hospitalizations: Yes No

If yes: What age: _____ Psychiatrist Name: _____
Name of Hospital: _____ Hospital Phone: _____
Address of Hospital: _____

Describe current motivation for seeking mental health services:

Describe desired outcome for mental health services: _____

Describe your religious orientation and participation in your home: _____

Would you appreciate spiritual issues to be discussed as part of your treatment? Yes No

The desire for religious training will be directed back to your preferred spiritual orientation/denomination.

If you wish that prayer to be a part of your treatment, please make that known.

Other Family Members in the Household

Name: _____

DOB: _____ Age: _____

Relationship to client: _____

Issues/Concerns: _____

Name: _____

DOB: _____ Age: _____

Relationship to client: _____

Issues/Concerns: _____

Name: _____

DOB: _____ Age: _____

Relationship to client: _____

Issues/Concerns: _____

Name: _____

DOB: _____ Age: _____

Relationship to client: _____

Issues/Concerns: _____

The above information and statements are true and correct to the best of my knowledge:

Signature X _____ Date: _____

**SIGNATURE PAGE FOR UPDATED
CLIENT AGREEMENT AND THERAPEUTIC POLICIES
FOR CIRCLE OF LIFE COUNSELING CENTER**

I, _____ have received on _____
PRINT NAME DATE

the updated Client Agreement and Therapeutic Policies for Circle of Life Counseling Center.

This updated Client Agreement and Therapeutic Policy supersedes any other signed consent /agreement. This document indicates you have been given a copy, read, understood and/or asked questions regarding the updated Client Agreement and Therapeutic Policies which cover in detail the following:

<p><u>Page 2:</u> Credit/Debit Card Authorization</p> <p><u>Part I: Authorization and Consent</u></p> <p><u>Part II: Therapist Information</u> Professional Orientation; Educational/ Training Background; Circle of Life Counseling Center’s scope of practice.</p>	<p><u>Part VI: Office Policies</u> Professional Fees: CASH-RATES all Circle of Life Therapists: \$180 / \$155 / \$125 / \$155 / \$185 / \$45</p>
<p><u>Part III: The Therapeutic Process</u> Benefits and Risks of Therapy; Communication with Your Therapist Outside of a Scheduled Appointment via E-Mail, Cell Phones, Texting, Computers and Faxes.</p> <p><u>Part IV: Client(s) Rights</u> Limits of Confidentiality; Minors & Parents.</p>	<p><u>Part VII: Health Insurance</u> IN-NETWORK / OUT-OF-NETWORK; Assignment of Insurance Benefits; Signature on File.</p> <p><u>Part VIII: Scheduled Appointments</u> ‘Late Cancellation’ / ‘No-Show’ Policy: Fee: \$50.00/per occurrence. PRIME-TIME ‘Late Cancellation’ / ‘No-Show’ Policy: Fee \$85.00/per occurrence.</p>
<p><u>Part V: Professional Records</u> Fees for involving any Circle of Life Therapist or staff member in any legal action including asking and/or being subpoenaed to provide written documentation or verbal testimony.</p>	<p><u>Part IX: Additional Policies and Procedures</u> <i>UTAH HIPAA NOTICE FORM</i></p> <p><u>Part X: Binding Arbitration Agreement</u></p>

This signed form will be kept in the client’s file indicating they have received detailed information regarding all of the above and agree to all parts.

Client Signature: _____ **Date:** _____

Guarantor Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____