CLIENT INFORMATION FORM

Full Name____ Today's Date________________

Birth date____________ Soc Sec #________________ Address____

City____________________________ State__________ Zip________________

Sex: Male ___ Female ___ Gender Identity: M___ Female___ Other____________ Marital Status: M___ S___ D___Sep___

Phone Number_____________________________________ Email Address ______________________________________

Employer ____Occupation____

Employer's address____

Responsible Party Information Full Name___________________________________ Relationship to Client____________

Birth date____________ Address_______________________________City_____________________State__________

Zip_______________ Phone___________________________Sex: M F Employer_______________________________

Insurance Information Primary Insurance Company_____________________ Name of Policy Holder_________________

Address__________________________________ City________________ State _______________Zip_________________

Phone Number____________________Policy Number__________________________ Group Number_________________

Insurance Plan Name______________________________ Policy Holder's Date of Birth_____________________________

Secondary Insurance Company_____________________________ Name of Policy Holder__________________________

Address___________________________ City______________________ State_______________Zip__________________

Phone Number___________________ Policy Number_________________________ Group Number___________________

Insurance Plan Name_____________________________ Policy Holder's Date of Birth_____________________________

Emergency Contact

Name____ Relationship to Client_____________________________

Home Phone_______________________ Work Phone________________________ Cell Phone_______________________

How did you hear about us?

☐ Google Search What did you search? ____

☐ Friend Who can we thank? ____

☐ Doctor Who can we thank? ____

☐ Facebook ☐ Instagram

Professional Service Agreement

Thank you for coming to Aspen Valley Wellness for mental health therapy and/or family medicine 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 relationship go smoothly.

Fees & Billing	**Insurance Rate**	**(Cash Rate)**
• Intake	$165	($150)
• Medical Intake		($150)
• Regular Medical Appointment		($120)
• Individual Therapy	$135	($120)
• Couples Therapy	$135	($120)
• Family Therapy	$135	($120)
• Group Therapy	$120	($45)
• Clinical Mental Assessment	$200	
• QEEG Analysis	----	($550)
• Neurofeedback Intake	$165	($150)
• Neurofeedback sessions		($75)

- Payment is due in full at the beginning of each session by cash, check, or card. By signing this form, you are giving your consent for Aspen Valley Wellness to charge the credit card on file for any outstanding balances in your account.
- There will be a $25 fee for any canceled check.

Health Insurance Coverage

We will work with your insurance company to pay for your visit for therapy sessions. However, all co-pays are due at the beginning of each session. If your insurance company does not pay for the visit, you will be responsible for the balance of all charges as outlined above or according to your insurance fee schedule.

Late Cancellation/No Show Policy

If you are unable to make your scheduled appointment, please cancel or reschedule at least 24 hours in advance so another client can be scheduled during that time**. No calls, no shows, and appointments canceled/rescheduled with less than 24 hour notice will be charged their FULL SESSION fee without the help of insurance to cover the bill.**

I understand, and agree to, the policies as stated above, and I give consent for treatment by Aspen Valley Counseling.

____ _____________________________

Client's Name Date

___________________________ __________________ ____________________________

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

Confidentiality Agreement

Confidentiality

- The information you share will be kept confidential. In order to release any information, including billing, to family members or to coordinate treatment with other healthcare professionals you must first sign a *Release of Information* form.
- 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 me telling.
2. If you are **involved in a law suit**, and you tell the court that you are in therapy, I may then be ordered to show the court my records. Please consult your attorney about these issues.
3. If you **threaten to harm** yourself or another person, the law requires me to try to protect you and/or that other individual.
4. If I believe a **child, an elderly individual, or a vulnerable adult has been or will be abused or neglected**, I am legally required to report this to the authorities.
5. If I **bill your insurance** 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 I may **consult with other mental health professionals** about your case.

If Case of Emergency
If you are experiencing an emotional, behavioral, or medical crisis, call 911 or go to the nearest emergency room. We do not provide 24-hour crisis services.

Informed Consent

- I have received a copy and read the HIPPA Privacy Policy for Aspen Valley Wellness
- I have received a copy of, understand, and agree to Aspen Valley Wellness' Service Agreement
- I consent to psychotherapy and/or medical treatment by Aspen Valley Wellness
- If my account is not paid, and therefore turned into collections, I will be responsible for all collection costs, court costs, and attorney fees.

I understand, and agree to, the policies as stated above, and I give consent for treatment by Aspen Valley Counseling.

____ _______________________________________

Client's Name Date

____ _______________________________________

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

CLIENT COPY

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____ ____________________________

Client's Name Date

____ ____________________________

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

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 APA Code of Ethics. It also describes your rights regarding how you may gain access to and control your protected health information.

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 any way 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 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 about 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 me to tell what information about your condition or treatment. You can tell me what you want and I 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 office.

- **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 office.