THERAPY UTAH
CENTER FOR HOPE AND HEALING

2940 Maple Loop Drive #201, Lehi, Utah 84043
Phone (385) 254-3522

CLIENT INFORMATION Date: _____

_____

First Name **Last Name**

Date of Birth: _____ /_____ /_____ **Age:** _____ **Male:** _____**Female:** _____

_____

Address **City, State** **Zip Code**

_____

Home Phone **Mobile Phone**

Are text message reminders and updates ok? ☐ YES ☐ NO May we leave voice messages? ☐ YES ☐ NO

Are we able to send you important information and receipts via email? ☐ YES ☐ NO

Single: _____ Married: _____ Other: _____ *Email Address: _____

Employed: _____ Full-time Student: _____ Part-time Student: _____ Other: _____

Family Doctor Name/Phone: _____

Are you currently on any medications? ____ If yes, please list: _____

How would you describe your physical health at this time? _____

Reason for seeking counseling at this time? _____

Name(s) of spouse/children participating in therapy: _____

Who may we thank for referring you to our office? _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Phone: _____

Relationship to client: _____

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PROFESSIONAL SERVICE CONTRACT

Appointments: Our appointments are your time to use as you wish. Those that are not utilized or are canceled without sufficient advanced notice will be charged the full fee. "Sufficient Advanced Notice" is at least 24 hours and more notice is appreciated. Please note that phone calls or any correspondence to the client or to any third-party individual that exceeds 10 minutes will be charged the hourly rate. Please also note that third-party payers will not reimburse you for the charges of missed appointments. If you need to cancel an appointment, please call our office at (385) 254-3522. If you are unable to reach us, please leave a voice message or send a text message.

Fees and Billing: Our services are based on a fee-for-service contract. Please be prepared to pay for services at the time of appointment. Depending on our front office schedule, fees will typically be charged within 72 hours of appointment date. Group Fees will be charged within the first week of the month. In special circumstances, payments can be delayed, but this must be arranged through our office manager. Interest will accrue at a rate of 1.5% per month. In the event that full payment for charges incurred is not made, you will pay all costs of collection, court cost, and attorney fees.

Insurance Coverage: Your work with your therapist may be covered by your health insurance. Please remember that your insurance is a contract between you and your insurance carrier that helps you meet your insurance expenses. We believe that the confidentiality of our client's lives is a very high priority; to that end we do not bill insurance companies. You are responsible for payment, and can seek reimbursement from your insurance if you wish to do so.

Confidentiality: Professional ethics, as well as the laws of the State of Utah, require that we honor your right to privacy and the confidentiality of our work together. We will not provide information about you to others without your informed consent and written permission except when required by law. We must report clear and present danger to human life and any form of child or elder abuse, as well as infectious diseases. Minors and Parents: Clients under the age of 14 who are not yet emancipated and their parents should note that the law may allow parents to examine their child's records unless deemed harmful to the child. Our policy is for clients 14-18 and their parents to contract about general information that can be shared with the parents. Laws regarding court proceedings are included in HIPPA regulations.

Emergency Coverage: *We do not provide 24-hour emergency coverage at this office.* In case of emergency, you may leave a message at (385) 254-3522 and request an emergency session and we will return your call as soon as possible. If you are unable to make contact with your therapist personally, we recommend that you contact your family physician, local hospital emergency room, or the crisis unit at your local mental health center.

Fees: The Initial Assessment fee is $125.00. Regular sessions are $125.00-$200.00, depending on the therapist. Weekend and emergency visits are $200.00.

Your signature below indicates that you have received the Notice of Privacy Practices indicating our compliance to HIPPA rules. You may ask questions regarding these practices at any time.

Client Signature: _____ Date: _____
(Responsible party signature if under 18)

Therapist Copy

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PAYMENT INFORMATION

We require payment information at the time of service. Your card will be charged within 72 hours of your appointment. If you are enrolled in any of our GROUPS, your card will be charged for the monthly group fee during the first week of the month. If you are enrolled in our IOP program, your card will be charged based on the plan chosen in the IOP financial agreement.

If you are receiving financial assistance from a third-party payer (i.e., bishop, family member, etc.), please fill out the Consent for Third Party Billing form. We ask that you also fill out your personal payment information below, which will be held on file in case the third-party payer denies/fails to make payments. *Any missed appointments that are not canceled 24 hours prior to appointment, will be charged to you directly. We do not bill Third Party Payers for missed appointments.*

Required Payment Information

Cardholder Information

Name on Card: _____

Card Type (please circle): Visa / MasterCard / American Express / Discover Card

Card Number: _____-_____-_____-_____ Expiration Date: _____

CVC Code: _____ Billing Zip Code: _____

**Please indicate the names of all others that will also be using this payment information:*

_____ _____

_____ _____

I, _____ (print name), authorize Therapy Utah to charge this credit card for all attended appointments, any appointments that are not cancelled within 24 hours of their scheduled time and/or any appointments which are missed without notice. I have read and understand the Professional Service Contract.

Cardholder Signature: _____ Date: _____

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Consent for Third Party Billing

If you are receiving financial assistance from a third-party payer (i.e., bishop, family member, etc.), Therapy Utah will submit authorization and claim forms directly to them. Our policy is not to charge third party payers for missed appointments, telephone consultations and certain other kinds of services, you will be responsible for these charges.

Please carefully review with your payer all information about charges and types of services they will cover. If you have questions, please contact your payer. It is particularly important to understand that third party payers may authorize payment for a specific number of sessions, or a specific dollar amount per visit. Third party payers may make their own decisions, independent of therapeutic recommendation, about how much or what kinds of treatment they will pay for or believe is necessary.

Third Party payers frequently require some information about your case when they agree to pay for treatment. Information required depends on the payer. Some examples of required information may include treatment attendance, treatment type, and progress or treatment summary reports. You are welcome to discuss what is disclosed to payers with the therapist you are currently seeing. Although community agencies or ecclesiastical leaders are typically required to keep such information confidential, we have no record or control over what they do with this information once it is in their files.

By signing below, you are agreeing to have any necessary information released to the payer in order for our office to obtain reimbursement for services, and you authorize direct payment to our office from the payer. It is the client's responsibility to obtain authorization from the third-party payer, prior to the first appointment. Furthermore, the client is responsible for payment for all services rendered and charges incurred that are not covered by a third-party payer.

IF YOU WISH TO HAVE A THIRD PARTY BILLED, PLEASE COMPLETE AND SIGN THE FOLLOWING:

Client Name: _____ Client Date of Birth: _____

If under 18 years of age, Parent/Guardian Name: _____

Signature: _____

3rd Party Payer Information:

Name: _____

Payer Address: _____

Phone Number: _____

3rd Party Payer has agreed to pay $_____ per session and/ or $_____ of monthly group rate.

Date Verified by Therapy Utah: _____ Staff initials: _____

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I, _____ whose birth date is _____ hereby authorize **Therapy Utah** to exchange confidential professional information with:

Name: _____

Agency: _____

Mailing Address: _____

City: _____State: _____ Zip: _____

Phone: _____ Fax # _____

It is requested that the following specific information be provided:

1. _____
2. _____
3. _____

In consideration of this consent, I hereby release the above parties from any and all liability arising therefrom.

Client or Guardian Signature: _____

Guardian Printed Name (if signature above is not client): _____

Date: _____

Witness: _____