



Where there is an open mind and a willing heart, there is a path to healing

Dear Client,

Welcome to *Advanced Health Clinic*. We are committed to bringing you the best practitioners and services available in Integrative & Holistic Medicine and the healing arts. As you embark on this new journey (or perhaps a well-traveled path), we are excited for the new discoveries you will make about yourself, your health and your well-being as you begin to create an *advanced* lifestyle – one that is full of healing, energy, and possibility!

To assist us in making your first visit an exceptional experience, we ask that you be prepared with the following:

1. **NEW CLIENT PAPERWORK:** Please fill out all paperwork *prior* to your appointment. We prefer you mail it to us if there is time. If for any reason you do not complete your paperwork, your appointment may be delayed and possibly cut short while you fill it out.
2. **CHILDREN:** If your child is under the age of 18, s(he) *must* be accompanied by an adult.
3. **PAYMENT POLICY:** Full payment is due at the time of service. ***We do not bill insurance.*** We accept cash, check, or credit card.
4. **CANCELLATION POLICY:** 24-hour notice is required for all cancellations. There is a charge for all missed appointments.
5. **PLEASE: DO NOT WEAR PERFUME OR COLOGNE** (As a courtesy, many of our clients and staff are chemically sensitive).

FOR HOLISTIC NURSING & BIONETIC APPOINTMENTS:

Your first visit will take approximately 1 to 2 hours.

Please bring:

1. All supplements and/or medications you are currently taking.
2. A sample of the water you drink (in a jar with a lid).

FOR CHIROPRACTIC CARE:

Your initial evaluation will take approximately 45 - 60 minutes.

FOR MASSAGE/CRANIAL SACRAL/VISCERAL MANIPULATION:

Appointment times range from 30 minutes to 2 hours, as scheduled. It is best to wear ***loose*** clothing.

VISCERAL MANIPULATION:

- Do not eat prior to coming (2 hrs)
- Do not wear under-wire bras
- Please, wear ***VERY LOOSE***, comfortable clothing

FOR COUNSELING SERVICES:

Appointments range from 1 to 2 hours, as scheduled. Please come 15 minutes before each scheduled appointment time to fill out questionnaire provided by your practitioner. You may also download this off our website. Please bring forms with you at the time of your appointment. Thank you for preparing for your visit with us.

We look forward to working with you as you experience more abundant health, a heightened sense of well-being and greater emotional freedom. We truly believe “*Where there is an open mind and a willing heart, there is a path to healing.*”



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630 W Shepard Lane, Farmington, UT 84025 • 801-447-8680 • appt@AdvancedHealthClinic.com • www.AdvancedHealthClinic.com

Today's date: **CLIENT INFORMATION** **(Please Print)**

LAST NAME:	FIRST:	MIDDLE INITIAL:	AGE:	DATE OF BIRTH:
ADDRESS: CITY: STATE: ZIP CODE:		SEX: <input type="checkbox"/> M <input type="checkbox"/> F MARITAL STATUS (CIRCLE ONE): MARRIED WIDOWED DIVORCED SINGLE SIGNIFICANT OTHER		

EMAIL (WE WILL NEVER DISTRIBUTE OR SELL YOUR INFORMATION):

HOME PHONE: CELL NUMBER:

OCCUPATION: EMPLOYER: EMPLOYER PHONE:

NAME OF PERSON WHO REFERRED YOU:

PAYMENT POLICY

PERSON RESPONSIBLE FOR BILL: ADDRESS (IF DIFFERENT): IS THIS PERSON A CLIENT AT ADVANCED HEALTH CLINIC? YES NO

HOME PHONE (IF DIFFERENT): CELL /WORK PHONE:

____ (Please Initial) I understand it is a courtesy to provide 48-hour notice (2 business days) in the event I need to cancel an appointment. If I am unable to provide 24-hour (1 business day) notice for any cancellation, I understand I will be charged for my missed appointment. (We never like having to do this so please call – Thank you!)

____ (Please Initial) I understand that payment for all fees are payable to Advanced Health Clinic, LLC, (AHC) in behalf of practitioner or entity by cash, check, or major credit card at the time services are rendered. If your check is returned unpaid, your account will be debited electronically for the original amount and electronically or via paper for the state's maximum allowable service fee. Payment by check constitutes authorization of these transactions. I further understand that 21% interest/annum for accounts 30 days past due. I further understand that payment is due at the time of, or previous to, services being rendered by cash, check, Visa, MasterCard, Discover, or a debit card. I understand AHC will never bill insurance nor file insurance claims.

IF YOU WILL BE HAVING US SHIP ANYTHING TO YOU, OR PAYING FOR A CHILD OR SOMEONE ELSE WHEN YOU ARE NOT HERE, PLEASE PROVIDE THE FOLLOWING INFORMATION:

I authorize Advanced Health Clinic to charge the following credit card account for services received at Advanced Health Clinic:
Please Sign: X

CREDIT CARD TYPE: V D MC DEBIT LAST 4 DIGITS OF CARD TO BE USED: XXXX XX _ _ _ _ (PLEASE PROVIDE ENTIRE NUMBER TO FRONT DESK)

IN CASE OF EMERGENCY CONTACT:

NAME OF LOCAL FRIEND OR RELATIVE:	HOME PHONE:
RELATIONSHIP TO CLIENT:	CELL/WORK PHONE:

HEALTH INFORMATION PRIVACY NOTICE

Your health information is private and protected by law. Your information will only be used or disclosed for the purpose of giving care, billing, or supporting day to day operations. You have the right to review your file. You may restrict all or part of your health information from being released, as allowable by law. If you request information to be transmitted electronically, please be advised that your private information may not be protected. Advanced Health Clinic transmits from a secure, encrypted network server, however, we cannot guarantee that any information you receive from AHC or your practitioner will be received through a secure network on your end. We will take every step necessary on our end to protect your privacy. A more detailed version of our privacy policies are available online or at Advanced Health Clinic, LLC (AHC). If you choose to contact us or your practitioner by electronic means, (ie: website, facebook, social media, text, email, etc), you understand that this is not a secured form of communication and your private health information may not be protected, and by contacting us via those means, you are waiving your Privacy Rights. Advanced Health Clinic cannot guarantee your information remains protected during electronic communication.

____ (Please Initial) I have received a notice of HIPAA NOTICE OF CLIENT PRIVACY PRACTICES (see above). I have had a chance to ask questions about privacy policies and I give my permission to this office to disclose my name and, or protected health information in accordance with such policies. I allow my health information to be shared among practitioners at Advanced Health Clinic, LLC, for the purpose of giving care. I further understand that my chart will always remain the property of and in the care of AHC. I give permission for my picture to be kept on file for identification purposes.



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INFORMED CONSENT

____ (Please Initial) By signing below, I am verifying that I have read this informed consent and I understand it. I am not a minor (under the age of 18). Additionally, I am here on this day and any subsequent visit, solely on my own behalf and not as an agent for any federal, state, or local agencies on a mission of entrapment or investigation and I also certify that I am signing my own true given, legal name and not an alias or false name.

____ (Please Initial) I understand that I have sought services provided through Independent Contractors at Advanced Health Clinic, LLC (AHC) for my personal wellness care or for my child or children who are minors. I understand that each and every practitioner I (they) see is a separate entity that leases from AHC and operate independently as practitioners and/or companies. I further understand that Therapeutic Spa, LLC and Health & Nutrition, LLC, are separate entities from Advanced Health Clinic, LLC (AHC). I further understand that a Practitioner and/or Entity that has their practice at AHC may specialize and employ methods that may be considered to be "unconventional" and/or "unorthodox", also known as "alternative", "integrative", "holistic" and/or "complimentary" medicine.

____ (Please Initial) I understand that AHC provides services for Independent Contractors and is exclusively an office-based practice. I recognize AHC is not affiliated with a local hospital. I further understand that **AHC STRONGLY RECOMMENDS IN ADDITION TO ANY CARE RECEIVED AT AHC AND/OR AN INDEPENDENT CONTRACTOR THROUGH AHC, THAT I MAINTAIN A RELATIONSHIP WITH ONE OR MORE PHYSICIANS QUALIFIED TO CARE FOR MY MEDICAL CONDITION(S)**. For example, in the case of children AHC advises that I seek the advice of a pediatrician; if I have cardiovascular disease I consult with a cardiologist; if I have mental illness, I consult with a mental health specialist; and if I have cancer I consult with an oncologist, etc.

____ (Please Initial) I understand that AHC and/or its employees, and/or its representatives make no representations, claims, or guarantees regarding the efficacy of a practitioner's practice, recommendations, treatments, procedures, or therapeutic services. I further acknowledge that I understand that any service and/or therapy I receive MAY alter, address, or decrease my pain, symptoms, or complaints, but also may have no effect at all.

____ (Please Initial) **CONFLICT RESOLUTION:** By signing this informed consent I consent and agree to hold harmless, Advanced Health Clinic, LLC (AHC), and/or their staff and/or employees, and/or associated entities from all professional and personal liability. I further understand and consent that that all services and/or therapies are patient and/or client directed therapies and I will direct my practitioner and/or staff to perform any therapy and/or service I receive at AHC. In doing so I, and any and all parties that may represent me or my estate, hold harmless Advanced Health Clinic, LLC, the practitioner, and/or staff and all other controlling or involved entities or manufacturers.

In the event I or my representative or heirs bring a legal case against AHC, I agree to be responsible for all legal costs and fees that may result from action(s) on my part or on the part of my representatives(s) against AHC or its representative(s). I agree that AHC shall be judged by the standards and principles of holistic/alternative/complimentary health care. I agree to settle any claim, dispute, or disagreement I have with Advanced Health Clinic and or Practitioners and/or Staff in person. If this is not possible, then I agree to enter into good faith non-binding mediation with Peacemaking and Conflict Resolution Services (PMCRS) as mediator, or if PMCRS is not available, I agree to meet with another mediator located in Farmington, Davis County, Utah or the surrounding area. If we are unable to settle via mediation, I further understand that any claim or dispute arising under or out of this Agreement shall be subject to binding arbitration pursuant to the Commercial Rules of the American Arbitration Association (AAA) and conducted in the City of Farmington, Utah, or within the surrounding area. There shall be a single arbitrator selected by the AAA. In no event shall either party be entitled to punitive damages. The parties shall split the cost of mediating and disputing equally. Any attorney's fees incurred during the mediation shall become a subject of the mediation and the parties will attempt to resolve attorney's fees during the mediation. The costs of binding arbitration shall be split between the parties equally and the arbitrator. Each party is responsible for their own attorney fees for arbitration.

I further understand and consent that I have the right to have this consent reviewed by my lawyer before accepting any medical, wellness care, and/or nutritional services from Advanced Health Clinic, LLC. Although AHC and/or the staff and/or practitioner will not be able to provide any professional services to clients and or patients who choose not to sign, we will provide any medical records we have in our possession to you so that you can select the healthcare practitioner of your choice for your continued care.

____ (Please Initial) **SEVERABILITY:** If any term, provision or condition of this Agreement, or any application thereof, should be held by a court of competent jurisdiction to be invalid, void, or unenforceable, all provisions and conditions of this Agreement and all applications thereof not held invalid, void or unenforceable, shall continue in full force and effect and shall in no way be affected, impaired or invalidated thereby, by entering my signature below I am acknowledging that I understand all terms, verbiage (language) and concepts herein.

I hereby consent to and authorize the above understandings of this Informed Consent for me and/or my child(ren). I have executed this agreement freely and willingly.

Client Name (Please Print) _____ Signature _____ Date _____

Parent or Guardian signature if under 18 _____ Date _____

Witness _____ Date _____



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Fee Acknowledgment

Preventative medicine, integrative medicine, holistic medicine, alternative medicine, bio-identical hormone replacement, IV nutritional therapy, chiropractic care, along with most services offered at the clinic are a unique practice and are considered a form of alternative medicine. Even though our practitioners are licensed and board certified, insurance does not recognize it as necessary medicine BUT is considered complimentary medicine and therefore is not covered by health insurance in most cases.

Advanced Health Clinic, LLC (AHC) (as well as any Practitioner who practices at AHC) is not associated with any insurance company, which means insurance companies are not obligated to pay for services you receive at Advanced Health Clinic (blood work, consultations, therapies, treatments, labs, IV's, insertions or pellets). We require payment at time of service and, if you choose, we will provide a receipt showing that you paid out of pocket and what the visit was for. WE WILL NOT, however, communicate in any way with insurance companies or Health Savings Plans. This is not a guarantee that those services will be paid for by your insurance company. Many of the services provided at AHC and/or by Independent Contractors (Practitioners) do not have medical billing codes.

For clients who have access to a Health Savings Account, some of your appointments may qualify for use with that credit or debit card. Please check with your plan to see what they will cover prior to using your Health Savings Account for your visit. If your plan covers those services and you wish to put it on your Health Savings Account, please inform your practitioner prior to the beginning of your appointment so that they prepare your receipt accordingly. Even then, this does not guarantee that your Health Savings Account will accept your claim. Most Health Savings Accounts will not cover supplements, vitamins, or minerals.

The form and receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, or make any contact with your insurance company. Any follow up letters from your insurance to us will be thrown away. If we receive a check from your insurance company, we will not cash it, but instead return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company.

**We accept the following forms of payment:
Master Card, Visa, Discover, Personal Checks and Cash.**

By signing below, I hereby acknowledge receipt and understanding of AHC Fee Policy:



_____ **Print Name**

_____ **Client Signature**

_____ **Date Signed**

INFORMED CONSENT
HEALTH & NUTRITION, LLC
630 W. Shepard Lane
Farmington, UT 84025
Phone: 801-447-8680 FAX: 801-447-4211

GENERAL UNDERSTANDING: I understand that Health & Nutrition, LLC, (H & N), is an **independent entity** who leases from Advanced Health Clinic, LLC (AHC). I understand that the primary business of H & N is to make available for purchase holistic and natural items including herbs, homeopathy, nutrients, whole foods, diodes, cd's, books, etc.

_____ **(Please Initial)** I understand that by signing this informed consent that I agree and understand that all supplements purchases are client directed purchases. I further understand, agree, and consent that in doing so I, and any and all parties that may represent me or my estate, hold harmless Health & Nutrition, LLC, Advanced Health Clinic and/or other controlling or involved entities or manufacturers from all professional and personal liability regarding any injury or harm that I may receive from services or purchase made from Health & Nutrition, LLC or Advanced Health Clinic, LLC. I further understand that Health and Nutrition, LLC, and/or Advanced Health Clinic, LLC and/or its employees, and/or its representatives make no representations, claims, or guarantees regarding the efficacy of Nutritional Supplements, or its services. I additionally understand that I am not required to purchase from H & N any supplement or nutritional recommendation made by any practitioner, employee, or representative who works at/or for AHC. I further understand that no profit is received by any recommendation that an employee and/or practitioner makes to me. I further understand that supplements are not meant to replace adequate medical care or pharmaceutical recommendations made by my physician. I understand and acknowledge that any **suggestion or recommendation made to me has not been prescribed to me for the treatment of any known or unknown medical disease or illness by anyone.** I further understand that any recommendation made to me by a practitioner and/or staff member are simply that, a recommendation. Any purchase I make is of my own free will.

_____ **(Please Initial)** I further understand that a BioCommunication device(s) is NOT a medical device, nor does it provide any diagnostic information. It is NOT a diagnostic tool, nor should I use a BioCommunication scan for that purpose. I understand that a BioCommunication "scan" is a client-directed service.. I further understand that BioCommunication (such as ZYTO technology) is referred to as wellness decision support technology. BioCommunication and/or ZYTO scans are not intended to treat or diagnose disease or illness.

PAYMENT POLICY: I understand that payment is due at time of service and that all fees are payable to Advanced Health Clinic, LLC, in behalf of Health & Nutrition, LLC by cash, check, or major credit card at the time services are rendered. In the event of a returned check, I will reimburse Advanced Health Clinic, LLC the total of the check by cash or credit card with an additional \$25 service fee and 21% interest/annum for accounts 30 days past due ,

By entering my signature below I am acknowledging that I understand all terms, verbiage (language) and concepts herein. I hereby consent to and authorize the above understandings for me and/or my child(ren). I have executed this agreement freely and willingly. (Please Sign below):

Client Name (Please Print) _____ Signature **X** _____ Date _____

Parent or Guardian signature if under 18 _____ Date _____

Witness _____ Date _____

INFORMED CONSENT
THERAPEUTIC SPA, LLC
630 W. Shepard Lane
Farmington, UT 84025
Phone: 801-447-8680 FAX: 801-447-4211

GENERAL UNDERSTANDING: I understand that Therapeutic Spa, LLC, (TS), is an **independent entity** who leases from Advanced Health Clinic, LLC (AHC).

I understand that the primary business is to offer **therapeutic spa services** available to clients who come to AHC. I understand that **Therapeutic Spa, LLC, AHC and/or its employees, and/or its representatives make no representations, claims, or guarantees regarding the efficacy of therapeutic spa treatments, procedures, or services. I understand that by signing this informed consent I agree to hold harmless, Therapeutic Spa LLC and its employees and/or representatives from all professional and personal liability regarding any injury or harm that I receive while visiting and/or receiving treatment from services at Therapeutic Spa, LLC.**

PAYMENT POLICY: I understand that payment is due at time of service and that all fees are payable to Advanced Health Clinic, LLC, in behalf of Therapeutic Spa, LLC by cash, check, or major credit card at the time services are rendered. In the event of a returned check, I will reimburse Advanced Health Clinic, LLC the total of the check by cash or credit card with an additional \$25 service fee and 21% interest/annum for accounts 30 days past due.

By entering my signature below I am acknowledging that I understand all terms, verbiage (language) and concepts herein. I hereby consent to and authorize the above understandings for me and/or my child(ren). I have executed this agreement freely and willingly. (Please Sign below):

Client Name (Please Print) _____ Signature **X** _____ Date _____

Parent or Guardian signature if under 18 _____ Date _____

Witness _____ Date _____

Child and Family Hope Center

K.Max Park L.M.F.T.
Advanced Health Clinic
630 W. Shepard Lane
Farmington, UT 84025

CLIENT INFORMATION FORM

First Name _____ Middle Initial _____ Last Name _____

M _____ F _____ Date of birth _____ Age _____

Address _____

City/State _____ Zip _____

Email: _____

ONE REQUIRED Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____

{Please only provide an email address and phone numbers where you are giving us permission to leave messages}

BACKGROUND INFORMATION

Why are you seeking counseling at this time?

Do you have any medical conditions that your therapist should be made aware of?

Are you taking medications of any kind?

Whom may we thank for referring you?

For Office Use Only

Dx Code: _____ Note: _____

VISA

MASTERCARD

DISCOVER

Credit Card # _____ - _____ - _____ CID# _____ EXP _____ / _____

Name as it appears on card _____

Address of card holder _____

Phone # of card holder _____ Email of card holder: _____

Cardholder Signature _____ Date _____

I authorize Advanced Health Clinic to charge the above card for services, product or fees.

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Farmington, UT 84025

THERAPIST-CLIENT SERVICE AGREEMENT

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 you and Child and Family Counseling Services . We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

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. Your therapist also has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. Psychotherapy 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.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some initial impressions of what your work might include. You should evaluate this information and make your own assessment about whether you feel comfortable working with Child and Family Counseling Services. If you have questions about our procedures, we invite you to discuss them with your therapist whenever they arise.

APPOINTMENTS

Appointments will ordinarily be 60 minutes in duration. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, we ask that you provide your therapist with 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, our policy is to collect the full amount of your session. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. If it is possible, we will try to find another time to reschedule the appointment. 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 and you will be charged the full amount for your session.

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PROFESSIONAL FEES

The standard fee for the initial intake is \$200.00 and each subsequent session is \$100.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check, cash, or credit card. Any checks returned to our office are subject to an additional fee of up to \$25.00 to cover the bank fee that is incurred. If you refuse to pay your debt, we reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, it is our practice to charge \$50 per hour for other professional services that you may require such as report writing, telephone conversations, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of us. If you anticipate becoming involved in a court case, we recommend that you discuss this with us fully to consider the effects this could have. Legal situations involving your treatment or treatment records will mostly result in you waiving your rights to confidentiality. If your case requires our participation, you will be expected to pay for the professional time required even if another party compels us to testify.

PROFESSIONAL RECORDS

We are required to keep appropriate records of the psychological services that we provide. Your records are maintained in a secure location in the office. We keep brief records noting that you received treatment, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records we receive from other providers, copies of records we send to others, and your billing records. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them with your therapist, or have them forwarded to another mental health professional to discuss the contents. If we refuse your request for access to your records, you have a right to have our decision reviewed by another mental health professional, which we will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request. The administrative fee you will be charged for each copy of your file will be \$50.00, due at the time of your request.

NO SECRETS POLICY

The "Treatment Unit" refers to a couple or family consisting of two or more members. While providing treatment services to the Treatment Unit, individuals are not viewed as being separate or individual clients. When working with a Treatment Unit, our office practices a No Secrets policy. Your therapist may schedule separate appointments with one or more members of the Treatment Unit to assist in the overall therapy process, please understand that any information shared with a clinical treatment staff member in any treatment setting, including times when all members of the Treatment Unit are not present, will not be held in confidence or maintained as a secret while treating any and all members of the Treatment Unit. We will encourage the client holding the secret to disclose the withheld information in a following session with all or part of the Treatment Unit and will support the client in doing so. We also reserve the right to share or disclose information revealed by one partner or family member in an individual session to the other partner or family members as we deem appropriate or necessary to support the treatment units overall treatment progress and goals. If you are seeking couples or family therapy, each member of the Treatment Unit will be required to complete and sign separate intake forms.

In addition, please note that there are limits to your confidentiality as defined by Utah State law. Under certain circumstances, our therapists and members of clinical staff have a legal obligation to report information disclosed in any type of mental health treatment setting to appropriate law enforcement or medical professional.

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PARENTS & MINORS

While privacy in therapy is crucial to successful progress; parental involvement in the treatment of minor children can also be essential. We request an agreement between the client and the parents allowing us to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless the therapist feels there is a safety concern in which case we will make every effort to notify the child of our intention to disclose information ahead of time and to handle any objections that are raised.

COMMUNICATION WITH YOUR THERAPIST

Boundaries with your therapist will be an important part of your treatment. Communicating with your therapist needs to be within professional boundaries. Treatment should take place through scheduled appointments. Treatment will not be offered through text messaging, email or instant messaging. Texting may be used for administrative purposes only. Texting is not HIPPA compliant and should you text a therapist on a therapeutic matter the therapist will ask you to setup either a billable phone call or it will be addressed in your next scheduled session. We ask that you respect our therapists' personal time away from the office.

There may be times when you would like to contact your therapist with an urgent need. Due to the nature of our business, we are often not immediately available by telephone. We do not answer the phone when we are in session or otherwise unavailable. At these times, you may leave a message on our confidential voice mail and your call will be returned as soon as possible: 801-447-8680. Please note that it may take 24-48 hours for non-urgent matters. If, for any number of unseen reasons, you do not hear from your therapist or the therapist is unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, immediately do one of the follow: 1) go to your Local Hospital Emergency Room, or 2) call 911 and ask to speak to the mental health worker on call. We will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering for your therapist.

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GENERAL AUTHORIZATION

Client's Name _____

I understand that by signing this informed consent I am authorizing Child and Family Counseling Services to disclose my health information to the persons and entities that I have listed below and that any health information or other confidential information in the possession of the persons and entities listed below may be disclosed to Child and Family Counseling Services. My health information includes without limitation, any records, reports, test results, assessments and other information relating to medical, emotional, education or psychological conditions. Disclosure may also be made to describe my condition and progress and to discuss treatment.

I understand that I may revoke this authorization at any time by sending a written notice to Child and Family Counseling Services. I understand that my revocation of this General Authorization will not affect a disclosure that Child and Family Counseling Services has already made under this authorization.

I understand that information used or disclosed under this General Authorization may be subject to re-disclosure by the recipient, and may no longer be protected by Child and Family Counseling Services confidentiality rules.

I waive any right of privacy that I have in connection with the disclosures hereby authorized.

This General Authorization is valid until _____ or until three months after the file is closed at Child and Family Counseling Services . This General Authorization requests and authorizes any necessary psychological and/or psychiatric evaluation and treatment.

For parents of minors receiving services: I am a legal guardian of _____ who is under 18 years of age and I authorize him/her to receive services provided by Child and Family Counseling Services . I understand that parental participation in one or more of the following may be required: assessment, individual counseling, family counseling, parenting skills training or group counseling.

Child and Family Counseling Services has my authorization to disclose my health information to the following persons and entities:

Please list the name of a third party billing payer above if we will be corresponding or billing them for services.

CONSENT TO PSYCHOTHERAPY

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

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Relationship to Patient if Personal Rep.

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CLIENT INFORMATION AND HISTORY

Client Name: _____ Age: _____ DOB: _____

Spouse: _____

Children:(circle Clients(s))

DOB age m/f circle one

_____ (_____) _____ biological/adopted at age _____
_____ (_____) _____ biological/adopted at age _____
_____ (_____) _____ biological/adopted at age _____
_____ (_____) _____ biological/adopted at age _____
_____ (_____) _____ biological/adopted at age _____
_____ (_____) _____ biological/adopted at age _____

Client's History (re: birthmother, what is known or has been reported) What prenatal care did she receive?

What were her emotional stressors during this pregnancy?

What types/quantities of alcohol/drugs were used by her during pregnancy? Describe your mother's attitude toward this pregnancy.

Please describe any delivery or medical complications.

Mental Health Treatment History

<u>Dr/Therapist</u>	<u>Clinic Name</u>	<u>in/outpt.</u>	<u>Dates from/to</u>	<u>Outcome</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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Do you or anyone in your family feel suicidal or threatened, and why?

Describe any reason that brought you into treatment.

Describe how you have treated or responded to these reasons.

Which bothers you the most?

Describe the impact this has had on your marriage, your family, your lifestyle and your personal well being.

Describe your support system and supportive relationships.

What are your strengths, talents, and skills?

What do you enjoy doing?

What are your worst fears?

What are your hopes and dreams?

What are your goals for individual/family therapy?

Additional Information you think I should know.