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 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.”*

630 W. SHEPARD LN. □ FARMINGTON, UT 84025 □ 801-447-8680/FAX 801-447-4211 □ 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: ☐ M ☐ F
Marital status (circle one):
Married Widowed Divorced Single Significant Other

Email (We will NEVER distribute or sell your information) if you desire, we will send you an occasional newsetter and a notice of upcoming events. If you wish to have financial records emailed (receipts, etc) please see privacy policies below:

Home Phone:	Cell Number:

Occupation:	Employer:	Employer Phone:

Name of Person who Referred you:

Other family members seen here:	Name/phone number of person/relative not living with you:

PAYMENT POLICY

Person responsible for bill: Is this person a client at Advanced Health Clinic? ❑ Yes ❑ No Cell
Address (if different):

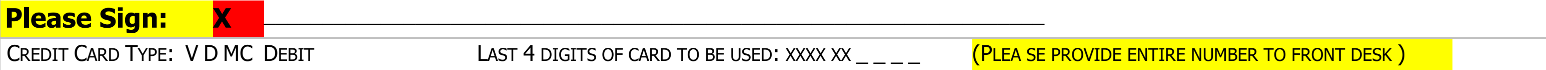
Home Phone (If different): /Work Phone:

______ **(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, 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. You may revoke this authorization by calling (800) 666-5222, ext. 2, to arrange payment for any outstanding checks and service fees due. 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 does not bill insurance nor file insurance claims.

If you will be sending in hair samples, 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 _ _ _ _ (Plea se 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:

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. 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 is available online or at Advanced Health Clinic, LLC.

_____ **(Please Initial**) *I have received a copy* ***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.*

INFORMED CONSENT

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. 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 Advanced Health Clinic, LLC (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. I understand that AHC provides services for Independent Contractors and is exclusively an office-based practice. I recognize they are 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, I MAINTAIN A RELATIONSHIP WITH ONE OR MORE PHYSICIANS QUALIFED TO CARE FOR MEDICAL CONDITION(S). 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 understand that by signing this informed consent I agree to hold harmless, AHC and its employees and/or representatives from all professional and personal liability. I understand AHC is constantly improving; therefore all policies are subject to change (for the better ☺).

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.

Client Name (Please Print) ______________________________ **Signature** ______________________________ **Date** ____________

Parent or Guardian signature if under 18 ____ Date______________________

Witness ____ Date ____________________________

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.

I understand that I am not required to purchase from H & N any 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 understand that supplements are not meant to replace adequate medical care.

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 recommendations made to me by practitioners are simply that, recommendations. Any purchase I make is of my own free will.

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.

Client Name (Please Print) ____________________ **Signature** ____________________ **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 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.

Client Name (Please Print) ____________________ **Signature** ____________________ **Date** __________

Parent or Guardian signature if under 18____________________ Date ____________________

Witness ____________________Date __________

APPLICATION FOR SERVICES

PERSONAL INFORMATION

First Name M.I. Last Name				Today's Date
Street Address City State Zip				Birth date
Home phone (ok to leave msg?)	Cell phone (ok to leave msg?)	Age	E-mail	Sex: M F

List present or previous health problems

List any medications you are currently taking and what they are prescribed for

Spouse/Parent Information if under 18

First name M.I. Last name			Marriage date
Street Address City State Zip			Home phone
Work phone	Birth date	Relationship to you	

List present or previous health problems

Children's Information

Name	Age	Lives with you?	Name	Age	Lives with you?

Other Information (PLEASE COMPLETE THIS SECTION)

List agencies or professionals who have provided you with services in the past and whether you felt they were helpful to you

What do you hope to accomplish by seeking help at this time?

What do you consider to be some of your personal strengths?

Signature	**Signature**

Sarah Carter, LCSW

Sarah Carter, LLC

STATEMENT OF DISCLOSURE

Sarah Carter completed a Bachelor's degree from University of Utah . Additionally, she holds a Master's degree in Social work. Sarah holds certification or has training in multiple therapeutic modalities including EMDR,Yoga Therapy, Dialectic Behavior Therapy and Seeking Safety. Sarah believes that body, mind, and spirit function synergistically as each intricately influences the other. Sarah also believes that we can be empowered and that within each of us we have the power to create changes in our body and mind. She is passionate about teaching clients learn ways that they can release negative emotions and experiences and create a positive future.

Sarah's goal as a mental health counselor is to assist you in doing the following:

- Changing behavior to increase life satisfaction
- Releasing negative patterns and associations in mind and body
- Recognizing the mind body connection and ways to create balance in your mind and body
- Viewing problems from a fresh perspective in order to facilitate change
- Increasing your sense of self & worth by giving you strategies to change negative patterns
- Understanding the mind body connection and how to reduce stress through therapeutic techniques

It is important for you to know that you retain the right to choose your mental health counselor, to discuss your treatment, to request a referral to another counselor or to discontinue counseling at any time. If you don't feel like this is a good fit for you, we, at the Advanced Health Clinic, would like to help you find a fit with another counselor who is right for you.

STATEMENT OF UNDERSTANDING

Confidentiality

Confidentiality will be strictly maintained except for the following circumstances: (1) with your permission and a signed release of information to a particular person or agency. (2) By law, any report of physical, sexual abuse, or neglect of a minor, or abuse of spouse or an elderly person. (3) If I have reason to assume that you may harm yourself or another person. To further protect confidentiality, if I encounter you unexpectedly outside of a session, I may nod or say hello but will not engage in conversation. I use a cell phone so that I am accessible, which cannot be considered 100% secure. For ethical reasons I cannot engage in "friendships" with clients nor see my friends professionally.

Payment for Services

Couples, family therapy and individual counseling sessions are $130 for 45-60 minutes. Additional time will be charged in 15-minute increments. Payments are to be made immediately following each session regardless of insurance coverage. I will provide necessary information for you to bill your insurance company upon request. Be aware that insurance companies may require a mental health diagnosis and additional information. The fee for the initial intake session is $160.

Cancellation of appointments

On occasion, a situation may arise which prevents you from keeping your scheduled appointment. Please notify me *24 hours* in advance of your appointment if you cannot keep it. Except in emergency situations, you will be expected to pay for any sessions that you miss without this advanced notice. If you cannot provide 24 hours advance notice, you have purchased the time as it was reserved for you, and will be billed accordingly.

- **I have received a copy of the statement of disclosure. I have read and understand the information provided.**
- **I have been informed of the terms of confidentiality and agree to them as stated above.**
- **I agree to pay for each session at time of service.**
- **I have read the above information, and understand that I am encouraged to ask questions, and give input regarding the counseling process at any time. If there is anything in this form that I do not understand, it is my responsibility to seek clarification.**

Client Signature: ______________________________ **Date: ____________________**

Parent or Guardian Signature ______________________________ **Date: ____________________**

Provider Signature ______________________________ **Date: ____________________**

Sarah Carter, LCSW for Sarah Carter, LLC

Sarah Carter, LCSW
Sarah Carter, LLC

AUTHORIZATION FOR RELEASE OFCONFIDENTIAL INFORMATION

(I/We)____

do hereby give permission to Sarah Carter, LCSW and Sarah Carter, LLC

Name: ____

Relationship: ____
Address: ____

To mutually exchange all information regarding (my/our) social, emotional, educational, religious, psychological and medical histories, including assessment, backgrounds, opinions, and any other relevant data necessary to assist Sarah Carter, LCSW, and Sarah Carter, LLC in providing continuity of services to (me/us).

(I/We) agree to indemnify and hold harmless all persons and groups named above from any and all liability for claims, actions, damages or suits arising from or relating to the release or exchange of information made pursuant to this Authorization for Release of Confidential Information.

Except as authorized herein, confidential information will not be disclosed without (my/our) consent, except where the law may compel disclosure (1) to inform appropriate persons if there is reason to believe I am in danger of doing serious harm to myself or someone else, or (2) if there is reason to believe that reportable child/spousal or other abuse has occurred.

(I/We) have read the foregoing, understand its content, and agree to these conditions. (I/We) understand that this consent may be revoked at any time, except to the extent that action has been taken in reliance on it, or until (I/We) cancel it by written notice to the agency. In any event this consent expires automatically ninety days after date of signature.

Signature____Date__________________

Signature____Date__________________
Witness____Date__________________

If under 18 years of age, signature of parent or legal guardian.

Signature____Date__________________

FOR CLIENTS CONTINUING SERVICES

A New Authorization for Release of Confidential Information is required is required for clients continuing services beyond ninety days. (I/WE) hereby authorize the above named individuals to mutually exchange information as needed as a condition of (/My/Our) continuity of services. (I/We) agree to the conditions stated in (my/our) original authorization above, and understand that this consent may be revoked at any time, except to the extent that action has already been taken in reliance on it, or until (I/We) cancel it by written notice. In any event this consent expires automatically ninety days after date of signature.

Signature____Date____________

Signature____Date____________

Witness____Date____________

If under 18 years of age, signature of parent or legal guardian.

____Date____________

Sarah Carter, LCSW
Sarah Carter, LLC

Coaching or Counseling Session Preparation Form

Name ________________________ Date ______________

1. How am I right now? How have the past few days been?

2. What benefits do I want from my session today?

3. What have I done related to my previous session since last week?

4. What do I want to be accountable about?

5. What issues, challenges or questions do I want to explore this week?

6. What are the results of last week's homework?

7. What else do I want to bring up?