Connections Counseling Services

Client Information

Name: _____

Referral Source: ◯ Internet Search ◯ Family/Friend ◯ Religious Leader

◯ Other: _____

Age: _____ Date of Birth: _____ Intake Date: _____

Address: _____

_____

_____

Home Phone: _____ Message OK? ◯ Yes ◯ No

Work Phone: _____ Message OK? ◯ Yes ◯ No

Cell Phone: _____ Message OK? ◯ Yes ◯ No

Email: _____

With whom do you live?

Name: _____ Knowledge of therapy? ◯ Yes ◯ No

Message OK? ◯ Yes ◯ No

Name: _____ Knowledge of therapy? ◯ Yes ◯ No

Message OK? ◯ Yes ◯ No

Name: _____ Knowledge of therapy? ◯ Yes ◯ No

Message OK? ◯ Yes ◯ No

Name: _____ Knowledge of therapy? ◯ Yes ◯ No

Message OK? ◯ Yes ◯ No

Name: _____ Knowledge of therapy? ◯ Yes ◯ No

Message OK? ◯ Yes ◯ No

In case of emergency, notify:

Name: _____

Phone: _____ Relationship to patient: _____

Connections Counseling Services

Notice of Privacy Practices

Uses and Disclosures of Health Information

We may use health information about you for treatment (such as sending your records or information to a specialist as part of a referral), to obtain payment for treatment (such as sending billing information to a health insurance plan), for administrative purposes, and to evaluate the quality of care that you receive (such as comparing patient data to improve treatment methods).

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, abuse or neglect reporting, auditing purposes, judicial and administrative proceedings, research studies, funeral arrangements and organ donation, workers' compensation purposes, specialized governmental functions, and emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. We may also initiate a face–to–face communication with you about goods and services related to your care. We may also contact you about appointment reminders or treatment alternatives. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, a notice will be posted in the waiting area. Clients may request a copy of our notice at any time. For information about our privacy practices, contact our administrative staff.

Individual Rights

You have the right to request your health record. The involved therapist will make the determination whether to release all or part of the requested session notes; discussion between the therapist and client may be required to make this decision. If you receive copies, we will charge you $0.50 for each page. If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information, or add the missing information.

You have the right to request your health information be communicated to you in a confidential manner, such as sending mail to an address other than your home. You may request in writing that we not use or disclose your information for treatment, payment, or administrative purposes or to persons involved in your care except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request. Under no circumstance will you be retaliated against for filing a complaint.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practice, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact:

Connections Counseling Services
Chris Hughes, PhD
Clinical Director
667 N 1890 W
Provo, UT 84601
(801) 272–3420

Acknowledgement

By signing below, I acknowledge that I have received the Connections Counseling Services Notice of Privacy Practices and have been offered an opportunity to request restrictions on certain uses and disclosures of my protected health information. Typing my name where indicated constitutes an electronic signature and is legally binding

Client's signature: _____

Signature of parent/guardian
if client is a minor: _____

Date: _____

Connections Counseling Services

Informed Consent and Agreement for Services

Welcome to Connections Counseling Services. This document contains important information and comprises an agreement ("Agreement") between you and Connections Counseling Services, setting forth the terms under which Connections Counseling Services agrees to provide therapy to you. Please read it carefully and initial or sign where required, typing your initials or name where indicated constitutes an electronic signature and is legally binding. We acknowledge the length and complexity of these documents.

EMERGENCIES: Connections Counseling Services does not provide 24–hour emergency care. Please call 911 if there is an emergency.

Initial _____

LENGTH OF SESSIONS AND TREATMENT: Individual therapy sessions typically last 85 minutes, although at certain points in the therapeutic process 55 minute sessions may be appropriate. The length of your sessions will be determined through discussion with your therapist. For information on expected length of treatment, please consult your therapist.

Initial _____

PAYMENT: All therapy sessions will be billed at the rate of $150.00 for an 85-minute session, $100 for a 55-minute session. This may need to change from time to time by written agreement. Payment for sessions is due at the time of each session unless arrangements have been made between the therapist and client.

Initial _____

MISSED APPOINTMENTS AND LATENESS: Appointments broken with less than one full business day's notice will be subject to a full session charge, exceptions may be made at the therapist's discretion.

Initial _____

CONFIDENTIALITY: Statements that are made by a client to a therapist are generally confidential. However, there are some exceptions that may lead to a waiver of the therapist–client privilege and to disclosure of otherwise confidential information. Exceptions vary from state to state and may include, but are not limited to:

1. If you put your mental condition at issue in a lawsuit or criminal proceeding;
2. If you disclose to your therapist your involvement in sexual or physical abuse of a child whether as perpetrator or victim (your therapist may be required to report this to Child Protective Services);
3. If you make a serious threat to harm a specific other person (your therapist is required by law to notify proper authorities);
4. If you threaten to harm yourself (your therapist is required to notify proper authorities);
5. If the therapist is required by a court order or subpoena to disclose your records; and

6. If there is an action that alleges a breach of duties running between therapist and client.

In addition, there may be a limited disclosure if a financial collection action becomes necessary. If the client is a minor, the parent(s) or legal guardian have access to information about their child's treatment and may authorize release of information on their child's behalf. If you want us to share information about you with another person or entity, we will do so after receiving from you a written and signed waiver of confidentiality for that specific person or entity.

Initial _____

STAFF CONSULTATION: Clinical staff of Connections Counseling Services routinely discusses cases on an as–needed basis in order to coordinate efforts and enhance treatment. By signing below, you authorize any and all clinical staff members with whom you work at Connections Counseling Services to share information with one another as necessary.

Signature of client
or parent/guardian: _____

Date: _____

NATURE OF THERAPY: Sometimes the psychotherapeutic process can bring up uncomfortable feelings such as anxiety, sadness, anger, and so on. Therapy may also evoke stressful feelings and temporary life changes that could be difficult to deal with. Please be aware that this is a normal response to dealing with unresolved life experiences. It is your responsibility to inform your therapist if you are beginning to feel overwhelmed or otherwise uncomfortable with the process.

Initial _____

DIRECTION OF TREATMENT: It is important that you feel in control of the direction of your treatment at all times. During the course of therapy, it is possible that your desires and goals may change. If so, or if the advice, counsel, or treatment being offered by your therapist violates your personal convictions or intentions, you agree to notify your therapist at once to re–evaluate the direction of your counseling. If you have any concerns about your treatment, records, or needs that you feel are not being addressed by your therapist, you may contact Connections Counseling Services's Clinical Director, Chris Hughes, PhD, at the main office telephone number, (801) 272–3420.

Initial _____

NO GUARANTEE OF SUCCESS: Because many variables affect the therapeutic process, no particular treatment can be guaranteed to be effective. Therapy requires the active participation of the client, and the client must be truthful with the therapist. Although most clients do experience benefit, they typically find that growth is an ongoing process. Also be aware that therapeutic homework will often be suggested by your therapist. Completion of this homework is considered essential to the success of the therapy. Failure to complete the homework will diminish the likelihood of a successful outcome.

Initial _____

CLIENT RECORDS: By receiving treatment at this office you will be a client of Connections Counseling Services. Your client records belong to Connections Counseling Services, and will remain the property of Connections Counseling Services at both the termination of treatment and the end of a therapist's contract with the clinic.

Initial _____

MEDIATION & ARBITRATION: If a dispute arises out of or relates to this Agreement, the breach thereof, or the treatment or therapy that is the subject of this Agreement, and if the dispute cannot be settled through negotiation, the parties agree first to try in good faith to settle the dispute by mediation administered in Utah, by the American Arbitration Association under its Commercial Mediation Procedures before resorting to arbitration. Any such controversy or claim, which is not settled through negotiation or mediation, shall be settled by arbitration administered in Utah, by the American Arbitration Association, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

Signature of client
or parent/guardian: _____

Date: _____

LIMITATION OF LIABILITY: The parties agree that in the event that any dispute arises from the provision of services pursuant to this Agreement, including but not limited to claims of malpractice, negligence, breach of contract, or any other legal theory, if the client prevails the client shall be entitled to recover no more than $50,000.00 or the total amount of fees paid, whichever amount is greater. It is the parties' intention to fix an amount that is reasonable in the event a dispute arises, with mutual acknowledgement that establishing the actual monetary value of damages in such an action would be inherently subjective and uncertain, and that Connections Counseling Services's willingness to provide the services set forth in this Agreement depends on this agreed limitation to Connections Counseling Services's potential liability arising from providing the services. This clause is to be construed in accordance with Utah law on limitation of liability.

Signature of client
or parent/guardian: _____

Date: _____

GOVERNING LAW: This Agreement and all issues arising out of the relationship and interactions of the parties hereto are to be governed by the laws of the State of Utah. Any disputes over the interpretation or enforcement of this Agreement are to be construed in accordance with Utah law.

Initial _____

OUTSIDE EVENTS: Your therapist may suggest that you participate in conferences, workshops, groups, retreats, trainings, or other events sponsored or organized by entities not affiliated with Connections Counseling Services. Such events are collectively referred to as "Outside Events." You acknowledge and agree that Connections Counseling Services makes no representations, guarantees, or claims about the benefits, risks, or costs of Outside Events, and you agree to hold Connections Counseling Services harmless from liability for psychological or physical injury that may result from your participation in Outside Events.

You acknowledge and agree that Outside Events are not a continuation of your treatment at Connections Counseling Services, are not required for your continued treatment at Connections Counseling Services, that your therapist's suggestion of an Outside Event is not an endorsement of the event by Connections Counseling Services, nor does it imply an affiliation with or endorsement of the organization sponsoring

the event. You acknowledge and agree that Connections Counseling Services staff members may be present at Outside Events, such staff member does not represent, speak for, or act on behalf of Connections Counseling Services during that event, and will not be available to you for therapy during the Outside Event.

Initial _____

CONSULTATIONS USING TELECOMMUNICATIONS TECHNOLOGY: Sessions are generally considered to be most effective when conducted in the form of regularly scheduled, face–to–face sessions. However some clients are unable to find a suitable therapist in their geographical area, or may require visits while traveling, and therefore he/she decides to conduct some sessions via telecommunications technologies. For these reasons, Connections Counseling Services offers visits via telecommunications technologies.

If you will be receiving therapy via telecommunication, you hereby acknowledge that you understand and accept the following as a condition of your participation: consultations via telecommunication may not be as effective as face–to–face sessions; the therapist providing the services is practicing under the jurisdiction of the State of Utah and is not necessarily licensed to practice in the state or country where you are physically located at the time the services are rendered. If this is the case, your sessions with an Connections Counseling Services therapist will be defined as coaching; the therapist will be acting in a life coach capacity, rather than as a therapist. Supplementary, face–to–face therapy or transfer to a local therapist for face–to–face sessions may be necessary if you should experience severe emotional disturbance, such as anxiety, depression, or suicidal thoughts, or if our office deems it appropriate.

Initial _____

SEVERABILITY: If any provision of this Agreement shall be held to be invalid or unenforceable for any reason, the remaining provisions shall continue to be valid and enforceable. If any provision of this Agreement is found to be invalid or unenforceable, but that limiting such provision would allow it to become valid and enforceable, then such provision shall be deemed to be written, construed, and enforced as so limited.

Initial _____

WAIVER OF CONTRACTUAL RIGHT: The failure of either party to enforce any provision of this Agreement shall not be construed as a waiver or limitation of that party's right to subsequently enforce and compel strict compliance with every provision of this Agreement.

Initial _____

AGREEMENT OF CLIENT: I understand this information and agree to be bound by the terms and conditions of this Agreement.

Client's signature: _____

Signature of parent/guardian
if client is a minor: _____

Date: _____

SECOND PARTY AGREEMENT: Should a second party (i.e. a parent, church, or other benefactor) have full or partial financial responsibility in paying for your sessions, please provide his/her information below. All payments by a parent must be made by credit card.

Name(s) of individual(s) responsible for payment (if other than Client): _____

Relationship to Client: _____

Mailing Address: _____

_____

Email Address: _____

Phone Number: _____

Date: _____

CREDIT CARD PAYMENT AGREEMENT: By including your information below, you authorize Connections Counseling Services to charge your credit card account as payment for services.

◯ VISA ◯ MasterCard ◯ Discover ◯ American Express

Card Number Expiration Date: _____

Cardholder's name: _____

Cardholder's billing address: _____

ACH BANK TRANSFER: By including your information below, you authorize Connections Counseling Services to initiate either an electronic debit or to create and process a demand draft against your bank account as payment for services. You acknowledge that the origination of ACH transactions to your account must comply with the provisioning of United States law. Please list your bank information below, and/or provide Connections Counseling Services with a copy of a voided check.

Bank Name: _____

ABA Number: Account Number:

Bank Account Type (check one that applies):

◯ Personal Checking ◯ Personal Savings ◯ Business Checking