Circle of Life Counseling Center

3375 Mayflower Ave, Suite A, Lehi, UT 84043
Phone: 801.331.6775 * Fax: 801.766.2010

Office Use Only:
CLINICIAN: ______________________
IA DATE: ______________________

*CONFIDENTIAL **NEW CLIENT** WELCOME PACKET*
Updated: 3/01/20

First Name:		**Middle**	**Last Name:**	**Preferred Name:**
DOB:	**Mailing Address:**		**City:**	**State:** **Zip:**

Mobile Phone: ___________________________ **Text OK?** Yes No **Voice message OK?** Yes No

Email: ____ Other Phone: __________________ Voice message OK? Yes No

Birth Sex: **[ ]** Male **[ ]** Female **Gender Identity:** _________________

Marital Status: **[ ]** Single **[ ]** Married **[ ]** Divorced **[ ]** Widowed **[ ]** Other

Employment: **[ ]** Employed **[ ]** Full-time Student **[ ]** Part-time Student **[ ]** Unemployed **[ ]** Other

Primary Insurance Information

POLICY INFORMATION		INSURED PARTY -the client is the:
2020 Insurance:		**Relationship**: [ ]**Self** [ ]**Spouse** [ ]**Child** [ ]**Life Partner** [ ]**Other**
Co-Pay: $	**Deductible:** $	**Policy Holder's Name:**
Member ID #:		**Policy Holder's DOB:**
Group #:		**Policy Holder's mailing address:**
Plan Name:		**City:** **State:** **Zip:**

Secondary Insurance Information YES or NO

Secondary POLICY INFORMATION		Secondary INSURED PARTY -the client is the:
2020 Insurance:		**Relationship**: [ ]**Self** [ ]**Spouse** [ ]**Child** [ ]**Life Partner** [ ]**Other**
Co-Pay: $	**Deductible:** $	**Policy Holder's Name:**
Member ID #:		**Policy Holder's DOB:**
Group #:		**Policy Holder's mailing address:**
Plan Name:		**City:** **State:** **Zip:**

Emergency Contact

Name: ____ Relationship to client: ______________________________

Mobile Phone: _______________________________ Other Info: ____

Credit Card Authorization Form

Circle of Life requires a credit card on file before any appointments will be scheduled regardless of your insurance benefits and regardless of Bishop pay or Third-Party pay clients.

Credit Card / Debit Card Information (confidential)

Card Type: **[ ] Visa** **[ ] MasterCard** **[ ] Discover** **[ ] Amex**

Name on the Card: ____
Card Number: ____
Expiration Date: ____________________ **Security Code:** __________________
Card Mailing Address: ____
City: ____________________________ **State:** ________ **Zip:** __________

Email Address: ____

I authorize Circle of Life Counseling Center to use the above payment method as my preferred method of payment for all services. I agree to pay the stated amount for services. I authorize Circle of Life Counseling Center to automatically charge any and all co-pays and/or co-insurance via a credit/debit card on file at the time of service. A $50 fee for no-shows or appointments cancelled without a 24-hour notice may also be charged to the above credit card.

By signing below, I am authorizing *Circle of Life Counseling Center* to use my credit card information to charge my credit card for a scheduled therapy session, in the event that I do not notify the office of my inability to attend a scheduled therapy appointment, do not cancel my appointment at least 24-hours in advance, or if a check is returned for any reason as agreed to in the Appointment and Professional Fees /Payment Arrangement policies stated in the signed Client Agreement and Therapeutic Policies Form that I have reviewed and signed. This card may be charged for scheduled appointments, no-shows, and late cancellations.

Card Holder Signature X___________________________ **Date:** ____________

Notes: ____
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If a Bishop or a Third party is going to pay for any portion of your therapy, a Bishop Authorization Form or Third-Party Authorization Form is required *in addition* to your credit or debit card information, before any services are rendered. Please find these forms on our website or ask for these forms to be emailed to you or pick them up in person before your scheduled appointment.

Part I: Health Insurance

IN-NETWORK

We are 'IN-NETWORK' contracted providers for numerous insurance companies. We will collect co-pays and/or coinsurance according to your plan before your session and we will submit claims on your behalf. However, if we are not familiar with your plan, we will collect our cash-rate fee up front and reimburse you later when and if the insurance pays. If for any reason the insurance does not pay for billed services, you are solely responsible for paying the fees billed.

OUT-OF-NETWORK

We are 'OUT-OF-NETWORK' providers for several insurance companies and we are **NOT** contracted with them. Clients who have an insurance in which we are 'OUT-OF-NETWORK' are required to pay our CASH RATES and the CLIENT is responsible for paying us first and for recovering the insurance reimbursement on their own. Upon request and payment in full, we can provide you with a billing statement that you can provide to your insurance company and other third-party payers.

Special Note: CNIC, CIGNA, VALUE-OPTIONS, BEACON HEALTH and TRICARE are the **only** five 'OUT-OF-NETWORK' insurance companies we will bill. We will collect your co-pay and/or coinsurance and we will submit the Health Insurance Claims for services rendered on your behalf. If for any reason the insurance does not pay for billed services, you are solely responsible for paying the fees billed.

Assignment of Insurance Benefits

The Circle of Life Counseling Center accepts many insurance plans: however, your therapist may or may not be a provider for a managed care company and you will be required to pay for the fees incurred. If you have insurance, we will help you receive maximum benefits. We may contact your insurance company before, during or after your first visit to verify coverage and benefits, therefore we require a copy of your insurance card. We require that you pay deductible and/or estimated co-payments before each session. We file claims as a courtesy to our clients. Insurance is a contract between you and your insurance company. You are responsible for the timely payment of your account. Circle of Life Counseling Center will not carry a balance of over $50.00 on an account. We accept cash, checks and major credit cards.

_________ I authorize payment of insurance benefits otherwise payable to the policy holder, to be paid directly to the Circle of Life Counseling Center for the services described on the health insurance claim form, unless other regulations apply. The undersigned authorizes, whether he/she signs as an agent/guarantor/client, the direct payment to Circle of Life Counseling Center of any insurance or health benefits otherwise payable to or on behalf of the client for treatment of outpatient services, including emergency services, at a rate not to exceed the Circle of Life Counseling Center's regular charges.

_________ It is agreed that payment to the Circle of Life Counseling Center pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations under the policy to the extent of such payment. In consideration services provided to the client, the undersigned hereby gives the Circle of Life Counseling Center an irrevocable assignment to any and all rights the client has in all insurance and health plan benefits payable to the patient or on his/her behalf. The undersigned directs all insurance companies, health plans and attorneys to make payments on behalf of the client directly to Circle of Life Counseling Center.

_________ The undersigned agrees that he/she and/or the client is responsible for charges not covered by this assignment. It is understood and agreed that any conditions precedent to recovery under any insurance or other types of indemnity contracts applicable to the treatment of said client shall be the sole responsibility of the client or guarantor.

Signature on File

_________ The undersigned authorizes, whether he/she signs as an agent/guarantor or client, Circle of Life Counseling Center to put the words "Signature on File" on claim forms submitted for payment to insurance companies. "Signature on File" will be in effect from the time of your first session at Circle of Life Counseling Center and I authorize a copy of this authorization form to be used in place of the original.

Part II: Scheduled Appointments

Your appointment time is reserved especially for you and we do not double book. Each therapy appointment is traditionally 45-60 minutes, unless specially arranged by the therapist. Once an appointment is scheduled, it is your responsibility to keep track of the dates and times of your appointment/s/**.** Regular attendance is recommended to ensure continuity and to enhance the effectiveness of the therapy. If you must cancel or reschedule, a minimum of a 24-hour notice is required.

Late Cancelation / Reschedule Request / No-Show (without a 24-hour notice):

Our scheduling system sends a reminder text to you at least 24-hours before your scheduled appointment. PLEASE RESPOND to this text message by either confirming or cancelling your appointment. It is the client's responsibility to ensure the correct and-up-to date cell number is on file for the client.

_________ **First** LATE CANCELATION / RESCHEDULE REQUEST / NO-SHOW (without a 24-hour notice) will incur a $50.00 fee. This fee must be paid before scheduling or rescheduling another appointment.

_________ **Second** LATE CANCELATION / RESCHEDULE REQUEST /NO-SHOW (without a 24-hour notice) or if two (2) appointments are canceled within a 30-day period, the client will be removed from the schedule and $50.00 fee must be paid before scheduling or rescheduling another appointment.

To get back on the schedule, client must pay 'Late Cancelation'/ 'No-Show' fee/s accrued, and client will only be able to schedule one appointment at a time for 30 days. Cancelations and Reschedule Requests must be made at least 24-hours before your scheduled appointment to avoid the $50.00 'Late Cancellation' fee.

After two 'Late Cancelations' and/or one 'No-Show' and before a client can get back on the schedule, the client will be required bring their account current and in addition will be required to PRE-PAY for your next session at the CASH-RATE, regardless of your insurance.

Insurance companies do not pay for LATE CANCELATION / RESCHEDULE REQUEST / NO-SHOW and the Circle of Life Counseling Center strictly adheres to this policy. We require a current credit card to be on file for this purpose and we reserve the right to terminate treatment with a client for failure to show up to two or more appointments. In cases of emergencies and/or hospitalizations, please discuss concerns with your therapist or the office manager, as reducing/waiving this fee is at the discretion of the individual therapist and/or office manager.

Part III: Binding Arbitration Agreement

The arbitration agreement requires that you submit all future claims to arbitration instead of having the claim heard in court by a judge or jury. This agreement is to minimize the cost of any disputes that may arise from your contact with The Circle of Life Counseling Center, its mental health providers, staff and affiliates. You may decline to sign the arbitration agreement and still receive mental health care from The Circle of Life Counseling Center and its mental health providers. Simply write "I decline the binding arbitration agreement" above your signature below.

Part IV: Authorization and Consent to Treat

Your Signature below indicates that you have read this agreement and consent to treatment by our providers under these terms and conditions. This agreement also serves as an acknowledgement that you understand Utah HIPAA guidelines. If you would like a copy of this agreement, and/or a copy of the current 'UTAH HIPAA NOTICE FORM' please ask the receptionist.

1. ***I agree by entering into therapy with Circle of Life Counseling Center, I will pay the full fee at each session. If I am late to a session, the length of the session may be shortened, and I agree to pay for a full session*.**

2. ***A 24-hour notice is required to reschedule or to cancel a scheduled session. If I do not meet this requirement, I agree to pay a $50.00 No-Show / Late Cancellation fee. I understand that this will be my responsibility, not that of a third-party payer.***

3. ***I agree that I will keep a current credit card on file.***

4. ***I understand that Circle of Life Counseling Center has the right to seek legal recourse to recoup any unpaid balance. In pursuing these measures, the therapist will only disclose biographical information and the amount owed, in order to ensure confidentiality.***

5. ***I understand that at the time of service I must pay for my sessions and/or co-pay using a major credit card, personal check or cash.***

Thank you for reviewing this information and please feel free to discuss any of this information with your Therapist or any Circle of Life Staff Member.

My signature on this 'Authorization and Consent to Treat' indicates I have read and understood the conditions of the services outlined. I have had the opportunity to clarify any questions and agree to the terms described above before receiving services. I have been offered and/or provided with a copy of this disclosure statement.

Adult Client Signature: X____ Date: ________________

If a minor:
Minor Client Print: ____

Guarantor Signature: X____ Date: _______________

CLIENT AGREEMENT, THERAPEUTIC POLICIES, HIPPAA
CIRCLE OF LIFE COUNSELING CENTER

I, _______________________________________ have received on __________________________
PRINT GUARANTOR NAME DATE

the Client Agreement and Therapeutic Policies for Circle of Life Counseling Center.

Client Agreement and Therapeutic Policy supersedes any other signed consent /agreement. This document indicates you have read, have understood and have asked questions regarding the Client Agreement and Therapeutic Policies which cover in detail the following:

Page 2: Credit/Debit Card Authorization Authorization to charge card on file. Third-Party Payer. **Part I: Health Insurance** IN-NETWORK / OUT-OF-NETWORK. Assignment of Insurance Benefits. Signature on File. **Part II: Scheduled Appointments** 'Late Cancellation' 'Late Reschedule' 'No-Show' Policy: Fee: $50.00/per occurrence. **Part III: Binding Arbitration Agreement** **Part IV: Authorization and Consent** **Part V: Client Agreement and Therapeutic Policies**	**Part VI: Therapist Information and the Therapeutic Process** **Part VII: Additional Policies / Procedures and HIPAA** **Part VIII: Client(s) Rights / HIPAA** Limits of Confidentiality. Minors & Parents. **Part IX: Professional Records / HIPAA** **Part X: Office Policies** Professional Fees: CASH-PAY and BISHOP-PAY RATES: $180 / $155 / $125 / $155 / $185 / $45

Pages 1-6 will be scanned into the client's EHR indicating they have received detailed information regarding all of the above and have agreed to all parts.

Client Signature: _______________________________________ Date: ______________________

Guarantor Signature: _______________________________________ Date: ______________________

Staff Signature: ____ Date: ______________________

PAGES 1-6 FOR OFFICE USE and SCANNED INTO EHR (ELECTRONIC HEALTH RECORD)
PAGES 7-12 FOR CLIENT
PAGES 13-15 FOR INITIAL ASSESSMENT THERAPIST

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Section
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Part V: Client Agreement and Therapeutic Policies

Welcome to Circle of Life Counseling Center! The next several pages contain our office policies/procedure including HIPAA, authorization and consent to treat. If you have any questions or concerns, your therapist or the receptionist will gladly discuss them with you. I consent to psychological treatment and psychological testing as necessary and desirable as the named client.

I understand that regardless of insurance coverage, I will provide a credit or debit card to be kept on file to use for charges incurred. I understand insurance benefits may or may not cover some types of treatment. I understand I am responsible for all charges for treatment, no-show or late cancellation fees, or services including additional legal and collection fees required as a result of non-payment. I agree to pay for treatment or services in full at the time of service. Circle of Life Counseling Center will not carry a balance over $50.00 on any account.

I understand that if insurance is billed, my insurance company may ask my clinician to provide certain information obtained during my session or treatment (mostly common diagnosis, treatment plans, or treatment methods, though it can be more involved in some instances). I authorize Circle of Life Counseling Center to release any medical or other information necessary to process claims.

I agree to notify this office immediately of changes in my insurance coverage. If not, I agree to be responsible for fees associated with non-authorized services. I also agree to notify this office of changes in addresses, employment, etc.

This agreement is intended to provide clients with important information regarding our professional services & business policies. This consent form will provide a clear framework for our work together & will facilitate the therapeutic relationship. Any questions or concerns regarding the contents of this agreement should be discussed with your Therapist / Circle of Life Staff prior to signing it.

Part VI: Therapist Information and the Therapeutic Process

Professional Orientation:

We provide individual psychological therapy and psychological testing for adults, adolescents, and children over the age of 12. We also provide Marriage/Couples Therapy, Family Therapy, Pre-Marital Therapy, Group Therapy, and Life Coaching. Depression, Anxiety, Post-Traumatic Stress Disorder, self-mutilation, addictions, behavioral issues, building, relationship improvements and Psychological Testing, are available in our practice. Non-identifying information may be used for Psychological Research.

The Circle of Life Counseling Center's scope of expertise does **NOT** include: Play Therapy, Treatment for Criminal or Violent Offenders, Juvenile Sex Offenders, Adult Sex Offenders, any Court ordered Treatment, Intensive Outpatient Treatment or those who in our professional assessment require a higher level of care and/or would be better served elsewhere– We reserve the right to refuse treatment for any reason.

Each therapist who practices at the Circle of Life Counseling Center hold one or more master's degrees and is either a psychologist, A-CMHC, CMHC, LMFT, A-MFT, CSW or LCSW in the State of Utah.

Benefits and Risks of Therapy:

Psychotherapy is a process in which you and your therapist discuss a variety of issues, events and experiences for the purpose of creating positive change so you can experience your life more fully. Participating in therapy may result in a number of benefits to you, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. The issues presented by you may result in unintended outcomes, including changes in personal relationships.
During the therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times but may also be slow and frustrating. Please address any concerns you have regarding your progress in a therapy session with your therapist.

Part VII: Additional Policies and Procedures and HIPAA

You should be aware that your therapist may practice with other mental health professionals and employs administrative staff and in most cases, there is a need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All mental health professionals are bound by the same rules of confidentiality. All staff members have been instructed about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member. *(UTAH HIPAA NOTICE FORM)*
If a client threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. There are some situations where we are permitted or required to disclose information without either your consent or authorization. *(UTAH HIPAA NOTICE FORM)*

If you are involved in a court preceding and a request is made for information concerning our professional services, such information is protected by the therapist -patient privilege law, we cannot provide any information without your written authorization, or a court order. If you are involved in, or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information. (UTAH HIPAA NOTICE FORM)

If a government agency is requesting the information for health oversight activities, we may be required to provide it to them. If a client files a complaint/lawsuit against us, we may disclose information from this client's record relevant to the complaint. *(UTAH HIPAA NOTICE FORM)*

If a client files a worker's compensation claim, and we are providing treatment related to the claim, we must, upon appropriate request, furnish copies of all medical reports and bills. There are some situations in which we are legally obligated to take actions, if we believe it necessary to protect someone from harm; in these rare cases, we may have to reveal some information about a client's treatment. These situations are unusual in our practice. *(UTAH HIPAA NOTICE FORM)*

If your therapist has reason to believe that a child, a disabled adult or elder person has been abused the law requires that a report be filed with appropriate agency, including but not limited to local law enforcement and/or DCFS. Once such a report is filed, we may be required to provide additional information. If your therapist has reasonable cause to believe that has been abused, it is required to be reported to the. Once such a report is filed, we may be required to provide additional information. *(UTAH HIPAA NOTICE FORM)*

If it is determined a client presents a serious danger of violence to himself/herself or another, we may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the client. If such a situation arises, your therapist will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to what is necessary. Please feel free to discuss and concerns or questions you may have about confidentiality. *(UTAH HIPAA NOTICE FORM)*

The undersigned agrees whether he/she signs as an agent/guarantor or client that to the extent necessary to determine liability for payment and to obtain reimbursement. Circle of Life Counseling Center may disclose portions of the client's records, including his/her treatment records to any person or corporation which is or may be liable for all or any portion of the Circle of Life Counseling Center's charges including, but not limited to, insurance companies, health care services plans or Worker's Compensation carriers. *(UTAH HIPAA NOTICE FORM)*

Communication with Your Therapist Outside of a Scheduled Appointment via E-Mail, Cell Phones, Texting, Computers and Faxes:

Telephone Calls
Please know that every call is important to us and we do our best to answer each call. If we are not able to answer your call immediately, please leave a voicemail or message with your name, number, and nature of the call, and we will return your call within the next business day. If you have an emergency or are in crisis, please call 911 or a crisis hotline:

Crisis Line of Utah County 24 hours / 7 days (801) 226-4433
Crisis Line of Salt Lake County 24 hours / 7 days (801) 261-1442

To ensure the safety and professional boundaries of the Therapeutic relationship between Client and Therapist:

1. Texting between Client and Therapist is **strictly prohibited**.
2. Chatroom and Blog interactions between Client and Therapist are **strictly prohibited**.

3. Social Media interactions between Client and Therapist are **strictly prohibited**. Please do not 'friend request' any therapist at the Circle of Life Counseling Center for they are REQUIRED to DENY any and ALL such requests unless such a request is made through a Therapist's Professional Page.
4. Unscheduled Phone Calls are **prohibited**.
5. Emailing between Client and Therapist is **prohibited**, without written agreement outlining the parameters of such emails.

It is very important to be aware that computers, E-mail, fax and cell phone communication can be relatively easily accessed by unauthorized people and, hence, can compromise the privacy and confidentiality of such communication. Although we only use computers that are equipped with a firewall, a virus protection and a password, E-mails are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Additionally, the emails sent by Circle of Life Therapists are not encrypted and Emails as well as faxes can easily be sent erroneously to the wrong address or recipient.

Part VIII: Client(s) Rights

1. You have the right to ask questions about any procedures used during therapy, and have your therapist explain his/her approach and methods to you.
2. You have the right to decide not to receive therapeutic assistance from us; if you wish, we will provide you with some names of other qualified professionals whose services you might prefer.
3. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those *already* accrued. We ask you have a discussion with your therapist before you make such a decision.
4. You have the right to expect that your therapist will maintain professional and ethical boundaries by not entering into other personal, financial, online, or professional relationships with you, all of which would greatly compromise the therapeutic relationship.
5. Therapy involves a partnership between therapist and client. Your therapist will contribute knowledge, skills and a willingness to do their best, while you as a client must adhere to the boundaries set by the therapist, comply with the treatment plan, therapeutic interventions and commit to doing *your* best.
6. One of the most important client rights involve confidentiality: within the limits of the law, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. (See 'Limits of Confidentiality')
7. Your therapist is legally prohibited from revealing to another person that you are in therapy nor can he/she reveal what you have said in any way that identifies you without your written permission. However, in the following instances, your right to confidentiality must be set aside as required by law or my professional standards.

Limits of Confidentiality:

a) Instances of actual or suspected physical or sexual abuse, emotional cruelty, or neglect of a child or an elder or dependent adult must be reported to the appropriate protective services.

b) If I have a reason to believe that a client poses an unavoidable and imminent danger of violence to another person, your therapist may warn the intended victim and notify the proper authorities.

c) If you, as a client, reveal a serious intent to harm yourself, your therapist is ethically bound to do what he/she can do to help maintain your safety, which may involve notifying others who may be of assistance.

d) If a judge orders your therapist's testimony or, in the context of a legal proceeding, you raise your own psychological state as an issue, your therapist may be required to release your confidential information to the court.

In all of the above cases, it is incumbent upon your therapist to release only that information necessary to appropriately carry out his/her responsibilities. Your confidentiality still remains an *ethical priority*.

Minors & Parents:

Clients under 18 years of age who are not emancipated, both minor and parents should be aware that the law allows parents to examine their minor's treatment records unless we believe that doing so would endanger the minor or we (minor, therapist, and parents) agree to do otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, at times, we will request agreements from parents that they consent to give up their access to their minor's records. If the parent agrees, during treatment we will provide them only with general information about the progress of the minor's treatment and his/her attendance at scheduled sessions. Any other communication will require the minor's authorization, unless we feel that the child is in danger or is a danger to someone else. If that is the case, the therapist will notify the parents of their concern. Before giving parents any information, your therapist will discuss matters with the minor, if possible, and do their best to handle any of their objections.

Part IX: Professional Records / HIPAA

1. Each therapist at the Circle of Life Counseling keeps a set of professional records, providing pertinent information regarding the contents of the session. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. Your therapist may take notes regarding treatment during the session called “psychotherapy notes”. These “psychotherapy notes” are given a greater degree of protection than your general PHI (protected health information) and are kept separate from your medical record. In essence these notes are considered the property of the therapist NOT the client.
2. Your “psychotherapy notes” cannot be sent to anyone else, including insurance companies without your expressed written consent. Insurance companies cannot require this as a condition of coverage nor penalize you in any way for your refusal to provide it. (UTAH HIPAA NOTICE FORM)
3. Professional records, providing pertinent information regarding the contents of the session including the “psychotherapy notes” constitute our clinical and business records, which by law, we are required to maintain. Should you request a copy of these records, such a request must be made in writing and in most situations, you will need to schedule a time with your therapist, appear in person and pay for the session before we are able to compile, consolidate, give or send these records. We reserve the right under Utah law, to provide you with a treatment summary in lieu of actual records. We also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. If these records are used in any type of court proceedings, please see: Subpoena/Testimony/Witness on the next page.
4. If your therapist refuses your request for access to your records, you have a "right of review" (this does not apply to information provided confidentially by people other than you), which your therapist will discuss with you upon request.
5. If you require paperwork to be filled out on your behalf, such as information to support Disability, FMLA, etc., you must schedule an appointment with your therapist. Your therapist will not fill out paperwork on your behalf without your presence. Professional records requested by Disability or any other third party will require you to schedule a one-hour appointment with your therapist, appear in person and pay the cash rate **(one-hour minimum charge)** before we will compile, consolidate, give or send these records.
6. We will maintain client’s records for 5-7 years following termination of therapy. After 7 years, your records may be destroyed in a manner that preserves your confidentiality.

SUBPOENA/TESTIMONY/WITNESS

CLIENTS ARE DISCOURAGED FROM THE FOLLOWING:

1. Having a Circle of Life Therapist/Staff subpoenaed or be a witness.
2. Asking a Circle of Life Therapist/Staff to supply verbal or written testimony in any type of court proceeding, litigation, suit, mediation, or disposition.
3. Asking a Circle of Life Therapist/Staff to write a letter for any type of court proceeding, litigation, suit, mediation, or disposition.
4. Asking a Circle of Life Therapist/Staff to participate, in any way, in any type of court proceeding, litigation, suit, mediation, or disposition.

If any legal action occurs in which a Circle of Life Therapist/Staff is requested or subpoenaed to provide written documentation or verbal testimony, in any type of court proceeding, litigation, suit, mediation, or disposition including

but not limited to divorce, custody, character witness, criminal cases, mental health status, personal injury and car accidents, you will be responsible to pay Circle of Life Counseling Center a **$1500.00 retainer** immediately and directly before any such written or verbal information is consider. In addition to the $1500.00 retainer, the following additional fees will immediately be in effect:

1. **The minimum charge for a court appearance: $1500 per day. The retainer of $1500 is due in advance.**
2. **Records Preparation: $250/hr. (one-hour minimum charge)**
3. **Phone calls: $250/hr. (one-hour minimum charge)**
4. **Depositions: $250/hr. (one-hour minimum charge)**
5. **Time required giving testimony: $250/hour (one-hour minimum charge)**
6. **Mileage: $0.40/mile**
7. **Writing any letter: $250/hour (one-hour minimum charge)**
8. **All attorney fees and costs incurred by the Circle of Life Therapist/Staff as a result of the legal action.**
9. **If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice, there will be an additional $250 "express" charge.**
10. **If the case is reset with less than 72 business hours' notice, then the client will be charged $500 (in addition to the retainer of $1500).**
11. **The $1500 fee is NOT negotiable nor is it reimbursable by a Third-Party Payer and is therefore the full legal responsibility of the client and/or the client's parent or legal guardian.**

Also, be aware that even though you are responsible for the above fees, it does not mean that a Circle of Life Therapist/Staff's testimony will be in your favor. Your therapist can only testify to the facts of the case and to their professional opinion.

Part X: Office Policies

Professional Fees:

Co-Pays, Co-Insurance, Service Fees and any outstanding balances are due before your therapy session begins. We ask that your account be kept current and payments be made at the beginning of each session unless we have obtained permission to bill an *LDS Bishop* on your behalf. We accept cash, check, Visa or MasterCard. If your check is returned, you will be responsible to pay the original amount due plus a $25 processing fee. We will not bill non-custodial parents or anyone else for 'their' half or 'their' portion for services; this is something you must coordinate on your own.

The Circle of Life Counseling Center is unable to carry a balance in excess of $50 00. Should the fees for two or more sessions not be paid, or there are fees owing, no future sessions will be scheduled until the balance is paid and/or payment arrangements have been made with the billing person. At the conclusions of treatment, all outstanding fees must be paid upon termination.

The undersigned agrees whether he/she signs as an agent/guarantor or client that in consideration of the services rendered to the client, he/she hereby individually obligates himself/herself to pay the account of the Circle of Life Counseling Center, including any late charges, in accordance with the regular rates and terms of the Circle of Life Counseling Center.

If an account is more than 90 days overdue, a collection agency will become necessary and your signature on this document indicates your agreement to pay the amount overdue as a collection fee in addition to all legal fees connected to the collection, with or without suit, including attorney's fees and court costs. All delinquent accounts, 30 days past the due date, shall bear interest at the legal rate. In general, it is important to discuss with your therapist any issues that arise in connection with your financial arrangements, so that they do not hinder the therapeutic relationship.

RATES for CASH-PAY and BISHOP-PAY for all Circle of Life therapists:

Billing Code: 10900	**Billing Code: 10901**	**Billing Code: 10902**	**Billing Code: 10903**	**Billing Code: 10904**	**Billing Code: 10905**
Couple/Family Initial Assessment **$180.00** 75-90 Min	Individual Initial Assessment **$155.00** 75-90 Min	Individual Session **$125.00** 60 Min	Couple/Family Session **$155.00** 60 Min	Crisis Session **$185.00** 60 Min	15 Min Add-On to Session **$45.00** 15 Min

Pages 13-15 MUST BE FILLED OUT BY THE PERSON BEING SEEN

Client's History for Clinical Purposes

(please print legibly and fill out completely)

Client Information

Client Name: ______________________________ **Page 13**

DOB: ______________________ Gender: [ ] Male [ ] Female [ ] Other

Email: ______________________ Work Phone: ______________________

Mobile Phone: ______________________ Home Phone: ______________________

Person or Agency who referred you: ______________________

Have you ever been court ordered to complete mental health evaluation or treatment? ______________________

____

Have you ever been court ordered to complete anger management, or substance abuse? ______________________

____

Have you ever been under any court jurisdiction? ______________________

Are you currently under any court jurisdiction? ______________________

____

FAMILY

Place of Birth: ______________________ Childhood Issues? ______________________

____

How many people are currently in your household? __________ Where do you fit in? ______________________

Describe your family dynamics: ______________________

____

____

____

____

Describe relationship with your **mother** and any significant issues whether good or bad:

____

____

____

Describe relationship with your **father** and any significant problems issues whether good or bad:

____

____

____

Marital Status: [ ] Minor N/A [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Describe your feelings about your current status (if Minor N/A):

____

____

____

Other Family or Relationship challenges / difficulties? ____

____

____

____

Medical History

Illness/Accident: ____ Age: ____________________

Describe: ____

____

____

Treatment/Results: ____

Illness/Accident: ____ Age: ____________________

Describe: ____

____

____

Treatment/Results: ____

Family Physician Name: ______________________________________ Phone Number: ___________________________

Current Medications & dosages: ____

____

Mental Health History

Prior mental Health Treatment: **[ ]** Yes **[ ]** No If Yes, for what issues ____

____

____

____

If Yes, for how long: _____________________ If Yes, what was the diagnosis/s/: ________________________________

If Yes, what were the treatment methods: ____

Was prior mental health treatment helpful? **[ ]** Yes **[ ]** No Why or why not? _____________________________________

____

____

____

Name of Therapist: ____________________________________ Location- City and State: ____________________________

Inpatient treatment or hospitalizations: **[ ]** Yes **[ ]** No

If yes, what age: _______________ Name of Treatment Center or Hospital: ____

Reason/s/ for treatment or hospitalization: ____

____

____

____

Trauma: ____ Age: ______________________

Describe: ____

____

Trauma: ____ Age: ______________________

Describe: ____

____

Describe current motivation for seeking mental health services: ______________________________________

____

____

____

Describe desired outcome for mental health services: ____

____

____

____

Describe your spiritual orientation and participation in your home:

While Growing up: ____

____

Currently: ____

____

Would you like prayer or meditation to be a part of your treatment? [ ] Yes [ ] No

____

Other Problems, Issues and/or Concerns to be addressed:

1. ____

____

____

2. ____

____

____

3. ____

____

Is there any other information you would like your therapist to be aware of:

____

____

____

The above information and statements are true and correct to the best of my knowledge:

Signature X____ Date: ________________________________