Associated Psychotherapists

Client Information

Identifying Information

Full Name: _____Today's Date: _____

Date of Birth: _____/_____/_____ Age: _____ Social Security Number: _____-____-_____ Gender: □ F □ M

Marital Status: M S D Sep W Spouse's Name:_____

Employment Status: □ Employed □ Full-Time Student □ Part-Time Student □ Other Employer:_____

Address and Contact Information

Address: _____

Street Apt# City State Zip

Financial Responsible Party: _____

Responsible Party Address:_____

Street Apt# City State Zip

Phone and Email

Home Phone: (____) ____-_____ Cell Phone: (____) ____-_____ Email: _____

Appointment Reminders By: □ Phone Call □ Text Message □ Email

Additional Information

Family Names and Ages: _____

How did you hear about us?: _____ Have you received therapy before? Y N Name of Therapist: _____

Current Medications: _____ Physician: _____

Reason for seeking therapy: _____

What do you hope to gain from therapy?: _____

Primary Insurance Information

Primary Insurance Company: _____ Phone: (____) ____-_____

Authorization #: _____

Insurance ID #: _____ Insurance Group #: _____ Effective Date: ____/____/_____

Insured Person Information

Client Relationship To The Responsible Party: □ Self □ Spouse □ Child □ Other _____

Full Name: _____ Gender: □ F □ M Date of Birth: ____/____/_____ SS#: ____-___-_____

Address: _____

Street Apt# City State Zip

Home Phone #: (____) _____-_____ Work Phone #: (____) _____-_____

Insured Person's Employer: _____ City: _____

Secondary Insurance Information

Secondary Insurance Company: _____ Phone: (____) ____-_____

Authorization #: _____

Insurance ID #: _____ Insurance Group #: _____ Effective Date: ____/____/_____

Other Insured Person Information

Client Relationship To The Responsible Party: □ Self □ Spouse □ Child □ Other _____

Full Name: _____ Gender: □ F □ M Date of Birth: ____/____/_____ SS#: ____-___-_____

Address: _____

Street Apt# City State

Zip

Home Phone #: (____) _____-_____ Work Phone #: (____) _____-_____

Insured Person's Employer: _____ City: _____

Associated Psychotherapists

John C. Christensen, EdD. LMFT ● John W. Arrington LMFT ● Jason J. Williams LMFT
Aaron F. Gardner LCMHC ● Cyndi Tangren LCSW
120 North Main
Brigham City, UT 84302
brighamtherapy.com

Informed Consent Notice
Fee and Payment Agreement

Welcome to our practice. Our goal is to provide you with quality mental health care. Your informed participation and understanding of payment arrangements are essential to our effort to help you, as well as to your effort to benefit from our time together. The following describes our agreement regarding the services that we will provide you and the fees that our office charges for our time and services.

Privacy & Confidentiality
The law protects the privacy of all communications between a patient and a mental health professional. In most situations, we can only release information about your treatment to others if you sign a written Authorization form.

Below are situations in which we are legally obligated to take actions, and make reports to state or law enforcement agencies and we may have to reveal some information about a patient's treatment.

- If there is reason to believe that a child has been or is likely to be abused or exploited.
- If there is reason to believe that any vulnerable adult has been the subject of abuse, neglect, abandonment or exploitation.
- If a patient 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.
- If a patient communicates an actual threat of physical violence against an identifiable victim, We are required to take protective actions. These actions may include notifying the potential victim and contacting the police.

If you become involved in legal proceedings in which your mental health is an issue – for example, a custody dispute or an injury lawsuit in which you claim compensation for emotional pain and suffering – then the court or the lawyers may insist upon, and may obtain your information from us. Similarly, you would lose the protection of your privilege if you file a complaint against us with the state licensing board. By your signature below you authorize our office to designate an appropriate custodian to assume responsibility for your record in the event of your counselor's death or disability. Your case may be staffed with other mental health professionals who are bound by the same laws relating to confidentiality.

The financial part of our relationship also imposes some confidentiality limits. If you are using insurance or another third party payer, our office must share certain information with them, including (but not limited to) your diagnosis and the dates of your visits. If there is a managed care company, they may require us to provide additional information, such as your symptoms and progress. By your signature below, you authorize our office to provide information to your insurance and managed care companies, or other third party payers to the extent necessary for them to pay for your services.

Privacy Practices Policy
Our privacy practices policy is available to you if you would like a copy.

Minors & Parents
Patients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records unless such access is likely to injure the child, or we agree otherwise. Since parental involvement in therapy is important as well as privacy of counseling sessions, before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have. Parents will be notified if the child makes any threat to harm themselves or others.

Mental Health Services
Psychotherapy varies depending on the personalities of the mental health professional and patient, and the particular problems you are experiencing. There are many different methods that may be used to deal with the problems that you hope to address. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. It is also recommended that if you have not had a physical examination that you do so in order to identify or rule out medical conditions that may be contributing to your mental health issues.

You should know that counseling is not always easy. You may find yourself having to discuss very personal information. You could find those conversations difficult and embarrassing, and you might be very anxious during and after such conversations. As you learn more about yourself, you might encounter increased conflict with friends, co-workers, and

family members. It is possible that you might become somewhat depressed. Counseling is intended to alleviate those problems, but sometimes at first, as you get to the root of some things, you may feel them even more acutely than in the past. We may also ask you to do some things that might, at first, make you feel uncomfortable or awkward. Sometimes counseling requires trying new ways of doing things. You will always be free to move at your own pace. We will work with you to make changes, but we cannot promise anything about the results you will obtain. Your outcome will depend on many things.

Our first session will involve an evaluation of your needs. You and your therapist can decide together if he/she is the best person to provide the services you need in order to meet your treatment goals. If we believe that your problem requires knowledge that we do not have, we may refer you for a consultation with someone with specific training or experience. We will discuss any such referral with you before we act.

Appointments
A therapy appointment is 55 to 60 minutes. Frequency of sessions will depend on your treatment needs – typically weekly or every other week. **Once an appointment hour is scheduled, if you do not provide 24 hours advance notice of cancellation or do not show up for a scheduled appointment you will be charged a late cancellation or no show fee of $50. It is important to note that insurance companies and other third party reimbursement sources do not provide reimbursement for cancelled sessions. You will be responsible for payment of such sessions.**

Professional Fees & Insurance Reimbursement
Our fees depend on the services provided. If you have insurance coverage, the amount you pay may vary depending on your coverage and our contract with your insurance company. You, not your insurance company, are responsible for full payment of fees. If, for any reason your insurance company does not pay it will be your responsibility. If 90 days lapse without receiving payment from your insurance company you will be asked to pay in full for services rendered to that point in time and at the time of any additional services. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator.

The initial therapy-session hour is $150.00. Subsequent therapy-session hours are $135.00. We charge $135.00 per hour for other professional services you may need, though we may break down the hourly cost if we work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records, forms, or treatment summaries, and the time spent performing any other service you may request of us.

If you become involved in legal proceedings that require our participation, you will be expected to pay for all professional time, including preparation and transportation costs, even if called to testify by another party. We charge $150.00 per hour for preparation and attendance at any legal proceeding.

Billing And Payments
Fees and copayments will be due and payable at the time of service. Payment for other professional services are payable in advance of such services or by agreement between us. Reports will not be released until accounts are paid in full.

In cases where there is a shared responsibility in payment of medical expenses between divorced parents, the parent presenting the child for treatment will be responsible for full payment of insurance copayments or cost of treatment and seeking reimbursement from the other party on their own.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require disclosure of otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, the costs will be included in the claim.

- I agree to pay all attorneys' fees, court costs, filing fees, including charges or commissions that may be assessed to me by any collection agency retained to pursue this matter, and an additional 50% of the principal balance owing applied to the account before it is turned over to a collection agency.
- I further agree to pay interest on overdue balances at the rate of 1½ % per month (18% per year) and to pay a service charge of $25.00 for every returned check in addition to any collection fees. *I further contract and promise that this provider is guaranteed the legal position of first claim to be paid and satisfied in the event of any competing claims.*

Contacting Us
Our office staff is usually available Monday – Friday from 9:00AM – 5:30 PM. Our therapists are often not immediately available by telephone. When our office staff is unavailable, you may leave a message. You will also have the option to be directed to the therapist on call if it is an urgent matter. In emergencies, if you are unable to reach us and feel that you need immediate assistance go to your nearest emergency room or call 911. If your therapist is unavailable another therapist will take emergency calls.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS THE INFORMED CONSENT NOTICE AND FEE AND PAYMENT AGREEMENT AND AGREE TO ITS TERMS.

Print Name of Patient

Signature of Patient

Date

Print Name of Parent, Guardian, or Personal Representative

Signature of Parent, Guardian, or Personal Representative

Date

If a personal representative of the patient signs the Agreement, a description of such representative's authority to act for the patient must be provided.