JORDAN WEST FAMILY COUNSELING SERVICE AGREEMENT

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex ☐Male ☐Female Age _____ Birth date _____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Patient Employed By _____ Occupation _____

Home Phone _____ Work/Mobile phone _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone _____

RESPONSIBLE PARTY

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birth date _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

PRIMARY INSURANCE

Subscriber Name _____ Relation to Patient _____ Birth date_____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Ins. ID No. _____

Names of other dependents covered under this plan _____

Is patient covered by additional insurance? ☐ Yes ☐ No If yes, is the policy listed above primary? _____

Employee Assistance Program (EAP)

Is patient covered by an EAP? ☐ Yes ☐ No If yes, what is the EAP Company? _____Phone #_____

Address_____ City_____ State _____ Zip _____ Authorization Number _____

Other Payment Source

Clergy? ☐ Yes ☐ No If yes, Clergy name _____ Phone #_____

Address _____ City_____ State_____ Zip_____

Other than listed above? ☐ Yes ☐ No If yes, source name_____ Phone #_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company

and assign directly to my provider all insurance benefits otherwise payable to me for services rendered. I understand that I am ultimately responsible for all charges accumulated. I hereby authorize Jordan West Family Counseling to release all information necessary to secure the payment of benefits, and authorize the use of this signature on all insurance submissions. I give permission for treatment of myself/my dependent to my assigned provider.

_____ _____ _____
Responsible Party Signature Relationship Date

Staff Initials_____
Chart Number_____

Patient Financial and Fee Agreement

Your insurance will be billed standard rates based upon the CPT (current procedural terminology) code. You will be responsible for co-pays, co-insurance, late cancelation, missed appointment fees or deductibles as directed by your insurance company at the time of service.

An appointment is a reservation for time with a counselor. Out of courtesy and respect for your counselor please contact Jordan West Family Counseling if you need to cancel an appointment. If an appointment is missed, without notifying Jordan West Family Counseling, a fee of **$50.00** will be assessed. If an appointment is cancelled less than 24 hour prior to the appointment a fee of **$50.00** will be assessed.

Due to insurance carriers' tardiness in regards to service claims submitted by providers, please read the following information:

- If your insurance company does not respond in a timely fashion a "Statement" will be released to you. Upon receipt of the "Statement" we suggest that you contact your insurance carrier and request that they process your claim.
- Should you receive any correspondence from your insurance company in regards to your services in this office, you must respond to that correspondence immediately, in order to have the claim processed and paid.
- Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay a fixed allowance for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance at the time of service.
- Jordan West Family Counseling will only bill the Primary Insurance. You will need to bill your Secondary Insurance. Documentation can be provided if it is required. You will be required to pay any co-payment or co-insurance at the time of service. Secondary insurance is not a substitute for co-payments/co-insurance.

Patient's or authorized person's signature: I authorize the release of any medical, behavioral health or other information necessary to process my insurance claim.

Insured's or authorized person's signature: I authorize payment of medical, behavioral health benefits to the provider for services. I fully understand that, regardless of insurance coverage, I am legally responsible for all fees due. I further understand Jordan West Family Counseling's missed appointment and late cancellation policy

Patient's authorized person's signature: I acknowledge if an appointment is cancelled less than 24 hour prior to the appointment or the appointment is missed a fee **$50.00** will be assessed.

Patient Name	Authorized Person	
Signature	Relationship to Patient	Date

Returned checks will be assessed a $30.00 fee. Please note that unless your appointment is cancelled with a 24-hour notice, late cancellation fees will apply. Delinquent accounts are subject to referral to collection agencies. If your account is referred to a collection agency the balance will be charged 35% collection fee. Interest will be assessed at a rate of 18% per annum will apply for balances over 60 days old.
Any questions regarding financial issues may be directed to the Office Manager.

Mental Health Family History

Patient's Name:_____ Patient's date of birth_____

Please answer these questions to the best of your ability.

Please give this document to your therapist during your 1st session

Please check the box that applies.

- ☐ Have you seen a mental health practitioner
- ☐ Been on psychiatric medications
- ☐ Received counseling
- ☐ Been hospitalization
- ☐ Suicide attempts
- ☐ Alcohol/drug treatment
- ☐ Legal problems
- ☐ DUI/DWI conviction

Problem Inventory

I am currently experiencing the following problems (please check all that apply)

- ☐ Marital relationship problems
- ☐ Physical abuse
- ☐ Problems on the job
- ☐ Losing someone or something close to me (person, job, pet, moving, etc.)
- ☐ Problems with my children
- ☐ Sexual abuse
- ☐ Current problems from past sexual abuse
- ☐ Alcohol abuse
- ☐ Feeling guilty about past misdeeds
- ☐ Feeling that I am no good
- ☐ Feeling the need to get more sleep
- ☐ Losing pleasure in my daily activities
- ☐ Often feeling restless or irritable
- ☐ Thinking about dying or killing myself
- ☐ Trouble keeping my mind on a task
- ☐ Feeling sad or "down in the dumps"
- ☐ Preoccupied with sexual thoughts or urges
- ☐ Needing less sleep than usual
- ☐ Spending sprees
- ☐ Trouble making myself slow down or talk less
- ☐ Feeling the urge to avoid certain places or objects
- ☐ Feeling troubled by repetitive thoughts
- ☐ Feeling anxious and nervous
- ☐ Worrying about things over and over
- ☐ Fear of crowds or public places
- ☐ Specific fear of a thing or place
- ☐ Attacks of fearfulness where I feel I need to run
- ☐ Heart palpitations
- ☐ Chest pains or discomfort
- ☐ Feeling dizzy or unsteady
- ☐ Feeling things that aren't there
- ☐ Tingling in hands or feet
- ☐ Hot or cold flashes
- ☐ Trouble breathing
- ☐ Feeling trembles or shaking
- ☐ Feeling the urge to do something unnecessary
- ☐ Checking, hand washing, hair pulling
- ☐ People following me out to hurt me or talking about me
- ☐ People reading my thoughts
- ☐ Hearing voices
- ☐ Thoughts being put into my head, controlling me, or making me do things
- ☐ Special messages to me from TV or radio
- ☐ Feeling emotionally "numb"
- ☐ Recurring nightmares
- ☐ Frequently feeling startled
- ☐ Being troubled by painful memories
- ☐ Parts of my body not functioning well
- ☐ Feeling aches and pains all over my body
- ☐ Often feeling sickly
- ☐ Fear of having or getting a disease
- ☐ Problems with my memory
- ☐ Knowing where or who I am
- ☐ Having trouble remembering my past
- ☐ Finding things I don't remember having
- ☐ Feeling that I've lost time
- ☐ Urges to do something harmful to myself or others
- ☐ Urges to set fires
- ☐ Difficulty controlling my temper
- ☐ Feeling anger or resentment
- ☐ Taking laxatives to control my weight
- ☐ Vomiting to control my calorie intake
- ☐ Exercising frequently and vigorously
- ☐ Fasting in order to control my weight
- ☐ Feeling helpless about my eating habits
- ☐ Extreme changes in my weight
- ☐ Fears of dying or going crazy
- ☐ Drug abuse
- ☐ Getting lost or confused

Primary reason for the visit and any problems not listed above

Treatment Agreement

I have reviewed a treatment plan course of action with my therapist and I approve.

_____ _____

Patient Date Therapist Date

This information is to be used by your therapist to help determine, with you, your treatment options. It is a confidential record.

Release of Confidential Mental Health Information

Client Name_____ SS# _____ DOB_____

Address _____ City _____ State_____ Zip_____

Disclosure of Mental Health Information: Your mental health information and communication of that information is essential to your treatment. We prefer to speak directly with each patient but we understand that other individuals of family members may have knowledge of and be assisting in your treatment and progress. Please, list the individual(s) who we are authorized to discuss your treatment/progress with. (NOTE: We cannot discuss your treatment/progress with others, including parents, spouse, other family members, caseworkers, attorney general, Guardian Ad Litem, Judge, or court clerks unless they are listed below.)

Name of the person	Relationship to Patient

Confidential Communication: Communication between Jordan West Family Counseling and you, the client is critical to your well-being. Please list the phone number(s) where we can reach you, your parent(s) or guardian.

Name of person	Phone Number	Relationship to Patient

Permissions: Children over the age of 12 will be given consent for a counselor / Jordan West Family Counseling to communicate with parent(s) regarding their progress. In cases of an "in custody" client, permission will be given to communicate with foster parent(s), caseworker(s), Guardian Ad Litem, Attorney General or Judge. In addition, clients who are court referred into treatment will give consent to communicate with probation officers, Judge(s) and court clerks in order to send updates, treatment progress, treatment summaries, and treatment termination.

Signature I hereby authorize the use or disclosure of my personal mental health information as described above . If patient is under the age of 18 a parent or guardian may sign that consent to disclose information

_____
Patient Name

_____ _____ _____
Signature Relationship to Patient Date

Note: This restriction applies only to mental health treatment provided by Jordan West Family Counseling. Other providers involved in your treatment may require you to complete a separate request for restriction. Either you, or Jordan West Family Counseling to may terminate this restriction by completing the following.

This agreement is terminated as of_____

_____
Patient Name

_____ _____ _____
Signature Relationship to Patient Date

Appointment Reminders

Jordan West Family Counseling utilizes an auto reminder tool to improve the service we offer to you, the customer. This service allows Jordan West Family Counseling to communicate electronically with mobile devices (cellular phones), landline phones and e-mail accounts.

Despite this being a service offered to you we still put you in 'the driver's seat', by enabling you to start and stop any further messages anytime you want. This service requires no purchase or fee to participate in the service, standard messaging and data fees may apply. Check your mobile plan for more details.

I agree to participate in this messaging service to have voice calls, text message or e-mail reminders sent, which relieves Jordan West Family Counseling of confidentially liability due to HIPPA compliance issues as you**,** the patient, are choosing the source of contact.

It is our belief that only you will be the person reading your email address. I understand that other members of my family may access messages left on my e-mail address. By signing this form, I agree to relieve Jordan West Family Counseling of any liability for this contact.

Your reminder call will come around 6:00 pm and no later than 8:00 pm the day prior to your appointment. If you need to cancel your appointment, please, contact Jordan West Family Counseling office 24 hours in advance to avoid a late cancellation or no show fee of **$50.00.**

The message that may be delivered is as follows: "John/Mary this important reminder is to let you know it is time for your appointment with (name of therapist)".

Please indicate only one method of call reminders that you would prefer.

☐ Voice Phone Call. Phone Number: _____
☐ Email message. Email Address: _____
☐ Text Message (SMS) Cell Number: _____

☐ No Reminder Calls / Messages. Please ask your counselor for a reminder card for your next appointment. Please initial that you understand you will NOT receive a reminder for your future appointments: _____

_____ _____
Patient name (please print) Patient name (please print)

_____ _____
Patient or Guardian Signature Date

Notice of Privacy Practices For Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office is required to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. This office will not use or disclose your health information except as described in this Notice. If you consent, the office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, medical history, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are:

- A provider or assistant obtains treatment information about you and records it in a health record.
- During the course of your treatment, the provider determines he/she will need to consult with another specialist in the area. He/she will obtain your signed authorization before sharing information with such specialists to obtain his/her input.
- Referral information may be forwarded to Diagnostic Testing Labs for further treatment or testing where the provider will want results of such treatment or testing reported bock to him/her.
- If the provider is a specialist, your health information and progress may be reported back to your primary care provider or referring provider, upon receipt of your written authorization.

Example of use of your health information for payment purposes:

- We submit requests for payment to your health insurance company. The health insurance company requests health information from us regarding medical care given. We will provide information to them about you and the care given. For example, a bill sent to your health insurance company may include information that identifies your diagnosis, and the procedures and supplies used.

Example of use of your health information for health care operations:

- We obtain services from our insurers or other business associates (an individual or entity under contract with us to perform or assist us in a function or activity that necessitates the use or disclosure of health information) such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical transcription, medical review, legal services, and insurance. We will share health information about you with our insurers or other business associates as necessary to obtain these services. We require our insurers and other business associates to protect the confidentiality of your health information.

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are the physical property of the treating provider. The information in it, however, belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted as required by law:
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health information ("Notice") by making a request at our office.
- Request that you be allowed to inspect and copy your billing record - you may exercise this right by delivering the request in writing to our office;
- Obtain an accounting of disclosures of your health information as required to be maintained by law, upon request. An accounting will not include internal uses of information for treatment, payment, operations, or disclosures made to you; and
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

Notice of Privacy Practices For Protected Health Information, Continued

OUR RESPONSIBILITIES

This office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy or our "Notice" or by visiting our office and picking up a copy.

TO REQUEST INFORMATION OR FILE A COMPLAINT

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Betty Owen at 801-566-0749. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Betty Owen. You may also file a complaint by mailing it to the Department of Health and Human Services. We cannot, and will not, require you to waive the right to file a complaint with the Department of Health and Human Services (HHS) as a condition of receiving treatment from the office. Likewise, we cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

OTHER DISCLOSURES AND USES

Notification of Family/Friends: Our office does NOT disclose protected health information or any other information to family members.

Appointment Reminders and Treatment Information: We may contact you and/or leave a message on your telephone answering machine to provide you with appointment reminders, lab results, prescription information, or billing information.

Workers Compensation: If you are seeking compensation through Workers Compensation, we may disclose your health information to the extent necessary to comply with laws relating to Workers Compensation.

Abuse, Neglect & Domestic Violence: We may disclose your health information to public authorities as allowed by law to report abuse, neglect, or domestic violence.

Law Enforcement: We may disclose your health information for law enforcement purposes as required by law, such as when required by a court order; for identification of a victim of a crime if certain protective requirements are met; to report a crime in emergencies; and other appropriate situations as permitted by law.

Judicial/Administrative Proceedings: We may disclose your health information in the course of any judicial or administrative proceeding as allowed or required by law or as directed by a proper court order or in response to a subpoena, discovery request or other lawful process if certain specific requirements are met. To avert a serious threat to health or safely, we may disclose your health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

Other Uses: Any other uses and disclosures of your health information besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

HIPAA requires that we make the Notice of Privacy Practices available to you. We ask that you sign and date this form. When you sign and date this form you are agreeing that you were given a copy of the Notice of Privacy Practices. You are not agreeing to what the notice says.

The undersigned has received the Privacy Policy of Jordan West Family Counseling

_____

Patient Name

_____ _____ _____

Signature | Relationship to Patient | Date