Bryan Wilde Counseling Services
Advanced Health Clinic
630 W. Shepard Lane
Farmington, UT 84025
www.advancedhealthclinic.com

CLIENT INFORMATION FORM

First Name _____ Middle Initial _____ Last Name _____

M _____ F_____ Date of birth _____ Age_____

Address _____

City/State_____ Zip _____

Email: _____

ONE REQUIRED Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____
{Please only provide an email address and phone numbers where you are giving us permission to leave messages}

BACKGROUND INFORMATION

Why are you seeking counseling at this time?

_____

Do you have any medical conditions that your therapist should be made aware of?

_____

Are you taking medications of any kind?

_____

Whom may we thank for referring you?

_____

For Office Use Only

Dx Code: _____ Note:
_____

We require that a credit card remain on file while your account is open

☐ VISA ☐ MASTERCARD ☐ DISCOVER

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Credit Card # _____-_____-_____-_____ CID# _____ EXP_____/_____

Name as it appears on card_____

Address of card holder _____

Phone # of card holder _____Email of card holder: _____

Cardholder Signature _____Date _____

I authorize Advanced Health Clinic to charge the above card for services, product or fees.

THERAPIST-CLIENT SERVICE AGREEMENT

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between you and Bryan Wilde Counseling Services, LLC. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in therapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. Your therapist also has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some initial impressions of what your work might include. You should evaluate this information and make your own assessment about whether you feel comfortable working with Bryan Wilde Counseling Services, LLC. If you have questions about our procedures, we invite you to dscuss them with your therapist whenever they arise.

APPOINTMENTS

Appointments will ordinarily be 45 minutes in duration. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, we ask that you provide your therapist with 24

hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, our policy is to collect the full amount of your session. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. If it is possible, we will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time and you will be charged the full amount for your session.

PROFESSIONAL FEES

The standard fee for the initial intake is $1450.00 and each subsequent session is $120.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check, cash, or credit card. Any checks returned to our office are subject to an additional fee of up to $25.00 to cover the bank fee that is incurred. If you refuse to pay your debt, we reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, it is our practice to charge $50 per hour for other professional services that you may require such as report writing, telephone conversations, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of us. If you anticipate becoming involved in a court case, we recommend that you discuss this with us fully to consider the effects this could have. Legal situations involving your treatment or treatment records will mostly result in you waiving your rights to confidentiality. If your case requires our participation, you will be expected to pay for the professional time required even if another party compels us to testify.

PROFESSIONAL RECORDS

We are required to keep appropriate records of the psychological services that we provide. Your records are maintained in a secure location in the office. We keep brief records noting that you received treatment, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records we receive from other providers, copies of records we send to others, and your billing records. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them with your therapist, or have them forwarded to another mental health professional to discuss the contents. If we refuse your request for access to your records, you have a right to have our decision reviewed by another mental health professional, which we will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request. The administrative fee you will be charged for each copy of your file will be $50.00, due at the time of your request.

NO SECRETS POLICY

The “Treatment Unit” refers to a couple or family consisting of two or more members. While providing treatment services to the Treatment Unit, individuals are not viewed as being separate or individual clients. When working with a Treatment Unit, our office practices a No Secrets policy. Your therapist may schedule separate appointments with one or more members of the Treatment Unit to assist in the overall therapy process, please understand that any information shared with a clinical treatment staff member in any treatment setting, including times when all members of the Treatment Unit are not present, will not be held in confidence or maintained as a secret while treating any and all members of the Treatment Unit. We will encourage the client holding the secret to disclose the withheld information in a following session with all or part of the Treatment Unit and will support the client in doing so. We also reserve the right to share or disclose information revealed by one partner or family member in an individual session to the other partner or family members as we deem appropriate or necessary to support the

treatment units overall treatment progress and goals. If you are seeking couples or family therapy, each member of the Treatment Unit will be required to complete and sign separate intake forms.

In addition, please note that there are limits to your confidentiality as defined by Utah State law. Under certain circumstances, our therapists and members of clinical staff have a legal obligation to report information disclosed in any type of mental health treatment setting to appropriate law enforcement or medical professional.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress; parental involvement in the treatment of minor children can also be essential. We request an agreement between the client and the parents allowing us to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless the therapist feels there is a safety concern in which case we will make every effort to notify the child of our intention to disclose information ahead of time and to handle any objections that are raised.

COMMMUNICATION WITH YOUR THERAPIST

Boundaries with your therapist will be an important part of your treatment. Communicating with your therapist needs to be within professional boundaries. Treatment should take place through scheduled appointments. Treatment will not be offered through text messaging, email or instant messaging. Texting may be used for administrative purposes only. Texting is not HIPPA compliant and should you text a therapist on a therapeutic matter the therapist will ask you to setup either a billable phone call or it will be addressed in your next scheduled session. We ask that you respect our therapists' personal time away from the office.

There may be times when you would like to contact your therapist with an urgent need. Due to the nature of our business, we are often not immediately available by telephone. We do not answer the phone when we are in session or otherwise unavailable. At these times, you may leave a message on our confidential voice mail and your call will be returned as soon as possible: 801-447-8680. Please note that it may take 24-48 hours for non-urgent matters. If, for any number of unseen reasons, you do not hear from your therapist or the therapist is unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, immediately do one of the follow: 1) go to your Local Hospital Emergency Room, or 2) call 911 and ask to speak to the mental health worker on call. We will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering for your therapist.

GENERAL AUTHORIZATION

Client's Name_____

I understand that by signing this informed consent I am authorizing Bryan Wilde Counseling Services, LLC to disclose my health information to the persons and entities that I have listed below and that any health information or other confidential information in the possession of the persons and entities listed below may be disclosed to Bryan Wilde Counseling Services, LLC. My health information includes without limitation, any records, reports, test results, assessments and other information relating to medical, emotional, education or psychological conditions. Disclosure may also be made to describe my condition and progress and to discuss treatment.

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I understand that I may revoke this authorization at any time by sending a written notice to Bryan Wilde Counseling Services, LLC. I understand that my revocation of this General Authorization will not affect a disclosure that Bryan Wilde Counseling Services, LLC has already made under this authorization.

I understand that information used or disclosed under this General Authorization may be subject to re-disclosure by the recipient, and may no longer be protected by Bryan Wilde Counseling Services, LLC confidentiality rules.

I waive any right of privacy that I have in connection with the disclosures hereby authorized.

This General Authorization is valid until _____ or until three months after the file is closed at Bryan Wilde Counseling Services, LLC. This General Authorization requests and authorizes any necessary psychological and/or psychiatric evaluation and treatment.

For parents of minors receiving services: I am a legal guardian of _____ who is under 18 years of age and I authorize him/her to receive services provided by Bryan Wilde Counseling Services, LLC. I understand that parental participation in one or more of the following may be required: assessment, individual counseling, family counseling, parenting skills training or group counseling.

Bryan Wilde Counseling Services, LLC has my authorization to disclose my health information to the following persons and entities: _____

_____

Please list the name of a third party billing payer above if we will be corresponding or billing them for services.

CONSENT TO PSYCHOTHERAPY
Your signature below indicates that you have read this Agreement and agree to the terms.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Relationship to Patient if Personal Representative