Audrey DuRoss, LCSW

3070 Rasmussen Rd. Suit #121 Park City, UT 84098

Client Registration

Client Name:
Sex (circle): Male Female
DOB:
~~SSN:~~ email -
Street Address:
City, State, Zip:
Phone Number:

Primary Insurance Information

Primary Insurance:
Company Address:
City, State, Zip:
Company Phone: ( )
Employer:
Policyholder Name:
DOB:
Identification Number:
Policy / Group Number:

Secondary Insurance Information

Primary Insurance:	
Company Address:	
City, State, Zip:	
Company Phone:	( )
Employer:	
Policyholder Name:	
DOB:	
Identification Number:	
Policy / Group Number:	

I understand that my therapist's goal is to provide the best possible service. While I expect benefits from this treatment, I fully understand and accept that because of factors beyond our control, such benefits and desired outcomes cannot be guaranteed. A variety of treatment methods will be used in attempts to provide relief of my symptoms and to improve my coping and problem solving skills.

I understand that for counseling services to be most effective, it is essential to have these services coordinated with other health care providers. Information will only be shared in accordance with the Privacy Policies of Audrey DuRoss, LCSW. For any person or institution that is not directly related to treatment, payment of services or health care operations of Audrey DuRoss, LCSW, all protected health information will be kept confidential UNLESS you sign a specific authorization. However, all health care providers are legally required to report and release the following information without specific authorization: suspected physical / sexual abuse and . or neglect of a child or elderly person, to prevent injury to self or other, in a medical emergency to save lives, or if ordered by the court.

I understand that the fee is $100.00 for a sixty-minute office visit, unless otherwise specified by my insurance company. I agree to make required payment at the time of service. Phone calls more than 10 minutes in length, written reports, and other professional contact will be billed at the same rate. I understand that a 24-hour notice for cancellation is required. Otherwise, I will be charged full fee for the missed appointment, and I understand that this charge is not billable to my insurance. I understand that I may choose to have charges submitted to my insurance carrier. I am solely responsible to pay all charges. Should my account become over 60 days delinquent, I understand that a finance charge of 1.5% per month will be added to my bill from the date of service. I will also be responsible for payment of any legal fees and / or collection costs if such services are required. I authorize the release of my identifying information to pay all costs of collection, including attorney fees, court costs, and collection agency charges and fees. A service charge of $15 will be added to my account for any returned check.

In the event of an emergency I will 1) call Salt Lake County Mental Health Suicide Prevention and Crisis Services at 801.483.5444 or 801.261.1442 2) call 911 or visit my nearest emergency room.

Audrey DuRoss, LCSW

3070 Rasmussen Road Suit #121 Park City, UT 84098
801-910-7193

HIPAA Privacy Notice

THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on my website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization. I may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Payment. I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. I may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, I must disclose your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. I may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. I may disclose PHI regarding deceased patients as mandated by state law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.

Medical Emergencies. I may use or disclose your protected health information in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. I may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. I may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing

person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. I may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, I may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. I may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process.

Verbal Permission. I may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to me.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI.
- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask us to amend the information although I are not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with us. I may prepare a rebuttal to your statement and will provide you with a copy. Please contact Kathy Cirello, LCSW if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with myself, Kathy Cirello, LCSW, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **I will not retaliate against you for filing a complaint.**

The effective date of this Notice is March 2010.

Audrey DuRoss, LCSW

3070 Rasmussen Road Suit#121 Park City, UT 84098 801-910-7193

Professional Service Agreement

The Treatment Process

Therapy has the potential to offer personal benefits, such as a decrease in level of distress and an increase in problem solving skills, communication effectiveness and cultivation of meaningful relationships. Therapy involves a commitment on your part not only to keep scheduled appointments, but also to coming to appointments prepared with meaningful topics to discuss. Much of the progress you will make will take place when you are outside of the therapy appointment, reflecting on topics and putting into practice techniques we have discussed. The relationship between client and therapist is essential in regards to honesty and trust. While therapy will be most effective when you "work" towards the change you would like to create, the work I do will be to create an environment that promotes self-awareness and growth. I believe that we all have the ability to change our perception, attitude, skills or circumstance.

Confidentiality

In order to create a safe environment to share thoughts and feelings, it is a priority for me to ensure your confidentiality. The law protects the privacy of all communications between a client and a therapist, which is why the Release of Information form is included in this packet, in the event that you do wish for me to have communication with a family member, employer, professional, etc. for your benefit. By signing the ***Agreement***, you are giving consent for communication as follows:

- If you choose to use your insurance company to pay for a portion of your therapy. Insurance companies typically require that I provide information relevant to these services including diagnosis, treatment plans or treatment summaries. In such circumstances, I make every effort to release the minimum amount of information necessary while still complying with the insurance company's request. If you request, I will provide you with a copy of any report I submit. By signing the ***Agreement***, you agree that I can provide requested information to your insurance carrier.

- I have a formal Business Associate Agreement with Mental Health management Inc., a company that provides billing services for me. As required by HIPAA, in the ***Agreement***, this business associate agrees to maintain the confidentiality of this data except as specifically allowed in the contract if otherwise required by law.

- I may occasionally consult with other health and mental health professionals for the benefit of my clients and the care that I provide. During a consultation, I do not share any personal or identifying information regarding any specific client. I will share any consultations with you if I believe they are important to our work together.

- I may share confidential information in accordance with the terms and conditions of the ***Agreement*** on wireless or cellular phones.

There are some situations where I am permitted or required to disclose information without either your consent of Authorization. These are described in the ***HIPAA Privacy Notice*** and include threats to health and safety, judicial or administrative proceedings, specific, public health activities, worker's compensation claims and other disclosures required by law or law enforcement entities.

There are some situations in which I am legally obligated to take actions that I believe are necessary to protect others from harm, and I may have to reveal information about a client's treatment. Situations such as these are very rare in my practice and include the following:

- If I believe that a child, elderly person, or disabled person is being abused or neglected, I am required to report this to the appropriate authorities or the police; and

- If I believe that you are threatening serious bodily harm to yourself of someone else, I am required to take protective actions, which may include notifying the potential victim of contacting the police.

Should a situation like this occur, I will make every effort to discuss it with you prior to taking any action, and I will limit my disclosure to what is necessary. I am happy to discuss with you any questions or concerns you may have now or in the future pertaining to confidentiality.

Client Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Record, and disclosures of PHI. These rights are described in the ***HIPPA Privacy Notice***. I am happy to discuss any of these rights with you.

Professional Records

In accordance with HIPAA, I keep Protected Health Information (PHI) with regards to you and your treatment in two sets of professional records. One set constitutes your Clinical Record. It includes demographic and insurance information about you as well as information about your reasons for seeking therapy; a description of the ways in which your problem affects your life; your diagnosis; our treatment

goals and your progress towards them; your medical, social and treatment history, treatment records I receive from other providers; your billing records, documentation of any professional consultations, and any reports that have been sent to anyone, including your insurance carrier. In most circumstances, you may inspect and/or receive a copy of your Clinical Record, if you request it in writing. Upon your request, I will discuss with you the details of this process.

In addition, I also write and keep progress notes regarding each session I have with every client. These notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of progress notes vary from client to client, they can include the content of our conversation, my analysis of those conversations, interventions used and progress regarding your goals. They can also contain particularly sensitive information that you may reveal to me that is not required to be included in our Clinical Record. These progress notes are kept separate from your Client Record, are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed authorization.

Contacting Me

I can be reached at 801-910-7193. Phone calls often go directly to voicemail since I am usually meeting with other clients. Please feel free to leave a confidential message and I will return your call as soon as possible. Remember to leave your phone number each time you leave a message, even if you think I already have it. I will do my best to respond to you within the next business day. However, on the weekends or times when I am out of town I will take longer to return your phone call. In the event of any emergency, call:

1. Salt Lake County Mental Health Suicide Prevention and Crisis Services at 801.483.5444 or 801.261.1442, or
2. 911

Going to your nearest emergency room is also an option. If I am out of town or unavailable for an extended period of time, I will arrange for a licensed therapist to provide coverage for me in my absence.

Cancellations

The appointment time you have scheduled is yours. If you need to cancel an appointment, ***please call 24 hours in advance*** so that the time can be rescheduled for someone else. Since I only have a limited number of treatment hours available during the week, ***you will be charged for missed appointments or those not canceled 24 hours in advance.***

Financial Policy

You are financially responsible for all charges, whether or not paid for by insurance. If you choose to use an insurance policy to pay for a portion of your care as started above, I am required to submit certain information about you in order to obtain partial reimbursement. I will discuss this with you when necessary, so that you may be aware of the type of information being requested. Please ask me if you have questions or concerns about your specific insurance policy.

In many cases, you are under no obligation to use your insurance. You may prefer to avoid filing insurance, having your diagnosis disclosed or having your care reviewed by a managed care organization. *I am pleased to discuss self-pay as an alternative to using insurance.*

If you elect to use your insurance to partially pay for your care, it is your responsibility to verify your insurance coverage and note any restrictions or limitations. Please understand that some or perhaps all of the services provided may be "non-covered" services or not considered medically necessary by your insurance carrier. If you want to use your insurance, you should:

- Determine if I am a contracted provider with your plan and if not, whether there is an out-of-network option covering a non-paneled provider.
- Obtain pre-authorization for you initial visit.
- Determine the co-payment you are required to pay for my treatment services
- Determine the amount of remaining unpaid deductible for your benefit year, the number of visits allowed per benefit year, and the beginning date of the benefit year.

Fees for my professional services are charged as follows:

- $150 for initial evaluation
- $100 for 60 minute therapy session
- $100 for 60 minute family therapy session
- $50 for 60 minute group therapy
- Evaluations, letters and reports required by an employer, their legal system or other entities are billed at $100 per 50 minutes and include preparation time. These charges are not covered by insurance and will be billed directly to you.
- Phone calls lasting more than 20 minutes may be prorated at the above rates.

- **Appointments not kept and not canceled at least *24 hours in advance* will be charged to you at the rate for the services and the time scheduled. Insurance will not cover these charges.**

You are expected to:

- Pay the amounts not covered by your insurance plan (ie. Copayments, unpaid deductibles, missed appointment fees) at the time of service unless other arrangements have been made.
- If you do not know the specific amount of your insurance coverage, pay 50% of the session charge at the time of service and any adjustments will be reflected on your monthly statement.
- Pay outstanding amounts on your statement within 30 days.
- If your account is overdue and sent to an attorney or collection agency to pursue collection, pay any collection fees, court costs, attorney fees and filing fees.
- Pay a $20 charge on any returned checks.
- Pay a 1.5% interest charge on unpaid balances over 30 days.

If you have any questions or concerns about the fee policy or your fee, I am happy to address them with you.

Please check one of the following:

☐ **I will NOT be using my insurance to pay for any part of my care. I will pay the full amount of each session at the time of service**

☐ **I want to use my insurance benefits to pay for a portion or my care.**

If I am using my insurance carrier(s) to partially pay for my care, I give permission to Audrey DuRoss, LCSW to release all necessary diagnostic and treatment information to the insurance carrier(s), and authorize my insurance carrier(s) to pay policy benefits directly to Audrey DuRoss, LCSW. I request that this assignment remain on file with my insurance carrier(s).

*I understand that I am financially responsible for all charges whether or not paid for by my insurance, including missed appointments and sessions not cancelled more than 24 hours in advance. I authorize the release of necessary information to a collection agency if that should become necessary. I permit a copy of this signed **Agreement** to be used in place of the original.*

*I may revoke this **Agreement** in writing at any time. That revocation will be binding on Audrey DuRoss,*

LCSW (1) unless she has taken actions in reliance on it; (2) if there are obligations imposed on Audrey DuRoss, LCSW by my health insurer in order to process or substantiate claims made under my policy; or (3) If I have not satisfied any financial obligations I have incurred.

I UNDERSTAND THAT MY SIGNATURE BELOW INDICATES THAT I HAVE READ THIS *AGREEMENT* AND AGREE TO ITS TERMS.

Client's Name – please print

_____ _____

Signature of Client Date

_____ _____

Signature of Parent of Guardian Date

(if client is a minor)

_____ _____

Witness Date

Audrey DuRoss, LCSW

3070 Rasmussen Road Suit #121 Park City, UT 84098 801-910-7193

Consent To Release Information

I, _____, do hereby authorize information to be released from and to Audrey DuRoss, LCSW from and to _____.

The purpose for releasing information is:

- ☐ Coordination of services
- ☐ Consultation
- ☐ Provision or reports needed by school, work, or funding agency
- ☐ Other _____

Information to be released included:

- ☐ Assessment
- ☐ Diagnosis
- ☐ Treatment description
- ☐ Recommendations
- ☐ Anything that Audrey DuRoss' discretion deems relevant and/or important
- ☐ Other _____

This release shall remain valid until _____. I understand that I may revoke this release at any time by providing the above party with written instruction to do so.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent of Guardian Date

(if client is a minor)

_____ _____

Audrey DuRoss, LCSW

3070 Rasmussen Road Suit #121 Park City, UT 84098 801-910-7193

Acknowledgement of Receipt of Notice of Privacy Practices and Policies

Attached, please find my Notice of Privacy Practices, which contains information regarding privacy, confidentiality of information and security required by new federal laws and guidelines that are in place to protect you. While it is very important, it is also very long and detailed. Please read it carefully. I am available to answer any questions that you may have now or at any time in the future about these federal laws or my privacy policies and practices.

I am required to demonstrate that I have made this information available for you to read. Please sign the statement below. Signing this form only signifies that a copy of this information has been made available to you, not that you have read it or agree with it.

Thank you for your assistance in this important process.

Sincerely,

Audrey DuRoss, LCSW

A copy of the Notice of Privacy Practices and Policies has been made available to me by Audrey DuRoss, LCSW. I understand that signing this form means only that the Notice was made available.

_____

Client Name (Please print)

_____ Date _____

Client Signature

_____ Date _____

Parent / Guardian Signature (if client is a minor)

_____ Date _____

Witness Signature