High Country Counseling and Consulting
4516 South 700 East, Suite 160
Murray, Utah 84107
Phone: (801) 918-0697
Pat@highcountryutah.com

CLIENT INFORMATION: (As it appears on your insurance cards)

Client Legal Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone Number/Type: _____ Alt. Phone/Type: _____
Email: _____
Social Sec. #: (REQUIRED) _____

INSURANCE INFORMATION: (Please provide the card to be copied for our records)

Policy or Medicaid Number: _____
Insurance Company Name: _____
Insured's Name: _____ DOB: _____
Group Number _____
Employer Name: _____

EMERGENCY CONTACT:

Name: _____
Relationship: _____
Phone Number: _____ Type: _____
Alternate Phone: _____ Type: _____

IF CLIENT IS A MINOR: (Parent / Guardian Information)

Please list name, relationship, phone(s), and a brief description of the custody situation for all parents and/or guardians:

_____

☐ Check if the client is currently in DCFS Custody The current permanency goal is: _____

CONSUMER AGREEMENT

- All clients are expected to actively participate in therapy. Family involvement is encouraged and often essential to successful treatment. Please be on time to your appointments and attend each scheduled session. Your success in therapy depends on your consistency, participation, and effort.
- Clients are not permitted to record in person or telehealth sessions at any time without the therapists advance knowledge and permission.
- If you cannot make a scheduled appointment, please call to cancel or re-schedule **AT LEAST 24 HOURS IN ADVANCE**. If you do not call, the session or no-show fee may be billed. Clients who miss multiple appointments may be terminated from treatment. The appropriate legal guardian or referring agency will be notified if termination is necessary.
- In the case of emergency, Highcountry staff needs permission to seek medical treatment for you in case you cannot help yourself. By signing below you agree to allow Highcountry staff to act on your behalf in case of emergency.
- All clients will be billed the standard rate for services provided unless other arrangements are made for payment. Highcountry will bill private insurance companies for services; however, you are responsible to pre-authorize treatment, and to know the mental health benefits for your particular insurance. By signing below you authorize us to bill insurance on your behalf and to provide necessary confidential information to your insurance regarding billing. You will be assessed a 1.5% finance charge per month **AFTER YOUR PAYMENT IS 30 DAYS LATE**. Unpaid accounts will be referred to collections. In the event payment under this agreement is not made at the time and in the manner required, the undersigned agrees to pay all costs of collection, including attorney fees, court costs, including charges and collection agency fee which would be 30% of the balance assigned, with or without suit.

Standard Charge for Services: Assessment Indiv/Fam $165/hr Group Therapy: $30/hr No Show/Late Cancel Fee: $40
Assessment: $200/hr

_____ _____ _____ _____
Client Signature Date Parent/Guardian/Responsible Party Signature Date

By signing above, I agree to these terms and consent to mental health treatment at High Country Counseling

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CONFIDENTIALITY AGREEMENT

Professionals who provide mental health services are required by laws and ethical standards to keep all communications between clients and therapists confidential. Information will only be shared about you when agreed to by your signature on a "Release of Information" form. There are some specific limitations to client confidentiality:

1. Suspected child or vulnerable adult abuse or neglect: We are required by law to report to the appropriate state agency if we suspect abuse or neglect of a child or a vulnerable adult.
2. Harm to self or others: If we conclude that a client is about to cause harm to themselves or someone else, we are obligated to report this and/or to take steps to prevent that harm.
3. Response to court subpoenas and orders: We are obligated to cooperate with lawful orders and subpoenas of courts of law. We will make all attempts to maintain your confidentiality in these cases.
4. We are required by some referring agencies to provide updates and progress reports. We will report to these agencies by developing a report or update together with the client in therapy. These reports will only be released with your written permission.

I understand and agree to these terms and limitations regarding confidentiality: _____ (Initial)

Utilizing electronic communication as a source of communication cannot be guaranteed to be confidential. If you choose to communicate with Highcountry or individual therapist via electronic communication including e-mail, text message, etc. you understand that this type of communication may risk your right to confidentiality.

I understand that by using electronic means, my communication may not be completely confidential: _____(Initial)

CLIENT RIGHTS AND GRIEVANCE POLICY

All clients have the right to be treated fairly, with respect, and with dignity. If you are mistreated please follow the grievance procedure outlined below.

1. All client information and records are confidential. Access to records will only be granted with client permission.
2. All individuals have the right to participate in therapy free from harm or threat. Any potentially harmful situation should be immediately reported to Highcountry staff. Threats or violence will not be tolerated and could result in termination of services.
3. Highcountry does not allow smoking in our offices or near public entrances in accordance with the Utah Clean Air Act.
4. All individuals have the right to be free from discrimination based on age, race, color, culture, religion, sexual orientation, or disability. If you feel that you have been discriminated against please follow the following grievance policy for remediation. Highcountry complies with all applicable laws regarding discrimination and any form of discrimination will not be tolerated.

Any individual who feels they have been mistreated or has any grievance has a right to be heard and have their issue addressed. Clients are first encouraged to address the problem directly with the offending person. If you are unable to do this for any reason you should contact the clinical director, Pat Gooley, LCSW. If you are still not satisfied, please contact the Utah Department of Human Services at 120 N 200 W. SLC, UT, Department of Professional Licensing, or your case worker or other referring professional.

I have read and understand my rights and procedure for grievances: _____(Initial)

HighcountryCANCELLATION/ NO SHOW POLICY

- All clients must give a 24 hour notice for cancelling appointments.
- Failure to cancel a scheduled appointment is considered a NO SHOW.
- **A $40.00 N0 SHOW fee will be charged**. This fee may be waived upon appeal.
- You are required to reschedule your next appointment.
- Recurring appointments that are missed are not scheduled for the next week unless specifically requested and approved by your therapist.
- A second NO SHOW may be considered self-termination.
- Your termination may be reported to any agency (DCFS, DJJS, courts,) that we are working with.
- If terminated for no-shows it will be your responsibility find another health care provider. We are happy to provide referrals if you call the office.

I have read and understand the No Show policy:

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CLIENT DEMOGRAPHIC INFORMATION

Client Legal Name: _____ DOB: _____

The following information is required by insurance even if the client is a child.

How was the client referred to High Country?

- ☐ Self
- ☐ Family / Friend
- ☐ Social Services Agency
- ☐ Educational System
- ☐ Court, Law Enforcement, Corrections
- ☐ Private Psychiatric / Mental Health Program
- ☐ Public Psychiatric / Mental Health Program
- ☐ Clergy
- ☐ Private Mental Health Professional
- ☐ Physician or Medical Facility
- ☐ Other Persons or Organization

Client's race:

- ☐ American Indian
- ☐ Pacific Islander
- ☐ Black
- ☐ White (Caucasian)
- ☐ Other
- ☐ Asian
- ☐ Alaska Native

Client's Hispanic / Spanish Origin:

- ☐ Not of Hispanic Origin
- ☐ Mexican / Mexican American
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other Hispanic

Client's marital status (fill out even if client is a child)

- ☐ Single - Never Married
- ☐ Married - Spouse in Home
- ☐ Married but Separated
- ☐ Divorced
- ☐ Widowed

Is the client currently enrolled in an education program? ☐ Yes ☐ No

Indicate the highest level of education completed:

- ☐ Preschool
- ☐ Kindergarten
- ☐ _____ Grade
- ☐ High School Graduate or GED
- ☐ Some College or Associates Degree
- ☐ College Graduate
- ☐ Some Graduate School
- ☐ Graduate School Graduate
- ☐ Never Attended School

Household Monthly Income: (NOTE: This cannot be zero.) $_____

List (name and relationship) people living in the home: _____

Is the client a Veteran? ☐ Yes ☐ No

What Language needs to be spoken during therapy? English

Has the client had previous mental health treatment, including hospitalization? If so, where and who was their primary provider?

Is the client currently pregnant? ☐ Yes ☐ No

Smoking Status? ☐ Current Daily Smoker ☐ Current Sometimes Smoker ☐ Former Smoker ☐ Never Smoker

Employment Status:

- ☐ Employed Full-time - 35+ Hrs
- ☐ Employed Part-time – less than 35 Hrs
- ☐ Homemaker
- ☐ Retired
- ☐ Supported / Transitional Employment (full-time)
- ☐ Supported / Transitional Volunteer
- ☐ Unemployed - Not Looking
- ☐ Unemployed - Disabled
- ☐ Unemployed - Looking

Has the client been arrested in the last 30 days? ☐ Yes ☐ No If YES, How many times? _____

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MORE ON REVERSE SIDE

YOU MAY FILL OUT AS MUCH OR AS LITTLE ON THIS PAGE AS YOU ARE COMFORTABLE

Please use this space to describe why you (the client) are seeking therapy.

CHECK ALL THAT APPLY:

☐ I have previously been in therapy for a mental health disorder. My diagnosis(es) was / were:

☐ I have been experiencing troubling symptoms or behaviors. They are:

☐ Others have observed troubling symptoms or behaviors. They are:

☐ My functioning in certain life areas is not what I would like it to be. Those areas are:

- ☐ Family / Home (Please explain):
- ☐ School / Work (Please explain):
- ☐ Social (Please explain):
- ☐ Romantic Relationships (Please explain):

☐ I have experienced events in my life that are causing me distress. They are:

☐ I am required to seek therapy by an outside person, agency, or the courts. They are:

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Treatment Team Release of Information Authorization

Client Legal Name: _____ DOB: _____

Please list full names, relationships, and telephone numbers of any members of your treatment team. These may include family members or friends who will be participating in treatment, your physician(s) if they referred you to therapy or if you are seeking medication management, school representatives, previous therapy providers, or anyone else who may need to be consulted in regards to your therapy. By listing these team members you are authorizing your Highcountry therapist or staff to contact these individuals and discuss your treatment, or provide documentation pertaining to your treatment.

If there are individuals you would like to receive only limited information regarding your treatment, please fill out a separate Release of Information Authorization form.

If you are working with an agency that will be funding your treatment, or are involved with the court system in any way, be sure to list your caseworker and/or probation officer.

Relationship AND/OR Agency	Name	Contact Information (phone/email)

I understand that I can end this authorization at any time; this will not include any information already shared. I should ask if I am required to sign this form in order to receive services. If I am court ordered into treatment and I end this authorization, it will likely put me in violation of court order. Once my records have been shared they may no longer be protected. If this authorization is for a minor, both minor and guardian must sign. I can request a copy of my record in writing, which will be approved by a licensed provider and can take up to 30 days to complete, charges may apply. I can also review my records with my therapist by scheduling an appointment.

By signing this form I attest that I have read and accepted the information outlined above.

☐ I would like a copy of this form for my records
☐ I do not need a copy of this form for my records

_____ _____ _____ _____
Client Signature Date Parent/Guardian/Responsible Party Signature Date

_____ _____
Witness Signature Date

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Telehealth Informed Consent

Please read through the following important information.

TECHNOLOGY USED AND CONDITIONS OF APPOINTMENT

Telehealth involves the use of electronic communications to enable mental health care providers at HCCC to share individual patient medical or mental health information for the purpose of providing patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

· Patient medical records.
· Medical images.
· Live two-way audio and video.
· Sound and video files.
· Text and email communication.

Electronic systems and platforms used may include Zoom meetings, Google Duo, FaceTime, or Skype to provide ease of use and accessibility to the patient. These electronic forms of communication are not guaranteed to be encrypted for the purposes of confidentiality and are not HIPPA compliant. Signing this document acknowledges that participating in telehealth with HCCC practitioners via these platforms has security risks.

Prior to your appointment, you will be able to communicate with your practitioner about which platform you prefer to use and which one is most accessible to you. Your practitioner will contact you using this agreed upon platform at the time of your scheduled appointment. You do not need to initiate the appointment. Your practitioner will send you a reminder of this appointment the day before it is scheduled to confirm the contact method and time. Your appointment will take place in a virtual 'meeting.'

Your practitioner will need to be able to hear you clearly. Please plan to have your telehealth session in a quiet place without background noise and other distractions. Be mindful of people in your surroundings to protect your own privacy. Please ensure that if you cannot hear properly on your end of the call or need instructions repeated that you inform your provider. For patient privacy, telehealth sessions may not be recorded by either the patient or the practitioner.

Your practitioner will need to confirm that it is indeed you. You will need to have sufficient lighting so that your provider can see you clearly. Please identify any persons who are outside the field of view but are participating in or listening to the call. To ensure the privacy of your information, please make sure you are in a safe and private location. *

I agree to the above statement(s). _____

POSSIBLE RISK:

· In very rare instances, security protocols could fail, causing a breach of privacy of personal information. *

I agree to the above statement(s). _____

BY SIGNING THIS FORM, I UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of health information also apply to telemedicine, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent, and outside of those uses permitted by law.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time.

3. I understand that a variety of alternative methods of treatment may be available to me through alternative providers, and that I may choose one or more of these at any time.

4. I understand that telehealth may involve electronic communication of my personal information via electronic technology, and that there may be risks associated with transmitting information electronically including theft, hacking, or data compromise.

5. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

6. I understand that communication may be lost during our visit due to technical failures, and that every effort will be made to preserve call quality and to resume an encounter if it is prematurely disconnected.

7. I understand that telehealth visits should NOT be scheduled with HCCC or its providers for emergency situations, and that it is my responsibility to seek emergency care immediately if I am having an emergency.

8. HCCC providers will assess patients individually to determine if they are appropriate telehealth candidates based on symptoms, diagnosis, stability, and severity of conditions and have the right to refer patients to appropriate alternative resources if necessary based on provider evaluation, observation, and assessment when telehealth is not deemed to be safe or appropriate.

9. I have read, understood, and agree to all items contained in this document.

10. I voluntarily consent to telehealth care for myself or my dependent.

_____ _____

Patient Signature* Parent/Guardian Signature DATE

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Authorization for Recurring Credit Card Charges

For your convenience, you may authorize recurring charges to your credit card to pay for your therapy sessions. If you choose not to put a card on file it is your responsibility to present your card or alternate payment at the time of service or otherwise contact the front desk to arrange a payment. You will be charged the day of your therapy appointment unless other arrangements have been made.

Name of Client:_____

Account Type: Visa MasterCard American Express (AmEx) Discover Other

Cardholder Name:_____ Card

Number:_____ Expiration

Date:_____ Billing Zip Code:_____

CVV (3 digit number on back of card. 4 digits on front of AmEx):_____

I authorize Highcountry Counseling to charge this credit card for professional services and associated charges as agreed below. These charges may include:

Co-pay and/or co-insurance for session

Self-pay for session or payment for session not covered due to deductible: $200-Intake $165 Individual Session/Family/Couples or Telemed.

Charge for cancellation without 24 hours' notice: $40-Weekdays $60-Weekends

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify this practice in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date.

Signature of Authorized Credit Card User:

_____ Date:_____

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screener/Recent – Self-Report

	In The Past Month	
Answer Questions 1 and 2	**YES**	**NO**
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts about killing yourself?***		
If **YES** to 2, answer questions 3, 4, 5, and 6. If **NO** to 2, go directly to question 6		
3) ***Have you thought about how you might do this?***		
4) ***Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?***		
5) ***Have you started to work out or worked out the details of how to kill yourself?*** ***Do you intend to carry out this plan?***		
	In the Past 3 Months	
6) ***Have you done any of the following?*** ***Attempted to kill yourself even if ending your life was only part of your motivation*** ***Started to do something to end your life but someone or something stopped you before you actually did anything*** ***Started to do something to end your life but you stopped yourself before you actually did anything*** ***Taken any steps towards making a suicide attempt or preparing to kill yourself*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. ***In your entire lifetime, how many times have you done any of these things?***		