RED CLIFF COUNSELLING
NANCY JENKINS PhD, LCMHC

PATIENT INTAKE FORMS

Patient Name: _____

Address:_____
(Street) (City, State, Zip)

Date of birth: _____ Best Phone # _____

Email Address: _____

Emergency Contact Person: _____
(Name and phone number)

Marital Status: _____ Best time to reach you: _____

Primary Physician: _____
(Name and phone number)

INSURANCE INFORMATION

Primary Insurance: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Member ID # _____

Policy Holder's address: _____
(Street) (City, State, Zip)

Insurance phone number: _____ Insurance Payer ID # _____

Secondary Insurance: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Member ID# _____

Policy Holder's address: _____
(Street) (City, State, Zip)

Insurance phone number: _____ Insurance Payer ID# _____

If not using insurance who is responsible party paying for services:

Name & Relationship to client: _____

Ph# and email: _____

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INFORMED CONSENT FOR PSYCHOTHERAPY

GENERAL INFORMATION
The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual, business agreement. The relationship is based on your willingness to disclose your most personally guarded secrets to a veritable stranger. Given this, it is important for us to reach a clear understanding of how our relationship will work and what each of us can expect out of the therapeutic relationship. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by signing your name at the end of this document.

THE THERAPEUTIC PROCESS
Psychotherapy aims to improve an individual's well-being and mental health, to resolve or lessen troublesome behaviors, beliefs, compulsions, thoughts, or emotions, and to improve relationships and social skills. You have taken positive steps by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may at times result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger depression, anxiety, etc. There are no miracle cures. I cannot promise that your behaviour or circumstances will change. I can promise to support you and do my very best to understand you and the repeating patterns, as well as to help you clarify what it is that you want for yourself. It is my intention to provide services that will assist you in reaching your goals.

Knowing this, you can choose to undergo psychotherapy, or not. Ask yourself, “Why am I here? How will therapy help me?” It is best to identify how therapy will serve you before you start the therapeutic process than to try to figure it out as you go. This can be achieved by asking questions. Remember, you can choose to leave therapy at any time. You don’t even need a reason. If you choose to leave, will your life situation remain as it is now? Do you want it to stay that way? If not, then talk therapy may be a solution for you, but not the only one.

CONFIDENTIALITY
The session content and all relevant materials to the client’s treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. However, there are circumstances in which (the least amount possible of) confidential information may be disclosed:

* As a licensed therapist, I am a mandated reporter for the state of Utah. If I have reasonable suspicion of abuse of a child under 18, an elder 65 or older, or a dependent & vulnerable adult, I am legally required to report my suspicion to the appropriate designated agency.

* If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a risk of incurring serious bodily harm, I have a responsibility to make a good-faith effort to protect the life of the client.

* If a client makes a serious threat of bodily harm or death to another person or threatens to damage their property, I have a responsibility to protect the intended victim(s).

* If a court of law issues a legitimate order for information stated on a court order, I am obligated to meet the requirements of that order.

* If I need to consult with other professionals in their areas of expertise in order to provide the best treatment for you, then I may share information about you in this context, however, without the disclosure of personally identifying information.

* In a medical emergency (for example, you pass out in my office and I call 911), I may provide the minimum necessary confidential information to the responder so that you may receive treatment.

What happens if I run into you at a public place? If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you. But I feel it would not be appropriate to engage in any lengthy discussions in public or outside of the therapy office.

CONFIDENTIALITY WITH MINORS
Communications between therapists and patients who are minors (over 12yo, but under 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, in the exercise of my professional judgment, I may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with me.

TERMINATION OF TREATMENT
Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. As long as it is safe for both of us, I will make an effort to discuss terminating therapy with you. Optimally, we mutually agree to end therapy. For the most part, you can decide when you want to terminate. You can end therapy at any time and you don't even need a reason. At the same time, the decision to end therapy can also be mine. If in the course of treatment I determine that our continuing therapy may not be good for either one or both of us, I have an ethical responsibility to let you know, work with you to find an appropriate referral, and end therapy. Should this course of action need to happen, it will take place after consultation with other professionals and careful consideration, but all of this can occur outside of your knowledge.

ABOUT THE THERAPIST
Nancy Jenkins has been a licensed clinical mental health counselor in Utah since 2006. She started counseling in 2004 as a counselling intern with a substance treatment program in SLC. She has a masters degree in Clinical Counseling from the University of Phoenix. She has a Doctoral degree in Counseling Psychology from Walden University in Minneapolis Minnesota. Nancy uses Acceptance and Commitment Therapy (ACT) and Cognitive Behavioral Therapy (CBT) as well as Solution Focused Therapy in her treatment approaches although other therapeutic techniques may be implemented. Feel free to ask questions about these theoretical orientations at any time during your sessions.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ AND UNDERSTOOD THE CONTENT OF THIS INFORMED CONSENT DOCUMENT.

_____ _____

Client/ Guardian Signature Date

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NANCY JENKINS PhD, LCMHC

BENEFITS INFORMATION SHEET

THIS INFORMATION MUST BE COMPLETED PRIOR TO YOUR FIRST APPOINTMENT. PLEASE BRING IT WITH YOU AT YOUR INTAKE SESSION. IT WILL ASSIST YOU AND ME IN NAVIGATING YOUR COSTS AND INSURANCE QUESTIONS.
(If not using insurance please disregard this page).

WHEN YOU CALL YOUR INSURANCE COMPANY, PLEASE SPECIFY THAT YOU NEED YOUR OUTPATIENT MENTAL HEALTH OR BEHAVIORAL HEALTH BENEFITS.

CLIENT NAME: _____ DATE OF BIRTH: _____

PRIMARY CLIENT COVERED ON THE INSURANCE: NAME AND FULL ADDRESS:

_____

NAME OF INSURANCE CARRIER: _____

MEMBER ID#: _____

WHAT IS THE PAYOR ID# FOR MY INSURANCE COMPANY? _____

INSURANCE CONTACT PHONE #: _____

QUESTIONS TO BE ASKED:

Is **Nancy Jenkins** in network for my plan? **(Tax ID# is 46-4470578 or NPI# 1457549958)**

Is there a copay? _____If so, How much $ _____

Is there a yearly deductible that must be met before the insurance will pay anything? _____

Do they pay a portion if my deductible has not been met? _____

Do I need preauthorization? _____ If yes Authorization number : _____

Is this plan an **Employee Assistance Program**? _____. If so who and how is the bill to be submitted? FAX #, PAYOR ID for EAP, etc,

_____

If your therapy sessions are not paid for by the insurance company, after reasonable attempts made by therapist to secure payments from your insurance company, then ultimately you are under obligation to pay for your therapy session/s. You are responsible for your co-payments at each therapy appointment. Accepted methods: Cash, Credit card (will incur $3. service fee) VENMO. **Discounts will be given for cash payments.**

_____ _____
Client/ Guardian Signature Date

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RESPONSIBLE PARTY FOR PAYMENT OF SERVICES

Responsible Party (RP) is the person who will be paying the fee for services
(Leave Blank If Same Person Is Patient)

RESPONSIBLE PARTY: _____ SSN: _____
(Bishop name, family/friend name) (needed only for Tricare Ins.)

PHONE #: _____ Email: _____

RP's ADDRESS: _____ CITY, STATE, ZIP: _____

RP's RELATIONSHIP TO PATIENT: _____

IF using Tricare Insurance Nancy will need the NPI # of the patient's doctor to bill Tricare:

Dr's NPI#: _____

Signature of Responsible Party: _____
Date

NO SHOW OR LATE CANCELLATION/ CREDIT CARD PAYMENT CONSENT FORM

I authorize Red Cliff Counseling to charge my credit/debit card for professional services as early as 24 hours before our scheduled appointment. If I do not cancel before 24 hours, I recognize that Red Cliff Counseling will charge my card $65. As a late cancellation fee. If I do not show for my appointment and fail to cancel, I will be billed for the full session charge of $100. which will be charged directly to my card. **Your information is required below.**

I verify that my credit card information, provided below, is accurate. I also understand by signing this form that if no payment has been made by myself, my balance will go to collections if another alternative payment plan is not made by me within thirty days. I give Red Cliff Counseling permission to charge my credit card for balance owing on my account.

Client Name:_____

Name on card if different than client: _____

Credit card number: _____

Expiration Date: _____ **Security Code (CVV)** _____

Billing Zip Code: _____

_____ _____
Client/ Guardian Signature Date

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NOTICE OF PRIVACY PRACTICES

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

1.Your medical records are used to provide treatment, bill and receive payments, and conduct health care operations. Examples of these activities include but not limited to review treatment records to ensure appropriate care, electronic or mail delivery of billing for treatment to you or other authorised payers, appointment reminder text messages, and records review to ensure completeness and quality care. Use and disclosure of medical records is limited to the information outlined above except required by law or authorized by the patient or legal guardian.

2. Federal and State laws require abuse and neglect, domestic violence and threats to be reported to social services or other protective agencies. If such reports are made they will be disclosed to you or your legal representative unless disclosure increases further risk.

3. Disclosed information will be limited to the minimum necessary. You may request an account for any uses or disclosures other than those described in sections 1 and 2.

4. You, or your legal representative, may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identify the person authorized to request release, specify the information you want disclosed, the name and address of the entity you want the information released to, purpose and the expiration date of the authorization. Any authorization provided may be revoked in writing at any time. Psychotherapy notes are part of your medical records. Red Cliff Counseling has 30 days to respond to a disclosure request and 60 days if the record is stored off site.

5. You may request corrections to your records.

6. A request for disclosure may be denied under the following circumstances: disclosure would likely endanger the life or physical safety of you or another person, requested information references other persons, except another healthcare provider, or if released to legal representative would likely cause harm.

Occasionally I may need to consult with other professionals in their area of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

BY SIGNING BELOW, I AM AGREEING THT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT:

CLIENT NAME: _____

CLIENT SIGNATURE: _____
(OR GUARDIAN SIGNATURE IF CLIENT IS A MINOR)

DATE: _____