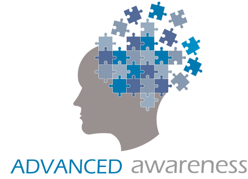
Client Name: ________________________________



COUNSELING SERVICES CLIENT INFORMED CONSENT, HIPAA, and CONSENT TO TREAT

COUNSELING is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

CLINICAL STAFF: Our clinical staff consists of the following: licensed counselors (designated as LCSW and CMHC), associate licensed counselors (designated at CSW and ACMHC), and intern level counselors (designated as MSW-i/CSW-i and ACMHC-i). Intern level may inform you of their intern status, it also shall be made apparent by their designation on our website and on their door, these designations are articulated above. All of the above mentioned clinician statuses are masters education level clinicians with the same scope of practice; they are educated in and proficient in the field of social work and/or counseling and the practice of mental health therapy, also known as psychotherapy, including the processes of diagnosing and treatment planning. You will be assigned to the most appropriate fit clinician based on clinician specialties. Clinicians undergo an intern and associate level status for a period of up to five years or more; during this time they have a senior clinician supervisor throughout the duration for quality assurance; the supervising clinician will be a direct supervisor and/or the clinical director of the facility. All services are documented as per ordinary procedure, with the involved supervisor or director as provider of record for the purposes of validating documentation. Further, on occasion, we will have bachelor level interns on site. They are there to assist with any office related needs or client questions. Bachelor level interns may assist therapists in group therapy but do not conduct therapy in any capacity; they are also given the option to sit in on sessions with explicit client permission for the purposes of their learning; should a bachelor level intern ask to sit in on your session, your primary therapist will discuss this with you and ask for your verbal permission. You have the right to decline.

CONFIDENTIALITY: All interactions with Advanced Awareness Counseling LLC, including scheduling of or attendance at consultations and appointments, content of your sessions, progress in counseling, and your records are confidential. No record of counseling is contained in any academic, educational, or job placement file. You may request in writing that the counseling staff release specific information about your counseling to persons you designate.

EXCEPTIONS TO CONFIDENTIALITY:

- The counseling staff works as a team. Your therapist may consult with other counseling staff and/or clinical supervisors to provide the best possible care. These consultations are for professional and training purposes.
- If there is evidence of clear and imminent danger of harm to self and/or others, a therapist is legally required to report this information to the authorities responsible for ensuring safety.
- Utah state law requires that counselors and staff who learn of, or strongly suspect, physical or sexual abuse or neglect of any person under 18 years of age must report this information to the department of child and family services.
- A court order, issued by a judge, may require the counselors and/or their staff to release information contained in records and/or require a therapist to testify in a court hearing.

APPOINTMENTS, FEES AND PAYMENT AGREEMENT:

- Therapy sessions are scheduled by appointment only directly with your therapist. If a different member of the Advanced Awareness Counseling team receives your call or correspondence they will direct your message accordingly.

- The normal length of time for a therapy session is 50 minutes, with 10 minutes of time for your therapist to dedicate to documentation of your session. The price of a therapy intake is $185; the cost of a therapy session is $160.00. A sliding scale fee option is available to qualifying parties who hold no current or active insurance. The sliding scale fee approval form will be provided to you upon request so that you may apply for qualification; income verification to qualify for a sliding scale reduced rate is required.

Initial Here__________

- *Payment Terms:* Payment for professional services is due when services are rendered prior to the beginning of your session, unless other arrangements have been agreed to. We do not utilize invoices for the collection of co-payments and coinsurances except if extenuating circumstances require it; if an invoice is sent, payment in full is required within five business days. If you

- have mental health insurance coverage, please check with your insurance company to determine whether Advanced Awareness Counseling is considered to be in network and what your co-pay or co-insurance cost is. If you require a receipt for payment of services, please request a receipt at the time of payment. No receipt will be provided otherwise.

- Advanced Awareness Counseling, LLC. only accepts payment at time of service (cash, check, Square, PayPal, debit, and HSA cards are accepted). Payment at time of services is $185 for an initial new client Intake Session and $160.00 for a standard 50 minute Counseling Session. Time of service payments may vary if client is insured; the associated fees would then be based on the individual insurance plan. Fees are subject to change at any time and without notice. Advanced Awareness Counseling, LLC. offers a sliding scale fee schedule to qualifying clients with proof of income.
- We require a credit card, debit card, or HSA card to be saved on our secure point of sale system and/or written on this contract, which will be stored in a secure and locked cabinet, before services will be rendered. It is our policy that all services are paid for at time of service. If services are not paid at that time, it is our policy that they shall be automatically billed directly subsequent to discovery of unmet payment.
- The sliding scale is by application only; no sliding scale fee can be offered without proof of income via previous year's tax return or two most recent paystubs. Payment at time of service applies to parties who are not actively insured by any insurance company and/or currently hold no insurance policy. Payment at time of service also applies to all insurance co-pays and/or co-insurances, insurance unmet deductibles, and insurance denials or no-pays.
- Clients who have been granted the exception to receive e-mailed invoices via PayPal for counseling service payments are kindly asked to pay their balance within 5 business days. If payment is not received within the billing grace period of 7 business days, Advanced Awareness Counseling will attempt to remind the client directly of the unpaid balance. If balance is not paid at that point, any outstanding will be sent Advanced Credit Management (ACM) for collections after 30 days.
- Advanced Awareness Counseling, LLC. accepts specific insurances. Please review our website for information on which insurances we are in network with. If you elect to utilize your insurance for counseling services you agree that it is your responsibility to ascertain the coverage of mental health services and for what duration. We can also assist you in verifying your insurance benefits upon request. We will bill out-of-network insurance upon client request, however, it is the client's responsibility to obtain authorization from the insurance provider and to provide an authorization number to your counselor at.
- If your insurance claim in denied, whether billed in-network or out-of-network, you as the client agree that you will be responsible for payment in full. We are in possession of the insurance EOBs and can furnish information regarding the denial of payment by your provider upon request. You should be receiving EOB's directly from your insurance company that matches what we receive.
- Further, you agree that you will be responsible for payment of co-payment or co-insurance as per the terms of your insurance plan. Payment for co-payment and co-insurance is due at the time of service. By agreeing to the utilization of your insurance, you agree to the release of information to your insurance provider and any billing providers at Advanced Awareness Counseling.

- *Insurance denial and no pay:* Advanced Awareness Counseling receives remittance advice and explanation of benefits for all payments paid or denied by your insurance provider. There are cases in which your insurance coverage will be denied (e.g. your deductible has not been met, restrictions on CPT code or diagnostic code, no mental health coverage, etc). In such cases, you will be required to pay either the full billable rate or the negotiated insurance rate. The insurance explanation of benefits will indicate if you are eligible to pay a discounted rate. You will be charged automatically for the agreed upon price with the payment information credit/debit/ or HSA card information on file. If there is no credit card information on file you will be asked to pay that fee by the next session or you will receive an invoice. Unpaid insurance claims exceeding 30 business days with no payment by the client will be sent to an external debt collection agency, Advanced Credit Management (ACM) for the collection of the debt.

- Please contact your therapist directly as a first response for notification of cancellation. If you cannot contact them, please notify us at (435) 224-4660 if you will be late or need to cancel. You may text or call. A ***twenty-four (24) hour*** notice of cancellation allows us to use the time for other clients. Cancellations made after this window are subject to a ***$50.00*** cancellation fee. Clients will be asked to sign written agreement regarding their understanding of this policy and agreement of automatic billing for any late cancellation or missed therapy sessions; your credit/debit card information will be collected and automatically billed with your signed consent. The written agreement is included in this consent. If you do not arrive for your first initial intake appointment, either due to a no show or a late cancellation, you will be billed the $50.00 fee upon rescheduling the intake appointment. If the no-show contract with credit/debit information and consent to bill has not yet been completed, you acknowledge that after the first late cancellation or no-show that you will receive an invoice via e-mail and/or by mail, for which you will be responsible to pay within 5 business days.

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- Unpaid no show or late cancellation fees are subject to being sent to collections for non-payment. No-shows and cancellations are kept on your therapy record, with documentation by the therapist with the explanation given by the client for the absence, along with date and time the cancellation or no show occurred.
- Your therapist reserves your appointment time to see no one else except you, therefore, appointment times not cancelled in sufficient time cannot be utilized by someone else. Missed appointments are not covered by insurance companies and the late fee must be paid for either by automatic billing, via invoice, or by the time of the next appointment if you plan to pay in person. A credit card information form is included with this consent for authorization to charge the no show/late cancellation fee. Unpaid late cancel or no show fees exceeding 30 business days with no payment response from the client will be sent to an external debt collection agency, Advanced Credit Management (ACM) for the collection of the debt.

- *Debt Collections:* Advanced Awareness Counseling, LLC. utilizes the services of an outside debt collector, Advanced Credit Management (ACM); this is a debt collector that handles debts that have not been paid at time of service, at the next visit, or via invoice sent direct by Advanced Awareness Counseling, LLC. Debts that can and will be sent to collections include the following: unpaid invoices or balances accrued for longer than 14 days and no commitment from client to pay these bills, insurance payment denials (patient responsibility), unpaid no-show or late cancelation fees. By signing this contract you agree that any unpaid bills that cannot be directly collected by Advanced Awareness Counseling, LLC from client directly or with the card saved on file, will be sent to Advanced Credit Management (ACM). Once debts have been sent to ACM, you acknowledge that Advanced Awareness Counseling, LLC. can no longer maintain contact with you regarding the debt or directly handle the collection of the unpaid or past due balance and from that point forward you must work directly with Advanced Credit Management (ACM). While it is not anticipated that there will be any problems with your account, in the event that collection procedures become necessary with respect to a delinquent account, all the costs and expenses, included but not limited to, reasonable attorney's fees, collection costs and interest (18%) incurred in collecting said delinquent account shall be added to your bill. By signing this document you agree to pay the cost of the collection fee, which is in addition to your already outstanding balance.

- *Domestic Violence and Substance Abuse group classes/sessions (and other groups) time of service fees:* Group classes/sessions are charged at $45.00 per 1-hour class. Often groups may be small in size; if there are fewer than 2 individuals able to attend a group, a group will not be available. Unpaid balances for these services fall within the same financial collection parameters as all other therapeutic services and late fees.

GRIEVENCES: Advanced Awareness Counseling strives to provide the best quality of care. We make every effort to ensure our staff is qualified and competent, that staff is continually training in their area of expertise, that staff is respectful and professional, and that staff are reasonably available to assist you. We further make every effort to ensure that the environment is appropriate and safe. Should any issue arise we will do our best to rectify the problem or accommodate your needs.

Should any issues arise you have the option of bringing your concerns to the attention of your individual therapist. You also have the option of bringing your concerns to the clinical director, Marissa E. Sherman, CMHC, at marissa.advancedawareness@gmail.com. Further, you reserve the right to bring your concern to the attention of the Department of Occupational Licensing and/or the Utah Department of Human Services.

NOTICE OF PRIVACY PRACTICES: Protecting your privacy and your medical information is at the core of our practice. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet.

Keeping your information: Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our right under the law or any agreement with you.

Working to meet your needs through information: In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide service to you and to process your claims.

Keeping information accurate: Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call the executive director at (408) 375-3311 or write us at advancedawarenessllc@gmail.com so we can take appropriate action to correct any erroneous information as quickly as possible.

How – and why – information is shared:

We limit who receives information and what type of information is shared.

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- *Sharing information within the practice.* We share information within our practice for the purposes of professional development and clinical supervision by a LCSW or CMHC for our therapists. Information is kept confidential within this dynamic.

- *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as insurance carriers and claim processing services. These companies act on our behalf and are obligated contractually to keep the information we provide them confidential.

- *Other*. Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission. Information sent to any other party requires a signed release of information from the client stating the information to be shared, with whom, for what purpose, and for what duration.

- *Notes*: If we receive a request to share you session notes we will notify you and discuss if this is something you feel comfortable with or desire to share. We will also ask for an additional release of information to ensure your rights and safety.

If we receive a subpoena or similar legal process demanding the release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Should we be required to attend court on your behalf you will be billed the standard time of service fee per hour. Further, no counselor at Advanced Awareness Counseling, LLC. will testify as an expert witness and would testify as a lay witness. Except as required by law or as described above, we do not share information with other parties, including government agencies. The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Client Records and Confidentiality Policy under HIPAA

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.

The Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule") establishes a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services ("HHS") issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Privacy Rule addresses the use and disclosure of individuals' protected health information ("PHI").

During the course of therapy, the Therapist shall keep and maintain accurate records of therapeutic services to include, but not be limited to, dates of services, types of services, progress or case notes and billing information (collectively referred to as the "PHI"). PHI may include, but is not limited to the identity, diagnosis, evaluation, or treatment of the Client. PHI may also include, but are not limited to, any information revealed by you in counseling or a therapy session and most information placed in your file.

AAC considers all information acquired during therapy as Protected Health Information under the Privacy Rule. As such, your therapist may disclose your PHI in only two circumstances: (a) you specifically authorize it; or (b) there is a specific exception under the HIPAA rule.

Your therapist may disclose PHI where such disclosure is for treatment, payment, or operational purposes. For example, AAC schedules facilities with a third-party provider. We consider having an appointment with a therapist as PHI. Prior to your appointment, we may disclose the day and time of your appointment to our provider for purposes of securing appropriate facilities and confirming your appointment. Therefore, we may disclose the day and time of your appointment with our third-party provider.

Your therapist may also disclose PHI in other situations: (1) where uses and disclosures are required by law; (2) where uses and disclosures concern victims of abuse, neglect, or domestic violence; (3) where uses and disclosures are for health and oversight activities (4) where uses and disclosures are for judicial and administrative proceedings; (5) where uses and disclosures are for law enforcement purposes; (6) where uses and disclosures are for research purposes; (7) where uses and disclosures are to avert a serious threat to health or safety; (8) where uses and disclosures are required under Workers' Compensation.

The Therapist shall keep your PHI for a minimum of 5 years for an adult client and 5 years beyond the age of 18 for a minor.

Communications between a client and a professional are confidential and may not be disclosed in civil cases. Records of the identity, diagnosis, evaluation, or treatment of a client, which are created or maintained by a professional, are confidential and shall not be disclosed in civil cases.

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There are important exceptions to confidentially. Under Utah law, a therapist is required to report the following: (a) abuse or neglect of minors; (b) abuse, neglect, or exploitation of elderly or disabled persons; (c) abuse, neglect, and illegal, unprofessional, or unethical conduct in an in-Client mental health facility, a chemical dependency treatment facility or a hospital providing comprehensive medical rehabilitation services; (d) sexual exploitation by a mental health services provider; (e) certain release and exchange of information concerning the treatment of a sex offender. In addition, a therapist must report sexual misconduct as follows: the Therapist has reasonable cause to suspect that a client has been the victim of a sexual exploitation, sexual contact, or therapeutic deception by another licensee or a mental health services provider during therapy or any other course of treatment, or if a client alleges sexual exploitation, sexual contact, or therapeutic deception by another licensee or mental health services provider (during therapy or any other course of treatment). Finally, our therapists will warn others if he or she reasonably believes that you may inflict harm on yourself or others. This document may be updated without notice so please review it each time you visit us. A copy of this statement is always available upon request.

DOMESTIC VIOLENCE AND SUBSTANCE ABUSE COURT ORDERED CLIENTS: Advanced Awareness Counseling, LLC. services populations involved in the court system and who are on probation for domestic violence and/or substance abuse issues. The policy of our facility regarding payment at time of service and treatment attendance is as follows:

- Court ordered and/or probation clients may not miss more than two (2) consecutive classes/sessions. If two consecutive classes/sessions are missed, Advanced Awareness Counseling, LLC. is obligated to notify the court and/or your probation officer. All court ordered and/or probation clients are required to remain in compliance with consistent attendance and payment.

- Court ordered and/or probation clients who carry a balance will not be considered in compliance or considered successfully terminated upon completion of classes/sessions until balance is paid in full. Non-compliance in paying an outstanding balance will result in notification to the court and/or probation officer of non-compliance and non-successful completion. As such, a successful completion letter will not be sent to entities involved in the case until balance is paid in full.
- Domestic Violence and Substance Abuse group classes/sessions time of service fees are charged at $45.00 per 1-hour class. Often groups may be small in size; if there are fewer than 3 individuals able to attend a group, a group will not be available. If no group class is available at time of requested service, the opportunity to be seen on an individual basis will be made available to you until a group is initiated.

CLIENT RIGHTS:

- You have the right to be treated with dignity and respect.
- You have the right to know the qualifications and professional experience of your therapist.
- You have the right to expect professional and competent help.
- You have the right to ask questions about anything related to your treatment.
- You have the right to know information concerning diagnosis and treatment philosophy.
- You have the right to participate in decisions related to your treatment.
- You have the right to request another therapist should you not be satisfied with the therapist assigned to you.
- You have the right to end therapy at any time.
- If this agency cannot meet your specific needs you have the right to request and be provided with referral sources for adjunct or alternative therapists and therapies.
- You have the right to see your records. (Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right.)
- You have the right to request a copy of your records, and we have the right to charge you a reasonable fee for them. (Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right.)
- You have the right to request amendments to your records.
- You have the right to receive a history of all disclosures of any protected health information (PHI). We have the right to charge you a reasonable fee.
- You have the right to restrict the use and disclosure of your protected health information (PHI) for the purposes of therapy, payment, and operations.
- You have the right to register a complaint with Utah Division of Occupational of Occupational and Professional Licensing if you feel your rights, herein explained, have been violated.

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DISCLOSURES: During the course of therapy, you should be aware and understand the following: Therapy may not be successful and could open unexpected emotionally sensitive areas. Success requires client participation. Although therapy is not for everyone, there may be risks associated with not engaging in therapy. Please discuss with your therapists the pros and cons of engaging or not engaging in therapy. If you do not feel that this organization and/or therapist is a good fit, Advanced Awareness will help provide you with referrals in order to seek appropriate treatment. These referrals are suggestions; you have the right to seek out other referrals or not contact suggested referrals.
The following therapy modalities and frameworks are some of those generally used with our Clients: a) motivational interviewing; b) emotionally focused therapy for couples and families; c) cognitive behavioral therapy; d) solution focused therapy; e) attachment theory; f) behavioral and cognitive therapy; and g) client-centered. In addition, other evidence based practice and practice based evidence models are used when available and appropriate for various presenting problems. These are widely-used, generally accepted modes of therapy.

Your therapist is not a physician and cannot prescribe medications. Your therapist is not an attorney and cannot give legal advice. Your therapist is not a financial consultant and cannot give investment or financial advice. Your therapist may need to consult with your physician, attorney, or other therapist. Prior to disclosure of any Protected Health Information, you must consent in writing to disclosure of such information (release of information form). If you request that we write any letter on your behalf we will require a release of information for each specific recipient. We will also request that you sign a waiver indicating that this letter has been requested for the specific purpose indicated by you as the client and that you shall not hold the therapist or Advanced Awareness Counseling, LLC. liable for the outcome or consequences of such letter. We hold the policy that we will not make attestations to the mental health of any client; if such information is needed in a letter we will use the language “client reports that” or similar language to indicate that information is based on client self-report. We will not provide professional opinions to outside parties regarding mental health status except in extraordinary circumstances.

Advanced Awareness does not keep or maintain emergency staff; nor will your therapist be available 24 hours a day**; Texting, emailing and telephoning your therapist will not be a reasonable substitute for necessary therapeutic support in an emergency. If an emergency occurs, you agree to contact 911 or go to your local hospital.**

CLIENT RESPONSIBILITIES:

- You have the responsibility of taking an active role in the counseling process.
- You have the responsibility of providing information about past and present physical and psychological problems including hospitalizations, medications and previous treatment.
- You have the responsibility of keeping your appointments.
- You have the responsibility of arriving on time for your appointment.
- You have the responsibility to pay for treatment at time of service.
- You are responsible for not bringing weapons to the counseling office. Weapons of any kid are prohibited.

CONSENT TO TREAT:

- I understand the purpose and course of therapeutic counseling treatment as outlined in the Welcome Letter I was provided, as well as by the explanation provided in this document and by the explanation given by the staff at Advanced Awareness Counseling, LLC.
- Additionally, I am aware that psychotherapeutic, counseling, and/or addictions/recovery services, while studied and reliable, are not exact science and that the type(s) of treatment I receive will depend primarily on my own needs and abilities. I understand that, as such, I cannot be given any guarantees about the results of any of these services. Further, I also understand that I may withdraw this consent at any time.
- By signing this document I grant my consent to begin therapy with my assigned counselor at Advanced Awareness Counseling, LLC.

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***By signing this document I acknowledge that I understand and agree to all of the information stated above, I am giving my consent to be treated by Advanced Awareness Counseling, LLC. for the purposes of mental health counseling, domestic violence counseling, and/or substance abuse counseling and/or assessment.*

I consent to the release of information provided to my insurance carrier for the purposes of billing and electronic remitance advice. I also consent to release of information for all other entities mentioned in this document above.

I understand the billing pocedures and that a diagnostic code will be provided to the insurance carrier for the purposes of billing and I give my consent for that information to be shared for those purposes. I understand that a diagnostic code will be included in my assessments sent to the court and/or my probation officer and I consent to release of information to entities involved in my court case and I will provide a separate written consent for these entities.

I understand that specific therapuetic information (e.g. session notes) will be kept confidential in all cases with the exception of subpeonas, an audit from the Department of Health and Human Services, the Department of Occupational Licening, or from my insurance provider; should an audit be required by any one of these entities, I grant my consent for the release of clinical and personal information. If additional parties are requested to be listed for release of information, an additional release form will be provided by me to Advanced Awareness Counseling, LLC. and I will sign for each party making a request.

I am fully aware of my payment responsibilities and agree to all terms regarding payment at time of service and automatic billing. I acknowledge that I am responsible to pay for balances that I carry and agree to automatic billing for unpaid services using any card information given to Advanced Awareness Counseling. I agree that I am required to pay for invoices that are sent to me, to pay session fees when insurance does not pay for my services, to pay for late cancellation and no show fees, and further understand the fact that a debt management agency will be utilized on any payment account where a balance or debt has become deliquint.

I understand that I am entitled to a copy of this consent and I understand that I must request a copy of this consent for my records. I am also aware that this consent and its provisions are also available online at www.advancedawarenesscounseling.com under the "paperwork" tab. If I do not accept and retain a copy of this consent at time of service I acknowledge that I am still bound by the content set forth in this contract.

*By signing this document I acknowlegde that I will abide by the terms of this contract and will make reference to it if I have any questions.***

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Insurance Information:

Insurance Company:____

Name of Patient:____

Patient Date of Birth: ____

Name of Insured (Policy Holder):_________________________________

Policy Holder Date of Birth:__________________________________

Client's Relationship to Insured/Policy Holder: □ **Self** □ **Spouse** □ **Mother** □ **Father** □ **Child** □ **Guardian**

Member ID#:____

Policy/Group#:____

Co-Pay $:________ **Deductible $:**________ **Coinsurance $:**_________

I acknowledge and understand that my signature or the signature of my legally responsible guardian on this page applies to: THE ENTIRETY OF THIS FORM (pages 1-9)/SERVICES AGREEMENT/RESPONSIBILIY TO PAY/CLIENTS RIGHTS AND RESPONSIBILITIES/CONSENT TO TREAT/INSURANCE INFORMATION/RELEASE OF INFORMATION FOR PURPOSES EXPLAINED:

___________________________________ **Date:**__________
Signature of Client

___________________________________ **Date:**__________
Signature of Guardian (if client is a minor)

___________________________________ **Date:**__________
Signature of Primary Therapist

___________________________________ **Date:**__________
Signature of Clinical Supervisor (if applicable)

___________________________________ **Date:**__________
Signature of Clinical Director

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Permission to Charge Credit/Debit/HSA for Session Fee and No Show/Late Cancellation Agreement Contract

We require a credit card, debit card, or HAS card to be saved on our secure point of sale system and/or written on this contract, which will be stored in a secure and locked cabinet, before services will be rendered. It is our policy that all services are paid for at time of service. If services are not paid at that time, it is our policy that they shall be automatically billed directly subsequent to discovery of unmet payment. As per the information provided in this consent, as the client, guardian of the client, or individual responsible for billing, you have agreed to pay at time of service. You have also agreed to pay for sessions not covered by your insurance provider, the cost of which will be the insurance negotiated rate and would be indicated on your explanation of benefits. All payments not made at time of service will be automatically billed to the credit, debit, or HSA card saved on file. Your card will be automatically billed before an invoice is sent; invoices are only sent for individuals who have not provided their billing information. Invoices not paid after 30 days will be sent to Advanced Credit Management, an external credit agency, for further handling and collection.
This document provides space below to include a specific card you would like to keep on file, however, any card given over the phone to a company staff member and/or that you use to pay at time of service, which is via the Square point of sale system, shall be considered a viable credit card for automatic billing. By signing this document you agree that card information given over the phone and/or saved via point of sale can and shall be automatically billed when conditions of non-payment are met.

We appreciate your prompt arrival for appointments. Please notify your therapist directly (first option) or contact the clinical director, the practice manager, Linda Bryan (435) 224-4660 before 24-hours of your appointment if you will be late or if you need to cancel your appointment. The practice manager will notify your therapist regarding your cancellation so that you will not incur a no-show fee. You must text or call to give ***twenty-four (24) hours*** prior notice of cancellation. This allows us to allocate that time for other clients. Cancellations made after this period are subject to a ***$50.00 cancellation/no-show fee***; this charge will be applied regardless of rationale for cancellation. This fee will be automatically charged to your credit card on file for the date of the missed appointment. Please understand that the therapist is still paid for their time whether a client arrives or not, as they have made the effort to accommodate and be in the office for your appointment.

Name on Card: ______________________________

Credit Card Number: ______________________________

Credit Card EXP: ______________________________

Credit Card Security Code: ____________________**Billing Zip Code:**____________

Your information will be kept confidential and protected and will not be used for any other purpose beyond which has been explained in this agreement/contract.

I ______________________________ have been made aware of, acknowledge, and
(Client's name)
understand and agree to the storage of my credit card information for the automatic billing for unpaid services, including insurance non-payments, as well as for the fees in the no show/late cancellation policy. I authorize that my credit card be automatically charged the amount owed for services unpaid, further, I authorize that my credit card to be automatically charged a $50.00 fee if I miss my scheduled appointment/session or cancel within less than twenty-four (24) hours prior notice. I understand, acknowledge, and agree that signature of this form additionally grants consent for automatic billing of payment card information given over the phone and/or saved to secure point of sale.

____
Client Printed Name

______________________________ ______________
Client Signature **Date**