HAPTEN COUNSELING SERVICES INFORMATION FORM

Full Name ____

Today's Date _________ Birth date_____________ Soc Sec #___________________

Address____

City______________________________ State___________ Zip_________________

Sex: M F Marital Status: M S D Sep

Home phone_______________ Work ________________ Cell ________________

Email Address______________________________________

Employer____

Employer Address ____

Occupation ____

Responsible Party Information

Full Name______________________________________

Relationship to Client _____________________

Birth date________________________ Soc Sec #_____________________________

Address____

City_______________________ State_________ Zip ___________________

Home phone________________Work ___________________ Cell _______________

Email address_________________________ Sex: M F Marital Status M S D Separated

Employer____

Employer Address ____

Employer Phone ______________________

Presenting Problem

Reasons for seeking therapy?

____

____

What do you hope to gain from therapy?

____

____

Client Medical History

Primary Care Physician ______________________________

PCP Phone _________________________ Fax________________________

PCP Address____

List any health concerns____

List Medications ____

Therapy History

Has client received therapy before? Y N

Name __________________________________

Address____

Phone_______________________Fax______________________

Was this helpful? ____

Have client ever seen a psychiatrist? Y N

Name __________________________________

Address____

Phone __________________________Fax ___________________________

Is client currently seeing a psychiatrist? Y N

Name ____

Address____

Phone_________________________Fax ______________________________

Is client currently taking psychotropic medication? Y N Please list:

____

Emergency Contact

Name____

Relationship to Client ____

Home Phone_______________ Work _______________ Cell ________________

Informed Consent

I have received a copy & read HAPTEN Counseling Services and HIPPA Privacy Policy.

I have received a copy of, understand, & I agree to HAPTEN Counseling Services Service Agreement.

Client’s Name ____ Date: ____________

Client’s Signature: ____ Date: ___________

Parent/Legal Guardian Signature (if client is a minor)

____ Date: ___________

Professional Service Agreement

This agreement is to clarify the business aspects of our relationship.

Fees & Billing

Private Clients:

- Individual Therapy (45-50 min) $105
- Family Therapy (45-50 min) $105

Health Insurance Billing or Reimbursement:

- Initial Assessment $125
- Individual Therapy (53-55 min) $125
- Family Therapy (55-60 min) $125

Health Insurance Coverage

- I am only a provider for PEHP insurance and while I do not work directly with other insurance companies, I can provide you with comprehensive receipts to submit to your insurance company for reimbursement of any mental health therapy fees they will cover. Call your insurance company to find out if you have out-of-network mental health benefits.
- Payment is due in full on the day of each session by cash, check, credit card and Venmo. Included in the above fees are brief phone calls (under 15 min) and routine paperwork.
- There will be a $25 fee for any cancelled check or declined credit card transactions.
- Any and all fees related to the collection of delinquent accounts(i.e. attorney's fees, court fees) will be the sole responsibility of the client or responsible parties indicated in this agreement.

Confidentiality

- The information you share will be kept confidential. I will ask you to *sign a release-of-information* form before discussing your treatment, or sending records about you to anyone else.
- Your confidentiality/privacy is protected by state law and by the rules of our profession, except in the following circumstances. The limits of confidentiality are:

1. If you were sent to me by a court or an employer for evaluation or treatment, the court or employer expects a report from me. You have a right to disclose only what you are comfortable with telling.

2. If you are **involved in a lawsuit,** and you tell the court that you are in therapy, I may then be ordered to show the court my records. Please consult your lawyer about these issues.

3. If you make a **serious threat to harm** yourself or another person, the law requires the therapist to try to protect you or that other person.

4. If I believe a **child, or a dependent adult, has been or will be abused or neglected,** I am legally required to report this to the authorities.

5. If you send a **health insurance** claim form to your insurance for reimbursement, it will have a mental health diagnosis listed and it will become part of your permanent medical record.

6. In order to provide you with the best treatment I may **consult with other mental health professionals** about your case.

Late Cancellation/No Show Policy

If you are unable to make your scheduled appointment, please cancel at least 24 hrs. in advance so another client can be scheduled during that time.

If 24 hrs. notice is not given, you will be charged $75 for the missed session. We reserve the right to charge credit cards that are kept on file for no shows and late cancellations.

In Case of Emergency

If you have an emotional, behavioral, or medical crisis call the University of Utah Neuropsychiatry Institute at 801-583-2500, call 911, or go to the nearest emergency room. HAPTEN Counseling Services does not provide 24-hour crisis services.

Special Note on Confidentiality with Children and Adolescents.

Therapy with people of any age relies on the client's confidence that what is shared with the therapist is private and confidential. While parents and guardians have the right to know general information about how the therapy with their child is progressing, **in signing this form you waive the right to know the private details of the child's therapy or to have access to the confidential therapy records of the child.** A general summary can be provided at any time upon request.

I understand, and agree to, the policies as stated above, and I give consent for treatment at HAPTEN Counseling Services.

Client's Name ____ Date: ___________

Client's Signature: ______________________________________ Date: ___________

Parent/Legal Guardian Signature (if client is a minor)

____ Date: ___________

CLIENT COPY

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Client's Name ____ Date: ____________

Client's Signature: ____ Date: ____________

Parent/Legal Guardian Signature (if client is a minor)

____ Date: ____________

CLIENT COPY

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW HEALTH 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”. This Notice of Privacy Practices describes how I may use and disclose your protected health information in accordance with applicable law and the ACA Code of Ethics. It also describes your rights regarding how you may gain access to and control your protected health information. As part of your protected health information I keep some specific information in what are called “psychotherapy notes”. These notes are kept separate from your health record and are given much higher privacy protection. They contain my impressions about you and details of the psychotherapy conversation I consider to be inappropriate for the health record. They contain information pertinent only to my future work with you. They are not available for your review, nor to insurance and managed care companies.

I am required by law to maintain the privacy of protected health information and to provide you with notice of my legal duties and privacy practices with respect to protected health information. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all protected health information that we maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy in the office, 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 protected health information 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.

For Payment : I may use and disclose protected health information 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 protected health information necessary for purposes of collection.

For Health Care Operations : I may use or disclose, as needed, your protected health information in order to support my 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 protected health information with third parties that perform various business activities (e.g., billing or typing services). This is allowed only if I have a written contract which requires that business to safeguard the privacy of your protected health information.

Required by Law : There are occasions which require me under law to disclose your protected health information with or without your authorization. Some examples are:

- If you are in imminent danger of committing suicide I am legally and ethically bound to intervene in anyway necessary to prevent that including contacting family members and the police.
- To the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the Federal privacy requirements.
- If you are at risk of being a serious and imminent threat to the health or safety of a person or the public, I will disclose information to prevent or lessen that serious threat. I will disclose it to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- If you are in imminent danger of committing suicide I am legally and ethically bound to intervene in anyway necessary to prevent that including contacting family members and the police.

- If there is suspicion of neglect or abuse of a child in the past, present or future I am required by law to report that to the Utah Division of Child and Family Services or the police.
- If I have reason to believe that a vulnerable adult is suffering from abuse, neglect, abandonment or exploitation, I am required by law to make a report to either the Utah Adult Protective Services or the nearest law enforcement agency as soon as I become aware of the situation.
- Utah law requires that I report the names of any individuals having communicable diseases to the Health Department.
- I may disclose your personal health information in accordance with workers compensation laws.
- If you become involved in the court system a judge can order that I provide information on you. Two examples of this are child custody cases and cases in which clients bring action against therapists.

With Your Verbal Permission: I can share some information about you with your family or close others. I will only share information with those involved in your care and anyone else you choose such as close friends or clergy. I will ask you about who you want us to tell what information about your condition or treatment. You can tell us what you want and we will honor your wishes as long as it is not against the law.

If it is an emergency - so I cannot ask if you disagree - I can share information if I believe that it is what you would have wanted and if I believe it will help you if I do share it. If I do share information, in an emergency, I will tell you as soon as I can. If you don't approve I will stop, as long as it is not against the law

With Your Written Authorization: Uses and disclosures not specifically permitted by the circumstances described above will be made only with your written authorization, which may be revoked.

Your Rights Regarding Your Protected Health Information: You have the following rights regarding protected health information I maintain about you. To exercise any of these rights, please submit your request in writing.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy protected health information

that may be used to make decisions about your care. Your right to inspect and copy protected health information 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.

- **Right to Amend.** If you feel that the protected health information I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your protected health information. 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 protected health information for treatment, payment, or health care operations. I am not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about health matters in a certain way or at a certain location. For instance, you can ask me to avoid calling you on selected phone numbers or ask that I send bills to an alternate address.
- **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 me 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.

Effective Date. The effective date of this Notice is February 1, 2012. (Updated January 2019)

This form will allow me to share information with current or previous treatment providers (ie. Psychiatrist, Inpatient Facility, Therapist, MD, Nutritionist, etc).

Consent to Release Protected Health Information

Client Name ___________________________________ Date of Birth ___________

I, ____, hereby authorize

_____________________________________ to release to and receive information from Nicki Hopwood, MSW, LCSW for the purposes of: (check all that apply)

_______ Coordination of Treatment

_______ Consultation

______ Assessment and Diagnosis

______ Treatment Summary and Recommendations

______ Psychological/Psychiatric Assessments

______ Medical Records/labs

______Other

Agencies/Individual Providers, Addresses, Phone Numbers, Fax, Emails

____

____

____

____

____

This authorization for release of protected health information is specifically limited to the information specified above and is made in accordance with the Health Insurance Portability and Accountability Act (HIPPA). State and federal laws prevent disclosure of your protected health information without your consent. This release shall remain in effect until 90 days after discharge from treatment.

Client signature ____________________________ Date _________________

Parent/Legal Guardian Signature (if client is a minor)

____Date _________________

Witness ___________________________________ Date _________________

<u>Minor Assent Form</u>

I understand that my parent or guardian may consent for my treatment; however, I have also been asked to give my assent for my own treatment. By signing below, I realize that Nicki Hopwood, has asked for my own assent to treatment.

Affidavit of Receipt and understanding of Client Rights

My rights as a client of HAPTEN Counseling Services include the following:

- To have privacy of information and privacy for both current and closed records
- To be informed that DCFS and DJJS may review their confidential information for auditing purposes
- To be informed of reasons for involuntary termination and criteria for readmission to the program
- Te be free from potential harm or acts of violence to self or others
- To be informed of my responsibilities, including privileges and rules of conduct
- To be informed of services fees and other costs
- To have a grievance and complaint procedure
- To be free from discrimination
- To be treated with dignity
- To communicate by telephone or in writing with family, attorney, physician, clergyman, and counselor or case manager, except when contraindicated by professional or supervisory personnel
- To have a defined smoking policy in accordance with Utah Clean Air Act
- To be informed of a statement of maximum sanctions and consequences

I, the undersigned, have been informed of the above rights. My signature herein indicates my receipt and understanding of such rights.

____

Client Signature/Date