New Client

Counselor’s Name:

**Please sign back page with your counselor**

**Welcome to Compass Counseling and Consulting.**

We are committed to helping you accomplish your goals through delivering high quality services.

Please read and complete the following information. If you have questions about the Informed Consent and Initial Paperwork, please consult with your therapist. This document needs to be completed and signed on the day of your initial appointment .

Please provide your therapist with a **copy of your insurance car**d/information + **photo identification**.

To begin, please list your top reasons or goals for seeking counseling at this time:

Reason / Goals:







Thank you.

Next, please complete the information below and sign where indicated. Locations for signature or initials are marked with an asterisk on the left hand column.

Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_

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| **CLIENT INFORMATION: (As it appears on Medicaid Card)** | | | | | | | | | | **If Client Is A Minor: (Parent / guardian information)** | | | | | | |
| **Client Legal Name** | | | | |  | | | | | Name |  | | | | | |
| Address |  | | | | | | | | | Address |  | | | | | |
| City/State/Zip | | | |  | | | | | | City/State/Zip | | |  | | | |
| Phone Number | | |  | | | | Alt. # | |  | Home Phone | |  | | | Work Phone |  |
| Client Birthday | | | | |  | | | | | Alternate/Cell Phone | | | |  | | |
| Email | |  | | | | | |  |  | Relationship | |  | | | | |
| Social Security # | | | | | |  | | | |  | | | | | | |
| **MEDICAID AND/OR INSURANCE INFORMATION:**  \*\***Please provide card to be copied\*\*** | | | | | | | | | | **EMERGENCY CONTACT:** | | | | | | |
| Medicaid Number: | | | | | | | | | | Name |  | | | | | |
| Insurance Co. Name: | | | | | | | | | | Address |  | | | | | |
| Insured’s Name: | | | | | | | | | | City/State/Zip | | |  | | | |
| Insured’s Birthday: | | | | | | | | | | Home Phone | |  | | | Work Phone |  |
| Group Number: | | | | | | | | | | Alternate/Cell Phone | | | |  | | |
| Employer Name: | | | | | | | | | | Relationship | |  | | | | |

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| --- | --- |
| **Responsible party for payment (if different than above)** | |
| Name: | Phone Number: |
| Address: | Relationship to patient: |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **All boxes must be filled out in order to be processed. Indicate only one answer for each box.**  **Answer *all* questions, even if client is a child.** | | | | | | | | | | | | | | | | | |
| **1) Date this form completed:** | | |  | | | | | | | | | | | | | | |
| **2) How was client referred?**    Caseworker/PO Name: | 01 Self  02 Family / Friend  03 Social Agency  04 Educational System | | | | 05 Court, Law Enforcement, Corrections  09 Private Practice Mental Hlth. Prof.  06 Private Psychiatric/Mental Health Prog.  10 Other Persons or Organization  07 Public Psychiatric/Mental Health Prog.  11 Unknown  08 Clergy  12 Physician or Medical Facility    Caseworker/PO Phone: | | | | | | | | | | | | |
| **BOTH # 3 and 4 must be answered:**  **3) Indicate patient’s race:** | | 01 American Indian  02 Pacific Islander  03 Black | | | | | 04 White (Caucasian)  05 Other  06 Asian | | | | | | | | | 07 Alaska Native | |
| **4) Client’s Hispanic / Spanish Origin (if any):** | | 09 Not of Hispanic Origin  01 Mexican / Mexican American | | | | | 02 Puerto Rican  03 Cuban | | | | | | | | | 04 Other Hispanic | |
| **5) List the client’s marital status (fill out even if client is a child)** | | 01 Single - Never Married  02 Married - Spouse in Home | | | | | | | | 03 Married but Separated  04 Divorced | | | | | | | 05 Widowed |
| **6) Indicate the client’s Current Education Type:** | | 01 Regular Education  02 Special Education  03 Alternative Education (toward high school degree) | | | | | | | | | | | | 04 Continuing Education  05 Vocational Training  06 Not Currently Enrolled | | | |
| **7) Indicate highest level of education completed:** | | P Preschool  K Kindergarten  01 1st Grade  02 2nd Grade  03 3rd Grade  04 4th Grade  05 5th Grade | | | | | | 06 6th Grade  07 7th Grade  08 8th Grade  09 9th Grade  10 10th Grade  11 11th Grade  12 12th Grade | | | | | | | A High School Graduate  B Post High School Graduate  C College Graduate  D Some Graduate School  E Graduate School Graduate  N Never Attended School | | |
| **8) List the Household Monthly Income (include parent/guardian income if client is a child) *(Do not list yearly income, hourly wage, or source of income in this box)*** *Income cannot be zero, but you can choose what you put*: | | | | | | | | | | | | | **$** | | | | |
| **9) List (name and relationship) the number of people living in the home (related and non-related):** | | | | | | | | | | | |  | | | | | |
| **10) Is client a veteran?:** | | 01 Yes  02 No | | | | | | | | | | | | | | | |
| **11) Indicate client’s preferred language:** | | ENGL English | | | | | | SPNSH Spanish | | | | | | |  | | |
| **12) Has client received mental health treatment before? (If more than one category fits, list MOST RECENT ONLY):** | | 00001 None  00002 Valley Mental Health  00004 Psychiatric Hospital | | | | | 00008 General Hospital  00016 Outpatient (non-VMH)  00032 Drug Program | | | | | | | | | 00064 Alcohol Program  00128 Residential Treatment (Non-Hospital) | |
| **13) Expected principal payment source as reported by staff?** | 01 Personal Resource  02 Service Contract  03 Medicare  04 Medicaid | | | | 05 Provider to Pay Most Cost  04 Workers Compensation  06 Commercial Health Insurance  05 Other Public Resources  07 Veterans Administration  06 Other Private Resources  08 CHAMPUS  03 Unknown | | | | | | | | | | | | |
| **14) List employment status (fill out even if client is a child):** | | 31 Employed Full-time - 35+ Hrs  32 Employed Part-time – less than 35 Hrs  33 Supported / Transitional Employment (full-time) | | | | | | 34 Supported / Transitional  35 Homemaker  36 Retired | | | | | | | 37 Volunteer  38 Unemployed - Not Looking  39 Unemployed - Disabled  40 Unemployed - Looking | | |
| **15) What is the client’s current living situation?** | | 01 On the Street / In a Shelter  02 Private Residence or Apartment | | | | | | 03 In A Nursing Home  04 In A Boarding Home  05 Other Residential Facility | | | | | | | 06 Jail / Correction Facility  07 Other Institution  08 Foster Care (Adult or Child) | | |
| **16) Indicate if client is seeking treatment voluntarily or involuntarily (court-ordered). If involuntary, indicate if court is *civil* or *criminal:*** | | | | | | | | | Voluntary  Involuntary/civil  Involuntary/Criminal | | | | | | | | |
| **17) Indicate client legal status*:*** State Hospital Committed | | | | | | | | | State Hospital Commitment  Not Civilly Committed  Civilly Committed | | | | | | | | |
| **18) Is the client seeking Alcohol and Drug Services?** | | | | | | 01 Yes  02 No | | | | | | | | | | | |
| **19) Is the client pregnant?:** | | | | 01 Yes  02 No | | | | | | | | | | | | | |
| **20) Was the client given crisis information?:** | | | | | | | | | | | 01 Yes  02 No | | | | | | |
| **21) Does client have Medicare? If so, list Medicare number:** | | | YES  NO | | | | | | **Medicare #:** | | | | | | | | |
| **22) Other insurance information:** | | | **Insurance Company** | | | | | |  | | | | | | | | |
| **Insured’s Name** | | | | | |  | | | | | | | | |
| **Insured’s Birth Date** | | | | | |  | | | | | | | | |
| **Group Number** | | | | | |  | | | | | | | | |
| **Employer Name** | | | | | |  | | | | | | | | |
| **23) Name and relationship of person providing information:** | | | | | | | | |  | | | | | | | | |

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| --- | --- | --- | --- | --- | --- |
| **24) Primary Source of Income (List one answer only):** | 01 Employment / Wages  02 Public Assistance  03 Social Security Benefits | 04 Unemployment  05 Workman’s Compensation | | | 06 Alimony / Child Support  09 Other |
| **25) Indicate if client has any handicaps or impairments *(choose from list only):*** | 0099 None  0001 Development / Mental Retardation  0002 Organically Based /Expressive Communication  0004 Blind or Severe Vision Impairment | | | 0008 Deafness or Severe Hearing Loss  0016 Non-Ambulation or Severe  0032 Moderate or Severe Medical | |
| **26) Was a release of information signed (ex: for client’s school, other medical providers, or social service agencies):** | | | 01 Yes  02 No | | |

**PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT**

This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about this agreement. When you sign this document, it will also represent an agreement between you and CCC. You may revoke this Agreement in writing at any time. That revocation will be binding on CCC unless CCC has taken action in reliance on it; if there are obligations imposed on CCC by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

**PSYCHOTHERAPY SERVICES**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the nature of your goals and concerns. There are many different methods your therapist may use to help you realize your goals. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing uncomfortable aspects of your life, you may experience uncomfortable feelings. Psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience in therapy.

The first few sessions will involve an evaluation of your needs and goals. By the end of the evaluation, your therapist will be able to offer you some first impressions of what our work will include if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your therapist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, your therapist will be happy to help you set up a meeting with another mental health professional for a second opinion. You may call the Clinical Director of CCC, Dr. Brad Lundahl, at 801 635 4141 with any questions you may have.

**CONTACTING US AND EMERGENCIES**

**In emergencies,** please contact an emergency room or the University of Utah’s Neuropsychiatric Institute at (801) 583-2500 and ask to speak with a Crisis Worker. If you are in a life threatening emergency, please call 911. You may also contact Dr. Lundahl at (801) 635-4141 in cases of non-life threatening emergencies.

* Due to scheduling, your therapist is often not immediately available by telephone. Please obtain the number of your therapist and feel confident to leave them a message.
* You may also call CCC’s main number: (801) 639 9544.
* You may send a fax to (801) 263 4333

**PROFESSIONAL FEES AND FINANCIAL TERMS**

Individual/Family Psychotherapy $110 per hour Dr. Lundahl’s fee $125 per hour

Group Therapy $45 per hour

Initial Assessment $150 per first visit

Missed appointment/Late Cancel $35

Unless otherwise agreed upon, the fees listed above will apply to your services. If you want your insurance company to pay for treatment, please co ntact them to ensure that Dr. Brad Lundahl is on their panel. Please use Dr. Lundahl’s **NPI Number (1033239827)** when consulting with your insurance company. CCC charges $110 per hour for services related to therapy that go beyond 10 minutes (e.g., phone calls, report writing). If you become involved in legal proceedings that require your therapist’s participation, you will be expected to pay for this time, including preparation and transportation costs. For legal related activities, CCC charges $150.00 per hour. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation unless we both agree that you were unable to attend due to circumstances beyond your control. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.If it is possible, CCC will try to find another time to reschedule the appointment. If you do not show for an appointment, it is your responsibility to reschedule. If there is a second “no show” this will be considered self-termination in which case you will be responsible for finding another healthcare / mental health care provider.

Patient and the undersigned, if other than the patient, each jointly and severally agree to pay for all health care services rendered to Patient from ***Compass Counseling Consulting*** including, but not limited to, any amounts not paid by any insurance company or other third party payor. Patient and the undersigned, if other than the Patient, remains responsible for all co-payments, deductibles, co-insurance, and/or non-covered services regardless of amount paid by insurance or third party payor. It is the policy of ***Compass Counseling Consulting*** to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. In the event that payment in full for charges incurred was not made, Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay interest at the rate of 18% annually on all past due balances from the original due date, plus court cost and reasonable attorneys’ fees, with or without suit, incurred in collecting any past due balance, and a collection fee if my account is assigned to a collection agency. Furthermore, the Patient or the undersigned, if other than the patient, each jointly and severally agree to pay a *$20.00 billing fee for any co-payments not paid for at the time of service* and to pay a service charge of $20.00 plus any bank charges in connection with any check or other instrument tendered by the Patient or the undersigned but returned unpaid to ***Compass Counseling Consulting***. In addition, it is the policy of ***Compass Counseling Consulting***, to assess a fee for missed appointments. The Patient and the undersigned, if other than the Patient agrees to pay *$35.00 for a missed (no-show) appointment* if the office of ***Compass Counseling Consulting*** is not notified within 24 hours of the appointment date.

**I have read the above and accept financial responsibility, in full, for this account.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient or Legally Authorized Representative Date**

**AUTHORIZATION FOR ASSIGNMENT - PAYMENT**

I, the undersigned, authorize the release of any medical or other information necessary for my insurance to process payment of received services. I also request that payment of authorized Medicare, Medicaid, or health insurance benefits are to be made to ***Compass Counseling Consulting*** for services rendered to myself or to the Patient, if acting as the legally authorized representative of the Patient.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient or Legally Authorized Representative Date**

**PATIENT RIGHTS**

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that CCC amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

**MINORS & PARENTS**

Patients under 14 years of age should be aware that the law may allow parents to examine their treatment records unless CCC decide that such access is likely to injure the child. Since parental involvement in therapy is important, it is our policy to request an agreement between a child patient between 14 and 18 and his/her parents allowing me to share general information about the progress of the child’s treatment and his/her attendance at scheduled sessions. Any other communication will require the child’s authorization, unless CCC feels that the child is in danger or is a danger to someone else, in which case, your therapist will notify the parents of his or her concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

**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 important limits to confidentiality.  Any communication by electronic means may have limits to your privacy.  While all client-related communications are kept confidential to the best of our ability, it is possible that others could intercept electronic communications.  There are specific limitations to client confidentiality:

1. Suspected *child or elderly 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 an elderly 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, should we be ordered to testify or to provide documentation regarding clients. 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)***

**Electronic Communications**

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

**\*\*\*\* I understand and agree that by using electronic means of communication I may violate my right to**

**confidentiality\_\_\_\_\_\_\_\_\_\_\_ (Initial)**

**CLIENT RIGHTS AND GRIEVANCE POLICY**

1. All client information and **records are confidential**. Access to records will only be granted with client permission. Records are kept behind locked doors.
2. All individuals have the right to **participate free from harm or threat**. Any potentially harmful situation should be immediately reported to Dr. Brad Lundahl, Clinical Director at 801 635 4141. Threats or violence will not be tolerated and could result in termination of services.
3. 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.
4. Compass Counseling and Consulting **does not allow smoking** in our offices or near public entrances in accordance with the Utah Clean Air Act.
5. 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. Compass Counseling complies with all applicable laws regarding discrimination and any form of discrimination will not be tolerated.
6. 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, Dr. Brad Lundahl (801) 635 4141. If you are still not satisfied, please contact the Department of Professional Licensing.

**\*\*\*\***  **I have read and understand my rights and procedure for grievances: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Initial)**

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ALL ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED INFORMATION ABOUT HIPAA DESCRIBED ABOVE. IF YOU ARE THE GUARDIAN, YOUR SIGNATURE INDICATES YOU AGREE TO THE TERMS FOR YOUR CHILD.

Name of adult client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

Name of adult client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

If Minor: Name of guardian: \_\_\_\_\_\_\_\_\_\_\_\_ Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

Therapist, please provide

|  |  |
| --- | --- |
| Working Diagnosis for insurance purposes | Treatment Goals |
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |

Therapist signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_