1945 S. 1100 E., Salt Lake City, UT 84106 (801.657.0897)

PATIENT REGISTRATION FORM

Please fill out information as listed on your insurance card. If you have a different preferred name or gender identity please specify in the margins of the intake paperwork.

Patient Name: _____

SS #:_____Date of Birth:_____ Sex: M / F

Street Address: _____City: _____State: _____ Zip Code: _____

Phone #:_____E-mail Address:_____

Would you be interested in having communications sent to you via your e-mail address? (Examples: appointment reminders, administrative updates and health bulletins) Yes / No

How did you hear about our Practice?

- Google.com
- Psycologytoday.com
- Facebook
- Creativelifeslc.com
- Goodtherapy.com
- Friend or Family
- Therapist:_____
- Doctor:_____
- Other:_____

Person responsible for bill (Complete only if different from patient)

Guarantor Name: _____Relationship to Patient: _____

SS #:_____Date of Birth:_____ Sex: M / F

Street Address: _____ City: _____ State: _____ Zip Code: _____

Phone:_____

Who to call for an emergency:

Name: _____ Relationship: _____Phone #:_____

PRIMARY INSURANCE INFORMATION

Insurance Plan Name:_____

I.D. Number: _____ Group Number: _____ Address:_____

Policy Holder Name: _____

Street Address:_____ City:_____ State:____ Zip Code:_____

Date of Birth:_____ SS#:_____ Sex: M / F

I understand that I am seeking counseling. I also understand that there may be risks associated with terminating treatment against medical advice. I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Creative Life Counseling, LLC. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ **Date**: _____

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COUNSELING
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PAYMENT AND COLLECTION POLICY

Payment is expected at the time of service. Unpaid balances left by your insurance companies will be your responsibility. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Cash, money order, and/or MasterCard, Visa and Discover are accepted forms of payment on the account. Please be advised that Creative Life Counseling is not a credit grantor and therefore, failure to maintain payment arrangements may result in the placement of your account with a collection agency or attorney for collection.

***Collection Policy: In the event that we do not receive payment within 30 days of our billing you, our collections policy is as follows: Any past due payment will start incurring an 18.5% APR on day 31. On day 90, your account will be turned over to a collection agency if the balance is not paid in full or a payment plan has not been set up with the office manager. Any legal/collection fees incurred in collection of your payment will be added onto your bill. Please avoid this by keeping up with your payments and communicating with your therapist. Your copay is due at the time of service. If you do not know the amount of your copay or if your deductible is met at the time of your first appointment it is our standard practice to collect 50.00 at the time of service until your benefits are determined.**

☐ **HEALTH INSURANCE**: Creative Life Counseling, as a courtesy to you will bill primary insurance. Patients are responsible for knowing their own insurance benefits for psychotherapy. Payment of insurance benefits is not forthcoming on chargers older than 60 days; therefore outstanding charges regardless of insurance carrier will be due by the patient above and beyond co-pay, co-insurance, deductible, and/or primary coverage classified as "above usual and customary" upon receipt of the Explanation of Benefits.

☐ **Fees for services are set with the director and agreed upon and are as follows**:

Initial Evaluation, Individual, and Family therapy rates unless contracted with your insurance company then the insurance plan determines the rate:

Intern:	$50.00
Mid-Level Clinician:	$75.00
Licensed Clinician:	$125.00

Emails, phone calls, and letter writing occurring outside of therapy sessions will be billed directly to the patient in 15 minute increments at the therapists established rate.

ATTENDANCE POLICY

Creative Life Counseling strongly discourages same day cancellations and failure to show for scheduled appointments. **Failure to give 24-hour notice or no show will result in a $50.00 fee for your appointment**. We are cognizant of life circumstances such as illness or inclement weather that result in same day cancellations and do not penalize these absences as long as notice is given. I understand that if I cancel more than 3 times in a six month period I may be referred out of the practice. The therapist maintains the right to deny treatment if the patient arrives late to avoid any overlap with patients who arrive on time.

Client Signature:_____ Date: _____

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Witness Signature: _____ Date: _____

Acknowledgement of Receipt of Privacy Practices & Emergency Contact

I acknowledge that I read a copy of the privacy practices for Creative Life Counseling and can obtain a hard copy by asking my provider for one at the time of service or go online at creativelifeslc.com to obtain a copy of the HIPAA privacy agreement. I agree to the terms indicated in the Privacy Practices Policy.

Client Signature: _____

Client Printed Name: _____

Relationship to Client: _____

If Client is a minor, please read and sign:

The Law: A parent who consents on the minor's behalf generally has the right to know the content of the child's treatment, with some exceptions.

Best Practice: Critical aspects of treatment include both a safe and secure working relationship between client and therapist and fostering an individual's autonomy. Therefore, good clinical treatment with a child or adolescent may require a zone of privacy. Therapist will consider client's preferences and best interests surrounding privacy and confidentiality and will communicate important information with parents as necessary. Therapist is mandated to report serious threats of harm to self or others, abuse, and neglect, to parents as well as to the proper protective services.

** Therapist reserves the right to withhold information if revealing said information could harm the patient or be destructive to the treatment.

Minor name (printed): _____

Minor Signature: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian name (printed): _____

Relationship to minor: _____

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CREATIVE LIFE COUNSELING, LLC
NOTICE OF PRIVACY PRACTICES
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.
If you have any questions about this Notice please contact our Privacy Officer who is Ashley Sutherland, LCSW

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your therapist's practice.

Following are examples of the types of uses and disclosures of your protected health information that your therapist's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other therapists who may be treating you. For example, your protected health information may be provided to a therapist to whom you have been referred to ensure that the therapist has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another therapist or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your therapist, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your therapist.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of counseling students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include: Required By Law: **We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures. Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability**

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information

include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws. Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your therapist may, using professional judgment, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a

disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your therapist and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your therapist is not required to agree to a restriction that you may request. If your therapist does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your therapist. You may request a restriction by **speaking with your therapist.**

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other

method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your therapist amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.
You may contact our Privacy Officer, Ashley Sutherland at (801) 657-0897 or Ashley@creativelifeslc.com for further information about the complaint process.

This notice was published and becomes effective on 02/10/2014