Firefox does not support filling out fields. If you open in another browser or Adobe PDF you can complete the packet on the computer, print & sign.

CENTER FOR FAMILY EVALUATION AND TREATMENT
5691 South Redwood Road #16, Taylorsville, UT 84123
801-265-3895

Patient Information Form ~ Please Complete All Entries

Minor or Dependent Patient Name (Last, First, Middle)	Sex ☐M ☐F	Date of Birth	Age	Social Security Number
Adult Patient Name (Last First, Middle) OR Parent/Guardian of Dependent Name Above	Sex ☐M ☐F	Date of Birth	Age	Social Security Number
Address:	Marital Status (CheckOne): Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated ◯			
City: _____ State & Zip Code: _____	Driver's License Number:			
Employer: _____ Employer Phone Number: _____	Email address: _____ By checking this box I give permission to use my email ☐			
Home Phone #:	Cell Phone #:			
Name of Spouse:	Sex ☐M ☐F	Date of Birth	Age	Social Security Number
Spouse's Employer:	Spouse's Work Phone #:			
Notify in Case of Emergency:	Emergency Contact's Phone #:			

INSURANCE INFORMATION

Primary Insurance Name:	Address (City, State, Zip)		Phone #:
ID #:	Group #:		
Name of Insured:	Relationship	Date of Birth	Social Security Number
Secondary Insurance Name:	Address (City, State, Zip)		Phone #:
ID #:	Group #:		
Name of Insured:	Relationship	Date of Birth	Social Security Number:

By signing below I understand and agree that I am ultimately responsible for payment.
I certify this information is true and correct to the best of my knowledge.

I understand that If I access CVR funding, I must see an in network provider.

Signature: _____ Date: _____

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CLIENT AND CONSUMER RIGHTS

As a client of the Center for Family Evaluation and Treatment you have the right to:

1. Privacy of information, your clinical record whether opened or closed, will not be released without a signed release of information, designating where the information should be sent. Exceptions include suspicion of child abuse or risk of suicide or homicide. Limitations also include legally mandated exceptions such as clinical supervision, court order, client-initiated lawsuit or commitment proceeding.
2. If your treatment is involuntarily terminated, you have the right to appeal this decision and a meeting will be scheduled with the clinical director to discuss your reinstatement. Possible reasons for involuntary termination include but are not limited to: probation/parole violations, assaulting another consumer/client or your therapist, excess account balance, etc.
3. Freedom from potential harm/acts of violence from other consumer/clients and staff.
4. 24 hour cancellation. If you do not cancel your scheduled appointment at least 24 hours in advance, you will be charged for the missed appointment. Most insurance does not pay for a no show. You will be personally responsible for the no show fee.
5. Participate in the planning and implementation of your treatment and to have your treatment plan reviewed periodically. This means your therapist has an obligation to inform you and to take those steps which maximize your participation in treatment planning.
6. Know the cost of your therapy sessions. If this has not been addressed prior to your intake, please ask for a copy of our current fees.
7. File a complaint or grievance about your therapist with the program director or file a grievance with the state licensing board.
8. Freedom from Discrimination.
9. To be treated with dignity.
10. Smoke outside the facility, at least 25 feet form the door.

ZERO TOLERANCE POLICY

If you suspect or witness abuse and/or harassment please tell your therapist or contact any of the following:

Abuse Hotline	**1-855-323-3273**
Crisis Line	**1-801-587-3000**
Domestic Violence Link Line	**1-800-894-5465**

As a human being you have the right to be free from abuse and harassment. You have the right to be free from retaliation for reporting incidents of abuse, neglect or harassment.

If you feel uncomfortable telling someone about suspected abuse, harassment or neglect please drop a note in our lock box located in the waiting area. Your report will be anonymous.

I have read the above rights and understand what my rights are as a client/consumer of the Center for Family Evaluation and Treatment. If I had any questions about my rights, they were clearly explained to me prior to signing this form.

_____ _____

Client/Consumer Signature **Date**

CENTER FOR FAMILY EVALUATION AND TREATMENT

CONSENT AND CONDITIONS OF SERVICE

Patient Name: _____ Date of Birth: _____

As either the patient or the legally authorized representative of the patient, the following consents, understandings, and agreements are made on my own behalf or on behalf of the patient in partial consideration of the healthcare services to be provided in the facility:

Consent for Treatment: On behalf of the Patient, consent is hereby given to the facility, its contractors, medical staff, and employees to provide healthcare services to patient and to administer therapist orders for the benefit of the Patient for this visit and any subsequent visits, and it is understood that this consent may be revoked in writing at any time. It is understood that there is a risk of substantial and serious harm involved in such healthcare services, and such risk is accepted in the hope of obtaining beneficial results from such services. No promises of any particular outcome or successful result have been made, it being understood that therapists are separately responsible to explain what they do and, in some cases, to obtain separate consent for some of the services they provide.

Release of Information: The law requires healthcare providers to make and keep records of your medical treatment, and the Center for Family Evaluation and Treatment safeguards those records. Access to medical records is limited to persons who are providing coordination or evaluation subject to applicable law. By receiving services at the Center for Family Evaluation and Treatment you agree to the release of medical record information for the uses specified above. You also agree to release claims related information to insurance companies or other third parties to assist in paying for your healthcare costs. Permission is given for the Facility, its contractors, medical staff, and employees to release medical and other information about the patient to insurance companies, to other third party payers who are or may be responsible to pay for all or any part of the healthcare services rendered to Patient, and to the agents or representatives of such companies or payers. Such information may be released without further authorization for the purpose of making, completing, and verifying claims and the receipt of services and in connection with prospective, concurrent, or retrospective review related to such healthcare services and the payment of such services.

Assignment of Benefits: Any and all benefits from insurance companies and other third party payers that are payable to Patient or on behalf of Patient for healthcare services and related payments for services rendered or provided to Patient are hereby transferred and assigned to Facility for the exclusive purpose of paying for charges associated with healthcare services provided to Patient in the Facility. It is understood and intended that all insurance companies and other third party payers will pay benefits directly to Facility in payment of Facility's charges and the charges of any other healthcare providers for whom Facility is authorized to bill in connection with healthcare services provided to Patient.

Medicare/Medicaid Patient's Certification: I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier or the State any information needed to process a claim for this or any related service. I request that payment of authorized charges be made in my behalf directly to the Facility for its charges and for any charges of therapists for whom the Center for Family Evaluation and Treatment is authorized to bill in connection with its service.

CHAMPUS/CHAMPVA Authorization: I request payment of authorized benefits to the Center for Family Evaluation and Treatment on my behalf for any services furnished me by the Center for Family Evaluation and Treatment, including therapist services. I authorize any holder of medical or other information about me to release to CHAMPUS/CHAMPVA and its agents any information needed to determine these benefits for any related services.

Financial Responsibility: Patient and the undersigned, it other than the patient, each jointly and separately agree to pay for all the healthcare services provided to Patient in the Facility including but not limited to any amounts not paid by any insurance company or other third party payer. 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 payer. It is understood and agreed that charges no paid in a timely fashion may be placed with a collection agency or attorney for purposes of collection. It is further understood and agreed by the Patient and the undersigned that any amounts not paid within 30 days of the date of the Facility's bill or statement for payment may be charged a delayed payment fee at the rate of 1% per month (12% per year) on the unpaid balance. In the event that any Patient, each jointly and separately agree to pay costs and reasonable attorney's fees in connection with the collection process. A service charge may be collected in connection with any check of other instrument tendered by the Patent or the undersigned but returned unpaid to the Facility.

The undersigned signs this document either as the Patient or as the agent or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient. I have reviewed the forgoing and have had the opportunity to ask any questions I may have about this document. Such questions have been answered to my satisfaction, and I indicate my understanding to what I am agreeing to by signing below. I understand that I am entitled to request and obtain a copy of this document. My consent for treatment will remain in effect unless revoked in writing.

Signature: _____ Today's Date: _____

Witness to signature: _____ Relationship: _____

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GRIEVANCE PROCEDURES FOR CLIENTS AND APPLICANTS

Clients and applicants have the right to present the Center for Family Evaluation and Treatment with their grievances. Grievances may include:

- ✧ Denial of services
- ✧ Exclusion from treatment
- ✧ Inadequacies or inequities in the program and services provided by the Center for Family Evaluation and Treatment

If the Center for Family Evaluation and Treatment or it's representative denies a grievance request about services or fails to respond to a grievance in a timely manner, the client or applicant may contact, in writing, the Department of Human Services/Division of Child and Family Services (DHS/DCFS) at: 645 East 4500 South, Salt Lake City, Utah 84107. The representative will attempt to resolve the grievance. If the client or applicant is dissatisfied with the representative's response, the client or applicant may file a written appeal to the Director of DHS/DCFS, and the director shall respond to the appeal in writing within 30 days. If the applicant or client is dissatisfied with the Director's decision, the client or applicant may request a hearing before the DHS Office of Administrative Hearings (OAH). This hearing request must be filed with OAH within ten (10) working days of receiving the Division Director's decision. If OAH finds that applicable law supports the client or applicant's request, OAH may order the Center for Family Evaluation and Treatment or the Department of Human Services to remedy the problem addressed in the grievance.

By signing below, I acknowledge that I have received a copy of this grievance policy and procedure.

_____ _____
Client/Applicant Signature Date

_____ _____
Witness Date

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Electronic Communication Policy

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, we have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of our profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss with your individual counselor.

Email Communications

We use email communication only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges with our office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email about clinical matters because email is not a secure way to contact us. If you need to discuss a clinical matter, please feel free to call the office so we can discuss it on the phone or wait so we can discuss it during your therapy session. If you elect to communicate with us by email at some point during your work at the office, please be aware that email is not completely confidential. Any email received from you, and any responses that are sent back, will be printed out and kept in your treatment record. Please allow up to 48 work hours for a response.

Text Messaging

Because text messaging is a very unsecured and impersonal mode of communication, we do not text message to nor respond to text messages from anyone in treatment regarding clinical matters. That means that text message exchanges with our office should be limited to things like setting and changing appointments. So, please do not text message unless you and your individual counselor have made other arrangements. Text messages sent on the weekend or after hours are not responded to until the work hours begin.

Social Media

We do not communicate with, or contact, any of our clients or past clients through social media platforms like Twitter, LinkedIn, or Facebook. In addition, if we have discovered that we have accidentally established an online relationship with you, we will cancel that relationship. This is because these types of causal social contacts can create significant security risks for you.

Many counselors here participate on various social networks, but not in a professional capacity. If you have an online presence, there is a possibility that you may encounter one of us by accident. If that occurs, please discuss it with your individual counselor during your time together. We believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact any of the counselors in this way. We will not respond and will terminate any online contact no matter how accidental.

The Center for Family Evaluation and Treatment does have a professional Facebook page. This page is purely professional and explains our services, hours, and location. If we receive any communication through post or message, it will not be responded to. If you need to reach one of us, please call the office phone number.

Websites

We have a website that you are free to access. We use it for professional reasons to provide information to others about our practice. You are welcome to access and review the information that we have on the website, and, if you have questions about it, we should discuss this during your therapy sessions.

Web Searches

We will not use web searches to gather information about you without your permission. We believe that this violates your privacy rights; however, we understand that you might choose to gather information about us in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about any of the counselors through web searches, or in any other fashion for that matter, please discuss this with your counselor during your therapy session so that it can be dealt with and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of one of the counselors with whom you are working, please share it with them so it and its potential impact on your therapy can be discussed.

I have read the above electronic communication policy of the Center for Family Evaluation and Treatment. If I had any questions about the policy, they were clearly explained to me prior to signing this form.

_____ ____ _____ _____ ____ _____

Client/Consumer Signature Date Witness Signature Date

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Acknowledgment of Receipt of HIPPA Privacy Notice

Consumer Name: _____ Date: _____

I acknowledge that I have been given a copy of the Center for Family Evaluation and Treatment's HIPPA Privacy Notice. I have reviewed the HIPPA Privacy Notice and have had the opportunity to ask any questions I may have regarding the information presented in the notice. Such questions have been answered to my satisfaction.

The undersigned signs this document either as the Patient or as the agent or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

HIPPA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS INFORMATION CAREFULLY.

Protecting Your Personal Health Information: The Center for Family Evaluation and Treatment values our relationship with you and we are committed to protecting the privacy of your personal and health information. We want you to understand how we protect the confidentiality of your personal and health information as well as how we use and disclose it. We are required by federal and state laws to maintain the privacy of your personal and health information. Personal and health information includes any information that is identifiable to you as your personal information, including information regarding your healthcare treatment and other identifiable factors such as name, age, address, income or other financial information.

How We Protect Your Personal Information:

- We treat all your personal information that we collect as confidential;
- We restrict access to your personal information to only those employees who need to know that information in order to provide our services to you;
- We only disclose your personal information to the extent necessary for an insurance company to perform its function on our behalf, and under the condition that the company agrees to protect and maintain the confidentiality of your personal information;
- We maintain physical, electronic and procedural safeguards that are in compliance with federal and state regulations to ensure confidentiality of your personal information; and
- We define confidentiality policies and practices in our employee procedure manual as well as disciplinary measures for failure to follow policies.

How We Use and Disclose Your Personal Information: When you receive cared from the Center for Family Evaluation and Treatment we may use your health information for treating you, billing for services and conducting our normal business known as healthcare operations. We will only disclose your personal information when we are required or allowed by law or in the event that you or your authorized representative gives us permission to do so. Uses and disclosures other than those listed below require your authorization. If there are other legal requirements under applicable state laws that further restrict our use or disclosure of your personal information we will comply with those legal requirements as well. The following are the types of disclosures that we may make as allowed or required by law:

- **Treatment**: We may use and disclose your personal information for our treatment activities or disclose your personal information to a provider in order for the Center for Family Evaluation and Treatment to effectively provide services to you;
- **Payment/Billing**: We may use and disclose your personal information for billing and payment purposes such as claims to insurance companies or Medicaid;
- **Mental Health Service Operations**: We may use and disclose your personal information for our internal operations to monitor and maintain high levels of service;
- **Business Associates**: We may also share your personal information with third party business associates who may be contracted to perform certain activities for us. We ask these business associates to treat your personal information in a manner consistent with the Center for Family Evaluation and Treatment;
- **To You or Your Authorized Representative**: Upon your request, we will disclose your personal information to you or your authorized representative. If you authorize us to do so, we may use your personal information or disclose it to the person or entity you name on your signed authorization. Once you provide us with an authorization you may revoke it in writing at any time. Your revocation won't affect any use of disclosures permitted by your authorization while it was in effect. In certain situations when disclosures of your information could be harmful to you or another person, we may limit the information available to you or use an alternative means of meeting your request;
- **To Your Parent if you are a minor**: Some state laws concerning minors permit or require disclosure of protected health information to parents, guardians, and/or persons acting in a similar legal status. We will act consistently with the laws of the State of Utah and will make disclosures consistent with such laws;
- **Your Family & Friends**: IF you are unable to consent to the disclosure of your personal information, such as in a medical emergency, we may disclose your personal information to a family member or friend to the extent necessary to help with your healthcare. We will only do so in the event we feel the disclosure is in your best interest. With your approval, we may disclose/request your personal health information to designated family, friends and others to assist that person in caring for you or in paying for services rendered to you;
- **Public Health & Safety**: We may disclose your personal information if we believe the disclosure is necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may disclose your personal information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes;
- **Required by Law**: We must disclose your personal information when we are required to do so by law;
- **Process & Proceedings**: We may disclose your personal information in response to a court or administrative order, subpoena, discovery request, or other lawful processes, and if required, to government oversight agencies conducting audits;
- **Law Enforcement**: We may disclose limited information to law enforcement officials; and
- **Military & National Security**: We may disclose to military authorities the personal information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials personal information required for lawful intelligence, counterintelligence and other national security activities.

Your Rights Regarding Our Use and Disclosure of Your Personal Information:

- **Access to Your Personal Information:** You have the right to review and receive a copy of your personal information. This right doesn't include the right to obtain copies of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in a civil, criminal or administrative action or proceeding; and protected health information that is subject to other state of federal laws that prohibit us to release such information. We may also limit your access to personal information if we determine that providing the information could possibly harm you or another person. if we limit access based upon the belief that it could harm you or another, you have the right to request a review of that decision;
- **Amendment:** You have the right to request that we amend your personal information. Your request must be in writing and must identify the information that you think is incorrect and explain why the information should be amended. We may decline your request for a variety of reasons. If we decline your request to amend your records, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you want amended. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment and to include the changes in any future disclosures of that information; and
- **Accounting of Disclosures:** You have the right to receive a report of instances in which we or our business associates disclosed your personal information for purposes other than for treatment, payment, mental health service operations and certain other activities. You are entitled to such an accounting for the six years prior to your request, though not for disclosures made prior to April 14, 2003. We will provide you with the date of which we made a disclosure, the name of the person or entity to which we disclosed your personal information, a description of the personal information we disclosed and the reason for the disclosure. If you request this list more than one time in a 12 month period, we may charge you a reasonable fee for creating and sending these additional reports.

This notice takes effect April 14, 2003 and will remain in effect unless revised. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We will notify you of any changes in regard to our privacy practices.