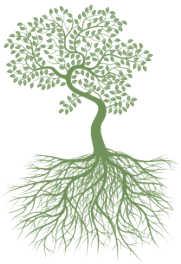

CREATING CHANGE

KATHY PARKER, LCSW • 801.671.1315 • CREATINGCHANGECOUNSELING.COM

Client Registration

Client Name (first and last):	DOB:
Address:	
What is your gender?	Email:
Best phone number:	May I leave a message / text at the provided number? ☐ YES ☐ NO
Primary Physician's name and phone number:	
Psychiatrist's name and phone number (if any):	
Emergency Contact Name and phone number:	

Confidential Client History

Occupation:		What is your relationship status?	
Name, age and *relationship* to people you are living with:	Name	Age	Relationship
Have you ever been to counseling before? ☐ YES ☐ NO	Who referred you?		May I send a thank you note?
Please list any chronic health problems:		Please list any current psychotropic medications you are taking:	

What are you seeking help with? _____

Professional Service Agreement

The Treatment Process

Welcome to my practice. Therapy has the potential to offer personal benefits, such as a decrease in level of distress and an increase in problem solving skills, communication and meaningful relationships. At times we feel worse before we feel better during the therapeutic process. I understand the value that the therapeutic relationship offers the process, which is why I create a trusting environment that promotes authenticity, clarity and confidence. Therapy involves a commitment on your part not only to keep scheduled appointments, but also to come to appointments prepared with meaningful topics to discuss. Much of the progress you make will take place when you are outside of the therapy appointment, reflecting on topics and putting into practice techniques we have discussed. You have the right to ask questions about anything that happens in therapy. I am always willing to discuss how and why I've chosen my therapeutic approach, as well as my training and experience regarding our work together. Thank you for the opportunity to embark on this journey with you.

Professional Records

The laws and standards of my profession require that I keep medical records on all clients. These records include the initial assessment, diagnoses, the day and time of our sessions, what interventions were used, the topics that we discussed and our plan for follow up. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term. All of the diagnoses come from a book titled the DSM-5. I have a copy in my office and will be glad to review it with you to help you understand your diagnosis. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your record at any time. You have the right to request that I correct any errors in your record and you have the right to request that I make a copy of your record available to any other health care provider at your written request. Because these are professional records, untrained readers can easily misinterpret them. If you wish to see your records, we can review them together so that we can discuss the contents. Our time spent reviewing records together is not covered by insurance companies and you will be charged the rate of a private fee appointment ($125). I maintain your records in a secure location that they cannot be accessed by anyone else.

Confidentiality

In order to create a safe environment, it is a priority for me to ensure your confidentiality. By signing the Agreement, you are giving consent for communication as follows:

- Insurance companies typically require that I provide information relevant to these services including diagnosis, treatment plans, treatment summaries or the entire medical record. This information becomes part of the insurance company's files and will be stored electronically. Though all insurance companies claim to keep such information confidential, I have no control over how they handle your medical record. In some cases, they may share information with a national medical databank. When insurance companies request information, I release the minimum amount of information necessary while still complying with the insurance company's request. By signing the Agreement, you agree that I can provide requested information to your insurance carrier.
- I may occasionally consult with other health and mental health professionals for the benefit of my clients and the care that I provide. During a consultation I do not share any personal or identifying information regarding any specific client. I will share any consultations with you if I believe they are important to our work together.
- I have a formal Business Associate Agreement with UHIN, a company that provides insurance billing services for me. As required by HIPAA, this business associate agrees to maintain the confidentiality of this data except as specifically allowed in the contract if otherwise required by law.
- I may share confidential information in accordance with the terms and conditions of the Agreement on cellular phones and via fax.
- A release of information is available, should you want me to communicate with a family member, employer or other health professional for your benefit.
- Treatment will not be provided to an individual who is currently in a counseling relationship with another mental health professional unless all parties have been informed and agree on the therapeutic purpose, without overutilization of services.
- I have permission to contact your identified emergency contact in the event of a medical emergency or transfer to a medical facility.
- I offer Telehealth services for clients when meeting in person is not possible or is less convenient for the client. I use a HIPAA compliant platform for these video sessions. Please keep in mind that I cannot control the privacy on your end of our session. It is up to you to ensure that you are in a place where you feel comfortable and safe having a therapy session over video. These sessions are covered under some, but not all, insurance plans. It is your responsibility to know if Telehealth is covered under your plan.

There are some situations in which I am legally obligated to take actions that I believe are necessary to protect others from harm, and I may have to reveal information about a client's treatment. Should a situation like this occur, I will make every effort to discuss it with you prior to taking any action, and I will limit my disclosure to what is necessary. Situations such as these are very rare in my practice and include the following:

- If I believe that a child, elderly person, or disabled person is being abused or neglected, I am required to report this to the appropriate authorities or the police.
- If I believe that you are threatening serious bodily harm to yourself of someone else, I am required to take protective actions, which may include notifying the potential victim and contacting the police.
- If you tell me of the behavior of another named health or mental health care provider that informs me that this person has either a. engaged in sexual contact with a patient, including yourself or b. is impaired from practice in some manner by cognitive, emotional, behavioral or health problems. I would disclose this information to the licensing board at the Utah Department of Health and I would inform you before taking this step. If you are my client and health care provider, however, your confidentiality remains protected under the law from this kind of reporting.

Contacting Me

I can be reached at 801.671.1315. Phone calls often go directly to voicemail since I am usually meeting with other clients. Please feel free to leave a confidential voicemail or text and I will get back to you as soon as possible. I will do my best to respond to you within the next business day. However, on the weekends or times when I am out of town I will take longer to return your phone call. In the event of any emergency, call Salt Lake County Mental Health Suicide Prevention or Crisis Services at 801.483.5444 or 801.261.1442. It is also an option to call 911 or go to your nearest emergency room.

While I do accept client messages via text and email for the purpose of billing and scheduling, please keep in mind that these methods of communication are not secure. With the permission of clients, I send text reminders for scheduled appointments.

Please do not use text and email for transmission of clinical information, as it will be considered part of the medical record. Licensed Clinical Social Workers are prohibited from accepting friend / follow requests on our personal social media sites. If there are topics from your online life that you wish to share in therapy please bring them to session with you where they can be shared and explored together.

Termination and Referral

In keeping with ethical standards of the profession and responsibilities to you, the client, Licensed Clinical Social Workers are required to terminate a therapeutic relationship when it is clear that the client is no longer benefiting, when services are no longer required or when the therapeutic approach of the therapist is insufficient or remit client's present symptoms. If I determine that my services are no longer benefitting you, alternative methods will be provided to you. Services may be terminated when clients do not pay fees or insurance denies treatment. In such cases, appropriate referrals will be offered. If I determine that my therapeutic services are not beneficial to the client, I may avoid entering the therapeutic relationship or terminate immediately. In such situations, appropriate referrals and alternatives will be provided to the client. When a client expresses self/other harmingideation, I will take steps to secure a safety plan and if necessary, refer to appropriate resources, higher level of care and/or contact the client's appropriate social support. You are free to terminate counseling at any time. You may request that I refer you to someone else if you believe I am not the best fit for you.

Financial Policy

You are financially responsible for all charges, whether or not paid for by insurance. In many cases, you are under no obligation to use your insurance. You may prefer to avoid filing insurance, having your diagnosis disclosed or having your care reviewed by a managed care organization. In that case, you are welcome to pay privately. If you elect to use your insurance to partially pay for your care, it is your responsibility to verify your insurance coverage and note any restrictions or limitations.

Fees for my professional services are charged as follows:

- $125 for all 50 minutes sessions is billed to private paying clients
- $180 for initial assessment / $150 for every 50-60 minute therapy session thereafter is billed to insurance companies
- Fees may increase yearly by no more than 8% to follow market rates, as well as to reflect inflation.
- Evaluations, letters and reports required by an employer, their legal system or other entities are billed at $125 per 50 minutes and include preparation time. These charges are not covered by insurance and will be billed directly to you.
- If I have to resist disclosures on your behalf, you are responsible for the attorney's fees

You are expected to:

- Pay for your session at the time of service and pay outstanding amounts on your statement within 30 days.
- Pay a $20 charge on any returned checks.

Please check one of the following:

☐ I will NOT be using my insurance to pay for any part of my care. I will pay the *reduced* self pay rate of $125 per 50 minute session

☐ I want to use my insurance benefits to pay for a portion of my care and I will pay the copay or coinsurance and balance as indicated by my insurance provider.

HMHI through the University of Utah and EMI (Educator's Mutual Insurance) are the only insurance companies Kathy Parker works with directly. If you have different health insurance, please click the first box next to "I will NOT be using my insurance." Feel free to request a Superbill from Kathy Parker to submit to your insurance company to be reimbursed any out of network benefits you may have.

Cancellations

The appointment time you have scheduled is yours. If you need to cancel an appointment, ***please contact me 24 hours in advance*** so that the time can be rescheduled for someone else. Please provide a credit card that will be charged the cost of a full session ($125) in the event of late canceled or missed appointments. Insurance will not cover the cost of this charge.

Credit Card Number:		
Expiration Date:	CVV:	ZIP code:

Responsible Party Information - Information for person responsible for paying for services, if different from the client

Name (first and last):	Relationship to client:
Address:	
DOB:	Phone number:

Complaints

If you are unhappy with what is happening in therapy, I encourage you to talk with me about it. I take such feedback seriously and with care and respect.

If I am using my insurance carrier(s) to partially pay for my care, I give permission to Kathy Parker, LCSW to release all necessary diagnostic and treatment information to the insurance carrier(s), and authorize my insurance carrier(s) to pay policy benefits directly to Kathy Parker, LCSW. I request that this assignment remain on file with my insurance carrier(s).

I understand that I am financially responsible for all charges whether or not paid for by my insurance, including missed appointments and sessions not cancelled more than 24 hours in advance. I authorize the release of necessary information to a collection agency if that should become necessary.

I understand that my signature below indicates that I have read and agree to the terms of this *AGREEMENT.*

Signature of Client _____ Date _____

Signature of Kathy Parker, LCSW _____ Date _____

Signature of Parent or Guardian (If client is minor) _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices and Policies

Please find my Notice of Privacy Practices attached to the clipboard or email with your welcome paperwork.

This contains information regarding privacy, confidentiality of information and security required by new federal laws and guidelines that are in place to protect you. I am available to answer any questions that you may have now or at any time in the future about these federal laws or my privacy policies and practices. I am required to demonstrate that I have made this information available for you to read. Please sign the statement below. Signing this form only signifies that a copy of this information has been made available to you, not that you have read it or agree with it.

Sincerely,

Kathy Parker, LCSW

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Kathy Parker's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Kathy Parker, LCSW

_____

Client's Name (please print)

_____ _____

Signature of Client Date

_____ _____

Signature of Kathy Parker, LCSW Date

_____ _____

Signature of Parent or Guardian (If client is minor) Date