Connections Counseling Services

Client Information

Name: _____ Intake Date: _____

Reason for starting therapy: _____

Date of Birth: _____ Social Security: _____

Referral Source: ☐ Internet Search ☐ Family/Friend ☐ Religious Leader

☐ Other: _____

Address: _____

_____

_____

Home Phone: _____ Message OK? ☐ Yes ☐ No

Work Phone: _____ Message OK? ☐ Yes ☐ No

Mobile Phone: _____ Message OK? ☐ Yes ☐ No

Text Message OK? ☐ Yes ☐ No Mobile Carrier: _____

Email: _____

Appointment Reminder Preference: ☐ Email ☐ Text

In case of emergency, notify:

Name: _____

Phone: _____ Relationship to patient: _____

Insurance Company: _____ Policy Number: _____

Insured's Name: _____ Insured's Date of Birth: _____

Insured's Relationship to Patient: _____

Connections Counseling Services

Notice of Privacy Practices

Uses and Disclosures of Health Information

We may use health information about you for treatment (such as sending your records or information to a specialist as part of a referral), to obtain payment for treatment (such as sending billing information to a health insurance plan), for administrative purposes, and to evaluate the quality of care that you receive (such as comparing patient data to improve treatment methods).

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, abuse or neglect reporting, auditing purposes, judicial and administrative proceedings, research studies, funeral arrangements and organ donation, workers' compensation purposes, specialized governmental functions, and emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. We may also initiate a face–to–face communication with you about goods and services related to your care. We may also contact you about appointment reminders or treatment alternatives. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, a notice will be posted in the waiting area. Clients may request a copy of our notice at any time. For information about our privacy practices, contact our administrative staff.

Individual Rights

You have the right to request your health record. The involved therapist will make the determination whether to release all or part of the requested session notes; discussion between the therapist and client may be required to make this decision. If you receive copies, we will charge you $0.50 for each page. If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information, or add the missing information.

You have the right to request your health information be communicated to you in a confidential manner, such as sending mail to an address other than your home. You may request in writing that we not use or disclose your information for treatment, payment, or administrative purposes or to persons involved in your care except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request. Under no circumstance will you be retaliated against for filing a complaint.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practice, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact:

Connections Counseling Services
Kyle Reid, LMFT
Clinical Director
1330 S. 740 E.
Orem, UT 84097
(801) 272–3420

Acknowledgement

By signing below, I acknowledge that I have received the Connections Counseling Services Notice of Privacy Practices and have been offered an opportunity to request restrictions on certain uses and disclosures of my protected health information. Typing your name where indicated constitutes an electronic signature and is legally binding.

Client's signature: _____

Signature of parent/guardian
if client is a minor: _____

Date: _____

Connections Counseling Services

Informed Consent and Agreement for Services

Welcome to Connections Counseling Services. This document contains important information and comprises an agreement ("Agreement") between you and Connections Counseling Services, setting forth the terms under which Connections Counseling Services agrees to provide therapy to you. Please read it carefully and sign where required, typing your initials or name where indicated constitutes an electronic signature and is legally binding. We acknowledge the length and complexity of these documents, by signing this agreement you acknowledge and agree to all below terms.

EMERGENCIES: Connections Counseling Services does not provide 24–hour emergency care. Please call 911 if there is an emergency

PAYMENT: All therapy sessions will be billed at the rate of $150-175 for an 80-minute session, $125-$135 for a 50-minute session. Intake sessions rate from $125-$150. This may need to change from time to time by written notice. Payment for sessions is due at the time of each session unless arrangements have been made between the therapist and client. Connections Counseling Services may submit insurance claims on the client's behalf for any insurance companies that the therapist is in network with, billed at the higher insurance rate. It is the client's responsibility to know if, and how, he or she is covered. Any quote of benefits by Connections Counseling Services is an estimate and not a guarantee of coverage. Deductible, coinsurance, co-pays, and any amounts not covered by the insurance are the client's responsibility and due at the time of service. It may be necessary to release information to the insurance company, for payment purposes only.

MISSED APPOINTMENTS AND LATENESS: Appointments broken with less than one full business day's notice will be subject to a full session charge. Client's are required to call or email 24 hours in advance of session. If you are unable to come into the office, speak with your therapist about a phone or web session.

CONFIDENTIALITY: Statements that are made by a client to a therapist are generally confidential. However, there are some exceptions that may lead to a waiver of the therapist–client privilege and to disclosure of otherwise confidential information. Exceptions vary from state to state and may include, but are not limited to:

1. If you put your mental condition at issue in a lawsuit or criminal proceeding;
2. If you disclose to your therapist your involvement in sexual or physical abuse of a child whether as perpetrator or victim (your therapist may be required to report this to Child Protective Services);
3. If you make a serious threat to harm a specific other person (your therapist is required by law to notify proper authorities);
4. If you threaten to harm yourself (your therapist is required to notify proper authorities);
5. If the therapist is required by a court order or subpoena to disclose your records; and
6. If there is an action that alleges a breach of duties running between therapist and client.

In addition, there may be a limited disclosure if a financial collection action becomes necessary. If the client is a minor, the parent(s) or legal guardian have access to information about their child's treatment and may authorize release of information on their child's behalf. If you want us to share information about you with another person or entity, we will do so after receiving from you a written and signed waiver of confidentiality for that specific person or entity.

STAFF CONSULTATION: Clinical and administrative staff of Connections Counseling Services (including therapists, coaches, and group facilitators) routinely discusses cases on an as–needed basis in order to coordinate efforts and enhance treatment. You authorize any and all clinical staff members to share information with one another as necessary.

RECORDING: No recording, audio or video, is permitted within the office of Connections Counseling Services in accordance with Utah Code 76-9-401, without previous written consent by all parties. You agree that all clients, non-clients, and staff of Connections Counseling Services are entitled to privacy within our office or during any

Initial _____
By initialing, I acknowledge that I have read the entirety of this document and agree to the terms.

program, seminar, session, group, or activity sponsored by Connections Counseling Services.

NATURE OF THERAPY: Sometimes the psychotherapeutic process can bring up uncomfortable feelings such as anxiety, sadness, anger, and so on. Therapy may also evoke stressful feelings and temporary life changes that could be difficult to deal with. Please be aware that this is a normal response to dealing with unresolved life experiences. It is your responsibility to inform your therapist if you are beginning to feel overwhelmed or otherwise uncomfortable with the process.

DIRECTION OF TREATMENT: It is important that you feel in control of the direction of your treatment at all times. During the course of therapy, it is possible that your desires and goals may change. If so, or if the advice, counsel, or treatment being offered by your therapist violates your personal convictions or intentions, you agree to notify your therapist at once to re–evaluate the direction of your counseling. If you have any concerns about your treatment, records, or needs that you feel are not being addressed by your therapist, you may contact Connections Counseling Services' Clinical Director, Chris Hughes, PhD, at the main office telephone number, (801) 272–3420.

NO GUARANTEE OF SUCCESS: Because many variables affect the therapeutic process, no particular treatment can be guaranteed to be effective. Therapy requires the active participation of the client, and the client must be truthful with the therapist. Although most clients do experience benefit, they typically find that growth is an ongoing process; also be aware that therapeutic homework will often be suggested by your therapist. Completion of this homework is considered essential to the success of the therapy. Failure to complete the homework will diminish the likelihood of a successful outcome.

PHYSICAL HARM: Any activity in the office is for therapeutic purposes. By participating in any activity the client agrees to acknowledge the risks and dangers and releases Connections Counseling Services of any liability. The client will be personally liable for any harm or damage that may be caused to himself or herself, any individual in attendance, as well as the office and contents of Connections Counseling Services.

FAMILY AND FRIENDS IN-OFFICE DISCLOSURE RELEASE: Through the course of treatment, it may be necessary for additional members of the family unit, relationship, or friendship to be included in the therapy process. These additional participants may see the therapist individually, or join the therapy session with the client. The therapist may share information learned during these sessions with the participating members. This disclosure policy is intended to facilitate the treatment of all parties to the best of the therapist's ability while keeping the identified client's interests first as to whether, when, and to what extent the disclosure is made. You agree that the therapist can and will, without prior consent, disclose information to any party that is invited to participate in the therapy process.

CLIENT RECORDS: By receiving treatment at this office you will be a client of Connections Counseling Services. Your client records belong to Connections Counseling Services, and will remain the property of Connections Counseling Services at both the termination of treatment and the end of a Connections Counseling Services therapist's contract with the clinic.

MEDIATION & ARBITRATION: If a dispute arises out of or relates to this Agreement, the breach thereof, or the treatment or therapy that is the subject of this Agreement, and if the dispute cannot be settled through negotiation, the parties agree first to try in good faith to settle the dispute by mediation administered in Salt Lake County, Utah, by the American Arbitration Association under its Commercial Mediation Procedures before resorting to arbitration. Any such controversy or claim, which is not settled through negotiation or mediation, shall be settled by arbitration administered in Salt Lake County, Utah, by the American Arbitration Association, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

LIMITATION OF LIABILITY: The parties agree that in the event that any dispute arises from the provision of services pursuant to this Agreement, including but not limited to claims of malpractice, negligence, breach of contract, or any other legal theory, if the client prevails the client shall be entitled to recover no more than $50,000.00 or the total amount of fees paid, whichever amount is greater. It is the parties' intention to fix an amount that is reasonable in the event a dispute arises, with mutual acknowledgement that establishing the actual monetary value of damages in such an action would be inherently subjective and uncertain, and that Connections Counseling Services' willingness to provide the services set forth in this Agreement depends on this agreed limitation to

Initial _____
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Connections Counseling Services' potential liability arising from providing the services. This clause is to be construed in accordance with Utah law on limitation of liability.

GOVERNING LAW: This Agreement and all issues arising out of the relationship and interactions of the parties hereto are to be governed by the laws of the State of Utah. Any disputes over the interpretation or enforcement of this Agreement are to be construed in accordance with Utah law.

OUTSIDE EVENTS: Your therapist may suggest that you participate in conferences, workshops, groups, retreats, trainings, or other events sponsored or organized by entities not affiliated with Connections Counseling Services. Such events are collectively referred to as "Outside Events." You acknowledge and agree that Connections Counseling Services makes no representations, guarantees, or claims about the benefits, risks, or costs of Outside Events, and you agree to hold Connections Counseling Services harmless from liability for psychological or physical injury that may result from your participation in Outside Events.

You acknowledge and agree that Outside Events are not a continuation of your treatment at Connections Counseling Services, are not required for your continued treatment at Connections Counseling Services, that your therapist's suggestion of an Outside Event is not an endorsement of the event by Connections Counseling Services, nor does it imply an affiliation with or endorsement of the organization sponsoring the event. You acknowledge and agree that Connections Counseling Services staff members may be present at Outside Events, such staff member does not represent, speak for, or act on behalf of Connections Counseling Services during that event, and will not be available to you for therapy during the Outside Event.

CONSULTATIONS USING TELECOMMUNICATIONS TECHNOLOGY: Sessions are generally considered to be most effective when conducted in the form of regularly scheduled, face–to–face sessions. However some clients are unable to find a suitable therapist in their geographical area, or may require visits while traveling, and therefore he/she decides to conduct some sessions via telecommunications technologies. For these reasons, Connections Counseling Services offers visits via telecommunications technologies.

If you will be receiving therapy via telecommunication, you hereby acknowledge that you understand and accept the following as a condition of your participation: consultations via telecommunication may not be as effective as face–to–face sessions; the therapist providing the services is practicing under the jurisdiction of the State of Utah and is not necessarily licensed to practice in the state or country where you are physically located at the time the services are rendered. If this is the case, your sessions with an Connections Counseling Services therapist will be defined as coaching; the therapist will be acting in a life coach capacity, rather than as a therapist. Supplementary, face–to–face therapy or transfer to a local therapist for face–to–face sessions may be necessary if you should experience severe emotional disturbance, such as anxiety, depression, or suicidal thoughts, or if our office deems it appropriate.

SEVERABILITY: If any provision of this Agreement shall be held to be invalid or unenforceable for any reason, the remaining provisions shall continue to be valid and enforceable. If any provision of this Agreement is found to be invalid or unenforceable, but that limiting such provision would allow it to become valid and enforceable, then such provision shall be deemed to be written, construed, and enforced as so limited.

WAIVER OF CONTRACTUAL RIGHT: The failure of either party to enforce any provision of this Agreement shall not be construed as a waiver or limitation of that party's right to subsequently enforce and compel strict compliance with every provision of this Agreement.

AGREEMENT OF CLIENT: I understand this information and agree to be bound by the terms and conditions of this Agreement.

Client's signature: _____

Signature of parent/guardian
if client is a minor: _____

Date: _____

Initial _____
By initialing, I acknowledge that I have read the entirety of this document and agree to the terms.

SECOND PARTY AGREEMENT: Should a second party (i.e. a parent, church, or other benefactor) have full or partial financial responsibility in paying for your sessions, please provide his/her information below. All payments by a parent must be made by credit card.

Name(s) of individual(s) responsible for payment (if other than Client): _____

Relationship to Client: _____

Mailing Address: _____

_____

Email Address: _____

Phone Number: _____

Date: _____

CREDIT CARD PAYMENT AGREEMENT: By including your information below, you authorize Connections Counseling Services to charge your credit card account as payment for services.

◯ VISA ◯ MasterCard ◯ Discover ◯ American Express

Card Number: _____ Expiration Date: _____ CVC: _____

Cardholder's name: _____

Cardholder's billing address: _____

Initial _____
By initialing, I acknowledge that I have read the entirety of this document and agree to the terms.

DASS21

Name: _____

Date: _____

Please read each statement and circle a number 0, 1, 2 or 3 that indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all

1 Applied to me to some degree, or some of the time

2 Applied to me to a considerable degree, or a good part of time

3 Applied to me very much, or most of the time

			for office use only: D	A	S
1	I found it hard to wind down	2			
2	I was aware of dryness of my mouth	3			
3	I couldn't seem to experience any positive feeling at all	0			
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0			
5	I found it difficult to work up the initiative to do things	0			
6	I tended to over-react to situations	0			
7	I experienced trembling (eg, in the hands)	0			
8	I felt that I was using a lot of nervous energy	0			
9	I was worried about situations in which I might panic and make a fool of myself	0			
10	I felt that I had nothing to look forward to	0			
11	I found myself getting agitated	0			
12	I found it difficult to relax	0			
13	I felt down-hearted and blue	0			
14	I was intolerant of anything that kept me from getting on with what I was doing	0			
15	I felt I was close to panic	0			
16	I was unable to become enthusiastic about anything	0			
17	I felt I wasn't worth much as a person	0			
18	I felt that I was rather touchy	0			
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0			
20	I felt scared without any good reason	0			
21	I felt that life was meaningless	0			

OFFICE USE ONLY

DASS Severity Ratings

The DASS is a **quantitative** measure of distress along the 3 axes of depression, anxiety[1] and stress[2]. It is not a categorical measure of clinical diagnoses.

Emotional syndromes like depression and anxiety are intrinsically dimensional - they vary along a continuum of severity (independent of the specific diagnosis). Hence the selection of a single cut-off score to represent clinical severity is necessarily arbitrary. A scale such as the DASS can lead to a useful assessment of **disturbance**, for example individuals who may fall short of a clinical cut-off for a specific diagnosis can be correctly recognised as experiencing considerable symptoms and as being at high risk of further problems.

However for clinical purposes it can be helpful to have 'labels' to characterise degree of severity relative to the population. Thus the following cut-off scores have been developed for defining mild/moderate/severe/ extremely severe scores for each DASS scale.

Note: the severity labels are used to describe the full range of scores in the population, so 'mild' for example means that the person is above the population mean but probably still way below the typical severity of someone seeking help (ie it does not mean a mild level of disorder.

The individual DASS scores do not define appropriate interventions. They should be used in conjunction with all clinical information available to you in determining appropriate treatment for any individual.

[1]Symptoms of psychological arousal
[2]The more cognitive, subjective symptoms of anxiety

DASS 21 SCORE

DEPRESSION SCORE	ANXIETY SCORE	STRESS SCORE

	Depression	Anxiety	Stress
Normal	0 - 4	0 - 3	0 - 7
Mild	5 - 6	4 - 5	8 - 9
Moderate	7 - 10	6 - 7	10 - 12
Severe	11 - 13	8 - 9	13 - 16
Extremely Severe	14 +	10 +	17 +

"No Secrets" Policy when Treating a Couple or Family

This written policy is intended to inform you, the participants in therapy, that when I agree to treat a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (treatment unit).

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure**.**
Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This "no secrets" policy is intended to allow me to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We, the members of the _____(couple/family or other unit) being seen, acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with _____(the therapist), and that we enter couple/family therapy in agreement with this policy.

Dated:_____ Signature_____

Dated:_____ Signature_____

Dated:_____ Signature_____

(Use additional date and signature lines as is necessary. If someone is signing in a representative capacity, such as a parent or a court-appointed guardian or conservator, such capacity should be stated and the person being represented should be specified.)