Aspen Ridge COUNSELING CENTER

DEMOGRAPHIC INFORMATION

CLIENT INFORMATION	MINOR CLIENTS- PARENT/GUARDIAN INFORMATION
Client Legal Name:	Name:
Address:	Address:
City, State Zip:	City, State Zip:
Mobile Phone #:	Mobile Phone #:
Other Phone #:	Other Phone #:
Birth Date: Legal Gender:	Relationship to Client:
Social Security #:	☐ **ONE PREFERRED BILLING METHOD**
E-mail Address:	☐ ELECTRONIC BILLING *MUST PROVIDE E-MAIL ☐ PAPER BILLING (+$2 CHARGE PER STATEMENT)

Responsible Party is the client if 18 yrs or older, or legal guardian if client is under 18. (Leave blank if same as client.)

Responsible Party:	Mobile Phone #
Street Address:	Other Phone #
City, State Zip	Responsible Party DOB:
Relationship to Client:	Responsible Party SSN:

Insurance Information	
Primary Insurance:	Policy Holder Name:
Insurance Claims Address:	Policy Holder Date of Birth:
City, State, Zip Code:	Identification Number:
Insurance Phone:	Policy/Group Number:
Employer:	Policy Holder SSN:
Secondary Insurance:	Policy Holder Name:
Insurance Claims Address:	Policy Holder Date of Birth:
City, State, Zip Code:	Identification Number:
Insurance Phone:	Policy/Group Number:
Employer:	Policy Holder SSN:
Emergency Contact	
Name:	Address:
Mobile #:	City, State Zip:
Other #:	Relationship to Client:

PERSON COMPLETING FORM/PROVIDING INFORMATION

If you are the client, you can leave this section blank

Name_____ Relationship to Client_____Date_____

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HOW WERE YOU REFERRED TO US?	☐SELF ☐FAMILY/FRIEND ☐PHYSICIAN/MEDICAL ☐SOCIAL/ COMMUNITY AGENCY	☐EDUCATION SYSTEM ☐COURTS/LAW ENFORCEMENT ☐PRIVATE MENTAL HEALTH ☐PUBLIC MENTAL HEALTH	☐CLERGY ☐OTHER
PREFERRED LANGUAGE	☐ENGLISH ☐SPANISH	☐AMERICAN SIGN LANGUAGE ☐OTHER_____	
EMPLOYMENT STATUS	☐EMPLOYED FULL-TIME 35+HRS ☐EMPLOYED PART-TIME <35HRS ☐SUPPORT/TRANS.EMPLOYMENT	☐RETIRED ☐HOMEMAKER ☐UNEMPLOYED-STUDENT	☐UNEMPLOYED-DISABLED ☐ UNEMPLOYED- NOT LOOKING ☐ UNEMPLOYED-LOOKING
CURRENT LIVING SITUATION	☐PRIVATE RESIDENCE/APPT ☐FOSTER CARE ☐ON THE STREET/SHELTER	☐ON THE STREET/SHELTER ☐JAIL/CORRECTIONAL FACILITY	☐OTHER INSTITUTION ☐OTHER RESIDENTIAL FACILITY
NUMBER OF FAMILY WHO LIVE AT HOME:			
CLIENT'S MARITAL STATUS:	☐SINGLE-NEVER MARRIED ☐MARRIED-SPOUSE IN HOME	☐MARRIED-SEPARATED ☐DIVORCED	☐WIDOWED
HOUSEHOLD MONTHLY INCOME:			
HISPANIC ORIGIN	☐NOT OF HISPANIC ORIGIN ☐HISPANIC	☐MEXICAN/MEX AMERICAN ☐PUERTO RICAN	☐CUBAN ☐OTHER
RACE:	☐ALASKA NATIVE ☐AMERICAN INDIAN ☐ASIAN	☐AFRICAN AMERICAN ☐PACIFIC ISLANDER ☐CAUCASIAN	☐OTHER RACE ☐2+ RACES
IS THE CLIENT IN AN EDUCATION PROGRAM?	☐YES	☐NO	
EDUCATION LEVEL	☐1ST GRADE ☐2ND GRADE ☐3RD GRADE ☐4TH GRADE	☐5TH GRADE ☐6TH GRADE ☐7TH GRADE ☐8TH GRADE ☐9TH GRADE	☐10TH GRADE ☐11TH GRADE ☐12TH GRADE OR GED ☐13-25 YEARS #_____
LEGAL STATUS FOR TREATMENT	☐NO CIVIL/FORENSICS COMMITMENT	☐CIVIL COMMITMENT	☐FORENSICS COMMITMENT
# OF ARRESTS IN LAST 30 DAYS			
IS CLIENT A VETERAN?	☐YES	☐NO	
I UNDERSTAND THAT SMOKING IS PROHIBITED AT THIS OFFICE	☐YES	☐NO	
TOBACCO USE:	☐NEVER SMOKED ☐SMOKELESS TOBACCO ☐FORMER SMOKER	☐CURRENT STATUS UNKNOWN	☐CURRENTLY DAILY ☐ CURRENT-SOME DAYS
CRISIS INFORMATION OFFERED TO ME (SEE INFORMED CONSENT)	☐YES	☐NO	
PREVIOUS MENTAL HEALTH TREATMENT OF ANY KIND?	☐YES	☐NO	
PREVIOUS MENTAL HEALTH TREATMENT AT THIS CENTER IN THE PAST?	☐YES	☐NO	
STATE HOSPITAL ADMISSION IN PAST?	☐YES	☐NO	
PRESENT LEGAL INVOLVEMENT?	☐YES	☐NO	

INFORMED CONSENT FOR TREATMENT

COUNSELING

I understand that the goal of Aspen Ridge Counseling Centers is to provide the best possible service. While I expect benefits from this treatment, I fully understand and accept that because of factors beyond our control, such benefits and desired outcomes cannot be guaranteed. A variety of methods will be used to provide relief of my symptoms, and to improve coping and problem-solving skills. I understand that counseling requires a lot of effort on my part to receive the best outcomes of treatment.

I understand that I can talk with my therapist if I feel my treatment needs any modification. This may be a simple case of updating treatment goals with a therapist or referring to other services or providers. It is also important to find a good fit for each client and you are welcome to ask for a referral from your therapist or contact the office to schedule with a different provider. Therapists are also able to refer to treatment providers outside of Aspen Ridge Counseling Centers. Therapists understand that each person may require a different style or personality and are open to discussing this with you.

I understand that counseling sessions are approximately 50 minutes in length depending on insurance. I understand that frequency of sessions, length of sessions and treatment goals may change as discussed in treatment planning with my therapist. I understand that if I am late for my appointment, it will still end at the regular appointment time. I understand it is important to communicate with my therapist if I'm running late to make sure the appointment does not need to be rescheduled.

INSURANCE/FEES

Aspen Ridge Counseling Centers will contact your insurance to learn about health plan benefits as it relates to mental health coverage. Benefit details given by my providers office are done as a courtesy, are based on information provided by my insurance company and are not a guarantee of payment. I understand that it is my responsibility to know my insurance benefits and limitations, prior authorizations requirements, network status and copay, prior to services being rendered. I understand that I am required to contact my insurance company with any questions regarding benefits and prior authorization requirements. *I am aware that the patient-responsibility portion of my payment is due at the time of service and that it is my responsibility to render payment to either the office staff or my provider.* In addition, not all services or diagnoses are covered benefits by all insurance companies. My insurance may arbitrarily select certain services as "non-covered". I understand that I am responsible for these charges. If I disagree with my insurance company's non-payment or limited payment of charges, I understand that I must pay my provider in full and work directly with my insurance company for payment. I understand that at the time of signing, the fee billed for the initial Mental Health Assessment is $200.000 and following sessions are billed at $170.00 for each visit. *I understand that Therapists update Mental Health Assessments once per year and thus the Mental Health Assessment rate may be charged annually.* These rates are subject to change. I understand if I am insured with an in-network insurance company, these rates will be adjusted according to my providers' contracted rate with my

insurance plan. I understand that by providing my insurance information, I give Aspen Ridge Counseling and affiliated agencies permission to bill my insurance for services rendered. I understand that payment is due at the time of service. Eligible Medicaid consumers cannot be charged for services or billed for the remainder not covered by Medicaid (balance billed). For uninsured individuals, a "prompt pay" discount is available. More information can be obtained by contacting the Aspen Ridge main office number or email. Phone calls more than 10 minutes in length, written reports, and other professional contacts will be billed at the same rate. I fully understand that I am responsible to pay all charges not covered by my insurance carrier.

I understand that if at any point my balance exceeds $500, my appointments will be discontinued until payment has been made to reduce my balance below that threshold. I understand my account will be assessed a service charge of $25.00 for any returned check.

There is a $65 fee for appointments that are considered no-shows or late-cancellations (see no-show/late cancellation form). This fee is not covered by insurance companies and is still payable by clients including those on Medicaid.

I understand that if I'd like to set up a payment plan to pay off my total balance, or have my credit/debit card charged automatically for my amount owed each session by placing my card on file, I can request this by contacting the main office to obtain a form to do so.

I understand that it is my responsibility to ensure my information is kept up to date (including phone number, mailing address, email address, and insurance.)

I understand that I will receive statements via email at no cost each billing cycle. However, if I'd like to receive mailed statements, I can do so by completing a written form at the office. There will however be a $2 charge added to mailed statements. I understand that if I disagree with any statements received, I must contact the office within 30 days to dispute. If the account is sent to collections and no disputes are filed, I understand that I am responsible for the balance. I understand it is my responsibility to request a receipt for all card, cash and check payments and keep them for my records. Receipts will be required from the client upon any invoice disputes.

In the event payment under this agreement is not made at the time and in the manner required, I agree to pay all costs of collection, including attorney fees, court costs, and collection agency charges and fees. This includes but is not limited to a 25% collections fee of the total balance owed on the account. I authorize the release of my identifying information to a collection agency if that should become necessary.

RECORDS/COORDINATION OF CARE

I understand that for mental health services to be most effective, it is essential to have these services coordinated with other health care providers. Aspen Ridge Counseling Centers uses a secure electronic medical records system to house your information. Information will only be shared in accordance with the Privacy Policies of Aspen Ridge Counseling Centers. For any person or institution that is not directly

related to treatment, payment of services or health care operations of Aspen Ridge Counseling Centers, all protected health information will be kept confidential UNLESS you sign a specific authorization. However, all health care providers are legally required to report and release the following information without specific authorization: Suspected physical/sexual abuse and/or neglect of a child or elderly person, to prevent injury to self or others, in a medical emergency to save lives, or if ordered by the court.

In the event of an emergency I will call: 1) University of Utah Neuropsychiatric Institute at (801)587-3000; 2) Salt Lake County Mental Health Suicide Prevention and Crisis Services at (801) 483-5444; or 3) 911 or the nearest hospital emergency room.

DIVORCE & CUSTODY ISSUES

Although it is common for clients to seek counseling services during times of divorce and separation, it is important to note that Aspen Ridge Counseling does not get involved in custody issues and does not make recommendations for custody or visitation.

This is a different service that can be found by looking for Custody Evaluators in other agencies. This is outside of Aspen Ridge Counseling's scope of practice and we want to separate individual and family counseling from this function in order to work with your family more effectively.

COURT APPEARANCES

Aspen Ridge Counseling does not attend court unless required to do so by a Judge's court order. If there is an instance where an employee does so, there is a charge of $200 per hour plus travel time to appear and this is not covered by insurance. If you are involved in a court case, you can talk with your therapist about providing a report to the court in lieu of testifying or making other arrangements.

PARTNERSHIPS

Aspen Ridge Counseling Centers works closely with Froerer Counseling and C. Hakes LLC. There is a Business Service Agreement in place to protect both clients and businesses above. These three entities may share administrative costs and storage and thus everyone working for the entities above are required to follow the rules set forth in this form along with HIPAA including payment and confidentiality rules. Thus, you may receive a bill or explanation of benefits from any of the above listed agencies for services rendered. This is all information covered within the Business Service Agreement with the three above entities and is done so to provide better range of service for clients.

TECHNOLOGY & ELECTRONIC COMMUNICATION

Aspen Ridge Counseling Centers use different methods of electronic communication as a convenience for staff and clients.
This is including but not limited to:

- Text messages
- Emails
- Faxes
- Video Chat/Telehealth

I understand that many forms of electronic communication may not be secure methods to communicate about my treatment.

I understand that Aspen Ridge Counseling therapists are not allowed to communicate via Social Media outlets with their clients or their supervisee's clients.

I understand that telehealth options are available for situations where travel is impacted, health issues limit contact, and scheduling conflicts. Telehealth options are offered in a variety of user-friendly platforms although many are not considered secure methods of communication. This is to help with issues with missing appointments and therefore delaying treatment. You may contact your therapist to discuss options for Telehealth/Video Chat. Telehealth is typically used to supplement face-to-face sessions and it is still important to try to find a calm environment with little to no distractions to gain the most benefit from this service. Telehealth options may be limited based on client insurance stipulations, licensure rules and/or location of services being provided. I understand I am responsible for knowing if my insurance covers these services, and I am responsible for payment of any non-covered services.

Aspen Ridge offers a courtesy email reminder for all appointments. Due to occasional technical issues, reminders may be delayed or missed. I acknowledge that I am responsible for attending my appointments, or canceling/rescheduling ahead of time regardless of whether or not I receive this reminder. Email addresses for reminders can be updated by contacting the main office.

I understand that I can talk with my therapist about which electronic methods of communication I feel comfortable with and can opt out of electronic communication at any time by completing a form at the office advising as such.

I have read and understand the above information and I consent to treatment by Aspen Ridge Counseling Centers under the described conditions.

_____	_____
Client Name	DOB
_____	_____
Responsible Party Name (Please Print)	DOB
_____	_____
Signature of Responsible Party	Today's Date

Billing Preferences

Choose **ONE** of the below options to receive your billing statements.

Please note that all statements sent via paper will include an additional service fee of $2.00 per statement.

☐ Please **EMAIL** my statements to:

_____

(Email Address)

OR

☐ Please **MAIL** my statements to (+$2.00 charge per statement):

_____ _____ _____

(Mailing Address/PO box) (State) (Zip)

_____ _____

Client/Responsible Party (Please Print) Date

_____ _____

Client/Responsible Party Signature Date

Aspen Ridge
COUNSELING CENTER

This notice describes how medical information about you may be used and disclosed and how you can get access to it. Please review carefully.

1. Your medical records are used to provide treatment, bill and receive payments, and conduct health care operations. Examples of these activities include but not limited to review of treatment records to ensure appropriate care, electronic or mail delivery of billing for treatment to you or other authorized payers, appointment reminder telephone calls, and records review to ensure completeness and quality of care. Use and disclosure of medical records is limited to the internal used outlined above except required by law or authorized by the patient or legal representative.

2. Federal and State laws require abuse, neglect, domestic violence and threats to be reported to social services or other protective agencies. If such reports are made they will be disclosed to you or your legal representative unless disclosure increases risk of further harm.

3. Disclosed information will be limited to the minimum necessary. You may request an account for any uses or disclosures other than those described in Sections 1 and Sections 2.

4. You, or your legal representative, may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identify the person authorized to request the release, specify the information you want disclosed, the name and address of the entity you want the information released to, purpose and the expiration date of the authorization. Any authorization provided may be revoked in writing at anytime. Psychotherapy notes are part of your medical records. We have 30 days to respond to a disclosure request and 60 days if the records is stored off site.

5. You may request corrections to your records.

6. A request for disclosure may be denied under the following circumstances: disclosure would likely endanger the life or physical safety of you or another person, requested information references other persons, except another healthcare provider, or if released to a legal representative would likely result in harm.

7. If a request for disclosure is denied for reasons outlined in Section 6, you or your legal representative may request review of the denial. A review will be conducted by another licensed healthcare provider appointed by the original reviewer, who was not involved in the original decision to deny access. A review will be concluded within 30 days.

8. You may request that we restrict uses and disclosures outlined in Section 1. However, we are not required to agree to the restrictions. If an agreement is made to restrict used or disclosure, we will be bound by such restriction until revoked by you or your legal representative orally or in writing except when disclosure is required by law or in an emergency. We may also revoke such restrictions but information gathered while required by law or in a emergency. We may also revoke such restrictions but information gathered while the restriction was in place will remain restricted by such an agreement.

9. If you wish to complain about privacy related issues you may contact the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington DC, 20201. In any case there will not be any retaliation against you or your legal representative for filling a complaint.

10. This agreement may be modified or amended as required by law or in the course of health care operations.

I HAVE READ AND UNDERSTOOD THIS PRIVACY NOTICE AND MY RIGHTS CONCERNING USE AND DISCLOSURE OF PROTECTED HEATLHCARE INFORMATION.

_____ _____

Individual or Legal Representative (**please print**) Date

_____ _____

Signature of Individual or Legal Representative Date

Late-Cancellation/No-show Policy

There is a $65 fee for No-shows or Late Cancellations of scheduled appointments. Late-Cancellation/No-show fees are an out of pocket expense that insurances or other agencies will NOT cover. Please initial on line next to these to show your understanding of our definitions of the following:

⌦_____No-shows:

- An appointment where the client does not contact Aspen Ridge to cancel and does not attend.

⌦_____Late Cancellations

- A cancellation with less than 24 hours' notice to Aspen Ridge.
- Appointments are approximately 53 minutes long. If you are late, the appointment will still end based on the scheduled appointment time. Please call us if you are running late.

⌦_____Extenuating Circumstances:

We understand that there are extenuating circumstances where you are not able to attend.

- Severe illness or hospitalization
- Miscellaneous--- Please contact your therapist if there is an extenuating circumstance for the owners of Aspen Ridge Counseling to consider in order to either be issued a refund or if timely enough to avoid charge completely.
- You may be required to present proof of extenuating circumstance in order to receive a refund or avoid charge.

Please initial below to show you've reviewed each section:

⌦_____We do offer a text reminder to Clients and those with mobile numbers and/or e-mails on file will be set-up for texts or e-mails 48 hours before client appointments. You may confirm or cancel appointments with the text messaging system but the system will not override a choice once you do this. You must call the office or your individual therapist if you need to change your appointment after confirming/cancelling with text reminder system. Our electronic medical record keeps a reminder log to show appointment reminders sent to clients. *Please do not text anything to this # besides your choice of cancellation or confirmation of an appointment as it is an automated reminder system and Aspen Ridge does not receive messages only the notification of confirmation or cancellation of appointment.

⌦_____A Late Cancellation/No-show fee must be paid prior to rescheduling another appointment. If you are set-up with your therapist to have recurring appointments (example- weekly appointments), they will cancel future appointments until this is settled.

⌦_____We do keep a credit or debit card on file for cases where there is a Late-Cancellation/No-show in order to charge for the missed scheduled appointment. Your therapist will attempt to contact you 15 minutes after your missed appointment once. However, it is up to you to keep updated contact information with therapist so you can be reached. It is therapist's discretion if they run the card at that time or wait a brief period of time (we may issue a refund on that card if there was an extenuating circumstance).

⌦_____If your card on file was charged successfully, you may now reschedule future appointments. However, it is important you contact your therapist after a late cancellation or no-show so they can put you back on the schedule. If your card on file is declined or expired, you will be billed for the fee and can reschedule after this is paid.

⌦_____There are always going to be things that keep us from being able to do what we need to do. So please contact us to make arrangements if these things come up. This policy at Aspen Ridge Counseling is in place to help us be able to see clients in need and help clients reach their goals. If we have no-shows or late cancellations, it doesn't allow us time to schedule other clients in need.

By signing this document, you state that you understand and agree to the Aspen Ridge Counseling Late-Cancellation/No-show policy.

_____

Responsible Party Signature Date

Complete either Section A or B

SECTION A: CREDIT CARD AUTHORIZATION

Client Information (if minor, put both Client name and Guardian)

Client Name: _____

Telephone: _____

Email: _____

Address: _____

_____

_____

_____

Country: _____

This form will be held in a secure records system and will only be accessed if appointments are listed as: LATE CANCELLATIONS or NO-CALL/NO-SHOWS

We may issue a refund or decide not to charge based on extenuating circumstances.

You may request in writing to remove this information from records and be destroyed. However, there must be a current credit or debit card on file in order to secure your appointments

Credit Card Account

Account Type: __ VISA __ MASTERCARD __ DISCOVER __ AMEX

Acct #: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Expiry Date: ☐☐☐☐☐☐☐☐

Security Code: ☐☐☐

Cardholder Name: _____

Address: _____

_____

_____

_____

It is the Customer's responsibility to inform ASPEN RIDGE COUNSELING of any changes to the billing address, expiration date and/or changes to the card holder's name of credit card account provided.
****If card is declined, amount will be billed to client and appointments will not be scheduled until payment is made.**

Any information provided in this form will be used only to secure appointments and will be charged $65 only per no-show or late cancellation of client appointment.

Authorization

I authorize Aspen Ridge Counseling/C Hakes, LLC to debit the credit card account provided above for late cancellations (less than 24 hours' notice) or no-shows for scheduled appointments. There is a $65 charge for each no-show or late cancellation.

Authorized Signature _____ Date _____

SECTION B: COMPLETE ONLY IF YOU DO NOT HAVE A DEBIT OR CREDIT CARD.

If you are in a position where you ***do not have access to a Debit or Credit Card***, please complete and sign below and review this with your therapist:

By signing this, I am reporting that I do not have any available access to a Debit or Credit Card. In the event of a Late-Cancellation or No-show, I must pay $65 cash to my therapist (request written receipt of payment). I understand that if this is not paid, no further appointments may be scheduled and I will be billed for this fee.

_____ _____

Responsible Party Date

Medical Coordination of Care Form

Client Name:	Client DOB:	Aspen Ridge Therapist:

At Aspen Ridge Counseling, we feel it is important to work with your Primary Care Physician/ Medication Prescriber to provide the best care possible. Please complete as much of this information as you can for your provider. We will be notifying the provider of your therapist information in case there is a need to coordinate care. If you have more than one main provider, please ask for another Coordination of Care form.

Primary Care Physician/Medication Prescriber Information:

Physician Name:	Clinic Name:
Address:	
Phone #:	Fax #:

Please check one of the following and sign:

☐ By checking this box and signing this Coordination of Care form, I agree to have Aspen Ridge Counseling contact my Physician and share necessary information to coordinate care related to my treatment.

☐ I do not currently have a regular Primary Care Physician or Medication Prescriber.

☐ I am not willing to have Aspen Ridge contact my Physician.

_____ _____

Client or Guardian Signature Date

Member Acknowledgement Form

I, _____, hereby acknowledge that I
Name of Consumer

have received a Medicaid Member Handbook and Provider Directory (either in the mail or from my provider). I understand that the purpose of the handbook is to insure I have information about my benefits, rights and responsibilities. The handbook also provides information on how to receive covered services, access to emergency services, transportation, and how to choose a provider. The handbook also addresses procedures for filing grievances and appeals.

I also understand that if I have been treated unfairly or discriminated against for any reason, I may file a complaint by contacting OptumHealth at: 1-877-370-8953.

My provider has reviewed these materials with me and answered my questions.

_____
Printed Member Name

_____
Minor Signature

_____ _____
Member Signature / Legal Guardian Signature Date