# Client Information

**Date:**___________________

**First Name:** ______________________ **M.I.:** _____________ **Last Name:** __________________________
**Address:** ______________________________________________________________________________________
**City:** _____________________________________ **State:** _______________________ **ZIP:** ______________
**Phone Numbers** *(Check box if we may call or leave messages at these numbers)*

**Home:** ☐ ____________________ **Work:** ☐ ___________________ **Cell:** ☐___________________

**S.S.#:** ______________________________ **Birthdate:** __________________ **Age:** _________
**Employer:** ________________________________ **Previous therapy?:** ________________________
**Marital Status:** _______________________________ **Spouse's name:** ___________________________
**Children (Names & ages):** ____________________________________________________________________
**Medications:** _______________________________________________________________________________

**Who were you referred by:** ___________________________________________________________________
**Primary Physician:** _____________________________ **Phone #:** _______________________________
**Emergency Contact (a relative, if possible):** _______________________________________________
**Phone #:** _______________________________________ **Relationship to Client:** _____________________

# Insurance Information

**PRIMARY INSURANCE**
**Insurance Company:** ______________________________________ **Phone #:** __________________________
**Address:** _________________________________ **City:** _________________ **State:** ____ **ZIP:** ___________
**Policy/Member/ID #:** _____________________________________ **Group #:** ___________________________
**Policy Holder Full Name:** ____________________________________________________________________
**Address:** _________________________________ **City:** _________________ **State:** ____ **ZIP:** ___________
**Phone #:** ___________________________ **Work #:** ________________________________
**Is this an employer health plan?** ________________ **Employer:** __________________________________
**S.S. #:** _____________________________ **Birthdate:** _______________________________________
**Sex (M or F):** _______________________ **Relationship to Client:** _________________________
**Authorization #:** _____________________________________________

**SECONDARY INSURANCE**
**Do you have dual insurance?**_________ **Secondary Insurance Company:** ________________________
**Secondary Policy Holder Name:** ______________________________________________________________
**Secondary Policy #:** ___________________________ **Policy Holder Birthdate:** _____________________

# Person Responsible for Payment

**First Name:** _____________________ **M.I.:** ________ **Last Name:** ____________________________
**Address:** ________________________________ **City:** _______________ **State:** _____ **ZIP:** ___________
**Phone#:** _____________________ **Work#:** ___________________ **Relationship to Client:** ____________

# Payment Options

- ☐ **Pay at the time of service**
- ☐ **Bill mailed monthly**
- ☐ **Insurance with co-pay due at time of service**
- ☐ **Shared billing - Please specify** ______________
- ☐ **Other - Please specify** ______________________
  _____________________________________

Canyon Counseling Center office policies and procedures.  Please review and sign this acknowledgement form:

## Appointments

Sessions are 45-55 minutes in length, beginning 10-15 minutes after the hour.  The therapists at Canyon Counseling Center try to see their clients promptly at the appointment time scheduled.  They request that you also be responsible for keeping appointments on time.  If you are late, your sessions will be shortened.  Please do not bring young children to therapy.  In case of appointments not kept or canceled with less than 24 hours notices, you will be charged in-full for that session.  Insurance and other third-party providers do not cover missed session charges. (Exceptions can be made for emergency situations, such as sudden illness.)

| Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|
| 9 am - 4 pm | 9 am - 7 pm | 9 am - 4 pm | 9 am - 7 pm | 9 am - 12 pm |

## Insurance Billing

As a professional courtesy to you, our office will bill your insurance company, where appropriate, on a weekly basis.  We request that you pay a minimum $20.00 co-pay at the time of your session. We would greatly appreciate your keeping current with your co-payments.  If you do not have insurance, a payment schedule will be arranged with you and on your initial visit.

## Limits of Confidentiality

Although confidence is very strict in therapy, there are some occasions when confidentiality must be broken:

- If there is ongoing child abuse.  This includes physical, emotional and/or sexual abuse.
- If you are or become suicidal, or you pose a threat to the safety of another. We are required to protect you, notify the authorities, and warn whomever may be in-danger.
- If you are ever in a court of law and use your mental status as a factor in your case.  Your notes may be subpoenaed by the court and we are required to provide all requested information.
- Without going into extreme details, third-party providers are entitled to know diagnosis, treatment, and/or prognosis.

Otherwise, you control the release of information.

## Court Appearances

Due to our heavy clinical schedules, and as a matter of policy, we do not testify in civil or criminal court proceedings. We will, however, supply the court and/or attorneys with a written summary of therapy if the client should so-desire. A signed release of information is required for each summary to be supplied.

## Phone Calls

Therapists will try to return phone calls as quickly as possible. Because the therapists have limited time between sessions, please be aware that calls may be returned at the end of the day or the following day. Issues that require more than 10 minutes on the phone may require a scheduled office visit.

## About Therapy

- There is a real possibility that you may feel worse at-times in therapy than when you started. This is because you may have to address some uncomfortable and painful issues. This is normal and should be anticipated.
- The length of therapy is determined by you. The amount of work that you are willing to do determines the speed and direction of your therapy. Your therapist will make recommendations for continued service, but feel free to give your input as-well.

I certify that I have read this document completely and agree to be bound by these office policies and procedures.

Print Name

Signature

Today's Date

# Canyon Counseling Center

3651 North 100 East, Suite 100 · Provo, UT 84604 · (801)356-0014

Scott D. Owen, Ph.D. Alan B. Hansen, Ph.D. Shawn C. Edgington, Ph.D.

## Self-Assessment

Below is a list of troublesome problems which often face people. Read each item slowly and place an appropriate number next to each item. Use the scale (1-5) below to indicate your level of concern. Use NA if the item does not apply to you.

| **SCALE:** | No Concern | 1 | Much Concern | 4 |
|---|---|---|---|---|
| | Little Concern | 2 | Very Concerned | 5 |
| | Moderate Concern | 3 | Does not apply | NA |

| | | | | | | |
|---|---|---|---|---|---|---|
| 1.______ Not sure about my career choice. | 2.______ Slow in getting acquainted with people. | 3.______ Feelings too easily hurt. | 4.______ Speaking or acting without thinking. | 5.______ Moodiness, "having the blues." | 6.______ Nervousness/ anxiety. | 7.______ Feeling tired much of the time. |
| 8.______ Not sure why I'm in school. | 9.______ Being shy or timid. | 10.______ Being left out of things. | 11.______ Lacking self-control. | 12.______ Unhappy too much of the time. | 13.______ Feelings of panic. | 14.______ Sleep difficulties. |
| 15.______ Fearing failure in college. | 16.______ Being nervous around other people. | 17.______ Being talked about. | 18.______ Afraid I might hurt someone physically or emotionally. | 19.______ Having feelings of extreme loneliness. | 20.______ Worrying too much. | 21.______ Eating, appetite, or weight problems. |
| 22.______ Not knowing how to study effectively. | 23.______ Too little social life. | 24.______ Too self-centered. | 25.______ Feeling angry or hostile. | 26.______ Feeling inferior. | 27.______ Sometimes worrying that I'm going crazy. | 28.______ Concerned about alcohol, drugs, or tobacco. |
| 29.______ Slow in reading. | 30.______ Not mixing well with opposite sex. | 31.______ Wanting a more pleasing personality. | 32.______ Having difficulty with authorities. | 33.______ Feeling guilty or having a troubled conscience. | 34.______ Finding it difficult to relax. | 35.______ Headaches, back-pain, dizziness, or stomach distress. |
| 36.______ Financial problems. | 37.______ Wondering if I'll find a suitable mate. | 38.______ Not being the kind of person I should be. | 39.______ Recent traumatic event (death, accident, etc.) | 40.______ Feeling hopeless about the future. | 41.______ Unable to concentrate well. | 42.______ Health problems. |
| 43.______ Disliking financial dependence on others. | 44.______ Grief over a broken relationship. | 45.______ Not knowing what I really want. | 46.______ Problems in my family. | 47.______ Sometimes wishing I'd never been born. | 48.______ Problems with memory. | 49.______ Problems with addictive behavior. |
| 50.______ Not reaching goals I've set for myself. | 51.______ Sexual problems. | 52.______ Confused in some of my religious beliefs. | 53.______ Emotional, physical, or sexual abuse. | 54.______ Thoughts of suicide. | 55.______ Can't make up my mind about things. | 56.______ Other problems: ______ |

**Name:** ______________________ **Date:** ______________________

# FINANCIAL AGREEMENT

In consideration of professional services already rendered and for professional services to be rendered in the future to the patient (or parent or guardian) whose (patient or responsible party) signature is placed below, the patient and/or responsible party and Canyon Counseling Center hereby agree to the following:

INSURANCE: Even though Canyon Counseling Center files insurance, this is only a professional courtesy. The patient/responsible party agrees to accept final responsibility for filing and collecting all insurance claims. The patient/responsible party agrees that any balance remaining as either a direct or indirect consequence of any communications with and/or action by and/or lack of action by the insurer is the patient's/responsible party's responsibility.

PAYMENT AGREEMENT: Patient/responsible party agrees to pay Canyon Counseling Center all sums incurred for professional services within the time specified below.

Payment may be made at a reduced rate at the time of service or may be billed on a 30-day net agreement. Any amounts not paid at the time of service and any insurance co-payments are due in full on the 15th day of the month following the month in which service was provided. If complete payment cannot be made at such time, formal payment arrangements must be made with Canyon Counseling Center's financial assistant immediately after the initial service. Any overdue balance shall bear interest at the rate of 18 percent per annum after 90 days delinquent until paid. Should the patient/responsible party default in the payment of any installment on the date when it becomes due and payable, under these circumstances, Canyon Counseling Center may elect to accelerate the maturity of all remaining sums so that the sum becomes due and payable forthwith. There will be a $20 fee assessed for a returned check.

All accounts 90 days overdue will automatically be turned over to an outside agency for collection. In the event that this agreement shall be placed in the hands of an outside agency for enforcement, or in the event that any other legal action be taken, patient/responsible party agrees to pay costs of collection (50%), court costs, and any reasonable attorney's fee. Patient/responsible party also agrees that should it be necessary, patient/responsible party will return from other geographic locations and other responsibilities to the County of Utah, State of Utah for legal proceedings and that patient/responsible party will pay all costs associated with this requirement. The accounts of Canyon Counseling Center are verified by a Certified Public Accountant.

An unpaid balance in excess of $1,000.00 may result in the suspension of clinical services until such time as the outstanding balance can be resolved.

FAILED APPOINTMENTS: Full charge will be made for missed appointments which are not canceled 24 hours in advance of the set time. This 24 hours is in addition to weekends, holidays, or other time when the office is closed. Parents are responsible for their minor child's actions as it related to this office policy and are responsible to advise children of this policy.

The undersigned person hereby agrees to all stipulations above and to pay all professional services rendered by Canyon Counseling Center in accordance with this agreement.

________________________ ____________________

Authorized Signature Date

I hereby request Canyon Counseling Center to file regular insurance claims to specified insurance companies. I hereby authorize Canyon Counseling Center to release information as to diagnosis, treatment, and/or prognosis, and any other non-medical related information. I further authorize payment of medical benefits to Canyon Counseling Center for any insurance claims processed in patient's behalf. I agree that a photocopy of this form is as valid as the original and that this authorization shall be valid for one year from date of latest service received by patient.

____________________ ____________________

Authorized Signature Date