

**SPRING VALLEY THERAPY**  
Office of Jennifer Gayan, LCSW  
Individual, Couples & Family Therapy: Child to Adult  
Web: [SpringValleyTherapy.org](http://SpringValleyTherapy.org)

Dear Client,

Welcome to Spring Valley Therapy. Our goal is to provide a high standard of professional service with a personal touch.

The following information is important for your consideration. Please read each section in its entirety and contact the office with any questions. Be sure to complete this packet prior to your first visit. For your convenience, this can be done in the following ways:

1. Open the document on our website and complete the highlighted fields by opening the New Client Packet electronically. Save and email the document to [SpringValleyTherapy@gmail.com](mailto:SpringValleyTherapy@gmail.com) prior to your appointment. We will print and have the forms ready for you to sign at your appointment.
2. Download the forms from our website at [SpringValleyTherapy.org](http://SpringValleyTherapy.org), print and fill out the forms by hand and bring the completed forms with you to your appointment.
3. Request a copy of the paperwork by email or mail. Contact the office and leave a message for the Practice Manager, Corrie, to request the New Client Packet. You can contact the office at 702-410-2649 or by email at [SpringValleyTherapy@gmail.com](mailto:SpringValleyTherapy@gmail.com). Bring the completed forms with you to your appointment.
4. Arrive 15 minutes early to your first appointment and fill out the paperwork in our office.

In this New Client Packet you will find:

- Welcome Letter (Page 1, retain for your records);
- New Client Registration Form with Consent (Page 2);
- Description of Services and Client Rights (Page 3);
- Office Policies (Page 4);
- Financial Policy and Agreement (Page 5);
- Phone and Electronic Communication Agreement (Page 6);
- Policies and Limitations Regarding Legal Matters (Page 7);
- Authorization for disclosure of Confidential Health Information (Page 8); and
- Notice of Privacy Practices (Pages 9-10, retain for your records).

We look forward to serving you. Please feel free to contact our office with questions, because we are here to help.

Sincerely,

Jennifer Gayan, LCSW  
Spring Valley Therapy

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**New Client Registration Form**

*CLIENT INFORMATION (Individual receiving services)*

Last Name	First Name	Middle Initial	Marital Status	Sex (circle one) Male    Female	Date of Birth	Age
Address			City	State	Zip	Social Security #
Home Phone Number		Cell Phone Number		Email Address		
Employer/School			Work Phone Number		Occupation	
Emergency Contact Person			Relationship to Client		Emergency Contact Phone	
Seeking insurance reimbursement? (circle) YES NO			Insurance carrier		Insurance Carrier Phone	
Referred by			Is client seeking services in affiliation with: (circle) MS Society   Religious Organization   Give an Hour (Military)   N/A			

*RESPONSIBLE PARTY/PARENT/GUARDIAN (Individual signing this form)*

Relationship to Client (circle one) SELF    PARENT    GUARDIAN    OTHER			If guardian/other state relationship with client and legal authority			
Last Name	First Name	Middle Initial	Marital Status	Sex (circle one) Male    Female	Date of Birth	
Address			City	State	Zip	Social Security #
Home Phone Number		Cell Phone Number		Email Address		
Employer			Work Phone Number		Occupation	

*CONSENT FOR TREATMENT*

I, \_\_\_\_\_ authorize Spring Valley Therapy to provide mental health services for myself or for the client. If the client named above is a minor or an adult who has been adjudicated legally incompetent, I certify that I am the legal guardian of such person and have the legal right to approve of such services. I grant permission for Spring Valley Therapy to contact the above named individual in case of an emergency. In signing this consent for treatment, I affirm I have read and understand all of the following policies and terms and agree to abide by all of my obligations contained therein.

\_\_\_\_\_  
Print Name of Client

\_\_\_\_\_  
Client/Responsible Party Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
For Responsible Party, indicate authority to sign

\_\_\_\_\_  
Date

## Description of Services and Client Rights

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### Goals, Outcomes, Benefits and Risks and Length of Treatment

Generally, therapy is most useful in helping individuals help themselves or improve their situation by changing feelings, thoughts, and/or behaviors. You determine the nature and amount of change you wish to make. To help you obtain the most from your experience, treatment recommendation and goals for therapy will be established following an individual assessment. Most people experience improvement or resolution to the concerns that brought them to therapy, but of course, there are no guarantees; and there are some risks. For example, therapy could open up new levels of awareness that may cause discomfort, or others may not be able to adapt well to changes that you make. Spring Valley Therapy generally uses a short-term therapy focus. This usually means fewer than twelve sessions. If it appears your situation requires more than twelve sessions, this will be discussed during treatment planning. Each therapy session lasts 45-50 minutes. Frequency of sessions will be determined following your assessment.

### Bill of Rights

As a client of Spring Valley Therapy, you are entitled to the following rights:

- To receive services without regard to your race, color, religion, sex, age, marital status, national origin, veteran status, or disability and to be treated with respect, consideration, and dignity;
- To receive appropriate treatment and services and to participate in the planning and periodic review of your individual treatment plan;
- To be informed about available treatment options and the effectiveness of such options;
- To terminate or decline treatment recommendations or services, and/or request referrals to another provider;
- To request a copy of your medical record in accordance with the policies and procedures which are governed by State and Federal law; and
- To understand the qualifications of your provider. To obtain licensure as an LCSW in the state of Nevada, individuals must hold bachelor's and master's degrees and complete 3,000 hours of post graduate work in psychotherapy under board-approved supervision and pass the state board licensing exam.

### Record Retention

Spring Valley Therapy will maintain records for the minimum amount of time required under current law. Anyone part of this organization or in collaboration with this organization will have access to records only on a need-to-know basis in accordance with HIPAA regulations. Upon the untimely death of your therapist, records will be maintained by the Practice Manager, Corrie, who can be contacted at 702-410-2649.

### Confidentiality/Notice of Privacy Practices

Signing this form acknowledges your receipt of Spring Valley Therapy's *Notice of Privacy Practices*. This document describes your rights and Spring Valley Therapy's obligations regarding the use and disclosure of your health information. Spring Valley Therapy will not release confidential information without this written authorization, unless otherwise authorized or required by law.

**I have read the above information in *Description of Services and Client Rights* and accept the terms as stated. If there is anything in this form I do not understand, it is my responsibility to seek clarification.**

\_\_\_\_\_  
Print Name of Client

\_\_\_\_\_  
Client/Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

## Office Policies

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### Contact with Spring Valley Therapy and Office hours

Clients may contact Spring Valley Therapy by phone or email in accordance with our Phone and Electronic Communication policy. For general questions, scheduling or billing, please contact the office at 702-410-2649 and leave a message for the Practice Manager, Corrie. The office email address is [SpringValleyTherapy@gmail.com](mailto:SpringValleyTherapy@gmail.com). The current office hours for Spring Valley Therapy are Tuesday, Wednesday and Thursday from 8:30 AM - 6:00 PM. The front door is locked prior to 8:30 AM and after 4:30 PM. If you have an appointment outside of these hours, please call the office at 702-410-2649 upon your arrival and your therapist will meet you at the front door.

### Scheduling/Cancelation of Appointments

Appointments are made by contacting Spring Valley Therapy directly. Once services have been established, return appointments will generally be scheduled at the conclusion of each visit. Schedules can change quickly and in order to avoid canceling, rescheduling, or missing appointments, up to two future appointments may be scheduled at a time. On occasion, a situation may arise which prevents you from keeping a scheduled appointment. As a courtesy, please notify Spring Valley Therapy at least 24 hours prior to your appointment if you cannot keep it. Except in emergency situations, you will be personally charged one-half the current hourly fee for late cancellations or for not keeping an appointment. The client will be referred to another provider after 3 late cancellations and/or for 3 missed appointments.

### Payment for Services

Clients are responsible for payment of services. Payments are made to Spring Valley Therapy and are due by the client at the time of service. The methods of payment accepted include cash, check, or credit card. A late fee of \$15 will be assessed for outstanding balances more than 30 days past due. Please be aware that appointments will not be scheduled for any client with an outstanding balance that is more than 60 days past due. After the third reminder of non-payment the client will be referred to another provider. If another party has authorized payment for services, authorization is required in writing prior to billing the party and any balance prior to receiving such authorization will be the client's responsibility.

### Children

Please arrange for children to remain at home unless specifically asked to bring them as part of the therapy session. Children under 12 years of age may not be left unattended in the waiting area.

### Request for Information (Letters, Records, etc.)

Requests for written documents (letters to insurance companies, status of treatment progress to another party, attendance of appointment letters for school or work, etc.) require a minimum of three business days to complete the request for information. Requests for records require five working days to be processed and a completed authorization to release information.

### Safety/Firearms/Weapons

When you come to an appointment with Spring Valley Therapy leave all firearms, knives, and weapons of any kind at home. No weapons are permitted in the office of Spring Valley Therapy at any time. Any violation will result in a referral to another provider.

**I have read, understand and agree to abide by Spring Valley Therapy's Office Policies.**

\_\_\_\_\_  
Print Name of Client

\_\_\_\_\_  
Client/Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

## Financial Policy and Agreement

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### Financial Policy and Agreement

Spring Valley Therapy is a private pay practice. Payment by cash, check, or credit card is due in full at the time of service and is accepted by the client directly or billed to a third party organization that has authorized payment. We do not accept insurance, however many insurance companies offer options for reimbursement and Spring Valley Therapy can provide you with the information your carrier may request. To find out more about your plan benefits, contact your insurance company and inquire about benefits for Out of Network Behavioral Health Providers and the process for requesting reimbursement. We will make every effort to help you obtain your benefits but cannot guarantee your insurer/other party will pay. In the event your claim is denied all monies are due in full by you. If applicable, co-payments for treatment are due in full at the time services are performed. Checks returned for insufficient funds will result in a returned check fee of \$50.00 and are subject to legal action. Spring Valley Therapy requires at least 24 hours prior notice for appointment cancellations. Late cancellations and missed appointments will be subject to a fee at half the current hourly rate. This fee is the sole responsibility of the client and cannot be billed to another party.

### Client Responsibility

I acknowledge my full responsibility for payment of services rendered by Spring Valley Therapy and the staff. I understand my responsibility is not modified by whether my insurance/other party pays for all, part, or none of my charges. I further acknowledge and agree that all accounts past 30 days shall bear a late fee for \$15. I also acknowledge and agree that in the event I do not pay for my treatment balance within 90 days my account may be placed with a collection agency. I agree to pay all costs associated with the collection, as well as attorneys' fees and court costs if a lawsuit is filed. I understand that Spring Valley Therapy has the sole discretion to refuse providing me with future appointments if my account is in arrears and that it is the policy of Spring Valley Therapy that after the third reminder of non-payment the client will be referred to another provider.

### Assignment and Release

I hereby guarantee payment for the entire balance of services rendered by Spring Valley Therapy. I authorize payment to be made directly to Spring Valley Therapy, and I accept financial responsibility for all service not covered by another party. I assign and authorize payment of medical benefits directly to Spring Valley Therapy and/or its representatives. Furthermore, I authorize Spring Valley Therapy to release my PHI, including my medical records and any other information requested by insurance companies, payers, or government agencies in connection with this assignment necessary to process any insurance claims or access employee benefits, including, but not limited to, my previous treatment history, mental health or substance use issues, and medical history.

### Signature

By signing below, I am confirming that I have read, understood, and agree to the described disclosure, financial policy, and various releases and guarantees. This agreement becomes effective the date I begin my first visit with Spring Valley Therapy.

\_\_\_\_\_  
Print Name of Client

\_\_\_\_\_  
Client/Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

## Phone and Electronic Communication Agreement

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Phone contact is always welcomed with Spring Valley Therapy. Email offers an easy and convenient way for clients and providers to communicate. In many circumstances, it has advantages over office visits or telephone calls. But remember there are important differences. Email is not the same as calling the office; there is no person at the other end of the call – just a computer. You can't tell for certain when your message will be read, or even if your provider is in the office or on vacation. Nonetheless, we believe that the ease of communication email affords is a benefit to client care. It will further assist us if you could identify the nature of your request in the subject line of your message. Below are the rules for contacting Spring Valley Therapy using phone and email.

- Phone and/or email messages may be used to communicate about scheduling, canceling, or confirming appointments.
- Email is never appropriate for urgent or emergency problems! If you experience a psychological or medical emergency, dial 911 or Montevista Hospital at 702-364-111 or go directly to the Emergency Department.
- Spring Valley Therapy will not engage in text messaging. Please call the office or use email in accordance with this policy.
- Email is great for asking those little questions that don't require a lot of discussion. Appropriate uses of email also include referrals, and appointment scheduling requests and billing/insurance questions.
- Emails should not be used to communicate sensitive medical information or emergencies.
- Email is not confidential. Email may be forwarded to the staff of Spring Valley Therapy for handling, if appropriate.
- The staff of Spring Valley Therapy may read your emails to handle routine, non-clinical matters. You should also know that if sending emails from work, your employer has a legal right to read your email if he or she chooses.
- Email may become part of the medical record when we use it; a copy may be printed and put in your chart.
- Email is not a substitute for seeing your therapist. If you think you might need to be seen, please call and schedule an appointment.
- Finally, either one of us can revoke permission to use the email system at any time by doing so in writing.

**I have read the above information and understand the limitations of security on information transmitted. I agree to abide by the phone and electronic communication agreement above and authorize communication with Spring Valley Therapy as follows:**

(Initial)\_\_\_\_\_ Email Address:\_\_\_\_\_

(Initial)\_\_\_\_\_ Home Phone:\_\_\_\_\_

(Initial)\_\_\_\_\_ Cell Phone:\_\_\_\_\_

(Initial)\_\_\_\_\_ Work Phone:\_\_\_\_\_

\_\_\_\_\_  
Print Name of Client

\_\_\_\_\_  
Client/Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

## Policies and Limitations Regarding Legal Matters

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1. The goal of psychotherapy services is to support clients in achieving personal therapy goals, not to address legal issues or engage in an adversarial role.
2. If you are involved or anticipate being involved in a court action, then you should discuss any legal issues with your attorney. Your therapist is not an attorney and therefore prohibited from giving legal advice.
3. Involving your personal therapist in any legal proceeding may damage or hinder the progress of your therapy and/or your legal proceeding.
4. If your therapist discovers a conflict between providing you with psychotherapy services and you being involved in any legal proceeding, then the therapist has the authority to decline to offer and/or discontinue providing psychotherapy services to you. In the event of such a conflict, your therapist may recommend alternative providers, or that you start psychotherapy services upon completion of your legal proceeding.
5. Spring Valley Therapy will not participate in any legal proceedings.
6. If your attorney or anyone on your behalf subpoenas your therapist to testify regarding your psychotherapy treatment in a legal proceeding, then that party will be billed at the rate of \$150/hour for time spent in the legal proceeding plus a reasonable amount of preparation time with a minimum half day (four hours) in fees to be paid prior to the therapist appearance in the legal proceeding. Should another party subpoena your therapist's testimony, that party will be billed in accordance with this policy.
7. As a client of Spring Valley Therapy, you agree not to involve your therapist in any legal proceedings or attempt to obtain records of treatment for legal proceedings.

**By signing this policy disclosure form, I acknowledge that I have read, understand, and will abide by each of the above policies.**

\_\_\_\_\_  
Print Name of Client

\_\_\_\_\_  
Client/Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

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Office of Jennifer Gayan, LCSW  
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**Authorization for Disclosure of Confidential Health Information**

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

I, \_\_\_\_\_, authorize the information specified below to be disclosed as follows:

☐ FROM ☐ TO SPRING VALLEY THERAPY \_\_\_\_\_  
6069 SOUTH FORT APACHE ROAD SUITE 100 LAS VEGAS, NV 89148  
PHONE (702) 530-3051 FAX (702) 410-2629 EMAIL: [SPRINGVALLEYTHERAPY@GMAIL.COM](mailto:SPRINGVALLEYTHERAPY@GMAIL.COM)

☐ FROM ☐ TO NAME / ORGANIZATION: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
PHONE/FAX/EMAIL: \_\_\_\_\_

Disclosure shall be limited to the following specific information contained in Client's records and/or obtained during the course of Client's diagnosis and treatment by Spring Valley Therapy:

	YES	NO		YES	NO
Assessment & diagnostic summaries	<input type="checkbox"/>	<input type="checkbox"/>	Billing payment records	<input type="checkbox"/>	<input type="checkbox"/>
Attendance record	<input type="checkbox"/>	<input type="checkbox"/>	Progress reports	<input type="checkbox"/>	<input type="checkbox"/>
Treatment goals	<input type="checkbox"/>	<input type="checkbox"/>	Discharge summary	<input type="checkbox"/>	<input type="checkbox"/>
Treatment plan	<input type="checkbox"/>	<input type="checkbox"/>	Verbal exchanges	<input type="checkbox"/>	<input type="checkbox"/>
Progress notes (specify dates below)	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>

If information in Patient's records pertains to HIV/AIDS, I expressly **DO / DO NOT** authorize Spring Valley Therapy's office to disclose such information pursuant to this authorization. Circle **N/A** if not applicable.

I am requesting that this information be disclosed for the purpose(s) of:

This authorization shall be in full force and effect until \_\_\_\_\_. If no expiration date is provided, this authorization shall expire 180 days after the date on which I signed below.

I am aware of the confidential and/or privileged nature of the information being disclosed and understand the benefits and/or disadvantages of disclosing such information. I hereby release Spring Valley Therapy and its affiliates, representatives and assigns from all legal liabilities that may result from the release of this information. I acknowledge that I have the right to revoke this authorization at any time by sending written notification to Spring Valley Therapy's office. I understand that a revocation is not effective if Spring Valley Therapy's office has already taken actions in reliance upon this authorization. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws and regulations.

\_\_\_\_\_  
Print Name of Client

\_\_\_\_\_  
Client/Responsible Party Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
For Responsible Party, indicate authority to sign

\_\_\_\_\_  
Date

*Notice to Recipient: This authorization provides for a release of information about an individual whose confidentiality is protected by federal and state laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (45 CFR 160-164) as well as 42 CFR Part 2 and 42 USC 290dd-2 and state confidentiality laws. No information disclosed from this authorization may be re-disclosed without the specific written consent of the individual to whom such information pertains.*



## Notice of Privacy Practices (client copy, retain for your records, page 1 of 2)

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This notice describes how medical information about you may be used and disclosed, please review it carefully.

### Why you are being provided with this notice

A federal law known as the *Health Insurance Portability and Accountability Act* (HIPAA) requires that you are provided with this Notice. This Notice will tell you about the ways in which Spring Valley Therapy may use and disclose health information about you and will describe your rights and Spring Valley Therapy's obligations regarding the use and disclosure of that information.

### Your health information

This Notice applies to the information and records Spring Valley Therapy has about your health, health status, and the health care services you receive from Spring Valley Therapy. This information and records relates primarily to therapy service you receive from Spring Valley Therapy.

I understand that most information disclosed to Spring Valley Therapy is protected by federal, state, and local laws and regulations governing confidentiality. As such, I understand that much information cannot be disclosed to others without my written authorization, except under limited circumstances. I understand that during the course of receiving services, Spring Valley Therapy receives, originates, maintains, discloses, and uses individually identifiable protected health information ("PHI"), including, but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, treatments, treatment plans, and billing and health insurance information. I understand that Spring Valley Therapy and its employees and contractors, other health care professionals, and administrative staff may use and disclose my PHI to perform the following tasks:

- Diagnose my medical, psychiatric, or psychological condition; Plan my care and facilitate counseling and other health treatment;
- Communicate with other health care professionals concerning my care;
- Document the services I receive in order to obtain payment or reimbursement by you, or another party; and
- Conduct routine health care operations related to Spring Valley Therapy, business, office operations, including quality assurance (the process of monitoring the necessity for, the appropriateness of, and the quality of care provided) and peer review (the process of monitoring the effectiveness of health care personnel).

### Special Situations

Spring Valley Therapy may use or disclose your health information without your permission for several reasons. These reasons include:

- Disclosing your health information when Spring Valley Therapy believes that disclosure is necessary to prevent a serious threat to your health and safety or the health and safety of another person, or if hospitalization is required due to mental illness, confidentiality may be suspended in order to protect the client or others, and treat the mental illness.
- Disclosing your health information as required by federal, state or local law.
- Disclosing your health information as required by law to prevent injury or suspected abuse or neglect. In cases of past or present suspected child abuse or neglect, a report must be made to Child Protective Services. In case of abuse or neglect of 1) an individual older than age 60; or 2) a disabled individual; or 3) individuals adjudicated legally incompetent, a report must be made to local law enforcement agencies.
- Disclosing your health information in response to a court order, subpoena, warrant, summons or similar process.
- Spring Valley Therapy may share confidential information about a deceased individual to the executor of the deceased's estate, or if a client's mental health information is necessary to determine the validity of a will.

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Notice of Privacy Practices (client copy, retain for your records, page 2 of 2)

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**Other uses and disclosures of health information**

Except where otherwise required or authorized by law, Spring Valley Therapy will not use or disclose your health information for any purpose without your written authorization. If you authorize Spring Valley Therapy to use or disclose health information about you, you may revoke your authorization, in writing, at any time by delivering to Spring Valley Therapy a written notice of revocation. If you revoke your authorization, Spring Valley Therapy will no longer use or disclose your health information for the reasons covered by your written authorization, however the revocation will not be effective to the extent that Spring Valley Therapy has already taken action in reliance on an earlier effective consent or authorization. You also understand that there are legal exceptions, in which my consent is not necessary to disclose PHI or similar information to others, as stated in the *Notice of Privacy Practices: Special Situations* section.

**Changes to this notice**

Spring Valley Therapy has the right to change this Notice without prior notice. If changed, the new notice will apply to the health information Spring Valley Therapy may already have about you and to the health information that Spring Valley Therapy receives in the future. Spring Valley Therapy is required to abide by the most current notice that is in effect. You are entitled to receive a copy of the most current notice.

**This notice is in effect July 1, 2013.**