LifeMatters Counseling Center

3120 S. Richmond St. (1300 E.) ▪ Salt Lake City, UT 84106
Phone: (801) 313-0555 ▪ Fax: (801) 313-9669
www.LMCounseling.com

Client Information: (As it appears on your insurance cards)

Client Legal Name: ______________________ DOB: __________
Address: ______________________
City, State, Zip: ______________________
Phone Number/Type: ______________ Alt. Phone/Type: ______________
Email: ______________________
Social Sec. #: (REQUIRED) ______________________

Insurance Information: (Please provide the card to be copied for our records)

Policy or Medicaid Number: ______________________
Insurance Company Name: ______________________
Insured's Name: ______________________ DOB: __________
Group Number ______________________
Employer Name: ______________________

Emergency Contact:

Name: ______________________
Relationship: ______________________
Phone Number: ______________ Type: __________
Alternate Phone: ______________ Type: __________

If Client is a Minor: (Parent / Guardian Information)

Please list name, relationship, phone(s), and a brief description of the custody situation for all parents and/or guardians:

____

____

☐ Check if the client is currently in DCFS Custody The current permanency goal is: __________

Consumer Agreement

- All clients are expected to actively participate in therapy. Family involvement is encouraged and often essential to successful treatment. Please be on time to your appointments and attend each scheduled session. Your success in therapy depends on your consistency, participation, and effort.
- If you cannot make a scheduled appointment, please call to cancel or re-schedule **AT LEAST 24 HOURS IN ADVANCE**. If you do not call, the session or no-show fee may be billed. Clients who miss multiple appointments may be terminated from treatment. The appropriate legal guardian or referring agency will be notified if termination is necessary.
- In the case of emergency, LifeMatters staff needs permission to seek medical treatment for you in case you cannot help yourself. By signing below you agree to allow LifeMatters staff to act on your behalf in case of emergency.
- All clients will be billed the standard rate for services provided unless other arrangements are made for payment. LifeMatters will bill private insurance companies for services; however, you are responsible to pre-authorize treatment, and to know the mental health benefits for your particular insurance. By signing below you authorize us to bill insurance on your behalf and to provide necessary confidential information to your insurance regarding billing. You will be assessed a 1.5% finance charge per month **AFTER YOUR PAYMENT IS 30 DAYS LATE**. Unpaid accounts will be referred to collections. In the event payment under this agreement is not made at the time and in the manner required, the undersigned agrees to pay all costs of collection, including attorney fees, court costs, including charges and collection agency fee which would be 30% of the balance assigned, with or without suit.

Standard Charge for Services:
Individual/Family/Couples Therapy: $120/hr Assessment: $150/hr Group Therapy: $30/hr No Show/Late Cancel Fee: $40

By signing below, I agree to these terms and consent to mental health treatment at LifeMatters Counseling and Health Center.

______________________ Client Signature ________ Date ______________________ Parent/Guardian/Responsible Party Signature ________ Date

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Confidentiality Agreement

Professionals who provide mental health services are required by laws and ethical standards to keep all communications between clients and therapists confidential. Information will only be shared about you when agreed to by your signature on a "Release of Information" form. There are some specific limitations to client confidentiality:

1. Suspected child or vulnerable adult abuse or neglect: We are required by law to report to the appropriate state agency if we suspect abuse or neglect of a child or an vulnerable adult.
2. Harm to self or others: If we conclude that a client is about to cause harm to themselves or someone else, we are obligated to report this and/or to take steps to prevent that harm.
3. Response to court subpoenas and orders: We are obligated to cooperate with lawful orders and subpoenas of courts of law. We will make all attempts to maintain your confidentiality in these cases.
4. We are required by some referring agencies to provide updates and progress reports. We will report to these agencies by developing a report or update together with the client in therapy. These reports will only be released with your written permission.

I understand and agree to these terms and limitations regarding confidentiality: _____________ (Initial)

Utilizing electronic communication as a source of communication cannot be guaranteed to be confidential. If you choose to communicate with LifeMatters or individual therapist via electronic communication including e-mail, text message, etc. you understand that this type of communication may risk your right to confidentiality.

I understand that by using electronic means, my communication may not be completely confidential: ________(Initial)

Client Rights and Grievance Policy

All clients have the right to be treated fairly, with respect, and with dignity. If you are mistreated please follow the grievance procedure outlined below.

1. All client information and records are confidential. Access to records will only be granted with client permission.
2. All individuals have the right to participate in therapy free from harm or threat. Any potentially harmful situation should be immediately reported to LifeMatters staff. Threats or violence will not be tolerated and could result in termination of services.
3. LifeMatters does not allow smoking in our offices or near public entrances in accordance with the Utah Clean Air Act.
4. All individuals have the right to be free from discrimination based on age, race, color, culture, religion, sexual orientation, or disability. If you feel that you have been discriminated against please follow the following grievance policy for remediation. LifeMatters complies with all applicable laws regarding discrimination and any form of discrimination will not be tolerated.

Any individual who feels they have been mistreated or has any grievance has a right to be heard and have their issue addressed. Clients are first encouraged to address the problem directly with the offending person. If you are unable to do this for any reason you should contact the clinical director, Rob Butters. If you are still not satisfied, please contact the Utah Department of Human Services at 120 N 200 W. SLC, UT, Department of Professional Licensing, or your case worker or other referring professional.

I have read and understand my rights and procedure for grievances: ________(Initial)

LifeMatters Cancellation/ No Show Policy

- All clients must give a 24 hour notice for cancelling appointments.
- Failure to cancel a scheduled appointment is considered a NO SHOW.
- **A $40.00 N0 SHOW fee will be charged**. This fee may be waived upon appeal.
- You are required to reschedule your next appointment.
- Recurring appointments that are missed are not scheduled for the next week unless specifically requested and approved by your therapist.
- A second NO SHOW may be considered self-termination.
- Your termination may be reported to any agency (DCFS, DJJS, courts,) that we are working with.
- If terminated for no-shows it will be your responsibility find another health care provider. We are happy to provide referrals if you call the office.

I have read and understand the No Show policy:

Client Signature	Date	Parent/Guardian/Responsible Party Signature	Date

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CLIENT DEMOGRAPHIC INFORMATION

Client Legal Name: ____ DOB: __________

The following information is required by insurance even if the client is a child.

How was the client referred to LifeMatters?

- ☐ Self
- ☐ Family / Friend
- ☐ Social Services Agency
- ☐ Educational System
- ☐ Court, Law Enforcement, Corrections
- ☐ Private Psychiatric / Mental Health Program
- ☐ Public Psychiatric / Mental Health Program
- ☐ Clergy
- ☐ Private Mental Health Professional
- ☐ Physician or Medical Facility
- ☐ Other Persons or Organization

Client's race:

- ☐ American Indian
- ☐ Pacific Islander
- ☐ Black
- ☐ White (Caucasian)
- ☐ Other
- ☐ Asian
- ☐ Alaska Native

Client's Hispanic / Spanish Origin:

- ☐ Not of Hispanic Origin
- ☐ Mexican / Mexican American
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other Hispanic

Client's marital status (fill out even if client is a child)

- ☐ Single - Never Married
- ☐ Married - Spouse in Home
- ☐ Married but Separated
- ☐ Divorced
- ☐ Widowed

Is the client currently enrolled in an education program? ☐ Yes ☐ No

Indicate the highest level of education completed:

- ☐ Preschool
- ☐ Kindergarten
- ☐ _____ Grade
- ☐ High School Graduate or GED
- ☐ Some College or Associates Degree
- ☐ College Graduate
- ☐ Some Graduate School
- ☐ Graduate School Graduate
- ☐ Never Attended School

Household Monthly Income: (NOTE: This cannot be zero.) $_____

List (name and relationship) people living in the home: ____

____

____

____

Is the client a Veteran? ☐ Yes ☐ No

What Language needs to be spoken during therapy? _____

Has the client had previous mental health treatment, including hospitalization? If so, where and who was their primary provider?

____

____

____

Is the client currently pregnant? ☐ Yes ☐ No

Smoking Status? ☐ Current Daily Smoker ☐ Current Sometimes Smoker ☐ Former Smoker ☐ Never Smoker

Employment Status:

- ☐ Employed Full-time - 35+ Hrs
- ☐ Employed Part-time – less than 35 Hrs
- ☐ Homemaker
- ☐ Retired
- ☐ Supported / Transitional Employment (full-time)
- ☐ Supported / Transitional Volunteer
- ☐ Unemployed - Not Looking
- ☐ Unemployed - Disabled
- ☐ Unemployed - Looking

Has the client been arrested in the last 30 days? ☐ Yes ☐ No If YES, How many times? _____

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MORE ON REVERSE SIDE

YOU MAY FILL OUT AS MUCH OR AS LITTLE ON THIS PAGE AS YOU ARE COMFORTABLE

Please use this space to describe why you (the client) are seeking therapy.

CHECK ALL THAT APPLY:

☐ I have previously been in therapy for a mental health disorder. My diagnosis(es) was / were:

☐ I have been experiencing troubling symptoms or behaviors. They are:

☐ Others have observed troubling symptoms or behaviors. They are:

☐ My functioning in certain life areas is not what I would like it to be. Those areas are:

- ☐ Family / Home (Please explain):
- ☐ School / Work (Please explain):
- ☐ Social (Please explain):
- ☐ Romantic Relationships (Please explain):

☐ I have experienced events in my life that are causing me distress. They are:

☐ I am required to seek therapy by an outside person, agency, or the courts. They are:

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TREATMENT TEAM RELEASE OF INFORMATION AUTHORIZATION

Client Legal Name: ______________________________ DOB: ____________

Please list full names, relationships, and telephone numbers of any members of your treatment team. These may include family members or friends who will be participating in treatment, your physician(s) if they referred you to therapy or if you are seeking medication management, school representatives, previous therapy providers, or anyone else who may need to be consulted in regards to your therapy. By listing these team members you are authorizing your LifeMatters therapist or staff to contact these individuals and discuss your treatment, or provide documentation pertaining to your treatment.

If there are individuals you would like to receive only limited information regarding your treatment, please fill out a separate Release of Information Authorization form.

If you are working with an agency that will be funding your treatment, or are involved with the court system in any way, be sure to list your caseworker and/or probation officer.

Relationship AND/OR Agency	Name	Contact Information (phone/email)

I understand that I can end this authorization at any time; this will not include any information already shared. I should ask if I am required to sign this form in order to receive services. If I am court ordered into treatment and I end this authorization, it will likely put me in violation of court order. Once my records have been shared they may no longer be protected. If this authorization is for a minor, both minor and guardian must sign. I can request a copy of my record in writing, which will be approved by a licensed provider and can take up to 30 days to complete, charges may apply. I can also review my records with my therapist by scheduling an appointment.

By signing this form I attest that I have read and accepted the information outlined above.

☐ I would like a copy of this form for my records
☐ I do not need a copy of this form for my records

Client Signature ____________ Date ____ Parent/Guardian/Responsible Party Signature ____________ Date ____

Witness Signature ____________ Date ____