LifeMatters Counseling & Health Center
3336 Pioneer Parkway, Suite 201 ■ West Valley City, UT 84120
Phone: (801) 313-0555 ■ Fax: (801) 313-9669
www.lifemattersutah.com
Email: reception@lifemattersutah.com

CLIENT INFORMATION: (As it appears on your insurance card(s)

Client Legal Name: ______________________________ DOB: ____________
Preferred Name and pronoun: ______________________ Phone: ____________
Address: ______________________________ City, State, Zip: ____________
Email: ____________________ Social Sec. #: (Req'd for all adults and Medicaid) ____________

INSURANCE INFORMATION: (Please provide the card(s) to be copied for our records)

Insurance Company Name: ______________________ Employer: ____________
Policy/Medicaid Number: ______________________ Group #: ____________
Policy Holder's Name: ______________________ DOB: ____________

EMERGENCY CONTACT or LEGAL GUARDAIN(s)/PARENT INFO (if client is a minor):

Name: ____________	Name: ____________
Relationship: ____________	Relationship: ____________
Phone: ____________	Phone: ____________
Email: ____________	Email: ____________
*Social Sec. # ____________	*Social Sec. # ____________

*At least one parent SSN required if client is a minor, SSN not required for emergency contacts)

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 cancel in time, the session or no-show fee may be billed. Clients who miss multiple appointments may be terminated from treatment.
- 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 Charges for Services*:
Individual /Family/Couples Therapy (In-person or Telehealth): $150/hr.
Assessment: $175/hr. Group Therapy: $30/hr. No-show/Late Cancel fee: $40

**Optum Salt Lake County Medicaid members do not have to pay for covered services received when they have Medicaid.*

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

____

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 a 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 funding/ 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 at least 24 hour notice for cancelling appointments.
- Failure to cancel a scheduled appointment is considered a NO SHOW.
- **A $40.00 N0 SHOW fee or the full session fee may 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.
- If terminated for no-shows it will be your responsibility find another health care provider. We are happy to provide referrals if needed.

I have read and understand the No Show/Late Cancel policy:

Client Signature	Date	Parent/Guardian/Responsible Party Signature	Date

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CLIENT DEMOGRAPHIC INFORMATION (please answer the best you can)

Client Legal Name: ____________________ DOB: __________

The following information is required by most funding sources even if the client is a child.

Client Gender: __________________

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)
☐ ___________
☐ 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

Approx. 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

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

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

CHECK ALL THAT APPLY:

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

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

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

Other Relevant information that may help us provide you with the treatment you need and/or assign you to the most appropriate provider.

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RELEASE OF INFORMATION AUTHORIZATION (optional)

Client Legal Name:____DOB:________________

Please list names, relationships, and telephone numbers of any individuals you would like us to communicate about your treatment. These may include family members or friends who will be participating in treatment, your physician(s) or other healthcare providers, school representatives, previous therapy providers, or anyone else who may need to be consulted in regards to your therapy. By listing these individuals you are authorizing your LifeMatters therapist or staff to communicate with 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 describe limitations below.

If you are working with an agency that will be funding your treatment, or are involved with the court system and would like us to communicate please list your caseworker and/or probation officer.

Name	Relationship AND/OR Agency	Phone/email)

Limitations to Release of Confidential Information:

____
____
____

Date this release of information ends (Leave blank if no end requested):____________

I understand that I may revoke this authorization at any time, I also understand I am not required to sign this form or release any information to anyone in order to receive services. Once my records have been shared, they may no longer be protected by this agreement. If this authorization is for a minor, both minor and guardian must sign. I can request a copy of my records 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	Date

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screener/Recent - Self-Report

	In the Past Month	
Answer Questions 1 and 2	**YES**	**NO**
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, answer questions 3, 4, 5, and 6. If **NO** to 2, go directly to question 6		
3) Have you thought about how you might do this?		
4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?		
5) Have you started to work out or worked out the details of how to kill yourself? **Do you intend to carry out this plan?**		
	In the Past 3 Months	
6) Have you done any of the following? **Attempted to kill yourself even if ending your life was only part of your motivation** **Started to do something to end your life but someone or something stopped you before you actually did anything** **Started to do something to end your life but you stopped yourself before you actually did anything** **Taken any steps towards making a suicide attempt or preparing to kill yourself** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **In your entire lifetime, how many times have you done any of these things?**		