Real Caring Integrative Therapy SUITE B199 * Therapeutic Lifestyle Center of Utah SUITE B175
1151 East 3900 South Salt Lake City, Utah 84124 Phone: 801-853-8744 Fax 801-855-7998

CLIENT REGISTRATION

_____ _____ ____/____/_____
Client Name Social Security Number Date of Birth

_____ _____
Parent/Guardian (as applicable) Phone

_____
Street Address City State Zip

Email_____ Preferred Phone_____

Appointment Reminder: ☐ phone ☐ email ☐ text

Emergency Contact_____ Phone_____

HEALTH INFORMATION *We work integratively with your healthcare provider(s) as necessary to be sure you're receiving comprehensive, whole person care. We request that you fill out the following health information and authorize your provider to coordinate care with your physician.*

Primary Care Physician:_____ Phone:_____

Physical conditions / symptoms:_____

Medications:_____

_____(initial) I authorize my provider at Real Caring Integrative Therapy to consult with my Primary Care Physician to coordinate care.

How did you hear about us?_____

PROVIDER USE	OFFICE USE
Diagnosis_____ Provider Name_____ Provider Signature_____	Benefits verified and entered:_____ Billing Specialist Signature _____ Date_____

INFORMED CONSENT

Consent for Treatment: I voluntarily consent to treatment. I consent to take part in the treatment services provided. I understand that developing a plan and regularly reviewing progress toward meeting my goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of services provided. I understand that the nature of the therapeutic process is such that the personal issues or circumstances for which I have sought assistance may, in some cases, worsen before improving or may not appear to improve at all. I am aware that I may stop treatment at any time. I will still be responsible for paying for the services I have received or for missed appointments. I understand that I may lose other service; or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court ordered, I will have to answer to the court.)

Assignment of Insurance Benefits: I hereby authorize billing my insurance company or other third party payers for any covered services received and authorize my insurance company to make direct payment for said services. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment. I further understand that portions of my clinical record may be disclosed to my insurance company or other third-party payers for reimbursement purposes.

Confidentiality of Information: You will maintain strict confidentiality (as outlined in your Professional Codes of Conduct and in accordance with HIPPA privacy regulations). Your office privacy practices are available for my review upon request. No third parties beyond pertinent third party payers will have access to my clinical information, unless otherwise agreed to with my express (normally written) permission. You will make every effort to communicate pertinent information (with my permission) to referring health professionals. I understand that I have a legal right to privacy concerning my medical recoils and it is your obligation to uphold that right and to make available a Notice of Privacy Practices for my review at any time during business hours. I understand that no staff member may in any way violate this confidentiality except with my consent and in accordance with policy, rules, and regulations, and the Utah State Administrative Code.

Limits of Confidentiality: Information discussed in the therapy setting is held confidential and will not be shared without my permission except under the following conditions: - I threaten suicide. - I threaten harm to another person(s) including murder, assault or other physical harm. - I (adult or minor) report suspected child abuse including but not limited to physical beating and/or sexual abuse. The law requires that the abuse be reported to an appropriate agency. - I am referred by the Court, Adult Probation and Parole, Salt Lake County Probation, or another corrections agency. A specific release of information will be required in order to coordinate services. Should such a release be refused, treatment may not be provided.- My records and/or the testimony of the therapist is subpoenaed by a court of law. Measures will be taken to protect my confidentiality by releasing the least amount of information that will satisfy court requests. - After I have made no payment for more than 60 days, my obligation to pay may be referred to an outside collection agency including small claims court - I request payment by a third-party payer including insurance companies, DCFS, etc.

Communication: I understand that reasonable security measures will be taken by Real Caring Integrative Therapy and Therapeutic Lifestyle Center of Utah for online sessions. I am aware that email and text are not considered to be a secure means of communicating and that if I choose to use these, I do so at my own risk. I understand that clear boundaries must be maintained and there will be no connection on any provider's **personal** social media account such as Facebook, etc. If we encounter each other in the community at large, as my treatment provider, you will not initiate contact in public. I am free to initiate contact with you. I am aware that I should call 911 in an emergency. If I have an urgent need outside of office hours, I agree to call the crisis line at the University of Utah 801-587-3000.

Fee Policy: I agree to adhere to the payment agreement attached to this registration form. If I am unable to pay my balance, I will notify the office as soon as possible and make payment arrangements.

I acknowledge that I have read the Agreement give Informed Consent to treatment as well as agree to the policies set forth in the Agreement. I acknowledge that I have the opportunity to read the separate Privacy Practices/Hipaa disclosure and that I may ask for copies of these forms. (If a minor child), I as parent/guardian give consent and agreement to services for my child as set forth in this Agreement.

Client Signature/Parent Guardian Signature (if minor)_____

Date_____

PAYMENT AGREEMENT

This form must be filled out completely. Put N/A in blanks that don't apply.

_____ _____
Responsible Party Name Client Name (if different)

_____
Street Address City State Zip

Credit Card It's our policy to keep a credit card on file to secure payment for services. The credit card number is stored in a HIPPA compliant encrypted Electronic Medical Record. Your card will be charged for session fees, co-payment, co-insurance and $60.00 fee for appointments cancelled with less than 24 hours notice. If you prefer not to have a credit card on file, please be ready to pay your co-pay/session fee in cash or check at each session. We will send you a statement before charging your card for the amount due if you have a balance beyond your co-pay, co-insurance or applicable cancellation fees. Please indicate how you would like to receive your statement:

☐ Email Statement ☐ Paper statement mailed

_____ _____/_____ _ _____
Credit Card # Expiration Date 3-digit code

_____ _____ _____
Card Holder's Name/address Card Holder's Signature Date

Please select your coverage status ☐ Private pay $_____ per session. ☐ Insurance (see below)
While we submit claims to your insurance company, we cannot guarantee that they will cover your sessions as expected. You will be responsible for any balance your insurance won't cover after 45 days.

_____ _____
Primary Insurance Company Primary Insurance Company

_____ _____ _____ _____
Member ID Group ID Member ID Group ID

_____ _____
Subscriber's (Insured's) Name Subscriber's (Insured's) Name

_____/_____/_____ _____ _____/_____/_____ _____
Subscriber Date of Birth Relationship to client Subscriber Date of Birth Relationship to client

☐ INSURANCE CO-PAY/CO-INSURANCE $_____ at each visit or _____% after insurance pays. *(this information is usually found on your insurance card. If not, please call your insurance company to verify the amount)*

☐ INSURANCE DEDUCTIBLE: I am using insurance and I have a deductible of $_____. My calendar year begins _____. *(please call your insurance company to verify your deductible and the calendar year it is applicable*

☐ INSURANCE BENEFITS UNKNOWN: I have NOT verified my benefits. I understand that it is my responsibility to know what my insurance will cover and that I will be billed for any balance due if my insurance does not cover my sessions. I'm responsible for costs not covered by my insurance plan.