**Changes Counseling & Consultation, LLC**

**8221 S. 700 E. Sandy, UT 84070**

## Phone: (801) 542-7060 Fax: (801) 542-7061

**info@changescounseling.org www.changescounseling.org**

 ***We Care***

# CLIENT INTAKE PACKET

***E-FORM TELETHERAPY VERSION***

\*In typing my name in the Client Signature boxes in the following forms, I authorize this as my electronic signature; subject to the same principles as if signed by my own hand. {See final page for additional information.}

**Please click/tab on each box to enter text. All Information given below is Privacy Protected.**

Client’s Name *(Last, First, Middle)*:

* List any Maiden Names, Aliases, *Dos Apellidos*, etc.:       [ ]  Male *[ ]*  Female

Full Address:

Cell Phone:       Home Phone:       E-mail:

SSN:       Birth Date:       Age:       Ethnicity:

Driver’s License #:

Marital Status: *[ ]* Single *[ ]* Married *[ ]* Separated *[ ]* Divorced *[ ]* Other

Religious Affiliation *(Voluntary):*  Background:       Current:

Please tell us, Who Referred You to Changes?

**Insurance/Medicaid Info (if desired):**

Company:  ID#:  County (Medicaid only):

Main Policy Holder Name:  DOB:  Phone:

**In Case of Emergency Contact (required by the State):**

Name:  Phone:  Relation to You:

Address:

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IN CASE OF EMERGENCY, PLEASE GO TO SOUTH PARKING LOT, USING EITHER LOWER OR UPPER LEVEL DOORS. DO NOT LEAVE GROUNDS SO WE KNOW YOU ARE NOT IN THE BUILDING! BY SIGNING, I AGREE I HAVE BEEN INSTRUCTED ON EMERGENCY PROCEDURES.

I agree to pay Changes Counseling & *Consultation*, LLC the stated amount for services at the beginning of each session or group. I agree that I am responsible for payment of all services provided including all broken appointment within 24 hours of appointment. I hereby authorize the clinician to furnish information to insurance carriers or the appropriate agency concerning my treatment. I further agree to pay all reasonable costs of collection, usually 40% of the balance, including attorney’s fees in the event any amounts billed or owing is not fully paid within 30 days. If required for any reason to make an appearance in court on my case I will be billed at the rate of $90.00 per hour for all time expended, including travel time.

|  |  |  |
| --- | --- | --- |
| Client E-Signature | Guardian Name/E-Signature (if under 18) | Date |

Updated 04/2020

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 **CONSENT FOR THE TWO-WAY RELEASE**

**OF CONFIDENTIAL INFORMATION**

**Client Name:**

**Please Note:** If your treatment is subject to supervision by a court, probation officer, or other supervising agency, you are required to provide proof of ongoing compliance to that agency. **Unless you specify otherwise below**, signing this document authorizes communication regarding your compliance between Changes Counseling, LLC. and your reporting agency (if any).

*[ ]  (Check this only if you’re sure): I* ***do not*** authorize communication with my court, probation officer, or reporting agency (if any).

*[ ]  (Check this only if you’re sure):* I want my evaluation sent **only** to my attorney, or other (please specify: ).

**(PLEASE LIST EVERYONE WHO NEEDS TO KNOW YOU CAME!** *(List fax/email if possible)*

|  |  |  |
| --- | --- | --- |
| **Court:**  | **Fax/Email:**  | **Phone:**  |
| * Case Number(s), if applicable:
 |
| **P.O./Agency:** | **Fax/Email:** | **Phone:** |
| **Attorney:** | **Fax/Email:** | **Phone:** |
| **Spouse/Family:** | **Fax/Email:** | **Phone:** |
| **Other:** | **Fax/Email:** | **Phone:** |

**The information I authorize to be disclosed is (check applicable items):**

**☒** Evaluation results, treatment recommendation, treatment summaries, progress reports, notice of completion/non-compliance and

*[ ]* Other (Please Specify):

I understand that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”), 45 C.F.R. Pts 160 & 164, and any alcohol and/or drug treatment records are protected under the federal regulations governing of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2. I understand that my treatment records cannot be disclosed without my written consent unless otherwise provided for in the regulations; and that I may revoke this consent with **written** notice.

**IF YOU WANT TO LIMIT HOW LONG THIS RELEASE OF INFORMATION LASTS, PLEASE SPECIFY EXPIRATION CONDITIONS BELOW:**

*[ ]* Six months following the discharge date from **Changes Counseling & Consultation, LLC.**

  **OR**

*[ ]* Six months following a formal and effective release from confinement, probation, parole or other proceeding under

 which I was mandated to attend treatment.

 **OR**

*[ ]* The th day of 20

**I have read the above, understand it and hereby give my consent to the above-mentioned disclosure. *In typing my name in the Client Signature boxes in the following forms, I authorize this as my electronic signature; subject to the same principles as if signed by my own hand.***

**Signature of Client:       Date:**

**Signature of Parent/Guardian (if under 18):** **Date:**

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**Consent to Treatment**

I acknowledge that I have received, have read (or have had read to me), and understand the information about the therapy I am considering. I have had all my questions answered fully.

 I do hereby seek and consent to take part in the treatment provided by this agency. I

understand that developing a treatment plan and regularly reviewing the work toward meeting the treatment 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 treatment or of any procedures provided by this agency and/or therapist at this agency.

 I am aware that I may stop my treatment at this agency at any time. The only thing I will still be responsible for is paying for the services I have already received or for missed appointment that I have not cancelled within 24 hours in advance. I understand that I may lose other services 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.)

 I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charge for that appointment. I also know that I will have to pay for missed class sessions incurred before I have made arrangements to cancel treatment.

 I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost, date(s), and providers of any services or treatment I receive. I understand that I will be responsible for the cost of all services provided. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

 My signature below shows that I understand and agree with all of these statements***. In typing my name in the Client Signature boxes in the following forms, I authorize this as my electronic signature; subject to the same principles as if signed by my own hand.***

Signature of Client Printed Name Date

 I, the therapist, have discussed the issues above with the client (and/or his or parent, guardian or other representative). My observations of this person’s behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of Therapist Date

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**Program Expectations Agreement**

 **In the event that I do agree to participate in treatment, I agree to the following:**

 I agree to pay at the beginning of each class or individual session. I agree to pay the fees for each scheduled group whether or not I am in attendance. I understand that once I am enrolled in a class,

 **I am responsible to attend and pay for each class.** This arrangement does not apply to the Prime for Life program. Prime classes must be attended consecutively, without interruption, or I will need to repeat the entire series.

 **Involuntary Termination** from my program may result if I fail to attend group sessions or contact Changes during any 30 day period. Upon Involuntary Termination, my file may be closed and I may be required to be re-evaluated, at my own expense, and pay any outstanding balance before being readmitted to the program. I understand that, upon Involuntary Termination, I may be required to start my program over.

 I agree to **arrive 5-10 minutes early** in order to check in, pay for class and be in class on time. I agree that, if I am more than 5 minutes late for class, I may not receive credit for that particular class even if I attend the class. If, for any reason, I do not think I will be able to attend a session, I will contact my instructor/therapist in advance. I will make arrangements for making up the class, in order to prevent a non-compliance letter from being sent to my judge, probation/parole officer or attorney.

 I agree to arrive and check in to my individual appointments 5 to 10 minutes early. If I am more than 10 minutes late Changes has the right to cancel my appointment and charge a late cancellation fee.

 I agree to **complete all homework assignments** given to me during my group/individual session and bring them to the next group/individual session. Homework will be due at the beginning of each session. If my homework is not completed and ready at the beginning of the group/session, Changes has the right to deny credit for that session.

 I Agree to **be fully engaged and free of all distractions** while in my online groups or individual session. This includes but not limited to driving, having anyone present that is not a client of Changes, engaging in conversation during groups/individual with someone not apart of the group/individual session while on mute. If I violate this, I understand the instructor/therapist has the right to remove me from the session, for which I probably will not get credit. I agree to fully participate in treatment and will not be disruptive or threatening in any way. I will not leave the class during session.

 I agree to keep the names and information revealed by other clients **confidential.**

 I understand that I am expected **to be free from the influences of any drugs and/or alcohol** at the time of my session. If I am under the influence of any substance, I am expected to report this to my instructor/therapist. I understand that I may not be allowed to participate in that particular session. If I am suspected of being under the influence of alcohol, I agree to submit to a Breathalyzer Alcohol Detector.

I agree to **refrain from any and all violent or threatening behavior** while on the premises.Such behavior may result in my being asked to leave the premises and/or being arrested.

 I will not bring drinks (other than water) or food into the meeting rooms and understand that **smoking is not permitted** inside the building. I will not eat during my online group. Due to the sensitive nature of treatment, I will not vape/smoke or use/drink any substances while in group/individual sessions. I understand this can cause triggers for others participating in the group and agree to respect those around me.

In the event my instructor/therapist is absent due to vacation or emergency, I understand that a qualified replacement will conduct the sessions as necessary. I will not be penalized if the group cannot be held.

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 Signature Date Print Name **Changes Counseling**

**Client Bill Of Rights**

As a client of Changes, Counseling & Consultation, LLC the following are among your rights:

* To have all personal information regarding your treatment to be kept private, except to those parties you designate.
* To know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.
* To receive respectful treatment that will be helpful to you.
* To received treatment without discrimination or harassment and to be treated with dignity.
* To be provided a safe environment, free from sexual, physical or emotional abuse.
* To be advised of changes’ policy regarding your rights to privacy (See HIPPA Notification).
* To report unethical and/or illegal behavior by a therapist.
* To ask questions about your therapy.
* To request and receive information about the therapist’s professional capabilities, including licensure, education, training, experience, professional association memberships, specialization and limitations.
* To have written information about fees, method of payment, insurance reimbursement, number of sessions, substitutions (in case of emergency or vacations) and cancellation policies.
* To refuse electronic recording; and I may request it if I wish.
* To refuse to answer any questions or disclosed any information I choose not to reveal.
* To know if there are supervisors, consultants, students, etc. with whom my therapist will discuss my case.
* To request and, in most cases, receive a summary of my file, including the diagnosis, my progress and the type of treatments.
* To request a copy of my file to any therapist or agency I choose.
* To receive a second opinion at any time about my therapy or therapist methods.
* To request that my therapist inform me of my progress.
* To have any and all grievances or complaints addressed in a timely fashion by contacting Chris Smalley, Director, in writing at Changes 8221. S. 700 E Sandy UT 84070.

**Limits of Confidentiality**

Information discussed in the therapy setting is held confidential and will not be shared without written permission except under the following conditions:

* The Client threatens suicide.
* The Client threatens harm to another person(s), including murder, assault, or other physical harm.
* Any Client, Adult or Minor (under 18) who reports suspected child abuse, including but not limited to, physical beating and/or sexual abuse.
* If a Client is 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.
* If a Client’s records and/or the testimony of the Therapist is subpoenaed by a court of law.
* If a Client’s obligation to pay is referred to an outside collection agency including small claims court, if no payment is made on an account for over 60 days, unless special arrangements have been made with the Therapist and/or the Office Manager.
* The Client request payment for third-party payer including Insurance Companies, DCFS, Crime Victim Reparations, etc.

E-Signature of Client or Guardian Date Revised: 10/2020

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**HIPAA Notice Of Privacy Information**

 **I hereby authorize the use of disclosure of my protected health information as described below and understand and acknowledge the following:**

* I am not required to sign this authorization and may in fact refuse to sign this authorization.

Changes Counseling & Consultation, LLC will not condition my treatment or payment for my treatment on obtaining this authorization from me, unless permitted by law.

* If the organization or person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected.
* I may inspect or copy the protected health information sought to be used or disclosed in this authorization, as permitted by the federal privacy regulations.
* I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to Changes Counseling & Consultation, LLC 8221 S. 700 E. Sandy Utah 84070. If I do revoke this authorization, however, my revocation will not affect any prior actions taken in reliance on my authorization.
* If I have questions about this authorization, I may contact Chris Smalley at (801) 542-7060, who will provide me with more information about this authorization, or about Changes Counseling & onsultations, LLC privacy practices.
1. **Client Name:**
2. This authorization applies to **Treatment Recommendations and Notices of Compliance** to specific agencies.
3. This authorization will expire upon the **Completion of Treatment.**

**I certify that I have read, signed and received a copy of the Notice of Privacy practices. *In typing my name in the Client Signature boxes in the following forms, I authorize this as my electronic signature; subject to the same principles as if signed by my own hand.***

E-Signature of Client Date

**Utah Dept of Health TB Screening Tool**

**Bureau of Epidemiology**

(Adapted from the ACHA TB Screening Tool)

**Part I: Tuberculosis (TB) Screening Questionnaire**

Patient Name: Click or tap here to enter text. DOB: Click or tap here to enter text. Date: Click or tap here to enter text.

Have you ever had close contact with persons known or suspected to have active TB disease?

[ ]  Yes [ ]  No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below)

[ ] Yes [ ] No

Afghanistan

Algeria

Angola

Anguilla

Argentina

Armenia

Azerbaijan

Bangladesh

Belarus

Belize

Benin

Bhutan

Bolivia (Plurinational State of)

Bosnia and Herzegovina

Botswana

Brazil

Brunei Darussalam

Bulgaria

Burkina Faso

Burundi

Cabo Verde

Cambodia

Cameroon

Central African Republic

Chad

China

China, Hong Kong SAR

China, Macao SAR

Colombia

Comoros

Congo

Côte d'Ivoire

Democratic People's Republic of Korea

Democratic Republic of the Congo

Djibouti

Dominican Republic

Ecuador

El Salvador

Equatorial Guinea

Eritrea

Estonia

Ethiopia

Fiji

French Polynesia

Gabon

Gambia

Georgia

Ghana

Greenland

Guam

Guatemala

Guinea

Guinea-Bissau

Guyana

Haiti

Honduras

India

Indonesia

Iran (Islamic Republic of)

Iraq

Kazakhstan

Kenya

Kiribati

Kuwait

Kyrgyzstan

Lao People's Democratic Republic

Latvia

Lesotho

Liberia

Libya

Lithuania

Madagascar

Malawi

Malaysia

Maldives

Mali

Marshall Islands

Mauritania

Mauritius

Mexico

Micronesia (Federated States of)

Mongolia

Montenegro

Morocco

Mozambique

Myanmar

Namibia

Nauru

Nepal

Nicaragua

Niger

Nigeria

Northern Mariana Islands

Pakistan

Palau

Panama

Papua New Guinea

Paraguay

Peru

Philippines

Poland

Portugal

Qatar

Republic of Korea

Republic of Moldova

Romania

Russian Federation

Rwanda

Saint Vincent and the Grenadines

Sao Tome and Principe

Senegal

Serbia

Seychelles

Sierra Leone

Singapore

Solomon Islands

Somalia South Africa

South Sudan

Sri Lanka

Sudan

Suriname

Swaziland

Tajikistan

Thailand

Timor-Leste

Togo

Trinidad and Tobago

Tunisia

Turkmenistan

Tuvalu

Uganda

Ukraine

United Republic of Tanzania

Uruguay

Uzbekistan

Vanuatu

Venezuela (Bolivarian Republic of)

Viet Nam

Yemen

Zambia

Zimbabwe

*Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to:* [http://www.who.int/tb/country/data/profiles/en/](http://www.who.int/tb/country/data/profiles/en/%20)

Have you had frequent or prolonged visits\* to one or more of the countries or territories listed above with a high prevalence of TB disease (or regular contact with people who are from one of these countries)? (If yes, CHECK the countries or territories, above)

Yes[ ]  No[ ]

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facility or homeless shelter)?

Yes[ ]  No[ ]

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?

Yes[ ]  No[ ]

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol?

Yes[ ]  No[ ]

Do you regularly use immunosuppressive medication, or have any of the following conditions: HIV, organ transplant recipient, diabetes, silicosis, cancer, end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, 10% or more below ideal body weight?

Yes[ ]  No [ ]

**If the answer is YES to any of the above questions, screening with a PPD or IGRA is indicated.**

SPECIAL INFORMATION REGARDING TELE-THERAPY, HIPAA COMPLIANCE DURING COVID, & E-SIGNATURES

In light of the Covid-19 pandemic – or in the case of tele-therapy – providing physical signatures for legal/medical documents may not be feasible, requiring the use of E-signatures instead. Please be advised that 1) if a document requires multiple witnesses to be legally binding (such as a Psychiatric Advance Directive or PAD) , yet Covid-19 prevents the availability of such witnesses, some Courts may not uphold its validity; and 2) by signing your name in the signature boxes contained in this and similar documentation, you acknowledge the following:

1) that you are the person of record or are authorized to act on their behalf;

2) that you consent to and authorize the use of electronic records and electronic signatures, and waive the use of cryptographically-based, digital signatures;

3) that you have the right to obtain a paper copy of such records, and the right to withdraw consent, except as otherwise stipulated in the present document;

4) that your electronic documentation remains confidential under HIPAA standards, as outlined at: <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>.

For more information on electronic signatures, and consumer consent disclosures, please reference the Uniform Electronic Transactions Act, as outlined in Utah Code at: <https://le.utah.gov/xcode/Title46/Chapter4/C46-4_1800010118000101.pdf>. You may also reference the Electronic Signatures in Global and National Commerce Act (E-Sign Act), at: <https://www.fdic.gov/regulations/compliance/manual/10/x-3.1.pdf>}.