Clear Horizons Clinical Services, LLC

853 West Center St. Orem, UT 84057 (801) 206-4200
Website: www.clearhorizons.org

***PATIENTS 18 OR OLDER ONLY** (THIS SECTION TO BE COMPLETED BY PATIENTS 18 YEARS OR OLDER) DATE: _____

Full Name: _____ Goes by: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Employer: _____ Social Security #: _____ Race: _____

Mailing Address: _____ City _____ State _____ Zip _____

Phone (primary): _____ Phone (alternate): _____ Email: _____

Marital Status: ☐ Single ☐ Married ☐ Other

***Please note that the information provided in this section will be used to contact you regarding appointments, account balances, and any other medical or billing issues regarding your account.**

FAMILY INFORMATION*

DATE: _____

Parent / Foster Parent: _____ Date of Birth: _____SS#: _____

Gender: ☐ Male ☐ Female Relationship to Child(ren): ☐ Parent ☐ Step-Parent ☐ Grandparent ☐ Other: _____

Mailing Address: _____ City _____ State _____ Zip _____

Phone (primary): _____ Phone (alternate): _____ Email: _____

Caseworker (if applicable): _____

Mailing Address: _____ City _____ State _____ Zip _____

Phone: _____ Email: _____

***Please note that the information provided in this section will be used to contact you regarding appointments, account balances, and any other medical or billing issues regarding your account.**

CHILDREN INFORMATION (CHCS participates in several state and federal programs that require data on race and ethnicity.)

IF 18 OR OLDER, SKP THIS SECTION AND FILL OUT "PATIENTS 18 OR OLDER" SECTION BELOW.
IF CASEWORKER INVOLVED, ONLY ONE (1) CHILD PER PAGE. PLEASE FILL OUT SEPARATE DOCUMENT FOR EACH CHILD.

1. Child's Full Name: _____ Date of Birth: _____ Goes by: _____
Sex: ☐ Male ☐ Female **Race:** ☐ Am. Indian ☐ Asian ☐ African American ☐ Hispanic ☐ White Other:_____

2. Child's Full Name: _____ Date of Birth: _____ Goes by: _____
Sex: ☐ Male ☐ Female **Race:** ☐ Am. Indian ☐ Asian ☐ African American ☐ Hispanic ☐ White Other:_____

3. Child's Full Name: _____ Date of Birth: _____ Goes by: _____
Sex: ☐ Male ☐ Female **Race:** ☐ Am. Indian ☐ Asian ☐ African American ☐ Hispanic ☐ White Other:_____

4. Child's Full Name: _____ Date of Birth: _____ Goes by: _____
Sex: ☐ Male ☐ Female **Race:** ☐ Am. Indian ☐ Asian ☐ African American ☐ Hispanic ☐ White Other:_____

PERSON RESPONSIBLE FOR INSURANCE (PRIMARY)	PERSON RESPONSIBLE FOR INSURANCE (SECONDARY)
Insurance Name:_____	Insurance Name:_____
Policy Holder: _____	Policy Holder: _____
Policy Number: _____	Policy Number: _____
Relationship to Patient:_____	Relationship to Patient:_____
Phone: _____ DOB: _____	Phone: _____ DOB: _____

**A quote of benefits and/or authorization does not guarantee payment or verification of eligibility.

EMERGENCY CONTACT (This person should live in the same state, but not in the same household)

Name: _____ Phone: _____ Relationship: _____

(CONTINUED ON BACK)

CONSENT FOR TREATMENT

I hereby consent to treatment by Clear Horizons Clinical Services, LLC (CHCS) and the therapist assigned. I understand that developing a treatment plan with this therapist and regularly reviewing our 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 the therapist. I am aware that I may stop my treatment with the therapist at any time. I understand that I may lose other services or may be accountable for problems that arise if I stop treatment (i.e. if my treatment is court ordered, I will have to answer to the court).

☞ **Patient (If 18 years or older) / Legal Guardian Signature:** _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES (NPP)

I acknowledge that I have received a copy of CHCS' NPP (available on wedsite-wwww.clearhorizons.org) and that it is my responsibility to read said notice to understand how my or my child(ren)'s Protected Health Information (PHI) may be used. I understand that no authorization is required from me in order for CHCS to use my or my child(ren)'s PHI for purposes of treatment, payment, or health care operations. Other uses or disclosures may require my written authorization. If teletherapy services are provided, I understand that Clear Horizons Clinical Services will not be responsible for any confidentiality concern where ever my location is. I will be liable for ensuring that my personal health information is not jeopardized by ensuring all of my internet connections are secure and the environment is confidential.

☞ **Patient (If 18 years or older) / Legal Guardian Signature:** _____ **Date:** _____

COMMUNICATIONS PERMISSIONS

By indicating it is okay to use email and mail communication and signing below, I understand that email communication is not a secure form of communication and the therapist cannot guarantee the safety of the information given by me or sent to me. I accept responsibility for what happens to personal health information once it has been sent through the internet. I further release CHCS from liability from any information they send or receive from me in the event it become public information.

☞ **Patient (If 18 years or older) / Legal Guardian Signature:** _____ **Date:** _____

☞ **Foster Parents (if applicable):** _____ **Date:** _____

TREATMENT CONTRACT

I will make and keep scheduled appointments with my therapists. I will cancel my appointments within 24 business hours if I cannot keep my appointment. I may be responsible for a $40 no show charge if not canceled in time. I will visit my primary care physician or other medical doctors when asked. I will take prescribed medications as instructed by my doctor, or I will give them as prescribed if client is a minor. Some appointments may be in the school or another public venue. While all attempts will be made to maintain confidentiality, it is possible that some people may be able to identify the relationship between client and therapist by presence. I have received, read and understand the Client's Rights and Responsibilities (available on website – www.clearhorizons.org).

☞ **Patient (If 18 years or older) / Legal Guardian Signature:** _____ **Date:** _____

☞ **Foster Parents (if applicable):** _____ **Date:** _____

PERMISSION TO RECORD

This consent is being given in regard to the professional services provided by the therapist assigned. I understand that if I do not agree to the uses of these materials or the recordings of meetings as indicated, I will not be penalized in any way and it will not affect the care I am to receive in any way. I understand that I may ask for the recording to be turned off or erased at any time during my sessions. I also understand that within 5 days following a session, I may request to review the recording with the therapist. I may also then ask for the recording to be destroyed. If I choose to ask this, I will deliver a written statement to this effect to the therapist within 5 days following the viewing of the recording. I understand that I am fully responsible for my own participation in any and all exercises and activities suggested by the therapist. I agree not to hold the therapist responsible for those exercises on me, whether during the session or later. I give the therapist named above my permission to use recording for ongoing treatment and evaluation of services. I understand they will be used in the process of continued treatment or for improving mental health work.

☞ **Patient (If 18 years or older) / Legal Guardian Signature:** _____ **Date:** _____

CREDIT AND FINANCE CHARGE POLICY AND AGREEMENT

I agree to be financially responsible for costs incurred in my, or my dependent's care. I understand that charges for services provided shall be paid for at the time of each visit. If medical claims are submitted to an insurance company by CHCS on my behalf, I understand that the copayment or deductible is due at the time care is rendered. I hereby authorize any benefits due me to be paid directly to CHCS (assignment of benefits). I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "non-medically necessary" by my third-party insurance carrier. I agree that I am responsible for satisfying any conditions necessary for insurance or health benefits. A finance charge (1.5% per month/APR 18%) will be added to any amount for which payment has not be received within **30 days** from the date of the statement on which the amount first appears. I hereby agree to pay a service charge of $15 for each check or other instrument tendered by me but returned to this facility. In the event any amounts are referred to a third party debt collection agency, I agree that in addition to any other amounts allowed by law (interest, court costs, attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principle amount owing as allowed by Utah Code Annotated section12-1-11. The terms of this paragraph shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility whether such amounts are incurred today or after today.

☞ **Patient (If 18 years or older) / Legal Guardian Signature:** _____ **Date:** _____