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) INTAKE 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 If other, explain _____

## PARENT OR FOSTER FAMILY INFORMATION (for MINORS)

INTAKE DATE:_____

CIRCLE ONE

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

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced **NOTE: If Divorced, please list responsible party/parties for balance due**

Name_____Address_____Phone_____

Name_____Address_____Phone_____

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

Mailing Address: _____ City _____ State _____ Zip _____

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

**Caseworker (if applicable):** _____

Phone: _____ Email: _____

***Please note that the information provided on this document 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.)

**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)**

Insurance Name:_____
Policy Holder: _____DOB_____
Policy Number: _____
Relationship to Patient:_____
Address: _____

**PERSON RESPONSIBLE FOR INSURANCE (SECONDARY)**

Insurance Name:_____
Policy Holder: _____DOB_____
Policy Number: _____
Relationship to Patient:_____
Address: _____

**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 TO TREATMENT

I consent to receive treatment from Clear Horizons Clinical Services, LLC (CHCS) and the assigned therapist. I understand that developing a treatment plan and regularly reviewing progress toward my goals supports effective care, and I agree to participate actively in this process. I acknowledge that no guarantees have been made regarding the outcomes of treatment or any procedures provided. I understand that I may discontinue treatment at any time; however, I recognize that doing so may affect my access to other services or result in additional consequences outside of CHCS's control (for example, if treatment is court-ordered, I am responsible for addressing this with the court). **I confirm that I have received a copy of CHCS' *Client Rights & Responsibilities* (available at www.clearhorizons.org) and understand that it is my responsibility to review this policy.**

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

## TREATMENT CONTRACT

I agree to schedule and attend all appointments with my therapist**. If I am unable to keep an appointment, I will provide at least 48 business hours' notice to cancel. I understand that failure to provide this notice may result in being charged the full-service fee at the current rate. If I miss three appointments without proper notice, I understand that I may be removed from recurring appointments on my therapist's schedule.** I agree to follow up with my primary care physician or other medical providers when recommended as part of my treatment plan. Some sessions may occur in a school or other public setting. While every effort will be made to maintain confidentiality, I understand that my presence in these settings may allow others to recognize that I am participating in therapy. **I confirm that I have received a copy of CHCS' Client Rights & Responsibilities (available at www.clearhorizons.org) and understand that it is my responsibility to review this policy.**

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

## COMMUNICATIONS PERMISSIONS

By signing below, I authorize CHCS to communicate with me via email, text (SMS), and mail. CHCS maintains secure systems and operates under a business agreement designed to protect the confidentiality of my information. I understand, however, that electronic communication methods such as email and text are not fully secure once messages leave CHCS's system, and information transmitted in this manner may be accessed by others. I assume responsibility for any risks to my personal health information (PHI) after transmission and release CHCS from liability should such information become accessible outside of CHCS's secure environment.

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

## RECORDING AND USE OF SESSION MATERIALS & SECURITY CAMERAS

I understand that materials or recordings of my sessions may be used by my therapist to support treatment, guide therapist training, and improve the quality of care. I may decline recording at any time without penalty. I may request that a recording be stopped or deleted during a session. Within five (5) days after a session, I may review the recording with my therapist and request its destruction in writing. I accept responsibility for my participation in any exercises or activities suggested by my therapist during or after sessions. I also understand that CHCS facilities use security cameras in common areas for the safety and protection of clients, staff, and property. These cameras do not record audio and are not used for clinical purposes.

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

## USE OF AI-ASSISTED CLINICAL DOCUMENTATION

I understand that my therapist may utilize secure, HIPAA-aligned AI tools to assist in generating and organizing clinical documentation. These tools support the accuracy, completeness, and regulatory compliance required by auditing and licensing standards. Because CHCS is obligated to meet these professional and regulatory requirements, the use of such tools is a required component of its documentation procedures.

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

## FINANCIAL RESPONSIBILITY AND AUTHORIZATION

I agree to be financially responsible for all costs related to my care or the care of my dependent(s). I understand that payment for services is due at the time of each visit. If CHCS submits medical claims to my insurance provider on my behalf, I agree to pay any co-payment or deductible at the time services are rendered.

If any unpaid balance is referred to a third-party collection agency, I agree to pay all amounts allowed by law, including interest, court costs, attorney's fees, and a collection fee of up to 40% of the principal amount, as permitted by Utah Code Annotated §12-1-11. These terms apply to all amounts incurred by me or any individual for whom I am legally responsible, whether incurred now or in the future.

**Assignment of Benefits Authorization:** I authorize Clear Horizons Clinical Services, LLC to release any information necessary to process insurance claims and to apply for benefits on my behalf. I assign payment of benefits directly to CHCS for services rendered. I understand that I am financially responsible for any charges not covered by my insurance plan, including deductibles, co-payments, and services deemed non-covered. I also agree to fulfill any requirements necessary for insurance or health-benefit coverage.

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