Today's Date _______________

Client Information Form

(Please do not provide any phone numbers that you are not giving us permission to leave a message on)

____ _________________ M __ F__
Client Name Date of birth

____
Street Address City Zip

______________________ ____________________ ___________________ ___________________________
Home Phone Work Phone Cell Phone Email

Marital Status: M ___ S ___Other ___ Employment: Employed ___ Unemployed/other ___ Student ___

____ ____________ ____________________
Financial Responsible Party (if client is a minor) Date of Birth Social Security Number

____
Address (if different from above)

____
Relationship to Client

Insurance Information

_____________________________________ If billing insurance, we need a copy of your insurance card.
Insurance Company

Background Information:
What are your chief complaints / the reasons for which you are here? ______________________________

Have you ever sought professional counseling before today? ___________________

If so, where and with whom? ____

Do you have any medical conditions that your therapist should be made aware of? ___________________

Are you taking psychotropic medications of any kind? ____ Inc. __________________________________

For office use:
DSM 5 code: _____________________________________
Insurance Authorization: ________________________
Client's copay: ___________________

1355 N. Main, Ste. 1 & 3, *Bountiful, Utah 84010*

Client's Privacy Practice

Client's Name (s) ____

(**Please initial each section after reading it**).

______ I understand that by signing this General Authorization I am authorizing the therapist to disclose my health information to the persons and entities listed below and that any health information or other confidential information in the possession of the persons and entities listed below may be disclosed to the therapist.

______ I understand that I may revoke this authorization at any time by sending a written notice to the therapist where I am receiving counseling. I understand that my revocation of this General Authorization will not affect a disclosure that RSI has already made under this authorization.

______ I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by RSI confidentiality rules.

This authorization is valid until three months after termination of services at Resilient Solutions, Inc.

____

Insurance Company Name Address/Phone Number Client's Initials

____

Ecclesiastical Leader/Other

____

____

Client's Signature

____

Signature of Parent/Guardian (if client is under 18)

Counseling Agreement
(Please initial each section after reading it).

****Cancellation of Appointments****

________ If you need to cancel an appointment, please notify your therapist no later than 24 hours prior to your appointment. **If no cancellation notice is received prior to the 24-hour time frame, your account will be charged the full amount for the time you have reserved.**

Supervision of Children

______ Children must have adult supervision at all times in the office. Children cannot be left unattended.

How Treatment Can Help

______ Counseling is most helpful in assisting individuals when the client is taking responsibility. This includes the following: 1- Being committed to change; 2- Attending all of your scheduled appointments; 3- Following through with assignments/tasks given to you by your therapist. You decide the nature of the changes you wish to make.

Legal obligation

______ We are required by law to report: if you are suicidal, homicidal, any abuse of a child or abuse of a vulnerable adult.

Payment for Services

______ Our fee schedule is:

$145 Initial Consultation, 45-50 min session
$115 Individual Therapy, 45-50 min session
$195 Individual Therapy, 90-min session

*Group Therapy, fee based on specific group.

______ As a courtesy to our clients who have insurance, we will submit services to your insurance company. Client is ultimately responsible for payment and <u>payment is due at time of service</u>.

______ There is a returned check fee of $25. Accounts that are over 60 days late will be assessed 10% to their bill and after 90 days account will be assessed additional 23% and turned over to a collection agency to cover collection costs.

______ I have completed the attached page and authorized my credit card for payment of services received.

I have read, understand and agree to the terms listed above. I understand, agree with, and give my therapist permission to release information to any third party listed as being financially responsible in order to facilitate and expedite payment for services rendered to me by them.

1355 N. Main, Ste. 1 & 3, *Bountiful, Utah 84010*

Name ____ Date _________________________________

Signature ____

Signature ____

Therapist____Date ________________________________

I authorize R S I to make payment through my credit card for amount due on my act ______

Full Name on Card ____

Type of Card _______________ **CC NUMBER on front of Card** ____________________________

Expiration Date _______________3-digit code ___________________

Address of card holder

____

City, State, & Zip code:____

Phone # of card holder ____

Email of card holder: ____

I authorize Resilient Solutions, Inc. to pay for services rendered through this card.

Card holder name ____

Card holder signature

____

Secondary Credit Card Information:

Full Name on Card ____

Type of Card _______________ **CC NUMBER on front of Card** ____________________________

Expiration Date _______________3-digit code ___________________

Address of card holder ____

City, State, & Zip code:____

Phone # of card holder ____

Email of card holder: ____

I authorize Resilient Solutions, Inc. to pay for services rendered through this card.

1355 N. Main, Ste. 1 & 3, *Bountiful, Utah 84010*