CLIENT INFORMATION SHEET

Pam Roskelley CMHC

150 South 600 East Suite 5A
Salt Lake City, UT. 84102
(801) 486-1113

Name: _____
Last First M.I.

Home Address:_____
Street Address City State Zip Code

Home Phone_____ **Work Phone** _____**Cell Phone**_____

SS#:_____-____-_____ **Age:**_____ **Date of Birth:**___/___/___

Employer:_____

Referred By:_____

PRIMARY INSURANCE INFORMATION (*please fill in all information on insurance holder*)

Primary Insurance:_____

SS# of **Policy Holder**: ___/____/____ Date of Birth of **Policy Holder:** ____/____/____

Name of **Policy Holder:** _____
Last First M.I

Address of **Policy Holder:** _____

Policy Holder's Employer: _____

_____
Insurance ID# Policy# Group#

FINANCIAL DISCLOSURE AND AGREEMENT

Pamala Roskelley CMHC

The fee schedule for services is as follows except as adjusted in accordance with any participating provider insurance fee agreements (fees are per hour of scheduled services):

Individual Assessment:	**$130.00**	**Appearance in Court:**	**$150.00**
Individual Therapy:	**$120.00**	**Couples Therapy:**	**$140.00**

These fees entitle you to the services listed above and the time involved in providing these services. They also provide for the time involved in preparation for session, including research on specific issues related to your concerns, for record keeping, and for necessary billing activities. Any services above and beyond these are billed at a pro-rated basis determined by the amount of time necessary.

Please provide me with specific information on you insurance as requested on the Client Information Sheet. Note that your insurance is a contract between you and your insurance carrier and that coverage for psychotherapy typically differs from coverage for medical visits. You are ultimately responsible for all changes. If you do not know the amount of your co pay, a $20.00 fee will be assessed until the proper amount is determined. At the time your account will be adjusted appropriately.

All fees are due and payable at the time of service unless other arrangements have been discussed. Accounts must be kept up to date or other arrangements for services will need to be made. If you are unable to continue therapy due to financial reasons, I will make every effort to refer you to another service provider. All modifications to this fee schedule must be negotiated with Pamala Roskelley.

Late Cancellation/No Show Policy

If you are unable to make your scheduled appointment, please cancel at least 24 hours in advance so another client can be scheduled during that time. If 24 hours notice is not given, you will be charged the full session amount. Pamala Roskelley Counseling reserves the right to charge credit cards that are kept on file for no shows and late cancellations.

Although circumstances rarely come to this, the ethical code for psychotherapists requires that you be informed of the following:

-If a collection agency is used in the settling of you account, it is understood that you have consented to the release of billing information to that agency.

-if a collection agency is used, you will assume all costs associated with this activity, including all legal or attorney's fees (these fees typically add 50% to your balance)

-All accounts over 90 days are subject to being sent to collections without notice.

By signing below, I certify that I understand and agree to all the information as presented above, including the financial terms described.

_____ _____

CLIENT SIGNATURE **DATE**

PATIENT RIGHTS AND INFORMED CONSENT FORM

Pamala Roskelley CMHC

Certified Mental Health Counselor

This is a statement of the information you need to know in order to make informed decisions about your therapy and to assist you in taking an active role in your therapy. If any of this information is unclear, please ask Pamala Roskelley to clarify it before you sign the form. Your signature indicates that all the information and conditions outlined here are understandable and agreeable to you.

1. Therapy is an interactive process meant to promote change and understanding in line with the goals that you set with Pamala Roskelley CMHC. You are expected to be an active participant in therapy and to contribute to all decisions regarding interventions and treatment plans and to ask any questions you may have.
2. You have a right to question any part of you therapy, to refuse any intervention that is suggested, and to discuss any concerns with Pamala Roskelley CMHC Pamala Roskelley will inform you of any therapeutic plans to help you reach your goals and shall describe any risks (if any) that may be involved.
3. The length of sessions and the total number of sessions required are both negotiated with Pamala Roskelley. Sessions are typically 50 minutes in length for individuals, and 1 hour and 20 Minutes for couples. The number of sessions will vary depending on your particular situation and issues.
4. You have the right to terminate therapy at any time and will be expected to pay only for those sessions completed. If you wish, Pamala Roskelley shall provide you with the names of other qualified therapists.
5. Psychotherapy sessions are confidential within the limits of the law of the State of Utah, HIPPA, and any relevant professional ethical codes. Specifically, this means that information you disclose in a professional relationships will not be revealed to anyone without your written permission, with the following exceptions:
    a. If you request that Pamala Roskelley submit an insurance claim on your behalf, information about your diagnosis, treatment plan and dates of session may be revealed to your insurance carrier.
    b. If there is evidence to suspect that a child or elder is being abused in any manner, Pamala Roskelley is required by law to report the "reasonable suspicion" of such abuse.
    c. If you are in imminent danger of harming yourself or another person, Pamala Roskelley is required to take reasonable steps to prevent such harm from taking place.
    d. In the event that the legal system becomes involved in any manner in your case, the implications of this will be discussed with you prior to any action being taken by Pamala Roskelley. If you tell me of a crime you intend to commit I am obligated to inform the legal authorities.

e. If you have a communicable disease you deliberately intend to pass on to a specific person, Pamala Roskelley is required to take reasonable steps to prevent this.
f. Occasionally, I consult with other professionals about cases. I will keep your information confidential if such consultation takes place.

6. While you have the right to review your clinical record at any time, these records belong to Pamala Roskelley. If you wish, Pamala Roskelley will review these records with you and answer any questions concerning information contained in the records. If you request, any part of your clinical record may be released to any person or agency you designate.
7. If you have an emotional, behavioral, or medical crisis call the University of Utah Neuropsychiatry Institute at 801-583-2500, call 911, or go to the nearest emergency room. Pamala Roskelley Counseling does not provide 24 hour crisis services.

By signing the below, I certify that I understand and agree to all the information as presented above.

_____ _____

CLIENT SIGNATURE DATE

Pamala Roskelley MA. CMHC
Certified Mental Health Counselor

150 South 600 East Suite 5A
Salt Lake City, UT 84102
801-486-1113
pamala@pamalaroskelleycounseling.com

Licensed Therapist- PATIENT SERVICES AGREEMENT

This Agreement contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. The *Notice of Policies and Practices to Protect the Privacy of Your Health Information* (NOTICE), which accompanies this agreement and is available in the waiting room, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session.

When you sign this document, it becomes an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy may involve a variety of activities designed to support you in successfully resolving the difficulties or conditions, which have led you to seek therapy. It is a learning process and our therapy will be most successful if you engage openly and honestly in it, and apply what you are discovering in how you live your life.

Psychotherapy can have risks as well as benefits. Since therapy often involves exploring unpleasant aspects of life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. These feelings (and others which you may dislike) are often an essential element in successful therapy; such therapy can lead to better relationships, solutions to specific problems, and significant increases in one's well being.

You should consider this information along with your own opinions in choosing whether to work with me. If you have questions about my approach or other relevant matter, please bring them up as they arise. If your reservation or objections persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS/SESSIONS

If we agree to begin psychotherapy, I will usually schedule appointments as agreed upon

between us. ***Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation.*** My fee is $120 for individual therapy and $140 per hour for couples counseling.

CONTACTING ME

Much of the time I am not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call promptly, with the exception of weekends and holidays. If you are difficult to reach, please leave in your message some times when you will be available. I may also be reached by email at pamala@pamalaroskelleycounseling.com. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the University of Neuropsychiatric Institute at 801-583-2500. If I will be unavailable for an extended time, I will provide you with a name of a colleague to contact if necessary.

CONFIDENTIALITY

Professional ethics as well as the laws of the State of Utah protect the privacy of communications between a client and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization.

I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. Unless you specifically request otherwise, your signature on this Agreement provides consent for those activities.

I am required to disclose confidential information if certain specific conditions exist. These are detailed in the accompanying *Notice of Policies and Practices to Protect the Privacy of Your Health Information*. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

PROFESSIONAL RECORDS AND PATIENT RIGHTS

HIPAA sets forth specific definitions and standards for Protected Health Information. These are detailed in the accompanying *Notice of Policies and Practices to Protect the Privacy of Your Health Information*.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Please make your check payable to Pamala Roskelley. If you are on an insurance program for which I am a provider, you will be expected to pay your co-payment each time.

Appointments not cancelled 24 hours in advance cannot be billed to insurance and may be billed in full to you.

If your account has not been paid for more than 60 days and arrangements for payment

have not been agreed upon, interest will accrue at the rate of 1.5% month, and I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. You will be responsible for all fees and costs that I may incur in this collection process.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will submit an insurance claim to your primary insurance. However, you (not your insurance company) are responsible for full payment of my fees. If you have questions about the coverage, call your plan administrator. Except in certain cases, secondary insurance billing will be your responsibility. Your signature below authorizes payment of insurance benefits directly to Pamala Roskelley CMHC.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE. THE HIPPA NOTICE FOLLOWS THE SECOND COPY OF THIS AGREEMENT.

Client
Signature_____Date_____

Name of Person
Responsible for
Payment:_____Signature_____Date_____