1601 N. Hill Field Road, Suite 201
Layton, Utah 84041

NEW CLIENT INFORMATION

Client Name: ______________________________________Today's Date:_______________________

Date of Birth: ___________Age:_____ Gender:_________Social Security #: ___________________

Address:____

City: ___________________________________State: _________Zip Code:_____________________

Primary Phone Number:______________________________ ☐ Cell ☐ Home ☐ Work

Secondary Phone Number:____________________________ ☐ Cell ☐ Home ☐ Work

Email Address:____

Would you like to receive a text or email reminder for your future appointments?
☐ Text Me ☐ Email Me ☐ No thank you

Emergency Contact: Name:____

Phone:____________________________ Relationship to Client:______________________________

Name of Insurance Plan:____

Insured's Member ID #:___________________________Insured's Group #:____________________

Insured's Plan # (if applicable):_______________ Copay Amount (if known):_________________

Name of Primary Insured or Person Responsible for Payment (if different than client):

_____________________________________ Employer of Primary Insured:____________________

Date of Birth of Primary Insured:______________ Relationship to Client:____________________

Address (if different than client):____

City: __________________State: _____Zip Code: _____________Phone:_____________________

Client Information

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

____ Aggression	____ Elevated mood	____ Panic attacks
____ Alcohol dependence	____ Fatigue	____ Phobias/fears
____ Anger	____ Gambling	____ Recurring thoughts
____ Anxiety	____ Hallucinations	____ Sexual addiction
____ Avoiding people	____ Heart palpitations	____ Sexual difficulties
____ Chest pain	____ High blood pressure	____ Sick often
____ Compulsions	____ Hopelessness	____ Sleeping problems
____ Cyber addiction	____ Impulsivity	____ Speech problems
____ Defiant	____ Irritability	____ Suicidal thoughts
____ Depression	____ Judgment errors	____ Thoughts disorganized
____ Disorientation	____ Loneliness	____ Trembling
____ Distractibility	____ Memory impairment	____ Withdrawing
____ Dizziness	____ Mood Swings	____ Worrying
____ Drug dependence	____ Obsessions	____ Other (specify): ______________
____ Eating disorder	____ Oppositional	________________________________

Have you received professional counseling in the past? ☐ Yes ☐ No

If yes, with whom and when?____

Name of Primary Care Physician/Clinic:____

Phone Number:____________________________Current Medications:______________________________

____

Please complete if client is over 18 years of age:

Years of Education:_______________Marital Status: ☐ Single ☐ Married ☐ Other__________________

Employment/School: ☐ Employed ☐ Full Time Student ☐Part Time Student ☐ Unemployed/Other

If you have children, please list how many and their ages:____

Please complete if client is less than 18 years of age:

Mother's Name:_______________________________Father's Name:____________________________________

Current School:____ Grade:_________________________

How many siblings and what are their ages?:____

Kay Psychological and Consulting Services, P.C.
1601 N. Hill Field Road, Suite 201
Layton, Utah 84041
Phone: (801) 776-1303

PROFESSIONAL SERVICES AGREEMENT

In this document (the ***Agreement***), we have written important information about our financial policies. We are happy to discuss with you any questions you might have about this information.

You are financially responsible for all charges whether or not paid for by insurance. If you choose to use an insurance policy to pay for all or a portion of your care, we are required to submit certain information about you in order to obtain reimbursement. Please ask us if you have questions or concerns about your specific insurance policy.

If you elect to use your insurance to partially or fully pay for your care, it is your responsibility to verify your insurance coverage and note any restrictions or limitations. If you want to use your insurance, you should:

Determine if I am a contracted provider with the plan;
Obtain pre-authorization for your initial visit if required;
Determine the co-payment you are required to pay and/or the amount of remaining unpaid deductible for your benefit year, and the number of visits allowed per benefit year.

Fees for our professional services are charged as follows:

a) If I am an **in-network** provider with your insurance, fees are set by your insurance and you are only responsible for paying your copay and/or your deductible as per your plan.
b) **Appointments not kept and not canceled at least 24 hours in advance will incur a $25 charge. Insurance will not cover these charges. Exceptions will be made in the case of unanticipated circumstances beyond your control.**
c) **Self-pay** clients not using health insurance receive a discounted rate of $100 per session for initial evaluation and therapy sessions.
d) Non-discounted rates are as follows: Initial evaluation session $175; Therapy session or consultation (50-60 minutes) $150; Psychological Evaluations, letters and reports required by an employer, the legal system or other entities are billed at $150 per 60 minutes. These charges are typically not covered by insurance.

You are expected to:

1. Pay the amounts not covered by your insurance plan (i.e., co-payments, unpaid deductibles, missed appointment fees) at the time of service unless other arrangements have been made;
2. Provide a credit/debit card, which we will swipe at your first appointment and will be kept on file in our secure billing software, to pay for any co-payments, deductible, or self-pay payments.
3. If your account is overdue and sent to an attorney or collection agency to pursue collection, pay any collection fees, court costs, attorney fees and filing fees;
4. Pay a $30 charge on any returned checks; and
5. On unpaid balances over 30 days, pay 1.5% per month on interest charges accrued.

By signing below, you are agreeing to the following:

If I am using my insurance carrier(s) to partially pay for my care, I give permission to Kay Psychological and Consulting Services, P.C. (KPCS) to release all necessary diagnostic and treatment information to the insurance carrier(s), and authorize my insurance carrier(s) to pay policy benefits directly to KPCS. I request that this assignment remain on file with my insurance carrier(s).

*I understand that I am financially responsible for all charges whether or not paid for by insurance, including missed appointments and sessions not canceled more than 24 hours in advance. I authorize the release of necessary information to a collection agency if that should become necessary. I permit a copy of this signed **Agreement** to be used in place of the original.*

I will provide KPCS with a credit/debit card to swipe, which will be kept on file in our secure billing software, to pay for any co-payments, deductible, or self-pay payments. If I am unable to provide such a card, I will make alternate payment arrangements with KPCS.

I authorize KPCS to contact the emergency contact person I listed in case of emergency or mental health crisis and authorize information to be provided to my emergency contact as needed.

I authorize KPCS to contact my Primary Care Physician (PCP) and the clinic at which they practice as needed to coordinate treatment and provide treatment updates if requested.

I acknowledge that I have received the attached HIPAA Notice of Privacy Practices, which provides information regarding privacy, confidentiality of information, and security. We are available to answer any questions that you may have now or at any time in the future about the Notice, or our privacy policies and practices.

*I may revoke this **Agreement** in writing at any time. That revocation will be binding on KPCS staff, (1) unless they taken action in reliance on it; (2) if there are obligations imposed on KPCS by my health insurer in order to process or substantiate claims made under my policy; or (3) if I have not satisfied any financial obligations I have incurred.*

I UNDERSTAND THAT MY SIGNATURE BELOW INDICATES THAT I HAVE READ THIS AGREEMENT, AND AGREE TO ITS TERMS.

Client's Name - please print **Date**

Signature of Client **Date**

Signature of Parent/Guardian (if client is a minor) **Date**

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Effective 4-14-03

Notice of Privacy Policies and Practices

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

Legal Duties
State and Federal laws require that I keep your medical records private. Such laws require that I provide you with this notice informing you of my privacy of information policies, your rights, and our duties. I am required to abide these policies until replaced or revised. I have the right to revise my privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to me in an evaluation, intake, or counseling session are covered by the law as private information. I respect the privacy of the information you provide us and I abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information
Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. I may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is my policy not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety
Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse
If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, I may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances
Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death
In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings

Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions

When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify me in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when I phone you at home or work, I do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to me, I will adhere to the following procedure when making phone calls: First I will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information I will say that it is a personal call. I will not identify the clinic (to protect confidentiality). If I reach an answering machine or voice mail I will follow the same guidelines.

Your Rights

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information are as follows. You may request a copy of your records in writing with an original (not photocopied) signature. I may deny access to your medical files under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $0.25 per page, plus postage.

You have the right to cancel a release of information by providing me a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if I do not agree with these restrictions, I am not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to me in writing.

Your have the right to disagree with the medical records in my files. You may request that this information be changed. Although I might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

Complaints

If you have any complaints or questions regarding these procedures, please contact Dr. Steven Kay at (801) 776-1303. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Utah Division of Occupational and Professional Licensing. If you file a complaint we will not retaliate in any way.