# New Client – Clinical Psychotherapy

Van Evans, PhD, LCSW

**Welcome to Counseling.**

We are committed to helping you accomplish your goals through delivering high quality services.

Please read and complete the following information. If you have questions about the Informed Consent and Initial Paperwork, please consult with your therapist. This document needs to be completed and signed on the day of your initial appointment.

Please provide your therapist with **photo identification**.

To begin, please list your top reasons or goals for seeking counseling at this time:

Reason / Goals:

1.

2.

3.

4.

Thank you.

Next, please complete the information below and sign where indicated. Locations for signature or initials are marked with an asterisk on the left hand column.

Your Name: _____ Today's Date: _____

| **CLIENT INFORMATION:** **(As it appears on Medicaid Card)** | **If Client Is A Minor:** **(Parent / guardian information)** |
|---|---|
| **Client Legal Name** | Name |
| Address | Address |
| City/State/Zip | City/State/Zip |
| Phone Number Alt. # | Home Phone Work Phone |
| Client Birthday | Alternate/Cell Phone |
| Email | Relationship |
| Social Security # | |
| **MEDICAID AND/OR INSURANCE INFORMATION:** ****Please provide card to be copied**** | **EMERGENCY CONTACT:** |
| Medicaid Number: | Name |
| Insurance Co. Name: | Address |
| Insured's Name: | City/State/Zip |
| Insured's Birthday: | Home Phone Work Phone |
| Group Number: | Alternate/Cell Phone |
| Employer Name: | Relationship |

**All boxes must be filled out in order to be processed. Indicate only one answer for each box.**
**Answer *all* questions, even if client is a child.**

**1) Date this form completed:**

**2) How was client referred?**

- ☐ 01 Self
- ☐ 02 Family / Friend
- ☐ 03 Social Agency
- ☐ 04 Educational System
- ☐ 05 Court, Law Enforcement, Corrections
- ☐ 06 Private Psychiatric/Mental Health Prog.
- ☐ 07 Public Psychiatric/Mental Health Prog.
- ☐ 08 Clergy
- ☐ 09 Private Practice Mental Hlth. Prof.
- ☐ 10 Other Persons or Organization
- ☐ 11 Unknown
- ☐ 12 Physician or Medical Facility

Caseworker/PO Name: Caseworker/PO Phone:

**BOTH # 3 and 4 must be answered:**
**3) Indicate patient's race:**

- ☐ 01 American Indian
- ☐ 02 Pacific Islander
- ☐ 03 Black
- ☐ 04 White (Caucasian)
- ☐ 05 Other
- ☐ 06 Asian
- ☐ 07 Alaska Native

**4) Client's Hispanic / Spanish Origin (if any):**

- ☐ 09 Not of Hispanic Origin
- ☐ 01 Mexican / Mexican American
- ☐ 02 Puerto Rican
- ☐ 03 Cuban
- ☐ 04 Other Hispanic

**5) List the client's marital status (fill out even if client is a child)**

- ☐ 01 Single - Never Married
- ☐ 02 Married - Spouse in Home
- ☐ 03 Married but Separated
- ☐ 04 Divorced
- ☐ 05 Widowed

**6) Indicate the client's Current Education Type:**

- ☐ 01 Regular Education
- ☐ 02 Special Education
- ☐ 03 Alternative Education (toward high school degree)
- ☐ 04 Continuing Education
- ☐ 05 Vocational Training
- ☐ 06 Not Currently Enrolled

**7) Indicate highest level of**

- ☐ P Preschool
- ☐ 06 6th Grade
- ☐ A High School Graduate

**education completed:**

- ☐ K Kindergarten
- ☐ 01 1st Grade
- ☐ 02 2nd Grade
- ☐ 03 3rd Grade
- ☐ 04 4th Grade
- ☐ 05 5th Grade
- ☐ 07 7th Grade
- ☐ 08 8th Grade
- ☐ 09 9th Grade
- ☐ 10 10th Grade
- ☐ 11 11th Grade
- ☐ 12 12th Grade
- ☐ B Post High School Graduate
- ☐ C College Graduate
- ☐ D Some Graduate School
- ☐ E Graduate School Graduate
- ☐ N Never Attended School

**8) List the Household MONTHLY Income (include parent/guardian income if client is a child)** ***(Do not list yearly income, hourly wage, or source of income in this box)*** ***Income cannot be zero, but you can choose what you put*****:** **$**

**9) List (name and relationship) the number of people living in the home (related and non-related):**

**10) Is client a veteran?:** ☐ 01 Yes ☐ 02 No

**11) Indicate client's preferred language:** ☐ ENGL English ☐ SPNSH Spanish

**12) Has client received mental health treatment before? (If more than one category fits, list MOST RECENT ONLY):**

- ☐ 00001 None
- ☐ 00002 Valley Mental Health
- ☐ 00004 Psychiatric Hospital
- ☐ 00008 General Hospital
- ☐ 00016 Outpatient (non-VMH)
- ☐ 00032 Drug Program
- ☐ 00064 Alcohol Program
- ☐ 00128 Residential Treatment (Non-Hospital)

**13) Expected principal payment source as reported by staff?**

- ☐ 01 Personal Resource
- ☐ 02 Service Contract
- ☐ 03 Medicare
- ☐ 04 Medicaid
- ☐ 05 Provider to Pay Most Cost
- ☐ 06 Commercial Health Insurance
- ☐ 07 Veterans Administration
- ☐ 08 CHAMPUS
- ☐ 04 Workers Compensation
- ☐ 05 Other Public Resources
- ☐ 06 Other Private Resources
- ☐ 03 Unknown

**14) List employment status (fill out even if client is a child):**

- ☐ 31 Employed Full-time - 35+ Hrs
- ☐ 32 Employed Part-time – less than 35 Hrs
- ☐ 33 Supported / Transitional Employment (full-time)
- ☐ 34 Supported / Transitional
- ☐ 35 Homemaker
- ☐ 36 Retired
- ☐ 37 Volunteer
- ☐ 38 Unemployed - Not Looking
- ☐ 39 Unemployed - Disabled
- ☐ 40 Unemployed - Looking

**15) What is the client's current living situation?**

- ☐ 01 On the Street / In a Shelter
- ☐ 02 Private Residence or Apartment
- ☐ 03 In A Nursing Home
- ☐ 04 In A Boarding Home
- ☐ 05 Other Residential Facility
- ☐ 06 Jail / Correction Facility
- ☐ 07 Other Institution
- ☐ 08 Foster Care (Adult or Child)

**16) Indicate if client is seeking treatment voluntarily or involuntarily (court-ordered). If involuntary, indicate if court is *civil* or *criminal*:** Voluntary ☐ Involuntary/civil ☐ Involuntary/Criminal ☐

**17) Indicate client legal status*:*** State Hospital Committed ☐ Not Civilly Committed ☐ Civilly Committed ☐

**18) Is the client seeking Alcohol and Drug Services?** ☐ 01 Yes ☐ 02 No

**19) Is the client pregnant?:** ☐ 01 Yes ☐ 02 No

**20) Was the client given crisis information?:** ☐ 01 Yes ☐ 02 No

| | | |
|---|---|---|
| **21) Does client have Medicare?**<br>**If so, list Medicare number:** | ☐ YES ☐ NO | **Medicare #:** |
| **22) Other insurance information:** | **Insurance Company** | |
| | **Insured's Name** | |
| | **Insured's Birth Date** | |
| | **Group Number** | |
| | **Employer Name** | |
| **23) Name and relationship of person providing information:** | | |

| | | | |
|---|---|---|---|
| **24) Primary Source of Income (List one answer only):** | ☐ 01 Employment / Wages<br>☐ 02 Public Assistance<br>☐ 03 Social Security Benefits | ☐ 04 Unemployment<br>☐ 05 Workman's Compensation | ☐ 06 Alimony / Child Support<br>☐ 09 Other |
| **25) Indicate if client has any handicaps or impairments *(choose from list only):*** | ☐ 0099 None<br>☐ 0001 Development / Mental Retardation<br>☐ 0002 Organically Based /Expressive Communication<br>☐ 0004 Blind or Severe Vision Impairment | ☐ 0008 Deafness or Severe Hearing Loss<br>☐ 0016 Non-Ambulation or Severe<br>☐ 0032 Moderate or Severe Medical | |
| **26) Was a release of information signed (ex: for client's school, other medical providers, or social service agencies):** | ☐ 01 Yes | ☐ 02 No | |

**PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT**

This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and 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. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about this agreement. When you sign this document, it will also represent an agreement between you and Van Evans. You may revoke this Agreement in writing at any time. That revocation will be binding on Van unless Van has taken action in reliance on it; if there are obligations imposed on Van Evans 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.

**PSYCHOTHERAPY SERVICES**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the nature of your goals and concerns. There are many different methods your therapist may use to help you realize your goals. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing uncomfortable aspects of your life, you may experience uncomfortable feelings. Psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience in therapy.

The first few sessions will involve an evaluation of your needs and goals. By the end of the evaluation, your therapist will be able to offer you some first impressions of what our work will include if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your therapist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our

procedures, we should discuss them whenever they arise. If your doubts persist, Van Evans will be happy to help you set up a meeting with another mental health professional for a second opinion.

## CONTACTING US AND EMERGENCIES

**In emergencies,** please contact an emergency room or the University of Utah's Neuropsychiatric Institute at (801) 583-2500 and ask to speak with a Crisis Worker. If you are in a life threatening emergency, please call 911. You may also contact Van Evans (801) 906-3107 in cases of non-life threatening emergencies.

## PROFESSIONAL FEES AND FINANCIAL TERMS

| | |
|---|---|
| Individual/Family Psychotherapy | $170 per 50 min session, $15 for each 5 minutes thereafter |
| Group Therapy | $55 per hour per person |
| Initial Assessment | $200 per first visit |
| Missed appointment/Late Cancel | $125 |

Unless otherwise agreed upon, the fees listed above will apply to your services. If you want your insurance company to pay for treatment, please contact them to ensure that Van Evans is on their panel. Please use Dr. Evans' **NPI Number (1932538519)** when consulting with your insurance company. I charge $150 per hour for services related to therapy that go beyond 10 minutes (e.g., phone calls, report writing). If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for this time, including preparation and transportation costs. For legal related activities, I charge $150.00 per hour. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation unless we both agree that you were unable to attend due to circumstances beyond your control. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. If it is possible, we will try to find another time to reschedule the appointment. If you do not show for an appointment, it is your responsibility to reschedule. If there is a second "no show" this will be considered self-termination in which case you will be responsible for finding another healthcare / mental health care provider.

By signing below you authorize Van Evans to bill insurance or your bishop in your behalf and to provide necessary confidential information to your insurance regarding billing. You will be assessed a 1.5% finance charge per month *after your payment is 30 days late.* Unpaid accounts will be referred to collections. In the event payment under this agreement is not made at the time and in the manner required, the undersigned agrees to pay all costs of collection, including attorney fees, court costs, including charges and collection agency fee which would be 30% of the balance assigned, with or without suit. If you want Van Evans to bill your insurance company, we reserve the right to charge you, not your insurance, $5 per service for some (not all) insurance companies; this is done because of the difficulty some insurance companies present in making accurate and timely payments.

******By signing below, I agree to these financial terms and consent to mental health treatment with Van C Evans.***

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| **Client** | **Date** | **Parent/Guardian/Responsible Party** | **Date** |

**** Optional *****

Due to financial distress, clients can request a fee different from the fees listed above. I , with the approval of Van Evans, agree upon the following fee for services: _____ dollars per hour.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| **Client** | **Date** | **Therapist** | **Date** |

**PATIENT RIGHTS**

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that Van Evans amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

**MINORS & PARENTS**

Patients under 14 years of age should be aware that the law may allow parents to examine their treatment records unless Van Evans decides that such access is likely to injure the child. Since parental involvement in therapy is important, it is our policy to request an agreement between a child patient between 14 and 18 and his/her parents allowing me to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Any other communication will require the child's authorization, unless Van Evans feels that the child is in danger or is a danger to someone else, in which case, your therapist will notify the parents of his or her concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

**CONFIDENTIDALITY AGREEMENT**

Professionals who provide mental health services are required by laws and ethical standards to keep all communications between clients and therapists confidential. Information will only be shared about you when agreed to by your signature on a "Release of Information" form. There are some important limits to confidentiality. Any communication by electronic means may have limits to your privacy. While all client-related communications are kept confidential to the best of our ability, it is possible that others could intercept electronic communications. There are specific limitations to client confidentiality:

1. Suspected *child or elderly adult abuse or neglect*: We are required by law to report to the appropriate state agency if we suspect abuse or neglect of a child or an elderly adult.

2. *Harm to self or others*: If we conclude that a client is about to cause harm to themselves or someone else, we are obligated to report this and/or to take steps to prevent that harm.

3. *Response to court subpoenas* and orders: We are obligated to cooperate with lawful orders and subpoenas of courts of law, should we be ordered to testify or to provide documentation regarding clients. We will make all attempts to maintain your confidentiality in these cases.

4. We are required by some referring agencies to provide *updates and progress reports*. We will report to these agencies by developing a report or update together with the client in therapy. These reports will only be released with your written permission.

**** ***I understand and agree to these terms and limitations regarding confidentiality: _____ (Initial)***

**Electronic Communications**

Utilizing electronic communication as a source of communication cannot be guaranteed confidential, as there are complications with electronic communication. If you choose to communicate with your therapist via electronic communication including e-mail, text, etc. you understand that this type of communication may risk your right to confidentiality.

**** **I understand and agree that by using electronic means of communication I may violate my right to confidentiality_____ (Initial)**

**CLIENT RIGHTS AND GRIEVANCE POLICY**

1. All client information and **records are confidential**. Access to records will only be granted with client permission. Records are kept behind locked doors.

2. All individuals have the right to **participate free from harm or threat**. Any potentially harmful situation should be immediately reported to Van Evans at 801 906-3107. Threats or violence will not be tolerated and could result in termination of services.

3. All clients have the **right to be treated fairly, with respect, and with dignity**. If you are mistreated please follow the grievance procedure outlined below.

4. I **do not allow smoking** in my offices or near public entrances in accordance with the Utah Clean Air Act.

5. All individuals have the right to be **free from discrimination** based on age, race, color, culture, religion, sexual orientation, or disability. If you feel that you have been discriminated against please follow the following grievance policy for remediation. We comply with all applicable laws regarding discrimination and any form of discrimination will not be tolerated.

6. Any individual who feels they have been mistreated or has any **grievance** has a right to be heard and have their issue addressed. Clients are first encouraged to address the problem directly with the offending person. If you are still not satisfied, please contact the Department of Professional Licensing.

****** I have read and understand my rights and procedure for grievances: _____ (Initial)**

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ALL ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED INFORMATION ABOUT HIPAA DESCRIBED ABOVE. IF YOU ARE THE GUARDIAN, YOUR SIGNATURE INDICATES YOU AGREE TO THE TERMS FOR YOUR CHILD.

Name of adult client: _____ Signature _____ Date: _____

Name of adult client: _____ Signature _____ Date: _____

If Minor:

Name of guardian: _____ Guardian's Signature: _____ Date _____