# The Green House Center
For Growth & Learning

## CLIENT INFORMATION

Name: _____
(First) (M.I.) (Last)

Age: _____ Gender (check one): ☐ Male ☐ Female

Date of Birth : _____ Race/Ethnicity: _____
(Month/Day/Year; i.e.: April 1 1999)

Address: _____ Home Phone #: _____
(Street Address)

_____ Cell Phone #: _____
(City, State, ZIP Code)

Email: _____ Alternate Phone #: _____
(By providing your email you are opting-in to receive newsletters and notifications from our company approximately twice a month)

Marital Status: _____

Spouse's Name: _____ Spouse's Phone #: _____

Emergency Contact: _____
(Full Name) (Phone #) (Relationship)

### GUARDIAN INFORMATION (IF DIFFERENT FROM ABOVE)

Parent/Guardian : _____ Relationship: _____

Address: _____ Home Phone #: _____
(Street Address)

_____ Cell Phone #: _____
(City, State, ZIP Code)

Email: _____ Alternate Phone #: _____
(By providing your email you are opting-in to receive newsletters and notifications from our company approximately twice a month)

Marital Status: _____

Spouse's Name: _____ Spouse's Phone #: _____

Employer: _____ Work Phone #: _____

### RESPONSIBLE PARTY INFORMATION

Name of person or agency responsible for payment: _____

Address (If Different From Above): _____
(Street Address) (City, State, ZIP Code)

Phone #: _____ Social Security #: _____
(Required Field if Self Pay)

Medicaid #: _____

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# CONSENT FOR TREATMENT, CONFIDENTIALITY AND HOLD HARMLESS AGREEMENT

Client Name: _____

For myself, or on behalf of the above named client, I hereby give my consent for them to receive individual, marital, family or group treatment.

I understand that all information obtained concerning me and/or my children, or anything I tell the staff, orally or in writing, will be kept confidential within The Green House Center for Growth & Learning, LLC with these exceptions:

1. If I sign a release request specifying to whom the information is to go, what information I want released and for what time period information is to be released.
2. Upon a proper court order
3. In emergencies when it appears that I may be a danger to myself or others
4. In child abuse cases as the law requires
5. As required by funding sources for The Green House Center for Growth & Learning, LLC to receive payment.
6. As outlined in the Notice of Privacy Practices

**Risks of treatment:** Sometimes when a client enters treatment there can be an initial increase of symptoms because of the need to explore and address issues. Your therapist will pace your work carefully and work with you to limit those risks.

**Neurofeedback:** The Green House Center for Growth & Learning, LLC offers EEG (brain wave) neurofeedback to clients in connection with a variety of conditions that appear to be associated with disregulation of brain activity. No guarantee is made that any individual client will improve with training. It is possible that for a few clients who do experience benefit, the improvement may fall off after the cessation of training. In addition, by signing this form, the client waives any claims of damages due to the neurofeedback, including worsening of the client's condition, claimed side effect or failure to improve, and further agrees to hold harmless The Green House Center for Growth & Learning, LLC.

**Additional Products Offered:** The Green House Center for Growth & Learning, LLC are not intended to be treated as medical advice and is not an endorsement for any specific person or organization. The products provided are considered a resource and buyer agrees to release and hold harmless the Green House Center for Growth and Learning for any liability relating to the use of obtained products. Seek professional medical advice before altering or beginning a new medical treatment of regimen.

**Client Rights:** The Green House Center for Growth & Learning, LLC and staff shall support and protect fundamental human, civil, constitutional and statutory rights of every individual.

**Policies**: The Green House Center for Growth & Learning, LLC has informed me of the following policies:

- Reasons for involuntary termination and criteria for re-admission to therapy. Initials:_____

- Freedom from potential harm or acts of violence to consumer or others. Initials:_____
- Grievance and complaint procedures. Initials:_____
- Program Fees and other costs Initials:_____
- Freedom from discrimination Initials:_____
- The right to be treated with dignity Initials:_____
- The benefits and concerns of participating in Neurofeedback Initials:_____
- The availability of third party products, which are only an additional resource to be used under the direction of your physician. Initials:_____
- Voluntary termination is honored at any time. Initials:_____
- Smoking policy in compliance with the Utah Clean Air Act. "Smoking is prohibited in all enclosed indoor places and public access…" Initials:_____

Client/Guardian Signature:_____ Date:_____

Witness:_____ Date:_____

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# NOTICE OF PRIVACY PRACTICES

**Your Information. Your Rights. Our Responsibilities.**

This notice describes how medical and mental health information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

## Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

**Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

**Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

**Our Uses and Disclosures**

**How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

**Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

**Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

**Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease

- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

**Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Client Name: _____

For myself or on behalf of the above named client I have reviewed the Notice of Privacy Practices from The Green House Center for Growth and Learning, LLC.

Client/Guardian Signature:_____ Date:_____

Witness:_____ Date:_____

# The Green House Center
For Growth & Learning

## RELEASE OF INFORMATION

Client Name: _____

For myself or on behalf of the above named individual I give permission for The Green House Center for Growth & Learning, LLC, to share information among staff members for scheduling and billing purposes as well as staffing. I also give permission for them to share information with the following agencies and individuals in regards to my case:

**Please note that your funding source already has access to billing information.**

**(Please initial all that apply and specify name if necessary)**

| | | |
|---|---|---|
| _____ | DCFS | _____ |
| _____ | Medicaid | _____ |
| _____ | Bishop and/or subsequent Bishops | _____ |
| _____ | Previous Therapist | _____ |
| _____ | Medical Doctor(s) | _____ |
| _____ | Inter-office email | _____ |
| _____ | Insurance | _____ |
| _____ | Email | _____ |
| _____ | Texting | _____ |
| _____ | Other | _____ |

Additionally, I authorize the release of my records to The Green House Center for Growth & Learning, LLC FROM the following agencies or persons:

1. _____
2. _____
3. _____
4. _____
5. _____

**Client/Guardian Signature:**_____ **Date:**_____

**Witness:**_____ **Date:**_____

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## CLIENT CONTRACT

Client Name: _____

We would like to welcome you to The Green House Center for Growth and Learning, LLC. We want to make your time here pleasant as you work on the challenging issues in your life. Here are a few items that may be helpful to know:

- ✓ **BE CONSISTENT:** You will have ups and downs as you go through the therapeutic process, and your therapist will be there to support you through them. On days that you feel better, or are especially upset, you may be tempted to skip therapy. We ask that you be committed to what you sign up for. Talk to your therapist about how long the therapeutic process might be for you and how to handle those ups and downs. We ask that you not just stop or cancel therapy. This can be more detrimental than never beginning and frustrating to both parties. Additionally, you have been given a much sought after slot with a therapist who has committed to you, while others are waiting. We ask that you think seriously about this commitment up front. When you or your therapist feels it is time to take a break or terminate therapy, please allow for 2-3 sessions to end appropriately.
- ✓ **CALL FOR HELP:** A crisis is when there is a life or death situation or there is a risk of danger to self or others. If you find yourself in a very serious emotional or physical crisis, please call the agency at 801-785-1169 and leave a message if you're unable to get a hold of someone. If it is after office hours you may call the Utah County Crisis Line at 801-691-LIFE. If it is not an emergency, please call the next morning during regular hours and we will have your therapist call you or schedule you an emergency session, if necessary.
- ✓ **BE COURTEOUS:** We ask that you not cancel your appointment any later than 48 hours before your scheduled time. There are often people waiting for cancellations and if we have notice, we can get them in. If you cancel **later than 24 hours** before your visit, we will charge **YOU** the **FULL** session price. If you are a DCFS or Medicaid client or coming with Bishop's funding, you will be required to cover this cost yourself. If you are sick and contagious we ask that you call and leave a message as soon as you are aware and we will reschedule if possible.
- ✓ **PARTICIPATE:** Research has shown that the number one success factor in therapy is the quality of the therapeutic relationship. This is developed with much of your own participation. Therefore, we ask that you not miss more than one consecutive session, and that you only miss when it is unavoidable. We know this can be hard, but this is what you are signing up for. In situations where your child is sick, or your car is broken down or a similar emergency occurs, it is possible to conduct your session over the phone or reschedule. Just call to arrange this. We also ask that you talk frankly to your therapist about any assignments that he or she may suggest, letting them know up front what you can and can't commit to. You have important input in this area, some clients like homework and others don't. Being open will help you find a rhythm that works for you and your therapist that doesn't create unnecessary starts and stops to your process. Lastly, it is your therapist's right to terminate therapy when the client does not meet expectations agreed upon in the treatment plan.
- ✓ **BE OPEN:** Our agency specializes in relationships and uses a systems approach to healing. There may be times when we will ask to see other key people in your life. Nobody lives or heals in a vacuum, so please be open to these other types of therapy. Your therapist will discuss this with you on a case-by-case basis.

Client/Guardian Signature:_____ Date:_____

Witness:_____ Date:_____

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# DIVORCE AND COURT SITUATIONS

Client Name: _____

**Divorce:** (In cases of joint custody) We require signatures of consent from both parents to treat your child unless there has been a termination of parental rights.

**Court:** We are not court appointed therapists, custody evaluators, parental fitness evaluators, or otherwise involved in court proceedings. If you need a letter for court, it can only reference you or your child's therapy goals and progress. We will need to have a release for that specific audience, and cannot reference anyone else in that letter unless they also have signed the release.

Father's Signature:_____ Date:_____

Mother's Signature:_____ Date:_____

Witness:_____ Date:_____

# The Green House Center
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# PAYMENT INFORMATION

Client: _____

**PERSON OR AGENCY RESPONSIBLE FOR PAYMENT: (PLEASE MARK ONE USING "X"):**

_____ Self Pay

_____ Credit Card #: _____ Exp: _____

(PLEASE NOTE: Your card number **WILL** get charged automatically)

_____ Medicaid

_____ Medicaid Card #: _____

(Please allow the office staff to make a photocopy of your Medicaid card)

_____ Bishop or Ecclesiastical Leader

Name _____ Contact Number _____

_____ Other

**SERVICES**:

_____ Individual or Family Weekly Session
(Intake $200 | Weekly sessions $135 – We offer a discount for payment on same day of services)

_____ Package (10 sessions for $1,050 + Intake $175 = $1250 paid in advance)

_____ Package (20 sessions for $1.900 + Intake $150 = $2,050 paid in advance)

**PLEASE NOTE THAT WE MAY NOT BE ABLE TO BILL YOUR INSURANCE COMPANY. YOU ARE RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A BILLING STATEMENT THAT YOU CAN GIVE TO YOUR INSURANCE COMPANY FOR ANY POSSIBLE REIMBURSEMENT.**

**Our Billing Policy:** Payment is due at the time of service. Please be aware that we may be unable to bill your insurance company. It is your responsibility to contact your individual company to be reimbursed. You are responsible for the entire balance of your account. We are happy to provide you with receipts/statements that you may forward to your insurance company. We are happy to guide you in the reimbursement process, if needed. If you need assistance, you may ask for an application for financial assistance.

**Initials:**_____

The regular cost for a 55 minute therapy session is $115 if paid on the same day/$135 if paid later. We accept VISA, MC, Discover and American Express credit cards. If a balance is carried, an additional $20 will be added per session. If you are a client through DCFS, Medicaid, WMH, VocRehab, CVR, or Bishop's Pay we will bill directly for the services you have received. However, if you have a co-pay and do not make the co-pay when you have your appointment, your payment is considered late and a $20 late fee may be added.

**Initials:**_____

If you have been scheduled for reoccurring appointments and are unable to keep an appointment, please notify our office at least **24 hours in advance**. Failure to do so will result in a charge of $135 for the missed appointment. If you pay on the same day as the missed appointment, the charge will be reduced to $115. We schedule on a weekly basis, so if you miss two appointments ("no show") or have excessive cancellations this will result in your being removed from the recurring appointment schedule. If needed, please call the office and we will attempt to find a more convenient time for your appointments. For financial arrangements, contact our billing department at 801-785-1169**.**

**REMEMBER, YOU ARE PERSONALLY RESPONSIBLE FOR ANY NO SHOW FEES AS THEY ARE NOT COVERED BY ANY REFERRING AGENCIES, OR OTHER FUNDING SOURCES. PLEASE CALL AHEAD TO AVOID HAVING THESE FEES ADDED TO YOUR ACCOUNT.**

**Initials:**_____

I understand and agree to the above billing policy:

Client/Guardian Signature:_____ Date:_____

Witness:_____ Date:_____