Deseret Counseling Consumer Agreement and Payment Policy.

Please read each of the statements because you will be held responsible for the following information. After reading and signing the form, no exceptions will be made.

- You will be required to keep a credit card on file with us. This will help us collect co-insurances, deductibles and any other unpaid balances. It is your responsibility to keep your credit card information up to date. By completing this form and signing below, you authorize Deseret Counseling to charge your credit card for any fees or costs due and owing to Deseret Counseling, including, but not limited to, co-pays, treatment costs not covered or declined by insurance, late cancellation fees, interest, and collection costs.

- If you are unable to make your appointment, please call to cancel or re-schedule 24 hours in advance. If you do not call within 24 hours of your scheduled appointment, you will be billed a $80.00 no- show or late cancellation fee. If you are on Medicaid $20.00 will be billed. (All fees will be charged to your credit card that will be on file).

- If you miss more than two appointments without calling or rescheduling, you may be terminated from treatment.

- All fees and co-payments must be paid prior to each appointment. If your payments or fees are not paid at time of your appointment, you will not be able to schedule any follow ups. You will also be responsible for any unpaid unbalances, which includes all unpaid balances that insurance companies may refuse to pay. **It is your responsibility to know if you have a deductable or co-payment prior to your appointments.**

- If your insurance is billed and declines payment, we will submit another billing. If the second billing is declined **it will be your responsibility for payment.**

- If your account is self-paid, all services will be paid for at the time of the first visit.

- If your insurance is out of network, we will expect payment from you at the time of service. It will be your responsibility to submit any claims to your insurance company for direct re-imbursement to you.

If there happens to be any emergency, Deseret Counseling requires your permission to seek any medical help if needed due to physical or mental incapacity. By signing below, you give permission for Deseret Counseling and staff to act on your behalf in case of an emergency.

Standard Charges for services:

Individual/Family Therapy:	**$155.00**
Initial Assessment:	**$175.00**
Group Counseling:	**$35.00**
Court Documentation:	**$100.00 per hour**

****Discounts will be given for Self Pay and/or Cash payments prior to appointment**

Fees:

Declined Credit Card:	**$30.00**
Returned Check:	**$30.00**
No Show/Late Cancel:	**$80.00**

If unpaid balances go longer than 30 days, a late fee of 25% APR interest will be assessed to your account. If your account goes 60 days without payments, you will not be able to schedule anymore appointments until your account is paid in full. Your account will be put on a cash basis only.

We reserve the right to send your account to collections after all options have been attempted. If this results, you will also be held responsible for any collection costs, including attorney's fees, that may be necessary.

Signature:_____

Name: **Date:**

Parent/Guardian:_____

Name: **Date:**

Confidentiality Agreement.

Issues that are discussed in therapy are very important and are kept confidential and Deseret Counseling follows all confidentiality laws including HIPAA. There are, however, times when Deseret Counseling is required to disclose confidential information. These times occur when:

1. **Suspected abuse or neglect of a child, disabled person or elderly person.**
2. **Therapist feels you are in danger of harming yourself or another individual. Also possible if you are unable to care for yourself.**
3. **If Deseret Counseling and/or your therapist is ordered by a court and/or is subpoenaed to release information.**

By signing below I agree and understand the confidentiality agreement:

Name: **Date:**

Parent/Guardian **Date:**

As indicated earlier, **Deseret Counseling** requires you to keep a credit card on file. This will help us collect co-payments, deductibles and any unpaid balances. This will also help us collect any deductibles that may be added towards your treatment. (It's best to know your benefits before coming). It is also your responsibility to make sure your credit card does not expire and continues to stay updated.

Credit Card Type:_____

Name as it appears on Card:_____

Credit Card number:_____

Expiration Date:_____

Security Number_____

(typically 3-4 digits located on the back of the card)

Intake Information **Date:** _____

Patients Name: _____

Date of Birth **Age**

Address: _____

Street **City** **State** **Zipcode**

Phone: _____

Work **Cell** **Email**

Insurance: _____

ID Number: _____

Employer: _____

Emergency Contact: _____

Who referred you: _____

By signing below I agree and give consent to mental heath and psychotherapy treatment:

_____

Client **Date**

_____

Parent or Guardian **Date**