Hope Haven
COUNSELING
11075 S. State Street Ste. #14 Sandy, UT 84070
Phone (801)676-8786 **Fax**(801)676-8797

Intake Information Date:

Client Name: _____Sex:_____ Date of Birth: _____Age:_____

Address: _____
Street City State Zip

Phone #s_____
Home Work Cell

E-mail Address _____

Primary Parent/Guardian_____
Name Address Phone(s)

Secondary Parent/Guardain_____
Name Address Phone(s)

Emergency Contact: _____
Name Relation Address Phone(s)

Who else lives in the home? (Please include names and ages)_____

_____

Attending School at: _____ Working at: _____

Who referred you? _____

By signing below, I agree to these terms and consent to mental health treatment at Hope Haven Counseling.

_____ _____
Client Date Parent/Guardian/Responsible Party Date

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Consumer Agreement

Please read the following statements very carefully as you will be held responsible for the information listed and there will be NO EXCEPTIONS made to these policies.

1. **If you cannot make a scheduled appointment please call to cancel or re-schedule 24 hours in advance**. If you do not call or call less than 24 hours in advance to cancel or re-schedule **you (not your insurance)** will be billed **the full session rate.** This fee will be charged to your credit card on file and **must** be paid prior to scheduling another appointment. _____***(Initial)***

2. Clients who **miss two** appointments without calling to cancel or consistently call to cancel or reschedule may be terminated from treatment. _____***(Initial)***

3. All **office visit fees are due at each appointment**. Failure to pay will prevent you from scheduling another appointment until your account is paid in full. All clients will be billed the standard rate for services provided. _____***(Initial)***

4. **Financial responsibility of divorced parents will be on the parent who seeks treatment for the child.** Although divorced parents may have a divorce decree that establishes their financial responsibilities, we are not a party to the decree. We require the parent accompanying the minor for treatment to accept primary responsibility for payment. Any responsibility of the other parent, as set forth in the divorce decree, or implied or agreed upon by the parents, will be the responsibility of the parents and we will not be involved. _____***(Initial)***

5. In the **case of emergency**, Hope Haven staff requires permission to seek medical treatment for you if you are physically or mentally incapacitated. By initialing you agree to allow Hope Haven staff to act on your behalf in case of an emergency. _____***(Initial)***

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Confidentiality 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 clientrelated 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)

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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 in locked filing cabinets and 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 Hope Haven staff. 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. Hope Haven **does not allow smoking** in our offices or near public entrances in accordance with the Utah Clean Air Act.

5. Those who possess **firearms or ammunition will not be allowed** to bring them onto the premises of Hope Haven Counseling, this includes those with concealed carry permits, due to the presence of children and vulnerable adults.

6. 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. Hope Haven complies with all applicable laws regarding discrimination and any form of discrimination will not be tolerated.

7. 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 unable to do this for any reason you should contact the clinical director, Miriam Harper LCSW. If you are still not satisfied, please contact the Department of professional licensing or other referring professional.

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

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Standard Charge for Services:

• Individual Therapy	$150/50 min.
• EMDR Therapy	$225/90 min.
• Family/Couple Therapy	$175/hr.
• Psychosocial Assessment	$180/hr.
• Court Letters/Revisions of Letters	$75/$50
• Court Appearances	$165/hr.
(Travel time, wait time, and actual time in court will be billed)	
• Correspondence with outside parties in divorce cases, reunification cases, mediation, or custody evaluations.	$35/15 min.
• No Show/Late Cancel Fee	Full Session Fee
• Returned Check Fee	$30
• Declined Credit Card Fee	$10

Fees

I acknowledge that I have received a copy of Hope Haven's Payment Policy. _____(*Initial)*