George J Limberakis, LCMHC

Associated Counseling Services, LLC

Legal Last Name:       First Name:       Middle:

Preferred Name:       DOB:       Age:

Street:       City:       State:       Zip:

Mobile Phone:       OK to leave mssg?: Yes [ ]  No [ ]  OK to text?: Yes [ ]  No [ ]

Other Phone:       OK to leave mssg?: Yes [ ]  No [ ]  OK to text?: Yes [ ]  No [ ]

Your Preferred Pronouns:        Relationship Status:

Spouse/Partner Name:       Their Preferred Pronouns:

Primary Emergency Contact:

Name:       Address:

Phone:       Relationship:

Secondary Emergency Contact:

Name:       Address:

Phone:       Relationship:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Stop here if you are providing a copy of your insurance card\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Co.:       Member ID #:       Company Phone:

Street:       City:       State:       Zip:

Name of insured:       DOB:       Relationship to patient:

Employer Name:       Address:

Secondary Insurance Co.:       Member ID #:       Company Phone:

Street:       City:       State:       Zip:

Name of insured:       DOB:       Relationship to patient:

Employer Name:       Address:



**Consent For Treatment**

In seeking counseling services, I,      , understand the following policies and procedures. I agree to read and, by initialing each section, indicate my understanding.

1. **Confidentiality:** All information I reveal to my counselor will be considered strictly confidential. Confidential information shared with supervisors or staff will be kept confidential. I understand that no information will be revealed to any outside party without my prior, written approval with the following exceptions:
2. If I make threats of physical harm toward myself or others.
3. If my counselor believes I am about to commit, or have been involved with, a violent crime.
4. If my counselor believes that I am, or have been involved, in the physical abuse, sexual abuse, neglect or exploitation of a child or a disabled adult.
5. If I have a life-threatening medical emergency.
6. If it is learned that I have a communicable disease that is reportable under Utah State Law and my counselor believes my behavior poses a risk of infection to others.
7. If I fail to meet my obligation to pay for services, an outside agency or small claims court may be informed of my failure to meet my obligation.
8. If a federal, state or local court orders (or subpoenas) my counselor or this facility to provide information to the court.
9. I understand that my counselor will, when requested by my insurance company or other third-party payer, release information regarding my diagnosis and/or treatment.
10. I have received a copy of my counselor’s Notice Of Privacy Practices – HIPAA (see below)

initial

1. **Treatment:** I agree to fully participate in my treatment in the following ways:
2. I will assist my counselor in formulating and periodically reviewing my treatment goals.
3. I will complete any homework that my counselor assigns to me to the best of my ability.
4. I will discuss with my counselor any concerns that I have regarding my treatment.
5. I will discuss, directly or in writing, with my counselor any dissatisfaction I have with my treatment.
6. I will submit, in writing, any request to review the information contained in my clinical record.
7. I understand that the goals of therapy are to improve intrapersonal as well as interpersonal functioning. The personal changes that I may experience as a result of therapy could alter present relationships in ways that cannot be predicted. I will discuss any changes in current relationships with significant others with my counselor.
8. I understand that no promises can be made to me as to the results of treatment provided and that the nature of the therapeutic process is such that the personal issues for which I have sought treatment may, in some cases, worsen before improving or may not appear to improve at all, with therapy.

 Initial

1. **Fees & Insurance:**
2. I understand that my insurance company may pay a portion or none of the cost of my treatment. I may be required to meet my insurance plan deductible before any treatment is covered. I agree to pay all costs of treatment, including co-payments, that are not covered by my insurance plan and to keep my account current. If I fail to keep my account current, my counselor may discontinue treatment.
3. I understand that I am responsible for the payment of all fees associated with my counseling at the time service is provided, unless other arrangements are agreed upon.
4. I understand that my counselor will assist me in receiving reimbursement from my insurance company and I give permission for my counselor to provide information to my insurance company, for billing purposes.
5. I understand that the fee charged to me per 25-minute session is $60.00, per 45-minute session is $110, per 60-minute session is $130.00 and per 75-minute session is $ 150.00. Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. I agree to discuss with my counselor any difficulties I may have in making timely payments to my account.
7. I understand that, in order for my insurance company to be billed for my treatment, it is necessary for my counselor to formulate and submit to my insurance company a psychological diagnosis. If I have concerns about a psychiatric diagnosis becoming part of my medical record, I will discuss this with my counselor.

 Initial

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1. **Appointments:**
2. I agree to arrive on time for my scheduled appointments.
3. I agree to give at least 24-hour notice if I am unable to keep a scheduled appointment.
4. I understand that my insurance company cannot be billed for missed appointments and that I am responsible for paying the full cost of missed and short-cancelled appointments.
5. I understand that I may be charged for missed or cancelled appointments if insufficient notice is given.
6. If it becomes necessary for my counselor to make changes to a scheduled appointment, I understand that all steps will be taken to inform me of the change as soon as possible.
7. I understand that my appointment will end 50 minutes from the time it is scheduled to begin. If I am late, no time will be added to the end of the appointment

Initial

1. **Complementary Therapies**

You may request or it may be suggested to you that Emotional Freedom Techniques (EFT) may be a helpful adjunct to more traditional modalities. Please be advised that EFT is an emerging therapeutic technique that continues to gain empirical support. If you request or your therapist suggests that EFT be included in your treatment, the final decision to do so will be made by you, the client, after being fully informed about EFT.

 Initial

1. **Solo Practice**

I understand that George J Limberakis, LCMHC is a sole practitioner and, therefore, may not be available to provide emergency or after-hours services or while away from the office. I understand that it is my responsibility to provide for my own safety and to seek assistance in the event of a psychological emergency.

 Initial

1. **Release of Liability**

Except in the case of gross negligence or malpractice, I or my representative(s) agree to fully release and hold harmless George J. Limberakis, LCMHC, Associated Counseling Services, LLC from and against any and all claims or liability whatsoever kind or nature arising out of or in connection with my session(s).

 Initial

These policies and procedures have been implemented to help assure that you receive maximum benefit from your counseling experience. Your counselor has agreed to abide by the Ethical Code of Standards endorsed by the American Counseling Association and the applicable laws of the State of Utah. If you are dissatisfied with the services provided to you, it is important that you make every effort to communicate your dissatisfaction to your counselor. If you desire to seek the services of another mental health provider, it is imperative that you inform your counselor of your intention to do so. If you need assistance locating another mental health care provider, I will be happy to assist you with an appropriate referral and, at your request, provide information to your new provider regarding your treatment.

I have read, understand and have discussed with my counselor each of the above policies and procedures. I agree to abide by these policies and authorize treatment to be provided to me (or my minor child).

**I authorize release of information for the purpose of billing any third-party source for benefits, which I am eligible to receive.**

**I agree to pay fees agreed upon in this form. Any unpaid balance may be turned over for collection after 90 days and I agree to pay all costs of collection, including but not limited to reasonable attorney’s fees.**

**I voluntarily consent to treatment and understand that it is my right to discontinue treatment at any time.**

**Client eSignature:** **Date:**

**Parent/Legal Guardian (if minor):** **Date:**

**NOTICE OF PRIVACY PRACTICES**

**HIPAA**

This Notice is effective as of April 15, 2003.

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

As a client of *Associated Counseling Services, LLC,* a private treatment provider, you are entitled to receive notice about our privacy practices and how we may use and disclose your personal health information in different circumstances. This Notice explains how we may use and disclose your personal health information, the choices and rights you have about how your personal health information may be used and disclosed and our obligations to protect the privacy of your personal health information.

**Introduction.** When you become a client of Associated Counseling Services, LLC, you provide us with information about your health. Each time you visit us, another record of your visit and what was done is made. Your health record is the information that we use to plan your care, provide treatment and receive payment for our services. It is important for you to understand that your health record contains personal health information that is protected by federal and state laws.

**Our Responsibilities.** Associated Counseling Services, LLC is required to maintain the privacy of your personal health information and to provide you with a notice about our legal duties and privacy practices with respect to your personal health information. We are also required to accommodate reasonable requests that you make to communicate personal health information by alternative means or at alternative locations. Any time we use or disclose your personal health information, we must follow the terms of this Notice.

**How We Use And Disclose Your Protected Health Information.**

**Uses and Disclosures for Treatment, Payment and Health Care Operations and Appointments**. We may use your personal health information to provide your treatment, to obtain payment for your treatment and for our internal health care operations. We may use and disclose your personal health information for such purposes in the following ways:

**(1) *For Treatment.*** We may use and disclose your personal health information to plan, provide and coordinate your health care services. For example, we may use the information you have given us in a staff meeting in order to formulate treatment goals.

**(2) *For Payment*.** We may use and disclose your personal health information to obtain payment for health care services we have provided to you. For example, we may send a diagnosis to your insurance company in order to receive payment for your treatment.

**(3) *For Health Care Operations.*** We may use or disclose your protected health information for our health care operations. For example, we may use or disclose your personal health information to perform risk assessments and other administrative tasks to monitor the quality of care that we provide.

**(4) Other ways we may use your information:**

1. Recommend treatment alternatives
2. Tell you about health services that may benefit you
3. Share information with family or friends directly involved in your care or in paying for your care
4. Remind you of appointments (Optional: notify receptionist if you do not wish to be reminded)

Sharing Your Health Information

There are limited situations when we are permitted or required to disclose health information without your signed authorization (permission). These situations include:

For public health purposes such as reporting communicable diseases, work-related illnesses or other diseases or injuries permitted by law

1. To protect victims of abuse, neglect or domestic violence
2. For health oversight activities such as investigations, audits and inspections.
3. For lawsuits and similar proceedings
4. When required by law
5. When requested by law enforcement as required by law or court order
6. To reduce or prevent a serious threat to public health and safety
7. For workers’ compensation or other similar programs if you are injured at work
8. For Vocational Rehabilitation Services and other similar agencies if you are requesting assistance
9. For specialized government functions such as intelligence and national security

Other uses and disclosures not described in this notice require your signed authorization. You may revoke your authorization at any time with a written statement submitted to this office.

**Your Rights.** You have the right to do the following:

1. Request special restrictions on how we use and share your health information. We will consider all requests for special restrictions carefully and are not required to agree to any restriction\*
2. Request that we use a specific telephone number or address to communicate with you\*
3. Inspect and receive a copy of your health information. Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information and you may request a review of the denial\*
4. Request an amendment to your health information\*

Requests marked with a star (\*) must be made in writing. Contact your therapist to initiate your request.

**Changes to Notice.** We reserve the right to change our privacy practices and to alter this Notice according to those changes. In the event that our Notice changes, we will mail you a copy of our revised notice to the address you have supplied us.

**Privacy Officer.** To contact our Privacy Officer, please address all requests to George J Limberakis, LPC, Associated Counseling Services, LLC PO BOX 526265 E Salt Lake City, UT 84152-6265 or by calling 801-487-4298.