Individual Counseling Contract

Thank you for choosing to see Anne Evans-Cazier, LCSW. I look forward to working with you. This agreement is to clarify the business aspects of our relationship, and to help our therapeutic relationship go smoothly. Please print this contract, supply the following information, read and sign it, and bring it to your first session with me. We will make time for any questions you have.

Client:

Last Name ______________________ First Name ______________________ Initial ____
Date of Birth ________________ Age ______ Gender ______ Marital Status: ____________
Home Address: Street ____________________________ City ______ State____ Zip ______
Phone(s) __________________________________ Email ______________________
Preferred method of contact: (circle one): phone voice message text email
How did you find the clinic? ____
In case of emergency, the name, address and telephone number of a person I may contact:
____

Relevant medical conditions (history, current condition, changes in condition)
____
____

Medications: Are you currently taking any psychotropic medications? (circle one) Yes No
Please list along with any other medications (dosage, dates of initial prescriptions, name of prescribing doctor) ____
____
____
Allergies/adverse reactions to treatment ___________________________________
____
____

Primary Care Physician Name ______________________ Phone __________________
Address ____

Have you ever received therapy before? (circle one) Yes No
Therapist's Name ______________ Address ________________________________
Phone __________________ Was it helpful? ______________________________

Are you currently seeing a psychiatrist? (circle one) Yes No
Psychiatrist's Name ______________ Phone _______________________________
Address ____

Anne Evans-Cazier, LCSW Evans Counseling, LLC | Resilient Life Center
1308 S. 1700 E. Suite 210, Salt Lake City, UT 84108 | 801-419-3312 | anne@ResilientLifeCenter.com

IF YOU NEED TO CONTACT ME

I can be reached for routine matters during business hours by phone, voice mail or text at 801-419-3312. Do not leave emergency messages on this line.

If you or a family member have an emotional or behavioral crisis call the University of Utah Neuropsychiatric Institute at 801-583-2500, or call 911, or go to the nearest emergency room. I will make every effort to return your call promptly, with the exception of weekends, holidays and during the night time. You may also contact me via email at anne@ResilientLifeCenter.com to communicate about scheduling issues only. Therapy happens in my office, during our scheduled time, not by text and email. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact for continuing treatment.

FEES AND BILLING

Clients are expected to pay the fee, agreed upon before therapy has begun, at the end of each session unless other arrangements have been made. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Please notify me if any problems arise during the course of therapy regarding your ability to make timely payments.

The full session fee will be charged for late cancellations and no shows. To avoid a late charge please cancel your appointment 24 hours in advance. Please do not come to the office if you are sick, even if it less than 24 hours in advance, please call and let me know you will not be coming in to avoid a no show fee of the full session charge.

Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. If agreed upon, I will provide you with a copy of your receipt, which you can then submit to your insurance company for reimbursement if you so choose. Not all issues/conditions/problems which are dealt with in psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If you have difficulties with your insurance company and/or with payment, please talk with me about it as soon as possible.

If your account is overdue and there is no written agreement on a payment plan, your signature below means that I can use legal or other means (courts, collection agencies, etc.) to obtain payment and that you agree to pay all attorney fees, court costs, filing fees, including charges or commissions, up to 50%, that may be assessed to me by a collection agency retained to pursue this matter, with or without suit. You further agree to pay interest at the rate of 1 ½% per month (18% per year).

Fees are reviewed and typically increased once a year.

CONFIDENTIALITY
I will make every effort to keep the information your share with me confidential. I will ask you to sign a release of information form before I discuss your treatment or send my records about you to anyone else.

At times I find it helpful to consult with other health and mental health professionals about my cases. During consultations, I make every effort to avoid revealing the identity of my clients. The consulted professionals are also legally bound to keep the information confidential. Unless you request otherwise in writing, I will not tell you about these consultations unless I feel that it is important to our work together. Unless you specifically request otherwise, your signature on this Agreement provides consent for this.

Electronic communication can be accessed by unauthorized people, compromising privacy. E-mails are particularly vulnerable to unauthorized access. Faxes can be sent mistakenly to the wrong address. Some phone systems are vulnerable. Please do not use e-mail, faxes or texts in emergency situations. I make every effort to safeguard your confidentiality, but as an extra precaution, do not text or email me anything you do not want a third party to see.

Your confidentiality/privacy is protected by state law and the rules of my profession with a few specific exceptions, which are detailed in the accompanying Notice of Privacy Practices.

Some important limits of confidentiality you should know about are:
1. If you are sent to me by a court or an employer for evaluation or treatment, the court or employer expects a report from me. You have a right to tell me only what you are comfortable with telling.

2. If you are involved in a lawsuit and you tell the court that you are seeing me, I may then be ordered to show the court my records. Please consult your lawyer with these issues.

3. If you make a serious threat to harm yourself or another person, the law requires me to protect you or that other person.

4. If I believe a child or dependent adult has been or will be abused or neglected I am legally required to report this to authorities. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

5. If you choose to submit a claim to your insurance company, they will frequently ask for more information on symptoms, diagnoses, and my treatment methods. This will become part of your permanent medical record.

MEDIATION AND ARBITRATION

If a dispute arises out of or relates to this Agreement, the breach thereof, or the treatment or therapy that is the subject of this Agreement, and if the dispute cannot be settled through negotiation, the parties agree first to try in good faith to settle the dispute by mediation administered in Utah, by the American Arbitration Association under its Commercial Mediation Procedures before resorting to arbitration. The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

LIMITATION OF LIABILITY

The parties agree that in the event that any dispute arises from the provision of services pursuant to this Agreement, including but not limited to claims of malpractice, negligence, breach of contract, or any other legal theory, if the client prevails the client shall be entitled to recover no more than $50,000.00 or the total amount of fees paid, whichever amount is greater. It is the parties' intention to fix an amount that is reasonable in the event a dispute arises, with mutual acknowledgement that establishing the actual monetary value of damages in such an action would be inherently subjective and uncertain, and that Evans Counseling's willingness to provide the services set forth in this Agreement depends on this agreed limitation to Evans Counseling's potential liability arising from providing the services. This clause is to be construed in accordance with Utah law on limitation of liability.

LITIGATION LIMITATION

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (the client) nor your attorneys, nor anyone else acting on your behalf will call on me, Anne Evans-Cazier, to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

YOUR SIGNATURE BELOW IS CONSENT FOR TREATMENT AND INDICATES THAT YOU HAVE READ AND AGREE TO THE TERMS OF THIS AGREEMENT AND ACKNOWLEDGES THAT YOU HAVE RECEIVED A COPY OF EVANS COUNSELING'S NOTICE OF PRIVACY PRACTICES AND UNDERSTAND THAT IF YOU HAVE ANY QUESTIONS REGARDING THE NOTICE OR YOUR PRIVACY RIGHTS, YOU CAN CONTACT ANNE EVANS-CAZIER AT THE ABOVE ADDRESS.

Client Name____

Signature (Client)______________________________ Date __________

Signature (Therapist)____________________________ Date __________

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Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed, and how you can get access to this information.Please review this notice carefully - Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as "protected health information." This Notice of Privacy Practices describes how I may use and disclose your protected health information in accordance with applicable law and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your protected health information.

As part of your protected health information I keep some specific information in what are called "psychotherapy notes." These notes are kept separate from your health record and are given much higher privacy protection. They contain my impressions about you and details of the psychotherapy conversation I consider to be inappropriate for the health record. They contain information pertinent only to my future work with you. They are not available for your review, nor to insurance and managed care companies.

I am required by law to maintain the privacy of protected health information and to provide you with notice of my legal duties and privacy practices with respect to protected health information. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all protected health information that we maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy in my office, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How I May Use and Disclose Health Information about You

For Treatment: Your protected health information may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members.

For Payment: I may use and disclose protected health information so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of protected health information necessary for purposes of collection.

For Health Care Operations: I may use or disclose, as needed, your protected health information in order to support my business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your protected health information with third parties that perform various business activities (e.g., billing or typing services). This is allowed only if I have a written contract which requires that business to safeguard the privacy of your protected health information.

Required by Law: There are occasions which require me under law to disclose your protected health information with or without your authorization. Some examples are:

If you are in imminent danger of committing suicide I am legally and ethically bound to intervene in anyway necessary to prevent that including contacting family members and the police.

To the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the Federal privacy requirements.

If you are at risk of being a serious and imminent threat to the health or safety of a person or the public, I will disclose information to prevent or lessen that serious threat. I will disclose it to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

If there is suspicion of neglect or abuse of a child in the past, present or future I am required by law to report that to the Utah Division of Child and Family Services or the police.

If I have reason to believe that a vulnerable adult is suffering from abuse, neglect, abandonment or exploitation, I am required by law to make a report to either the Utah Adult Protective Services, or the nearest law enforcement agency as soon as I become aware of the situation.

Utah law requires that I report the names of any individuals having communicable diseases to the Health Department.

I may disclose your personal health information in accordance with workers compensation laws. If you become involved in the court system a judge can order that I provide information on you. Two examples of this are child custody cases and cases in which clients bring action against therapists.

With Your Verbal Permission: I can share some information about you with your family or close others. I will only share information with those involved in your care and anyone else you choose such as close friends or clergy. I will ask you about who you want me to tell what information about your condition or treatment. You can tell me what you want and I will honor your wishes as long as it is not against the law.

If it is an emergency: so I cannot ask if you disagree — I can share information if I believe that it is what you would have wanted and if I believe it will help you if I do share it. If I do share information, in an emergency, I will tell you as soon as I can. If you don't approve I will stop, as long as it is not against the law.

With Your Written Authorization: Uses and disclosures not specifically permitted by the circumstances described above will be made only with your written authorization, which may be revoked.

Your Rights Regarding Your Protected Health Information: You have the following rights regarding protected health information I maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer, (Anne Evans-Cazier, 1308 S. 1700 E. Suite 210, Salt Lake City, UT 84108 (801) 419-3312).

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy protected health information that may be used to make decisions about your care. Your right to inspect and copy protected health information will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the protected health information I have about you is incorrect or incomplete, you may ask me to amend the information although I am are not required to agree to the amendment.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that I make of your protected health information. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your protected health information for treatment, payment, or health care operations. I am not required to agree to your request.

Right to Request Confidential Communication. You have the right to request that I communicate with you about health matters in a certain way or at a certain location. For instance, you can ask me to avoid calling you on selected phone numbers or ask that I send bills to an alternate address.

Right to a Copy of this Notice. You have the right to a copy of this notice.

Complaints: If you believe I have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, (Anne Evans-Cazier, 1308 S. 1700 E. Suite 210, Salt Lake City, UT 84108 (801) 419-3312) or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling 202-619-0257. I will not retaliate against you for filing a complaint. Effective Date - The effective date of this Notice is January 9, 2006.

Coordination of care can be important. This form will allow Anne Evans-Cazier, LCSW, to share protected health information with selected professionals or other concerned individuals of your choice. This information may include diagnosis, treatment plan, and progress, and will not be released without your signed authorization.

Patient Rights

- You may end this authorization any time by contacting Anne Evans-Cazier.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the Notice of Privacy Practices.
- You will not be required to sign this form as a condition of treatment.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your services will not be affected.

Patient Authorization

I hereby authorize Anne Evans-Cazier, LCSW, to release verbally or in writing information regarding any medical, mental health, and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the below identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

Anne Evans-Cazier, LCSW, is authorized to release protected health information related to the evaluation and treatment of ______________________________ DOB___/___/___

The information may be released to the following person or entity:

____

Phone ____________________ Address ______________________________

The information may be released to the following person or entity:

____

Phone ____________________ Address ______________________________

Signature ______________________________________ Date ____________

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