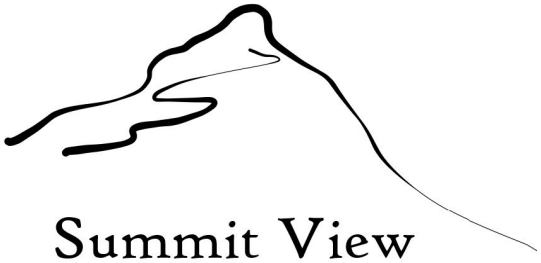

Summit View Counseling

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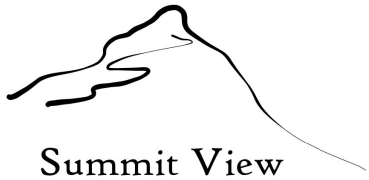
Intake Information

Client Name: _____ Social Security #:_____
Marital Status: _____ Sex: _____ Date of Birth: _____
Age: _____ Race: _____ Driver's License #:_____
Address:_____
Street City State Zip
Home Phone:_____ Cell: _____ Work: _____
Email address: _____
Spouse Name:_____
Spouse Address:_____ Phone: _____
Emergency Contact:_____Phone:_____
Place of Employment: _____ For how long? _____

By signing below, I understand and agree to the terms and conditions outlined in the following documents, including: Informed Consent/Client Rights and Consumer Agreement/Payment Policy, and I consent to mental health treatment at Summit View Counseling.

_____
Client Signature Date

_____
Parent/Guardian/Responsible Party Date



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Informed Consent/Client Rights

I, _____, authorize Brody Bates, CMHC to provide mental health services. I understand that I have a right to withdraw consent at any time.

Confidentiality: All information and records will be kept confidential and will be held in accordance with state and federal(HIPAA) laws regarding the confidentiality of such records. However, records and/or information will be released regardless of consent under the following circumstances:

• *According to state and local laws, clinicians must report all cases of physical and sexual abuse or neglect of minors or the elderly to the appropriate agency;*

• *According to state and local laws, clinicians report all cases in which there exists a danger to self or others;*

• *In the event that a client is in need of emergency services and other medical personnel need to be contacted; and*

• *In the event that your records may be subpoenaed by court.*

Right to Access Records: Adult clients and legal guardians of minors have the right to access the record of the services provided for them by Brody Bates, CMHC. Records will be retained for seven years. Records whose retention has been met shall be destroyed by shredding to protect client confidentiality.

Treatment: Clients have a right to receive and understand information and instructions about their treatment, know the nature and purpose of services, receive services based on an individual treatment plan, and be part of the process of updating the treatment plan when his or her needs change.

Treatment of Minors: Treatment of children less than 18 years of age will be provided only with the consent of the legal guardian. By signing this consent form, the client acknowledges that he or she is the legal guardian of any minor presented for treatment.

Voluntary Termination: Clients have the right to make informed choice of services, consent to or refuse services before they are provided, and refuse services with the receipt of information and the consequences of refusal.

Involuntary termination: Services may be terminated if a consumer fails to keep their scheduled appointments following excessive no shows. Services may be terminated if a determination is made that the client is unsafe to others or themselves, and their presence is disruptive and/or unsafe to others seeking or providing treatment. If services have been terminated, client may request a review of the situation and reinstatement of those services from Brody Bates, CMHC.

Freedom from Potential Harm: All clients have the right to humane care and protection from harm. Brody Bates, CMHC and Summit View staff are prohibited from any use of psychological abuse, including humiliating, threatening, and exploiting actions. All instances of abuse or neglect of an adult should be reported to Adult Protective Services at 1 (800) 371-7897. Circumstances of child abuse and neglect should be reported to Utah's Division of Family and Children's Services (801) 538-4171 or to the local Police Department.

Client Signature: Date:

Client Signature: Date:

Client Signature: Date:

Client Signature: Date:

Client Signature: Date:

Client Signature: Date:

Client Signature: Date:

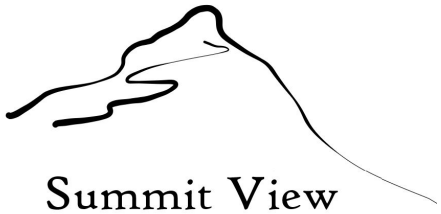
Client Signature: Date:

Client Signature: Date:

Client Signature: Date:

Client Signature: Date:

Staff Signature: Date:



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Consumer Agreement/Payment Policy

Client Name: _____ Date: _____
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 reschedule 24 hours in advance. If you do not call, or call less than 24 hours in advance to cancel or reschedule, you 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. _____ (Client/Responsible Party initials)
2. Clients who miss two appointments without calling to cancel, or consistently call to cancel or reschedule, may be terminated from treatment. _____ (Client/Responsible Party initials)
3. 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 reimbursement to you. Failure to pay will prevent you from scheduling another appointment until your account is paid in full. Interest shall accrue on any amounts not paid at the time of service (other than insurance and crime victim reparation payments) at a rate of 1 ½ % per month (18% per annum). In the event of nonpayment, Summit View Counseling may recover the cost of collection, including a reasonable attorney fee. All clients will be billed the standard rate for services provided. You will be responsible for any unpaid balance if your insurance company or clergy refuses payments. Please pre-authorize treatment with your insurance company if necessary and know the limitations of your coverage. _____ (Client/Responsible Party initials)
4. In case of an emergency, Summit View Counseling staff requires permission to seek medical treatment for you if you are physically or mentally incapacitated. By initialing, you agree to allow Summit View Counseling staff to act on your behalf in case of an emergency. _____ (Client/Responsible Party initials)

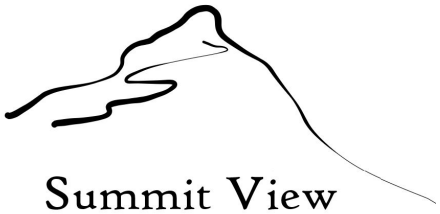
Standard Fee for Services:

Individual Session: $130/50 min
Sliding Scale Session: $____/50 min
Family/Couple Session: $150/50 min

No Show/Late Cancel Fee: Full Session Fee
Returned Check Fee: $30
Declined Credit Card Fee: $30

I acknowledge that I have read and agree to Summit View Counseling's Payment Policy

_____ Client/Responsible Party



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Payment Information

As indicated in the Payment Policy that you received, Summit View Counseling requires you to keep a credit card on file so we can collect co-insurances, deductibles, and other unpaid account balances as soon as your insurance carrier assigns the appropriate amount of patient responsibility. During the time you leave a credit card on file, if it expires or otherwise becomes uncollectible, we will expect you to promptly provide a new means of payment.

Credit Card Type: _____
Credit Card #: _____
Three digit code: _____

Expiration date: _____
Name on card: _____

I hereby authorize Summit View Counseling to bill my credit card for any coinsurances, deductibles, and other unpaid account balances.

_____

Client/Responsible Party Date