Chat & Change 535 East 4500 South Suite D 280 Salt Lake City, UT 84107

Phone : 801-699-3133 or 385-368-8228 Fax: 801-747-6858

**CONSENT FOR TREATMENT**:

I voluntarily consent to treatment; I consent to take part in the treatment services provided. I understand that developing a plan and regularly reviewing progress toward meeting my goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of services provided. I understand that the nature of the therapeutic process is such that the personal issues or circumstances for which I have sought assistance may, in some cases, worsen before improving or may not appear to improve at all. I am aware that I may stop treatment at any time. I will still be responsible for paying for the services I have received or missed appointments. I understand that I may lose other services: or may deal with other problems if I stop treatment. (For example, if my treatment has been court ordered, I will have to answer to the court.)

**ASSIGNMENT OF BENEFITS**:

I hereby authorize billing my insurance company or other third party payers for any covered services and authorize my insurance company to make direct payment for said services. I understand that if payment for the services I received here is not made, the therapist may stop treatment. I further understand that portions of my clinical record may be disclosed to my insurance company or other third party payers for reimbursement purposes.

**CONFIDENTIAILITY OF INFORMATION:**

You will maintain strict confidentiality (as outlined in your Professional Codes of Conduct and in accordance with HIPPA privacy regulations.) Your office privacy practices are available for my review upon request. No third parties beyond pertinent third party payers will have access to my clinical information, unless otherwise agreed to with my express (normally written) permission. You will make every effort to communicate pertinent information (with my permission) to referring health professionals. I understand that I have a legal right to privacy concerning my medical records and it is your obligation to uphold that right and make available a Notice of Privacy Practices for my review at any time during regular business hours. I understand that no staff member may in anyway violate this confidentiality except with my consent and in accordance with policy, rules and regulations, and the Utah State Administrative Code.

**LIMITS OF CONFIDENTIALITY**:

Information discussed in the therapy setting is held confidential and will not be shared without my permission except under the following conditions:

A: I threaten suicide

b. I threaten harm to another person (s) including murder, assault, or other physical harm.

c. I (adult or minor) report suspected child abuse including but not limited to physical beating and/or sexual abuse. The law requires that the abuse be reported to an appropriate agency

d. I am referred by the Court, Adult Probation and Parole, Salt Lake County Probation, or another corrections agency. A specific release of information will be required in order to coordinate services. Should such a release be refused, treatment may not be provided.

E.My records and/or the testimony of the therapist are subpoenaed by a court of law. Measure will be taken to protect my confidentiality by releasing the least amount of information that will satisfy the court request.

f. After I have made no payment for more than 60 days, my obligation to pay may be referred to an outside collection agency including small claims court.

g. Frequent payment by a third party payer including insurance companies, DCFS, etc.

**COMMUNICATION**:

I understand that reasonable security measures will be taken by Chat and Change for online sessions. I am aware that email and text are not considered to be a secure means of communicating and that if I choose to use these; I do so at my own risk. I understand that clear boundaries must be maintained and there will be no connections on any therapist’s personal social media account such as Facebook, etc. If we encounter each other in the community at large, as my treatment provider, you will not initiate contact in public. I am free to initiate contact with you. I am aware that I should call 911 in an emergency if I have an urgent need outside of office hours; I agree to call the crisis line at the University of Utah at 801-587-3000.

**FEE POLICY**:

I agree to pay fees at the time of service. I authorize Chat and Change to keep my credit card information securely on file and to charge my credit card for copay, missed appointments, late cancel ( less than 24 hours), and any balance not paid by insurance.

I acknowledge that I have read the Agreement, give informed Consent to treatment as well as agree to the policies set forth in the Agreement. (If a minor child), I as parent/guardian give consent and agreement to services for my child as set forth in this agreement.

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**Client Signature/Parent Guardian Signature (if minor) Date**

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