



Amy Cluff LCSW, PC

Healing~Growth~Harmony

CLIENT INFORMATION

Amy Cluff, LCSW, PC

First Name _____ Last Name _____ Date _____

Address _____ City, State _____ Zip Code _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Date of birth ____/____/____ Age ____ Male ____ Female ____

Single ____ Married ____ Other ____ Email Address _____

Employed ____ Full-time Student ____ Part-time Student ____ Other ____

Family Doctor Name/Phone _____

Current Medications _____

Who referred you? _____

EMERGENCY CONTACT INFORMATION

Name _____ Phone _____

Relationship to client _____

SESSION COSTS/ FEES

Initial Assessment: \$120.00 per 60 minute session, unless otherwise agreed upon with Amy Cluff, LCSW. Payment will be taken upon arrival, prior to your session.

Therapy Session Fee: \$110.00 per 50 minute session, unless otherwise agreed upon with Amy Cluff, LCSW. Payment will be taken upon arrival, prior to your session.

Court- Related Services: \$150 per hour. Please see additional policies on court/ legal- related services.

CANCELLATION/ NO SHOW Because the scheduling of an appointment involves the reservation of time specifically to you, a minimum of 24 hours notice is required for canceling an appointment. Unless we reach a different agreement, the full session fee will be charged to you for sessions missed without such notification. Attached is a credit card authorization form that will only be used in the event of a cancellation or no show within the 24 hour notice policy. Insurance companies and third party payers will not be responsible for reimbursing cancellations/ no shows.



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PAYMENT INFORMATION

If you, the client, are responsible for payment, do not re-enter information here; otherwise complete this section. If more than one party is responsible, please indicate (such as parent and Bishop).

Note to parents sharing costs of child's services: full payment is expected at time of service. It is your responsibility to seek reimbursement from the other parent or both parents provide their portion prior to service.

Title	First Name	Last Name
Address		City, State
		Zip Code
Home Phone		Mobile Phone
Relationship to Client _____		

Title	First Name	Last Name
Address		City, State
		Zip Code
Home Phone		Mobile Phone
Relationship to Client _____		

INSURANCE Yes/ No? If yes, please read and initial below.

- Amy Cluff is accepting Blue Cross Blue Shield Insurance.
- Copays/ deductibles are your responsibility and payable at the time of service.
- It is your responsibility to contact your insurance provider to determine your copay/ deductible.
- You are responsible for full payment of services in the event that you have not met your deductible or if the insurance denies coverage.
- If you have insurance other than Blue Cross Blue Shield, **you are responsible for payment at the time of service.** You are responsible to contact your insurance provider to determine if they will reimburse you for costs of services. The necessary forms to file for your insurance will be provided.

_____ I have read the insurance policy and agree to its terms.



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FAMILY INFORMATION

Name of Spouse_____

Minor client's parent(s)/ guardian(s). If address of either parent is different, please list

First Last Phone

Address City, State Zip Code

Participating in child's Therapy? Yes/ No_____

First Last Phone

Address City, State Zip Code

Participating in child's Therapy? Yes/ No_____

Children of an adult, or siblings of a child client, and/or others living at home that you want Amy to be aware of.

Name Age In Home? Participating in Therapy?

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____



NOTICE OF PRIVACY PRACTICES

This notice describes how mental health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

MENTAL HEALTH PROFESSIONAL'S PRIVACY DUTIES

Your mental health record contains personal information about you and your health. This information that may identify you, your mental health, and related health care services provided to you is referred to as Protected Health Information (PHI). I understand that protecting your PHI is important.

I am required by law to:

- Maintain the privacy of your PHI
- Provide this Notice that describes my legal duties with your PHI and ways I may use and share your PHI.
- Follow the terms of the Notice currently in effect.
- 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 PHI that I maintain at that time. Current notices will be maintained on site, and you may request a copy on site or by mail.

HOW I MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

I may use or disclose your PHI for treating you, billing for services, and conducting normal business known as health care operations. Examples of how I use your PHI include:

- Treatment is when I provide, coordinate, or manage your mental health care and other services related to your health care. This includes consultation with another health care provider, such as your family physician or another mental health professional.
- I may use or disclose your PHI to family members that are directly involved in your treatment. In couple, child, and family mental health treatment, I may use or disclose PHI that is directly relevant to treatment of you or them, unless otherwise agreed upon. In such cases, the "client" is defined as the family unit receiving treatment. I will use my clinical judgment when using or disclosing PHI between and among family members.
- Payment is when I obtain payment from you, your insurance company, or other third party for treatment services provided. I may disclose your PHI to your health insurer to obtain prior approval for treatment, reimbursement for your care, and to verify eligibility for coverage. If it becomes necessary to use collection processes due to lack of payment for services, I will disclose the minimum PHI necessary for the purpose of collection.
- Health Care Operations are activities that are related to the performance and operation of my practice. Health care operations include but are not limited to quality assessment and improvement activities, staff training, conducting required business duties, audits and administrative services, and case management and coordination.



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- I may also use your PHI to recommend treatment alternatives, share information with third parties who assist me with treatment, payment, and mental health care operations. My business associates must follow federal privacy practices.
- I may use your PHI to call you or contact you regarding appointment scheduling and treatment.

USE AND DISCLOSURE REQUIRING AUTHORIZATION

Uses and disclosures not specifically permitted by applicable law will be made only when your appropriate authorization is obtained. Your authorization is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization from you before releasing the information. You may revoke any or all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization to obtain information or (2) if the authorization was given as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy. All other uses and disclosures, not described in this notice, require your signed authorization.

USE AND DISCLOSURE WITH NEITHER CONSENT NOR AUTHORIZATION

There are limited situations when I am permitted or required to use or disclose your PHI with out signed authorization. These situations are:

- As required by law, mandatory reporting of child, elder, and disabled abuse neglect, or domestic violence.
- Mandatory government audits, inquiries, or investigations, including but not limited to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the privacy rule, the Department of Occupational and Professional Licensing, worker's compensation, intelligence or national security, or the Public Health Department for communicable diseases.
- For lawsuits and similar proceedings, when requested by court order and otherwise required by law.
- To reduce serious threat to public health and safety.
- To take precautions to protect the rights and safety of others if I have reason to believe that there is a clear and imminent danger that you will attempt to inflict serious bodily injury upon an identifiable person.

CLIENT'S RIGHTS

You have the right to:

- Request restrictions on certain uses and disclosures of PHI about you. However, I am not required to agree to a restriction you request.
- Request and receive confidential communications of PHI by alternative means and at alternative locations, such as using an alternative address.



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- Inspect and/ or copy your PHI for as long as the PHI is maintained in the record. Under certain circumstances, I may deny your access to a portion of your PHI, and you may request a review of the denial. *
- Request and amendment of your PHI for as long as the PHI remains in the record. Your request may be denied. *
- Receive an accounting of certain disclosures of your PHI. The accounting does not include disclosures made for treatment, payment, or health care operations and some disclosures required by law, to individuals of their own PHI, pursuant to an authorization, incidental to use or disclosure permitted by privacy standards, to a family member directly relevant to their involvement in the individual's care, or as part of a limited data set. Your request must be within six years prior to your request and exclude dates prior to April 14, 2003. *

Requests marked with a * must be made in writing.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that was made about access to your health information, you may contact the Privacy Officer at 393 East Riverside Drive Suite 3A, St. George, Utah 84790. Alternately, you may send a written complaint to the Secretary of the US Department of Health and Human Services. There will be no retaliation for filing a complaint.



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**NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGMENT OF NOTICE**

Client Name: _____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Amy Cluff, LCSW, PC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the privacy officer at Alliant Counseling and Education.

**Amy Cluff, LCSW
Alliant Counseling and Education
393 East Riverside Drive Suite 3A
St. George, Utah 84790
435-688-2123
435-688-2353**

Signature of Client

Date

Signature of Parent, Guardian, or Personal Representative

Date

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

____ **Client refuses to acknowledge receipt;**

Signature of Staff Member

Date



Amy Cluff, LCSW, PC
Licensed Clinical Social Worker
Utah License # 5116356-3501
Alliant Counseling and Education
393 East Riverside Drive Suite 3A
St. George, Utah 84790
(435) 688-2123

OFFICE POLICIES AND INFORMED CONSENT AGREEMENT TO THERAPY SERVICES

CONFIDENTIALITY All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law or within the parameters of the Notice of Privacy Practices.

WHEN DISCLOSURE IS REQUIRED BY LAW Some of the circumstances where disclosure is required by law are: when there is report or reasonable suspicion of child, dependent, or elder abuse or neglect; where the client presents a danger to self, to others, to property, or is gravely disabled, or when a client's family members communicate to Amy Cluff, LCSW that the client presents a danger to self or others.

WHEN DISCLOSURE MAY BE REQUIRED Disclosure may be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/ or testimony by Amy Cluff, LCSW.

I may use or disclose your personal health information to family members that are directly involved in your treatment. In couple, child, and family therapy, confidentiality and privilege will not apply between the couple, parents, or family members, unless otherwise agreed upon. In such cases, the "client" is defined as the family unit receiving the therapy. I will use my clinical judgment when using or disclosing information between and among family members. You have the right to request restrictions on certain uses and disclosures of your information. However, I am not required to agree to the restriction you request.

EMERGENCIES If there is an emergency during our work together, or in the future after termination where Amy Cluff, LCSW becomes concerned about your personal safety, the possibility of you injuring some one else, or about you receiving proper psychiatric care, she will act, within limits of the law, to prevent you from injuring yourself or others and to ensure that you receive proper medical care. For this purpose, she may also contact the person whose name you have provided on the intake form for your emergency contact.

HEALTH INSURANCE AND THE CONFIDENTIALITY OF RECORDS

Disclosure or use of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you instruct Amy Cluff, LCSW, only the minimum necessary information will be communicated to the carrier. Amy Cluff, LCSW has no control or knowledge over what insurance companies do with the information submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future capacity opportunities.



OTHER THIRD PARTY PAYERS AND CONFIDENTIALITY OF RECORDS

Disclosure or use of confidential information may be required by your third party payer in order to process claims/billing, such as with Crime Victims Reparations or church/clergy members. If you instruct Amy Cluff, LCSW, only the minimum necessary information will be communicated to the third party payer. In most cases, Amy Cluff, LCSW will request that you sign an authorization for the release or exchange of information in order to process payment. Amy Cluff, LCSW has no control or knowledge over what third party payers do with the information submitted or who has access to this information. You must be aware that having a third party payer carries a certain amount of risk to your personal health information.

LITIGATION LIMITATION Due to the nature of the therapeutic process and the fact that it often involves making full disclosures with regard to many matters that are confidential in nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, parent time, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on Amy Cluff, LCSW to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy treatment records be requested, unless otherwise agreed upon by Amy Cluff, LCSW.

CONSULTATION Amy Cluff, LCSW consults regularly with other professionals regarding her clients; however, client's identity remains completely anonymous and confidentiality is fully maintained. Consultation is a best practice policy, in an effort to provide quality therapeutic treatment.

E-MAIL, CELL PHONES, COMPUTERS, FAXES It is very important to be aware that these communication devices can be relatively easily accessed by unauthorized people, and hence, can compromise the privacy and confidentiality of such communications. The emails sent by Amy Cluff, LCSW or Alliant Counseling and Education are not encrypted. Amy Cluff, LCSW only uses computers that are equipped with firewall, virus protection, and password protection. Records are backed up off-site and encrypted for maximum privacy. Please notify Amy Cluff, LCSW if you decide to avoid or limit the use of any or all communication devices. Please do not use email or fax for emergencies.

RECORDS AND YOUR RIGHTS TO REVIEW THEM Both the law and my standards require that I keep appropriate treatment records. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances, or when Amy Cluff, LCSW assess that releasing such information might be harmful in any way. In such cases, Amy Cluff, LCSW will provide the records to an appropriate and legitimate mental health professional of your choice. You have the right to review the denial of releasing records. You have the right to request amendments to your records as long as the personal health information remains in the record. This request may be denied. Please refer to Notice of Privacy Practices.

PAYMENT AND INSURANCE REIMBURSEMENT Clients are expected to pay the standard unless other arrangements have been made with Amy Cluff, LCSW. Support services, such as telephone and electronic communications, case management, coordination and consultation with treatment providers, site visits, report writing and reading, travel time, longer sessions, etc. will be charged at the same hourly rate. Amy Cluff, LCSW has the right to request prepayment or a retainer fee to cover charges if the client will have significant amounts of support services. Please notify Amy Cluff, LCSW if any problems arise during the course of therapy regarding your ability to make timely payments. If your account is overdue (unpaid) and there is no written agreement on a payment plan, Amy Cluff, LCSW, PC can use legal or other means to obtain payment.

Court/ Legal Related Services

All legal/court related services are charged at \$150 per hour. This includes psychotherapy, mediation, assessments, case consultation, management, and coordination, telephone and electronic communications with client, attorney, or any related party, report preparation and reading, travel, legal proceedings of any kind, etc. If legal/ court related services account for only a portion of your services, it is the discretion of Amy Cluff, LCSW to determine if



psychotherapy will be billed at the regular rate of \$120 or the \$150 rate. Amy Cluff, LCSW has the right to request prepayment or a retainer fee to cover charges if the client will have significant amounts of support services.

Blue Cross Blue Shield Insurance

Amy Cluff, LCSW is a mental health treatment provider for Blue Cross Blue Shield insurance (BCBS). It is your responsibility to notify Amy's office staff that you carry Blue Cross Blue Shield and that you want to use your benefits. You are responsible to contact BCBS to verify your deductible and copayment amounts. Please pay your copay prior to services. Amy's office will submit claims to BCBS for reimbursement, but the client is responsible to pay in full if the deductible is not met. The client is responsible to pay in full if for any reason BCBS denies the claim. If you choose to use your BCBS insurance after treatment is started, Amy Cluff, LCSW, PC will not adjust your payment rate for prior services; however, as a courtesy, her office will submit your claims to BCBS to see if they will reimburse you.

All Other Insurance Companies

Clients who carry insurance should remember that professional services are rendered and charged to the client, not the insurance company. Be prepared to pay at the time of service. It is recommended that you contact your insurance carrier to see if treatment with Amy Cluff, LCSW will be reimbursed. Unless agreed upon differently, Amy Cluff, LCSW will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance carrier for reimbursement, if you choose. At this time, I am only a Blue Cross Blue Shield provider. If you have a different insurance provider, it is the decision of your provider if treatment will be reimbursed. It is your responsibility to verify the specifics of your coverage.

MEDIATION AND ARBITRATION All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a precondition of the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of Amy Cluff, LCSW and the client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement shall be submitted to and settled by binding arbitration in Washington County, Utah in accordance with the rules of the American Arbitration Association. Notwithstanding the foregoing, in the event that your account is overdue and there is no agreement on a payment plan, Amy Cluff, LCSW can use legal means to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum as and for attorney fees. In the case of arbitration the arbitrator will determine that sum.

THE PROCESS OF THERAPY/ EVALUATION AND SCOPE OF PRACTICE

Participation in therapy can result in a number of benefits to you, including improving your mental health, interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to experience growth and change in your thoughts, feelings, and behavior. Amy Cluff, LCSW will ask for your feedback and views on your therapy and will expect you to respond openly and honestly. Therapy can result in you experiencing considerable discomfort or strong feelings as you work through the process of growth. Your assumptions and views may be challenged. Attempting to resolve issues that brought you to therapy in the first place may result in changes that were not originally intended. Sometimes, another family member may have negative views on decisions and changes that other family members experience positively. Growth will sometimes be easy and swift, but often can be slow and difficult. During the course of therapy, Amy Cluff, LCSW is likely to draw on various treatment approaches, including cognitive-behavioral, cognitive, behavioral, emotion-focused, family centered, developmental, humanistic, psycho-educational, and experiential. Amy Cluff, LCSW does not provide custody evaluations, medical prescription recommendations, nor medical advice, as these activities are without her scope of practice.

Amy Cluff, LCSW does not perform custody evaluations. Amy Cluff, LCSW provides therapeutic treatment to children/ families involved in custody disputes, co-parenting issues, parent time issues, and parent-child issues. Upon agreement with Amy Cluff, LCSW, she will provide recommendations, input, and progress information in legal proceedings, where appropriate (including but not limited to coordinating with custody evaluators, judges,



attorneys, Guardian ad litem, DCFS). Amy Cluff, LCSW has the right to decline providing input and making recommendations in legal proceedings if it poses a significant risk to the therapeutic relationship with her clients.

DISCUSSION OF TREATMENT PLAN Within a reasonable period of time after the initiation of treatment, Amy Cluff, LCSW will discuss with you her understanding of the problems, treatment plan, objectives, and her view of the possible outcomes of treatment. If you have any questions about any of the procedures used in the course of your therapy, their possible risks, Amy Cluff, LCSW's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that Amy Cluff, LCSW does not provide, she has an ethical obligation to assist you in obtaining those treatments.

TERMINATION As set forth above, after the first couple of meetings, Amy Cluff, LCSW will assess if she can be of benefit to you. Amy Cluff, LCSW does not accept clients who, in her opinion, she cannot help. In such cases, she will give you a number of referrals, who you can contact. If at any point in treatment, Amy Cluff, LCSW feels she is not helping you reach the therapeutic goals, she is obligated to discuss it with you and if appropriate, to terminate treatment. In such cases, she will give you a number of referrals for you to contact. You have the right to terminate therapy at any time. If you choose to do so, Amy Cluff, LCSW will offer to provide you with names of other qualified professionals. With written authorization, Amy Cluff, LCSW will talk with your new chosen treatment provider to give essential information.

CANCELLATION/ NO SHOW Because the scheduling of an appointment involves the reservation of time specifically to you, a minimum of 24 hours notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full session fee will be charged for sessions missed without such notification. Insurance companies and third party payers will not be responsible for reimbursing cancelled/no show sessions.

Social Media Policy Therapy will not be provided via e-mail, twitter, texting, or other such forms of communication. E-mail may be used to exchange information only, such as scheduling appointments. They may have limits in of confidentiality and security. I encourage you not to share personal information as I cannot guarantee your privacy is secure with e-mail.



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**OFFICE POLICIES AND INFORMED CONSENT
AGREEMENT TO THERAPY SERVICES**

I have read the above Agreement, Informed Consent, Office Policies, and General Information carefully. I understand them and agree to comply with them:

Client Name (print)

Date

Signature

Custodial Parent/ Caregiver (print)

Date

Signature

Therapist

Date

Signature