**CLIENT CONFIDENTIAL PERSONAL INFORMATION**

Client Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date (mm/dd/yyyy):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ Sex : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Phone (Circle one): Home Cell Work Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May a voice message or text from Cobalt Counseling be left on this number? (Circle one): Yes No

Alternative Phone (circle one): Home Cell Work Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May a voice message or text from Cobalt Counseling be left on this number? (Circle one): Yes No

Preferred E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May an e-mail from Cobalt Counseling be sent to this e-mail address? (Circle one): Yes No

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Medical/Counseling Issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications Currently Taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Presenting Issue: What brings you in for counseling at this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designated Parent Information (if Client is Under 18)

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Primary Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Phone (Circle one): Home Cell Work Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May a voice message or text from Cobalt Counseling be left on this number? (Circle one): Yes No

Preferred E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May an e-mail from Cobalt Counseling be sent to this e-mail address? (Circle one): Yes No

Payment Arrangement: (Circle one)Cash Check Credit Card Health Savings Sponsored

Emergency Contact (if different from the designated parent listed above):

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Signature (of designated parent if under 18)

**AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Cobalt Counseling and the entities or persons listed below to mutually release and disclose my (or my child’s) health information for the following purposes (check all that apply):

\_\_\_\_\_\_   Consultation

\_\_\_\_\_\_   Coordination of Treatment

\_\_\_\_\_\_    Assessment and Diagnosis

\_\_\_\_\_\_ Billing

\_\_\_\_\_\_   Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that by signing this release, I am authorizing two-way communication between Cobalt Counseling and the below listed entities or persons.

I understand that I may revoke this authorization by submitting a written notice to Cobalt Counseling at any time during my treatment.  I understand that if this occurs, Cobalt Counseling will no longer disclose my health information for the reasons outlined in my written authorization.  I understand that any uses or disclosures already made with my permission prior to the written request to revoke my authorization cannot be taken back.

I also understand that the above mentioned information used or disclosed under this authorization may be subject to re-disclosure by the person or entity identified below and that the confidentiality rules of Cobalt Counseling may no longer be protected in that regard.

This release is not applicable in cases of threats to harm yourself, others, or in certain legal situations. This release shall remain in effect until terminated by client in writing.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Name of Person/Agency Phone/Fax Client’s Initials

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Name of Person/Agency Phone/Fax Client’s Initials

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Name of Person/Agency Phone/Fax Client’s Initials

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Name of Person/Agency Phone/Fax Client’s Initials

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Name of Person/Agency Phone/Fax Client’s Initials

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designated Parent’s Signature (if under 18) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

**INFORMED CONSENT**

As client or designated parent, I understand that the below signature confirms that I have received a copy, read through and understand Cobalt *Counseling Notice of Privacy Practices* and *Clinical Service Agreement.* I consent to receive therapeutic treatment with Cobalt Counseling. I consent that I am financially responsible for my therapeutic treatment, in the event that my financial sponsor fails to make payment.

As financial sponsor, I understand that the below signature confirms that I have received a copy, read and understand Cobalt Counseling *Notice of Privacy Practices* and *Clinical Service Agreement.* I consent to be financially responsible for the therapeutic treatment of said client, with Cobalt Counseling.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name Client Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designated Parent Name (If under 18) Designated Parent Signature (If under 18)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Financial Sponsor Name Financial Sponsor Signature (If applicable)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**CLINICAL SERVICE AGREEMENT**

Thank you for trusting Cobalt Counseling as you pursue your therapeutic needs. To ensure that you receive the best therapy possible it is important that you understand what to expect from us and that you also are aware of what will be expected from you.

**TREATMENT GOALS AND OVERALL OUTCOME**

As you begin the therapeutic process, we will set specific treatment goals together. Your treatment goals will be reviewed every 90 days. The outcome of your goals is primarily based on you. Therapy is not like a typical visit to the dentist. Instead, it calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things that are discussed during therapy sessions at home, between appointments. Your role in therapy is essential.

**TREATMENT PROCESS**

During the initial session, we will typically complete an intake interview and gather information about your concerns, symptoms and background. Sometimes formal psychological testing is involved in this process. If you decide to pursue psychotherapy, there will be a series of 50-minute unit sessions (one appointment = 50 minutes duration) Schedule on a weekly, bi-weekly, or monthly basis depending on clinical concerns and treatment goals. It will be important for you to come on time so you receive the benefit of a full-length session. If you are late for your appointment, it is likely that your session will be completed at the time it was scheduled to end.

**BENEFITS AND POSSIBLE RISKS**

One of the benefits of therapy is that you begin to address current issues, identify their causes, will hopefully begin to see improvement and become more self-aware. As this occurs, you may have a heightened sense of awareness regarding your past, present or future. As you address current issues and identify their causes, you may feel some emotional discomfort. Likewise it is important to be aware that healing cannot be guaranteed as it is a process, not an event.

**CONFIDENTIALITY**

Your privacy is protected by state law and by rules of our profession. By signing this Clinical Service Agreement you are confirming that you have received Cobalt Counseling Notice of Privacy Practices. The notice describes, in great detail, how your health information may be disclosed as well as how you can receive access to that information. Because your therapist is licensed by the State of Utah, they are required to disclose certain information as outlined in Cobalt Counseling Notice of Privacy Practices.

By agreeing to receive treatment with Cobalt Counseling, you agree to not engage in the recording of counseling sessions. The recording of sessions poses a serious threat to client confidentiality, and will result in legal action. Cobalt Counseling and its counselors DO NOT authorize the recording of any counseling sessions.

In general, the privacy of all communications between a client and counselor is protected by law, and Cobalt Counseling can only release information about therapy work to others with your written permission. Typically, you will be asked to sign a release to share information with your physician for care coordination. Often other family members are involved with treatment; a signed release would be required for their involvement as well. If payment of services involves a third party (such as an ecclesiastical leader) you must sign an Authorization to Release Information Form with their information on it so that we can bill them. Likewise, if you have a desire for your therapist to contact a third party to discuss treatment, you must sign an Authorization to Release Information Form for that to occur. There are a few exceptions to confidentiality, and they include the examples listed below. These situations have rarely occurred in this practice.

1. There are some situations in which your therapist is legally obligated to take action to protect others from harm, even if some information about the patient’s treatment has to be revealed. For example, if we learn of suspected or alleged abuse or neglect of a child, elderly person, or disabled person, we must file a report with the appropriate state agency. If a minor witnesses domestic abuse or drug abuse in the home, these are also reportable concerns.
2. If we believe that a patient is threatening serious bodily harm to another, we are required to take protective action. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm him/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.
3. Your therapist may occasionally find it helpful to consult other professionals about a case. During a consultation, we will make every effort to avoid revealing the identity of clients. The consultant is also legally bound to keep the information confidential. If you don’t object, your counselor will not tell you about these consultations unless he feels that it is important to the psychological work together. Likewise, if your therapist is away from the office for a few days, we may have a trusted counselor “cover” us.
4. If a minor reveals that s/he is at risk for self-harm through high-risk behaviors or suicidality, these issues will be discussed with the designated parent.

If there are ANY questions regarding confidentiality, please refer to your copy of Cobalt Counseling Notice of Privacy Practices. If the question isn’t answered by reading the copy of Cobalt Counseling Notice of Privacy Practices, please ask your therapist immediately.

**PSYCHOLOGICAL THERAPY**

Therapy is a partnership between you and your therapist, to find new ways of handling problems of daily living. There are many different methods Cobalt counselors may use to deal with the problems that you hope to address. Our primary treatment approach is Cognitive Behavioral Therapy (CBT). The focus of Cognitive Behavioral Therapy is on understanding the connection between our thinking, our emotions, and how we respond, interact or behave in our environment. There is an emphasis on identifying new ways of thinking about difficult and stressful events, as well as developing healthy coping tools/strategies for handing physical and emotional symptoms. CBT is goal oriented in that the focus of therapy is on effecting measurable change in an individual’s emotional, behavioral, or physical symptoms and thereby improving the quality of his/her life. Cobalt Counselors also utilize motivational interviewing techniques, Rational Emotive Behavior Therapy, behavioral parent training, interpersonal psychotherapy, and family therapy techniques regularly when appropriate.

**FEES AND BILLING**

The fee for the first 60-minute session is $155.00. Following this session, a written assessment including a diagnosis is created. A written treatment plan is also created. The fee for each additional 50-minute session is $110.00. Additional time will be charged in half-hour increments. **Payment is due in full at the beginning of each session**. A $35.00 fee will be given for a bounced check. Please note that any fees related to delinquent accounts will be the sole responsibility of the client or the designated parent of the client if the client s under the age of 18. See below for fees related to administrative and judicial proceedings.

Again, if there is a third party paying for services, you **must** sign an Authorization to Release Information Form with their information on it so that we can bill them.

We do not accept insurance at this time. Payment arrangements are as follows:

Cash Credit Health Savings Card Check Ecclesiastical Sponsor

**CANCELLATIONS AND NO SHOW POLICIES**

If you are unable to keep an appointment, please give notice prior to 24 hours before the appointment, by calling the telephone number your therapist has provided to you. Messages left within the given timeframe are acceptable ways to cancel appointments. There will be no charge for a cancellation if more than 24 hour notice is given. **Half the hourly fee ($55.00) will be charged to you (or the designated parent if the child is under 18) for cancellations that occur *after* 24 hours (this is considered a late cancellation) or if an appointment is missed (this is considered a no show).** Emergency situations will be assessed and accommodated as deemed appropriate by the therapist or office manager.

It is important for you to understand that this practice is busy. As a result, you may not always have the ability to reschedule easily for the same week in which you cancelled or missed an appointment. However, this office will do the best that we can to work with you on any scheduling concerns that you may have. This office will provide reminder text or email as a courtesy. However, please understand that it is still your responsibility to attend sessions when they are scheduled, even if you did not receive the reminder notification, although every effort will be made to provide you with this service. Please don’t rely solely on a reminder message, as you may miss your appointment. In cases of severe weather, this office will make effort to contact you by phone if the clinic is closing.

**DELINQUENT ACCOUNTS**

If your account balance has not been paid for more than 90 days and arrangements for payment have not been agreed upon, our office has the right to use legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such action is necessary, its costs will be included in the claim. Returned checks will incur an additional $35 fee.

**MEDICARE/MEDICAID**

Cobalt Counseling is not a covered provider for Medicare or Medicaid. What this means is that Cobalt Counseling is excluded from Medicare under the Social Security Act, and that you or your legal representative accepts full responsibility for payment of all charges congruent with Cobalt’s clinical service policies. Usual Medicare limits to charges and services do not apply. By choosing to work with Cobalt Counseling, you agree that neither you nor any representative will submit a claim to Medicare, nor will you ask Cobalt Counseling to submit a claim to Medicare.

**PERSONS WITH DISABILITIES**

If there is an injury, physical limitation or disability that could reasonably affect the quality of treatment received, please inform your therapist **immediately** so that reasonable accommodations can be made.

**EMERGENCY SITUATIONS**

Because of the nature of our employment, we are not always available by telephone. When we are unavailable, the telephone is answered by voice mail. We will make every effort to return your call during the same week you make it, with the exception of holidays or vacations. If you are unable to reach us and feel that you can’t wait for a returned call, contact your primary care physician or the nearest emergency room and ask for the psychiatrist on call.

If you have a medical emergency, please dial 911 immediately or go to the nearest emergency room. **Cobalt Counseling does not provide 24 hour crisis services.** If you have an emotional or behavioral emergency and are in need of immediate assistance, please call the crisis team at the University of Utah’s Neuropsychiatric Institute at 801-587-3000.

**E-MAIL & TEXT CONTACT**

At times, Cobalt Counseling may use e-mail to communicate with you regarding appointment information, session information, or answer your questions. Copies of all e-mails are placed in your client record. Email is not considered “Secure”. You should not use e-mail for medical emergencies or to send time-sensitive information. You should understand and agree that it is your responsibility to follow up with your therapist if you have not received a response to an e-mail within a reasonable time period. **We do not provide counseling services via TEXT or EMAIL.**

**SOCIAL MEDIA**

Your therapist does not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). Adding clients as friends or contacts on these sites can compromise your confidentiality and respective privacy. It may also blur the boundaries of the therapeutic relationship. If there are things from your online life that you wish to share, please bring them into scheduled sessions where they can be viewed and explored together, during therapy. You may find Cobalt Counseling on sites such as Yelp, Yahoo Local, Bing, or other places which list businesses. If you should find this listing on any of these sites, please know that Cobalt Counseling’s listing is NOT a request for a testimonial, rating, or endorsement from you as a client. Due to confidentiality, Cobalt Counseling will not respond to any review on any of these sites whether it is positive or negative. You are urged to take your own privacy as seriously as we take our commitment of confidentiality to you. It is hoped that you will bring your feelings and reactions to therapy directly into the therapy process. This can be an important part of therapy, even if you decide it is not a good fit. None of this is meant to keep you from sharing that you are in therapy with Cobalt Counseling wherever and with whomever you like. You are more than welcome to tell anyone you wish that you are receiving therapy or how you feel about the treatment provided to you, in any forum of your choosing.

**COURT TESTIMONY**

In some court proceedings, a judge may order psychologist’s testimony if he/she determines that the issues demand it. As your therapist, it is my ethical duty to provide you the best care possible. If asked to provide records or testimony about treatment to the court, this can contribute to a “dual-role” relationship. A dual-role relationship means that Cobalt Counseling is providing services for conflicting roles (i.e., expert witness and therapist), and can be potentially damaging to the future therapy experiences due to possible violations of therapeutic trust. In addition, we have an ethical responsibility to only release records when accompanied by your signed written permission. Exception to this policy would include cases where you have threatened harm to yourself or others, in which case the counselor is ethically obligated to report. Finally, Utah law and ethical standards mandate that the counselor protect privacy of mental health records. Because the counselor cannot control the number of people that have access to the mental health records in the court setting, concerns for the patient’s privacy may exist. For these reasons, we reserve the right to terminate services. Clients are discouraged from having their therapist subpoenaed due to the nature of a dual role/relationship. Even though you are responsible for the testimony fee, it does not mean that my testimony or professional opinion will be solely in your favor. I can only testify to the facts of the case and to my professional opinion.

**FEES FOR ADMINISTRATIVE AND JUDICIAL PROCEEDINGS**

Preparation time (including submission of records): $110/hour  
Phone appointment: $110/hour  
Depositions (Including Time away from office due to deposition): $175/hour  
Testimony (Including time away from office due to testimony): $175/hour  
Mileage: $0.53/mile

Level II Psychological evaluation and report: $400  
You are responsible for all attorney fees and costs incurred by the therapist as a result of this legal action.  
Filing a document with the court: $110/hour + disbursements (if any)  
Court appearance: $175/hour

Minimum $1200 retainer fee due in advance

If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice there will be an additional $175 “express” charge. If the case is reset with less than 72 business hours’ notice, then the client will be charged $175 (in addition to the retainer of $1200). In the event that the case is settled prior to any court appearance, disbursements and other counseling fees will be billed against the retainer, any remaining balance will be refunded to the client or sponsoring party.

**REFERRALS TO OTHER AGENCIES**

If, at any juncture, you or the therapist feels that a medical or mental health referral is necessary, referrals will be given to you to seek additional or alternative treatment. This may occur if an assessment for medication would be appropriate or if another practitioner/agency appears more appropriate given specific issues. This may also occur if you feel your treatment needs may be better addressed elsewhere.

Services are provided at Cobalt Counseling’s discretion. We reserve the right to terminate therapy services if you behave inappropriately towards our office staff; or if Cobalt Counselors are court-ordered to testify (thus causing a dual-role relationship with you or your child); or if there is consistent failure to attend scheduled appointments; or if there is failure to complete payment for services; or if either custodial parent/guardian does not consent for services.

**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.**

Federal law requires us to give you a Notice of Privacy Practices in accordance to the Health Insurance Portability and Accountability Act (HIPAA). As you are aware, your health record contains personal health information (PHI) about you, your health status, and your health care. This is information that may identify you and that relates to your past, present, or future physical or mental health or past, present, or future payment for your health care. Although this notice applies to the information and records regarding your PHI, this information relates primarily to the mental health treatment received from Cobalt Counseling. This notice informs you about how we can use and disclose your PHI in accordance with the NASW Code of Ethics and with applicable law. It also informs you of how you can gain access to you records as well as how you can control your PHI.

**How We May Use and Disclose PHI About You**

For Treatment- Cobalt Counseling may use or disclose your PHI to provide, coordinate, or manage your health care treatment and related services.

For Payment- Cobalt Counseling may use or disclose your PHI so that we may receive payment by you or a third party providing payment, such as an ecclesiastical leader. Please note that this can only be done with your authorization.

For Health Care Operations-Cobalt Counseling may use or disclose your PHI for activities related to the performance and operation of our business. This may include but isn’t limited to quality assessment and improvement activities, audits, and contacting you to confirm appointments.

**Requirements By Law**

There are situations under the law which requires me to disclose your PHI with or without your permission. Those situations may include but are not limited to:

* The Secretary of the Department of Health and Human Services for investigation purposes to determine my compliance with the Federal privacy requirements.
* If it is believed that the disclosure is necessary to prevent a serious threat to your physical health and safety or the physical health and safety of another individual.
* If there is suspicion of past, present or future abuse, neglect or maltreatment of a child, or vulnerable adult. This could include but isn’t limited to the Division of Child and Family Services, Adult Protective Services and the police.
* In response to a court order, warrant, summons, subpoena or similar court process.
* In accordance with workers compensation laws
* As required by state law if there is a communicable disease. This would be reported to the Health Department.

**Written Authorization**

Uses and disclosures not specifically permitted by the circumstances listed above can only be made with written authorization. You may revoke such authorization, in writing, at any time. If this occurs, we will no longer use or disclose your PHI for the reasons outlined in your written authorization. Please note that we cannot take back any uses or disclosures already made with your permission prior to the written request to revoke your authorization.

**Your Rights Regarding Your PHI**

Below is a list of your rights regarding your PHI. To utilize these rights, please submit a written request ATTN: Privacy Officer, (5667 S. Redwood Road, Suite 7A, Taylorsville, UT 84123).

* You have a right to receive a copy of this notice.
* You have a right to inspect and copy your health information; however your right to inspect and copy your PHI will be restricted only in those cases where there is compelling evidence that access to these records would cause serious harm to you. There will be a cost-based fee for copies. As part of your PHI, “psychotherapy notes” are kept and include but are not limited to observations made in session, details of our psychotherapy conversations considered to be inappropriate for the health record and other impressions. These notes contain information relevant only to my future work with you. These notes are not available for your review, nor the review of insurance and managed care companies.
* You have a right to amend your PHI if at any juncture you feel it is incorrect or incomplete. We are not required to comply with this request.
* You have a right to obtain an accounting of all disclosures of your PHI. Again, a cost-based fee for these copies may be given.
* You have a right to request restrictions or to limit our use or disclosure of your PHI to only treatment, payment or health care operations. We are not required to comply with this request.
* You have a right to request that we communicate with you about your health matters in a certain way or in a certain location such as asking that we only contact you in a specific way regarding confirmation of appointments or regarding where you would like to have bills be sent.

**Changes in the Notice of Privacy Practices**

Please note that we do reserve the right to change the terms of this notice in the future. If this occurs, the new notice will apply to any PHI that has already been obtained and that we receive in the future. If the terms change, you will be given a written copy of the new notice upon your next appointment.

**Complaints**

If, at any juncture, you believe that your privacy rights have been violated, a complaint may be filed with Bo Buchi 801.680.6492, 5667 S. Redwood Road, Suite 7A, Taylorsville, UT 84123 or with the Security of the U.S. Department of Health and Human Services at 200 Independence Ave. S.W. Washington, D.C. 20201 or by calling 202-619-0257. There will be no retaliation or penalty for filing a complaint, as it is your right.