

Inner Spectrums, Inc

3051 Maple Loop Drive

Suite 201

Lehi UT 84043

Phone (801)636-6609 (801)400-5096 innerspectrms@comcast.net Fax (801)341-8218

Client Intake Form (These forms must be completed before we can see you)

Date:
Therapist:
Client's Name:
Client's Soc Sec No.:
Birthday:
Age:
Marital Status: Single, Married, Widow(er), Divorced, Married or Divorced more than once, Partner, Significant relationship, Currently Lives with Parents, Cares for Parent
Number of children and pregnancies
Names of living children
Significant Other Name:
Significant Other Soc Sec No.:
Birthday:
Age:
Drivers License No. of Responsible Party:
Clients Address:
City:
State:
Zip:
Home Phone:
Cell Phone:

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Work Phone:
May we leave messages for you at your home? Yes/No
Cell Phone? Yes/No
Who referred you to Inner Spectrums?:
Can we thank them? Yes/No
In case of emergency first contact:
Name:
Address:
Phone:
Relationship to you?

Health Insurance:

Health insurance may help you pay for your treatment costs at Inner Spectrums, Inc. However, insurance companies must limit the insurance information they provide to us. We cannot guarantee your benefits.

You are ultimately responsible for any bills you accumulate at Inner Spectrums. You the client are responsible for any required initial preauthorization. Please provide the following information for our records.

Name of Insured:
Address:
Phone:
Insured's Birthday:
Insured's Address:
City:

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State:
Zip:
Client's Relationship to Insured:
Insured's Employer:
Business Phone:
Employer's Address:
Primary Insurance Company:
Phone:
Address:
City:
State & Zip:
Insurance Contact Person:
Insured's ID #
Group Enrollment #
Policy #
Effective Date:
Deductible \$
Amount Met \$
Month Insurance Begins:
Referral Required?
Referral Obtained?
Authorization #
Sessions Authorized:
Sessions Allowed Per Year:
Co-Payment Amount \$
Monetary Limits per Year

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Secondary Insurance Company:
Phone #
Policy #
Group/ Enrollment #
Deductible \$
Effective Date:
Amount Met \$
Month Insurance Begins:
Physician's Name:
Authorization #
Sessions Authorized:
Allowed Per Year:
Copayment \$
Monetary Limits per Year
Pre-existing conditions or other limitations?

Another Responsible Party

The other responsible party will also need to sign a payment contract with Inner Spectrums before the second session. If the other responsible party resides outside Utah County, these payments are to be made at the time of service or in advance of the service.

Name of Responsible Person:
Relationship to the Client:
Address:
City:
State & Zip:
Home Phone:
Drivers License State and Number:
Employer:
Business Phone:
Employer's Address:

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Consent to Use and Disclose Health Information

This consent is an agreement between you, and Inner Spectrums, Inc. When we use the work “you “it will mean you or your child, relative or other person if you have written his or her name below. When we examine, diagnose, treat or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide on what treatment is best for you and to arrange payment for your treatment or for other business or governmental functions. By signing this form you are agreeing to let us use your information here and send it to others. Our Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you. In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from us. If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You should make that request in writing. Although we will try to respect your wishes, we are not required to agree with these limitations. However, if we do agree, we promise to comply with your wish. After you have signed this consent, you have the right to revoke it by writing a letter telling us you no longer consent and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that. This agreement complies with the national Health Insurance Portability and Accountability Act (HIPA) 45 CFR 164.520 effective April 14, 2003. PHI includes your demographic information, counseling session dates and times, medication monitoring, treatment modalities and frequencies, results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date. PHI does not include psychotherapy notes of the content of conversations during a private counseling session. Psychotherapy notes are protected from release except in certain circumstances to avert a serious and imminent threat to health or safety, to a coroner or medical examiner, or required by subpoena.

Billing Policies

The undersigned agrees to the following billing policies:

1. Counseling services are to be paid for on the day of service. A \$10 dollar billing fee will be charged monthly for billing for unpaid co-pays or only partially made co-pays. However, you have up until the 25th of each month to make this payment.
2. Based on the information you provide to us, insurance reimbursement claim forms (HCFA;s) will be completed by Inner Spectrums, Inc. Should there be a problem with receiving payment Inner Spectrums will bill your insurance company up to two times. After that time you will be responsible to receive payment if the insurance firm makes a mistake.
3. Responsibility for payment of all fees remains with the client/responsible party since the contract for insurance is between the employee, employer and insurance company.
4. Client and any other responsible party are responsible to meet his/her insurance company's preauthorization requirement, present a current authorization or precertification as required by your insurance company, and to pay any amount his/her insurance does not pay.

Financial Agreement

In consideration of professional services and treatment the undersigned3d agrees:

1. To pay the amount charged for all professional services and treatment of the undersigned and his/her family members who are clients.

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2. That payment is due on the date service is rendered unless special arrangements are made for a monthly billing. **Monthly bills are due on the first day of the month with a 5 day grace period.**
3. All bills must be paid within 30 days of the date of service.
4. Bills with an unpaid balance beyond 30 days of service will be charged a \$20.00 late fee each month that the bill is not brought to a zero balance. A \$35.00 late fee will be charged for bills that are 60 days past due.
5. Additionally, a 2 % (annual percentage rate 24%) will be charged on any remaining balances not paid within 30 days of service.
6. Should we need to collect this money, you agree to pay all court costs, attorney fees or collection fees that might be incurred in collecting a past due accounts with or without suit.
7. That authorization is given to release information necessary to process and collect health benefits claims.
8. That authorization is given to release payment from the insurance carrier to the provider named on the health benefit claim forms.
9. That authorization is given to release your information to collection agencies should you not fulfill your financial obligation to Inner Spectrums.
10. That the usual, reasonable and customary fee for a full session (\$125.00) at Inner Spectrums will be charged for any appointment canceled with less than 24 hours notice of where client does not cancel but does not appear at the scheduled appointment time. If you want to change your appointment, please give us as much lead time as possible so that another client may take the appointment time that you won't be using. Thank you for your help with this.

X

Date

X

Signature of Client or Personal Representative

Printed Name of the Personal Representative:
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Relationship to Client:

Authority of Personal Representative:

X

Printed Name of the Client