Korinne Bouwhuis, LMFT

Individual, Couple and Family Therapy

New Client Instructions:

Thank you for selecting this practice for your therapy needs. Information needed to get started follow in this document. To avoid taking extra time during the first appointment, please fill out the Client Information Form which follows. Also please read the Information to Clients Regarding Services and the Fee Agreement forms, also attached. Please be prepared to sign at initial appointment, and be advised that payment is due at the time of service, unless previous arrangements have been made.

Please notify me if you need to cancel or change this or subsequent appointments **no later than 24 hours prior to your scheduled appointment time**. This is best done through the client portal, but you may call or text as well if needed. Directions and a map are attached.

I appreciate the opportunity of working with you and look forward to meeting you.

Sincerely,

Korinne Bouwhuis, LMFT
KB Therapy
435.512.5100

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Individual, Couple and Family Therapy

Client Information Form

I. CLIENT INFORMATION:

Client Name: _____ M____ F____ Date of Birth:_____ Age:_____

Address: _____ City:_____ State:____ Zip:____

Home Phone:_____ Work #: _____ Cell #: _____ Email:_____

Employer: _____

Marital Status: _____ Referred By: _____

II. FINANCIAL RESPONSIBILITY

Financially Responsible Party: _____ Date of Birth: _____ Age:_____

Address (If different from Client address): _____ Home Phone #: _____

Employer: _____ Work #: _____

Relationship to Client:_____ Emergency Contact: _____

****If you would like insurance to be billed a copy of your insurance card is required.****

III. BACKGROUND INFORMATION:

What is your primary reason for seeking therapy at this time?: _____

Primary Care Physician: _____ Phone: _____

Have you ever sought professional counseling before today?: _____If so, where and with whom?:

_____

Do you have any medical conditions that your therapist should be made aware of: _____

If so, please list: _____

Are you taking any medications of any kind?:_____ Please List: _____

INFORMATION TO CLIENTS REGARDING SERVICES

BY SIGNING THIS FORM, YOU ARE AGREEING TO EACH OF THE ITEMS BELOW.

Thank you for selecting this office for your appointment. The following information is provided to clarify services and rights you have as a client. Please feel free to ask your therapist any other questions you may have regarding the services provided.

All individuals receiving services are considered to be clients. This includes parents, legal guardians, minor children, adolescents and adults, regardless of the services rendered. As a client, you have the right to expect the following:

1. To receive the best professional services within your personal belief system, including the right to an individual treatment plan.
2. To ask any questions about services, professional background, areas of specialization and limitations.
3. To participate in the development of and approval of treatment plans and programs, receive information on an estimated length of treatment, and to know about specific treatment strategies.
4. To know about and request alternative services, be aware of potential risks for each, and to have the right to refuse any particular treatment.
5. To request a referral to a different therapist or service provider.
6. **To expect that information, verbal or written provided to the therapist, will be kept confidential.** No information will be communicated to other individuals or agencies unless specifically authorized by signature of the patient, parent, or legal guardian in writing (see Release of Information Form), **with the following exceptions:**
   - A. If a clear emergency exists where there may be danger to the client or others.
   - B. If it is necessary to comply with state statutes, such as a mandatory reporting when child abuse is suspected or reported.
   - C. If your therapist is an Intern working towards licensure thus requiring the therapist to staff all cases with their state licensed supervisor.
   - D. Client obligation, name and address may be referred to outside collection agencies, including Small Claims Court, if no payment is made on an account over 60 days old unless specific arrangements have been made.
   - E. Court-ordered subpoena of client records as a result of a judicial decree to release such records, and Court-ordered subpoena to testify as a result of a judicial decree.
   - F. Information may be released to insurance carriers regarding your diagnosis and type of treatment provided. Some managed care companies and EAP programs are authorized, by your signature, to obtain additional information regarding treatment, prognosis, and any other additional information that they deem as part of your contract with them. Please check with your plan to see if this exception applies to you.
   - **G.** At your request (indicated by your response to the insurance or financially responsible party section of the patient information form), we may be billing a third party (such as insurance companies, bishops/ecclesiastical leaders, family members, etc.). Often third party payers will request information about the case (such as diagnosis, progress, attendance, and other miscellaneous details). **Are you giving your therapist permission to discuss your case with this third party, thus waiving your rights to confidentiality?**
     ____ YES ____ NO (In some cases, your refusal to allow your therapist to contact the third party may result in the third parties refusal to provide financial support. You will consequently become the financially responsible party)
7. To be informed when confidential information has been requested and options available to you.
8. To be fully informed regarding fees for treatment.
9. To ask any question at any time, to terminate at any time, and to refuse to answer any questions at any time.
10. **Termination of services** in three different methods:
    1). At client's request: A courtesy referral can be made to another therapist at your request if desired.
    2). At therapist's request: When there is a concern regarding the therapist's scope of practice, effectiveness of treatment, or if conflicts of interest arise.
    3). With passage of time since contact: Once 60 days have passed without treatment in this office. Of course, in this case, clients are still welcome and encouraged to return to this clinic at any point they desire.

Your involvement with the therapist is governed by this agreement and by the laws governing each therapist's scope of practice. Your treatment should be fully informed and voluntary. Your signature below signifies that you understand and agree to the conditions of the treatment specified above, and give consent for treatment by your therapist.

_____ _____

Signature Date

_____ _____

Witness Date

Fee Agreement

Below is our fee schedule. These fees include expenses for the office use, billing, telephone, and emergency services. These fees are accepted by the community and are generally viewed by insurance companies as fair, reasonable and customary. If you feel you will have any difficulty in paying these fees, please discuss this issue with your therapist PRIOR to beginning therapy.

The office of Korinne Bouwhuis, LMFT. is not responsible to collect from your insurance company. You are the guarantor of your bill, and by signing below, you are stating that you are fully responsible for all fees and legal expenses regardless of insurance coverage or third-party payments. However, insurance billing is provided as a courtesy to make any possible coverage as accessible as possible.

At your request (indicated by your response to the insurance or financially responsible party section of the patient information form), we may also courtesy bill to a religious or ecclesiastical leader, and/or other third-party payers.

A credit card shall be kept on file for each client. If an HSA card is kept on file, an additional credit card needs to be stored on file as well as HSA cards decline frequently due to insufficient amounts or holds placed on them while the HSA verifies the medical necessity of prior charges. Credit card information is encrypted and once entered not visible to the practice. However, the card may be charged at any time for fees the client is responsible for. Session fees may be charged on date of service or at another time during the month. This includes missed appointment fees, and also differences in expected versus actual patient amounts once insurance responds with their payment processing.

Overdue accounts are turned over to either a collection agency or Small Claims Court if efforts to collect unpaid balances have not been successful within a reasonable time period. A balance is considered overdue if there has been no payment for sixty (60) days or if you balance is carried for longer than sixty (60) days. If payment becomes difficult, please consult your therapist or the office staff. We reserve the right to charge a late payment fee or any other reasonable fee to those accounts that maintain a balance beyond ninety (90) days or have required excessive attention from our staff due to difficulties created by the client, insurance company or ecclesiastical leader.

If you cancel an appointment, please notify this office no later than 24 hours prior to your appointment time. **If cancelation notice is less than 24-hours prior to the scheduled time, the client will be billed 50% of the rate of the scheduled time. If no cancelation is given, clients will be billed 100% of the fee** for the time scheduled for the missed appointment. Since insurance and ecclesiastical leaders will not reimburse for no-show appointments, the full balance will be added to your account and will be your own financial responsibility.

FEES FOR SERVICE ARE AS FOLLOWS:
Korinne Bouwhuis, L.M.F.T.

	Self-Pay	Insurance
Initial Appointment (50-60 min):	$140.00	$160.00
50-60 Minutes psychotherapy:	$100.00	$130.00

Additional time past 60 minutes will be billed at a prorated session fee in 15-minute increments, these session extensions are not billed to insurance companies and will fully be the client's financial responsibility. ****Late cancellations and no-show appointments will be charged for the time reserved, as described above****

I, the undersigned, have read, understand and agree to the terms listed in the Information to Clients Regarding Services and the Fee Agreement. I understand, agree with, and give my therapist permission to release information to my insurance company, and/or any other third party listed as being financially responsible, in order to facilitate and expedite payment for services rendered to me by them. By so doing, I agree to release Korinne Bouwhuis, LMFT from any liability associated with the release of this information. I understand that if my account is in arrears, I agree to pay a delayed payment fee at a rate of 15% per month on the unpaid balance and to pay any and all costs, including account balance, interest, attorney's fees, Court cost and any other such cost that are incurred by the provider in the collection of delinquent accounts.

Name: (please print)_____

Signature_____ Date_____

Witness_____ Date_____

Korinne Bouwhuis, LMFT

Individual, Couple and Family Therapy

RECEIPT OF PRIVACY PRACTICES

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. This is called the Health Insurance Portability and Accountability Act (HIPAA).

I am required by law to maintain the confidentiality of your health information and provide you with a notice of my legal duties and privacy practices with respect to protected health information (PHI).

Your signature below is only acknowledgement that you have received a copy of my **Notice of Privacy Practices**.

Print Name: _____

Signature: _____ Date: _____

Please be aware that professional consultation is part of best practices for maintaining quality care and handling therapy needs appropriately and ethically. As such, your therapist may consult with colleagues in coordinating best practices for your care. This is always done without identifying information included in the conversation. If a client is experiencing something is considered situationally identifiable based on familiarity in a small area, consultation is done with colleagues outside of Wasatch County.

Korinne Bouwhuis, LMFT

Individual, Couple and Family Therapy

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting Your Personal and Health Information

I am committed to protecting the privacy of your personal information. I am required by federal and state laws to maintain the privacy of your personal health information. This notice explains my privacy practices, legal duties, and your rights concerning your personal health information. Personal Health Information (referred to in this notice as PHI) means any information that is identifiable to you as your personal information, including information regarding your health care and treatment; identifiable factors including your name, age, address, or other financial information that is maintained or transmitted in any form. I will follow the privacy practices that are described in this notice while it is in effect.

I am required by law to: maintain the privacy of your health information, provide this notice that describes ways I may use and share your health information, and follow the terms of the notice currently in effect. I reserve the right to make changes to this notice at any time in accordance with federal and state laws and make the new privacy practices effective for all information I maintain.

How I use your health information: When you receive care from me, I may use your PHI to carry out treatment, payment, or healthcare operations. Examples of how I may use your information include:

Treatment: I keep records of the care and services provided to you. As a health care provider, I use these records to deliver quality care to meet your needs. **Some health records, including confidential communications with a mental health professional, have restrictions for use and disclosure under state and federal laws.**

Payment: I keep billing records that include payment information and documentations of the services provided to you. Your information may be used to obtain payment from you, your insurance company, or other third party. I may also contact your insurance company to verify coverage for your care or to notify them of upcoming services that may need prior notice or approval. For example, I may disclose information about the services provided to you to claim and obtain payment from your insurance company.

Health Care Operations: Health care operations includes a broad category of activities ranging from quality assessment to utilization review to conducting or arranging for medical reviews, legal services, and auditing functions, business planning and administrative services. A few examples specific to my practice are listed below. I may use your PHI to:

- -Remind you of an appointment
- -Call you by name in the waiting room
- -Report items required by law such as abuse, neglect, or communicable diseases
- -Keep you safe in a life threatening situation to self or others
- -In legal proceeding against me
- -Upon a judges signed order

All other uses and disclosures not described in this notice require your signed authorization. You may revoke your authorization at any time with a written statement.

Following is a statement of your rights with respect to your protected health information.

You have the right to:

-Inspect and copy your PHI. Fees may apply. Under federal law, however, you may **not** inspect or copy the following records: **psychotherapy notes**; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to other state or federal laws that prohibit me to release such information.

-Request restrictions on how I use and share your PHI. I will consider all requests carefully, but I am not required to agree to any restriction.

-Confidential communication; You may request that I use a specific telephone number or address to communicate with you, or can make specific requests concerning messages to be left at these numbers or addresses.

-Request corrections or additions to your health information.

-Request an accounting of certain disclosures of your health information made by me. This accounting does not include disclosures made for treatment, payment, and health care operations and some disclosures required by law. Your request must state the period of time desired for the accounting, which must be six years prior to your request and excludes dates prior to April 14, 2003. Fees may apply.

-Request a paper copy of this notice even if you agree to receive it electronically.

If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision made about access to our health information, please send me a written notice to:

Korinne Bouwhuis, LMFT
PO Box 957
Midway, UT 84049

You may also submit a written complaint to the Office of Civil Rights of the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

This notice was published and becomes effective April 14, 2003 in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Directions to KB Therapy (230 East Deer Ridge Way, Midway, UT 84049):

From Park City:

- Continue on Highway 40 past Jordanelle reservoir into the Heber Valley
- Head **west** on **River Road**, the **1st light** off of Hwy 40
- Take the **second exit from the roundabout**, continuing West on Burgi Rd.
- Turn on your **second right, Interlaken Drive**
- **First street on your right is Deer Ridge Way.**
- **Office is in red home on corner** of Deer Ridge and Interlaken. House numbers 230 are to the right of the door on a timber column.

From Heber City:

- Head **west** on **100 S** in Heber City
- Street becomes Midway Lane and then Main Street
- Turn **right** on **River Road**
- At **roundabout, take 3rd exit,** heading west on Burgi Lane
- Turn on your **second right, Interlaken Drive**
- **First street on your right is Deer Ridge Way.**
- **Office is in red home on corner** of Deer Ridge and Interlaken. House numbers 230 are to the right of the door on a timber column.

From Orem:

- Travel East on Highway 189 toward Heber City / Midway
- Turn **left** after Deer Creek Reservoir on **Charleston Road, Highway 113** toward Midway
- **Continue straight**, crossing Main Street Midway onto **Center Street in Midway**.
- Center Street becomes 100 East
- Where this road T's, turn right onto Burgi Lane.
- Turn **right** on **200 East** to access parking behind building. (Building on corner)
- Take **3rd left, Interlaken Drive,** just after an open field, dog park area
- **First street on your right is Deer Ridge Way.**
- **Office is in red home on corner** of Deer Ridge and Interlaken. House numbers 230 are to the right of the door on a timber column.

On Arrival:

- Please park on paved turnaround driveway.
- As I am often with another client until your scheduled appointment time, please feel free to **let yourself in, entering through the main front door**, there will be a waiting room to your right, and a client bathroom straight ahead of you.