The Greater You Client Intake Package

THESE FIRST 10 PAGES ARE FOR YOU TO REVIEW & KEEP.
PLEASE FILL OUT & RETURN ONLY PAGES 11-14.

The Greater You, Inc.
Notice of HIPAA Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

As a client of The Greater You, Inc, you are entitled to receive notice about our privacy practices and how we may use and disclose your personal health information in different circumstances. This notice explains how we may use and disclose your personal health information, the choices and rights you have about how your personal health information may be used and disclosed, and our obligations to protect the privacy of your personal health information. The Greater You, Inc is a corporation licensed by the state of Utah.

Introduction

When you become a client of The Greater You, Inc, you provide us with information about your health. Each time you visit or meet with us, another record of our meeting and what was done is created. Your health record is the information that we use to plan your care, provide treatment and receive payment for our services. It is important for you to understand that your health record contains personal information that is protected by federal and state laws.

Our Responsibility

The Greater You, Inc is required to maintain the privacy of your personal health information and to provide you with a notice about our legal duties and privacy practices with respect to your personal information. We are also required to accommodate reasonable requests that you make to communicate personal health information by alternative means or at alternative locations. Any time we use or disclose your personal health information, we must follow the terms in this notice.

How we use and disclose your personal health information:

Uses and disclosures for treatment, payment and health care operations. After making a good faith effort to provide you with notice, we may use your personal health information to provide your treatment, to obtain payment for your treatment and for our internal health care operations. We may use and disclose your personal health information for such purposes in the following ways:

1. *For Treatment.* We may use and disclose your personal health information to plan, provide and coordinate your health care services.
2. *For Payment.* We may use and disclose your personal health information to obtain payment for health care services we have provided to you.

3. *For Health Care Operations*. We may use or disclose your protected health information for your health care operations. For example, we may use or disclose your personal health information to perform risk assessments and other administrative tasks to monitor the quality of care that we provide.

Uses and disclosures with Authorization for uses and disclosures of your personal health information not involving treatment, payment or health care operations, we will receive your written authorization prior to using or disclosure of any personal health information set forth below. You have the right to revoke any authorizations previously granted. If you have any questions, please contact our office and we will provide you with the information you will need to revoke your authorization.

Uses and disclosures without authorization. We may use and disclose your personal health information without obtaining your consent or authorization, in the following situations:

1. *Business Associates*. There are some services that we provide through contracts with our business associates. In such situation, we may disclose your personal health information to our business associates so that we can perform the job we asked them to do, or the job they asked us to do. These entities may include but are not limited to fitness camps and referral sources. We require all business associates to appropriately safeguard your information, in accordance with applicable laws.
2. *Directory.* Unless you object, we may include your name, location, general health condition and religious affiliation in our facility directory. Religious affiliation will only be provided to clergy. All other information may be provided to people who ask for you by name.
3. *Notification of Family or Close Friends.* We may use or disclose your personal health information to notify a family member, personal representative or another person responsible for your care, provided you have the opportunity to agree or object to the disclosure. If you are unable to agree or object, we may disclose this information as necessary if we determine that it is in your best interest based upon our professional judgment. In all cases, we will only disclose the health information that is directly relevant to the person's involvement with your health care.
4. *Required by Law.* We may use or disclose your personal health information to the extent that we are required by law to do so. The use or disclosure will be made in the full compliance with the applicable law governing the disclosure.
5. *Public Health Activities*. We may disclose your personal health information for public health activities to a public authority authorized by law to collect or receive information for the purpose of controlling disease, injury, or disability. We may also disclose your personal health information to a public authority authorized to receive reports of child abuse or neglect or to report information about products or services under jurisdiction of the United States Food and Drug Administration. Additionally, we may disclose your personal health information to a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease and to your employer for certain work related to illness or injuries.
6. *Health Oversight Activities.* We may make disclosures of your personal health information to a health oversight agency charged with overseeing the health care industry. Disclosures will be made only for activities authorized by law.
7. *Judicial and Administrative Proceedings.* We may disclose your personal health information in

the course of any judicial or administrative hearing in response to an order of the court or administrative tribunal, or in response to a subpoena discovery request or other lawful process where we receive satisfactory assurance that appropriate precautions have been taken. In all cases, we will take reasonable steps to protect the confidentiality of your health information.

8. *Law Enforcement.* We may disclose your personal health information for a law enforcement purpose to law enforcement officials in compliance with and as limited by applicable law.
9. *Marketing.* For marketing activities, we will obtain your written authorization prior to sending any information to you, unless we are not required by law to do so.
10. *Research.* We may use or disclose your personal information without your authorization for research purposes when such research has been approved by an institutional review board that has reviewed the research to ensure the privacy of your personal health information, or as otherwise allowed by law.
11. *Victims of Abuse, Neglect or Domestic Violence.* We may disclose personal health information about an individual whom we reasonable believe to be a victim of abuse, neglect or domestic violence to a government authority, including a social service or protective service agency authorized by law to receive reports of child abuse, neglect or domestic violence. Any such disclosures will be made in accordance with and limited to the requirements of the law.
12. *Limited Government Functions.* We may disclose your personal health information to certain government agencies charged with special government functions, as limited by applicable law. For example, we may disclose your health information to authorized federal officials for the conduct o national security activities, as required by law.
13. *Organ Procurement.* As allowed by law, we may disclose personal health information to organ procurement organizations of organ, eye or tissue donation purposes.
14. *Coroners, Medical Examiners and Funeral Directors.* We may disclose personal health information to a coroner or medical examiner to identify a deceased person, determined a cause of death or for other duties as authorized by law. We may also disclose personal health information to funeral directors in accordance with applicable laws.
15. *Health and Safety.* We may disclose your personal health information to prevent or lessen a serious threat to a person(s) or the public(s) health and safety. In all cases, disclosures will only be made in accordance with applicable law and standards of ethical conduct.
16. *Workers Compensation.* We may disclose your personal health information in accordance with the workers compensation laws.

Your Rights: you have the right to do the following:

- Right to receive a copy of this notice. Upon request, you have the right to receive a paper copy of this notice.
- Right to receive further information. You have the right to contact our office if you want additional information about our privacy practices, your privacy rights, or disagree about a decision we made about your personal health information, or if you believe that your privacy right have been violated. The contact person will provide you with the information you will need to file a complaint.
- Right to inspect and copy your personal health information. Upon written request, you have the right to access and obtain a copy of your health information maintained by us. Please contact our Privacy Officer at our office for information you need t o access and copy your protected health information.

- Right to amend your health information. You have the right to request in writing that we amend health information maintained in your health record. We will comply with your request in the event that we determine the information would be amended if false, inaccurate or misleading. Please contact our Privacy Officer at our office for information you will need to request an amendment of your personal health information.
- Right to request additional restrictions on uses and disclosures of your health information. You have the right to request in writing that we place additional restrictions on how we use or disclose your personal health information. While we will consider any request for additional restrictions, we are not required to agree to your request. Please contact our Privacy Officer at our office for information you will need to request additional restrictions on how we may use and disclose your personal health information.
- Right to request an accounting of disclosures. You have the right to request in writing an accounting of certain disclosures made by us of your personal health information. For each disclosure, the accounting will include the date the information was disclosed, to whom, the address of the person or entity that received the disclosure (if known) and a brief statement of the reason for the disclosure. Please contact our Privacy Officer at our office for the information you will need to request an accounting of disclosures.
- Right to request confidentiality in certain communication. You have the right to request to receive your health information by alternative means of communication or at alternative locations. We will accommodate any such reasonable written request on your behalf. Please contact our privacy officer at our office for the information you will need to request confidentially in certain communications.
- Request to file a complaint. If you believe your privacy rights have been violated, in addition to filing a compliant with us, you have the right to file a written complaint with the Office of Civil Rights of the United States Department of Health and Human Services. Upon request, the privacy officer will provide the information needed to file your complaint. Under no circumstances will we retaliate against you for filing a compliant with us or the Office of Civil Rights.

Changes to Notice: We reserve the right to change our privacy practices and to alter this Notice according to those changes. In the event that our notice changes, we will mail you a copy of our revised notice to the address you have supplied us.

Privacy Officer. To contact our Privacy Officer, please address requests to:

The Greater You, Inc
1526 Ute Blvd Suite 110
Park City, UT 84098

The Greater You, Inc
Consent to Treatment

CONSENT

I understand that as a client of the The Greater You, Inc, I am entitled to the services available to help me cope constructively with the potential, present or past problems associated with my personal emotional health or my use of drugs or alcohol. These services may include group and family therapy, individual counseling, education support and psychological testing. I understand I may be referred for medical evaluations.

TREATMENT PLAN

I understand a clinician will be assigned to me and will help you to develop a treatment plan containing specific goals and assignments to be accomplished. I further understand that I have the right to refuse any or all parts of the treatment plan except for emergency treatment designed to protect the health and personal safety of others or myself. If treatment is refused, I will be required to leave the program.

DIGITAL COMMUNICATION

Digital communication, including texting, cell phone calls, web based video and audio (ie. Skype or Facetime, etc), and email are all relevant forms of communication that TGY personnel are available to use. Notes are kept electronically on secure computers and programs/applications. Confidentiality will be protected and guarded within the regulations outlined in this document. If there is ever a breach of digital information clients will be notified immediately and TGY will use all available resources to reclaim the information. TGY uses passwords and all other relevant means of securing client information both digitally and hard copy.

RELEASE OF INFORMATION

I understand that my relationship with The Greater You, Inc is confidential and no information will be released without prior consent from me or my parent or legal guardian. The only exceptions to confidentiality are as follows: you are the potential risk to harm to yourself or someone else (suicidal or homicidal), or in cases of physical or sexual abuse (for both victim and/or perpetrator), or in instances of neglect. Licensed Therapists of TGY are legally mandated by law to report to proper authorities in any of the above instances.

I understand that if I am over the age of 18 The Greater You, Inc may disclose all or any part of my record upon written consent by me.
If I am under 18 years of age, such consent must be given by the minor's parent, guardian, or other person authorized under state laws to act in his/her behalf.
I hereby authorize The Greater You, Inc. to contact my insurance companies to obtain information regarding my insurance coverage. I further authorize The Greater You, Inc. to make inquires about any claims they have filed on my behalf. I also authorize The Greater You, Inc. to release my medical record if requested by the insurance company in order to process my claim.

CONSUMER RIGHTS

I have been given a copy of the consumer's rights.

The Greater You Client Intake Package
Please Read Fully. Then fill in, sign, and return pages 11 through 14 only.

I understand a grievance procedure exists and I may follow this procedure at any time.

PERSONAL VALUABLES

It is understood and agreed that The Greater You, Inc. shall not be liable for the loss or damage to valuable and /or personal belongings brought into this facility.

The Greater You, Inc.
Financial Agreement

Payments are to be paid in full at the time of each 50 minute session. Schedule of fees are subject to change at any time with notice to each client. TGY accepts cash, check, or credit card payments and does not take insurance. Note that not all HSA cards are taken by my credit card service.

Sessions are 50 minutes, unless otherwise agreed upon.

It is understood that charges will be added to your account for additional professional services rendered by your therapist (i.e. phone contact over five (5) minutes, preparation of special forms, reports, court time etc.)

<u>Statement of Agreement:</u>

- **A. I agree that I am responsible for all fees regardless of my insurance benefits and that I will pay any unpaid balance, in full, within 30 days of the date of service. I agree to pay 10% interest per annum on any unpaid balance not paid within 30 days.**
- **B. In the event that my account is not paid as agreed, I agree to pay collections costs, including reasonable attorney fees, in addition to my balance, for such collection procedures.**
- **C. The Greater You, Inc. does not pursue insurance for payment. In the event I choose to pursue insurance reimbursement on my own, I hereby give my permission and consent to The Greater You, Inc, and its staff, to talk to my insurance company and its representatives. I understand this means release of information, medical and otherwise.**

The Greater You, Inc.
Cancellation & Rescheduling Policy

We must receive 24 hours advance notice when canceling any scheduled appointment for any reason. If we do not receive 24 hours advance notice, you will be billed in full for the missed appointment.

If you cancel without 24 hours advance notice, you may still reschedule your appointment for a later date, however, payment for the missed appointment is due in full at the time of your next appointment.

If you cancel without 24 hours advance notice a second time, you will not be able to schedule any further appointments until we have received payment in full for both appointments previously missed.

The Greater You, Inc
Description of Client Rights

As a client served at The Greater You, Inc, you have specific rights. The purpose of this form is to inform you of your rights as our client.

RIGHT TO VOLUNTARY SERVICES

If you are a legal adult (18 years old in this state), you have the right to request voluntary services. You have the right to:

● have a staff person assigned specifically to work with you in resolving your problems and ensuring that service is properly provided.
● a personal individualized assessment of your needs.
● an individualized service plan, which will be reviewed regularly, developed with your input, and implemented with your consent.
● services beginning with a reasonable time and ending when they are no longer needed or effective.
● another opinion regarding services provided (however, seeing someone outside of this setting is done at your own expense).
● referrals to other competent professional and sources of help as indicated by your service plan.
● terminate service if your circumstances require it or you feel it is in your best interest, unless doing so puts you or others in grave danger.
● resume service following termination.

RIGHT TO REFUSE SERVICE

You have the right to:

● refuse any form of service or treatment unless it has been ordered by the court or in emergency situation when necessary to prevent harm to yourself and others (if you must receive services not by your own choice, you have the right to a lawyer, a court hearing, and an appeal of the decision to a higher court. If you cannot afford a lawyer, the court will appoint one for you).
● refuse service with your primary clinician and request another practitioner in the same setting or a referral to another setting.
● be informed that without services, your situation may get worse.
● refuse to be filmed or audio taped without your written permission.
● refuse to take part in research studies without your written permission.

RIGHT TO CONFIDENTIALITY/PRIVACY

All information about you is understood to be confidential to protect your privacy. This information includes the fact that you have or have not received services. All professionals and other staff associated with this setting are obligated to preserve your privacy to the extent permitted by law.

You have the right to:

● determine the amount of information to be released whether to or from anyone outside the

setting, by a signed permission form entitled "Authorization for the Release of Protected Health Information"

● sign a permission form to release information that is specific to each situation when information is to be released.

● determine the length of time that information may be released and cancel your permission at any time.

RIGHT TO HUMANE MENTAL AND PHYSICAL ENVIRONMENT

You have a right to:

● courtesy, respect, and professionalism from everyone involved in your service in this setting.

● facilities that are comfortable and safe, promote dignity, ensure privacy, and contribute to positive outcome of your service.

RIGHT TO INFORMATION

You have a right to verbal and written information about:

● your rights, role and responsibilities as a client in this setting.

● your primary clinician's right, role and responsibilities in this setting.

● what you can expect during your service process-appointments costs, handling of emergencies, and other practices and procedures of this setting as they affect you.

● any rights that are taken away and your right to a review of this action by requesting a Grievance Procedure.

● your primary clinician's credentials and professional code of ethics.

● the name of and means to contact your primary clinician's supervisor.

● procedures for reviewing your clinical records.

RIGHT TO A GRIEVANCE PROCEDURE

Any client or legal representative of a client may file a grievance as a formal notice of dissatisfaction regarding the operation of this service and the actions or omissions of staff. If you wish to file a formal complaint, ask any staff member in the setting for the handout, "how to file a complaint in this setting". The State regulatory board or the practitioner's professional association also processes grievances. Information about how to contact these organizations can be provided.

The Greater You, Inc.
Counseling Intake Information

Treatment Provider:_____ Date: _____

Print Legal Name:_____

Address:	City:

State:	Zip Code:	

Home Number: ( )	Cell Number: ( )

Phone number where a message can be left_____

DOB: / /	Age:

Employer:	Work Number: ( )

Email	This will be used for billing for most clients:

Person to contact in case of an emergency:

Name:	Relationship:

Phone Number: ( )	

***Information of Guardian if client is a minor* (under the age of 18 years old)**

Print Legal Name of Guardian:_____

Address:	City:

State:	Zip Code:	

Home Number: ( )	Cell Number: ( )

Please fill out billing address if different than Primary Address:

Billing Company/Contact Name/Billing Email Address:	

Address:	City:

State:	Zip Code:	

Relationship:	Phone Number: ( )

Please give a brief explanation for your visit today:

PLEASE LIST ALL CURRENT MEDICATIONS:

Name _____dosage _____
Name _____dosage _____
Name _____dosage _____
Name _____dosage _____
Name _____dosage _____
Name _____dosage _____
Name _____dosage _____
Name _____dosage _____

Note all consultations are considered confidential and are protected under the law. With your signature below, you agree all information provided is current and true as of today's date.

PERMISSIONS AND RELEASES

I give permission for TGY Therapists, Life Coaches, Trainers, and other in house professionals to coordinate treatment interventions. I give permission for TGY therapists to communicate with physicians, psychologists, counselors, legal counsel, guardians, and other pertinent professionals I deem appropriate to support myself or my family member who is under the care of TGY in progressing in treatment. I understand the greatest discretion and care will be taken when discussing my case to insure protection of health information and confidentiality; that only appropriate information will be shared and discussed.
Name and contact information of people or parties you want your therapist to be able to communicate with:

_____

_____

Client Name (Please Print):

Client Signature**:**

X	Date:

Signature of legally responsible parent or guardian (if required)

X	Date:

Acknowledgement of & Agreement to the Policies & Practices of The Greater You, Inc.

I certify that I have received and read The Greater You, Inc.'s HIPAA Privacy Policy Practices. _____**(Please Initial)**

I certify that I have received, read and agree to the terms of The Greater You, Inc.'s Consent to Treatment form. _____**(Please Initial)**

I certify that I received, read, and agree to the terms of The Greater You, Inc.'s Financial Agreement and The Greater You, Inc.'s Cancellation and Rescheduling Policy. _____**(Please Initial)**

I certify that I have received and read The Greater You, Inc.'s Description of Client Rights. _____**(Please Initial)**

By my signature below, I certify that I have read, understood, and agree to the Policies and Practices of The Greater You, Inc.

Client Name (Please Print):

Client Signature:

X	**Date:**

Signature of legally responsible parent or guardian (if required):

X	**Date:**