CENTRAL UTAH COUNSELING CENTER PATIENT INFORMATION

Please note: The information provided is based on the person being seen. If you are a parent or guardian, use your child's information.

Last Name:				First Name:			
Middle Name/Initial:		Date of Birth:		SSN:			
Email:		Home Phone:		Mobile Phone:			
Physical Address:							
City/State/Zip:				Are you a Veteran:		⬜ Yes	⬜ No
Gender:	⬜ Female	⬜ Male	⬜ Non-Binary	Gender Identity:	⬜ Female	⬜ Male	⬜ Non-Binary
Marital Status:	⬜ Divorced	⬜ Never Married	⬜ Now Married	⬜ Separated	⬜ Widowed		
Emergency Contact:				Emergency contact phone:			
Emergency Contact Address:							
Are you currently seeing a Primary Care Physician, if so who?							
Would you like us to communicate with your Primary Care Physician? ⬜ Yes ⬜ No ******If so, please request a Release of Information form at the Front Desk******							

CONSENT TO RECEIVE TEXT OR EMAIL APPOINTMENT REMINDERS

I give Central Utah Counseling Center (CUCC) permission to send appointment reminders to the following email address/or cell phone number.

Email Address:_____

Mobile Number for Text Messages:_____

Do you prefer to receive appointment reminders by (check all that apply): ⬜ Email ⬜ Text ⬜ Both ⬜ None

_____
Patient Name (please print)

_____ _____
Signature of Patient or Guardian (if required) **Date**

INSURANCE INFORMATION

Primary Coverage Insurance	Secondary Coverage Insurance
Insurance Address	Insurance Address
City/State/Zip	City/State/Zip
Policyholder Relationship to Client	Policyholder Relationship to Client
Insurance Number	Insurance Number
Policy Holder Name/DOB	Policy Holder Name/DOB
Policy Holder Address	Policy Holder Address
Policy Holder City/State/Zip	Policy Holder City/State/Zip

CENTRAL UTAH COUNSELING CENTER

Co-Pay Discount Form
*****Please be aware: ALL copays are due at the time of service*****

I, _____, do hereby swear that my present total family income is as follows

FINANCIAL INFORMATION *(if the client is a minor use the guardians information)*

Employment Type (please check one)	**Primary Source of Income**	**Source(s) of income, please check all that apply**
☐ Contract	☐ Disability/Worker's Compensation	☐ Self
☐ Regular	☐ Legal Employment - Wages & Salary	☐ Parent
☐ Seasonal	☐ None	☐ Spouse
☐ Temporary	☐ Other _____	
	☐ Pension	
	☐ Welfare/Public Assistance	

Please list your total household Gross Monthly Income (before taxes):$	**Please list the number of family members dependent on your household income: Adults_____ Children:_____**	
My Wage:$	**My Spouse's Wage:$**	**Other Income:$**
Please list your employers' name:	**Please list your employers' address:**	

I guarantee the above financial information is correct. I understand I must notify the Center immediately if there is a change in my financial and/or payer status. I authorize Central Utah Counseling Center to exchange pertinent information with any payees from whom I am eligible to collect. I assign insurance benefits directly to the Center. Additionally, I, the undersigned, agree to pay the copay amount as listed below per service at the time of each service.

Name of Responsible Party if different than Client:

_____

Birthdate:_____

Address:_____

Phone: _____

_____
Signature of Applicant, Parent, or Other Responsible Party **Date**

*******OFFICE USE ONLY*******

Co-Pay amount (if applicable) taken from Mental Health Portion of Insurance card of Co-Pay Schedule	**$**
Co-Pay amount reduced to this amount per service	**$**

Co-Pay Discount Request (Therapist)
Please describe the reason(s) the standard Co-Pay may create a financial hardship:

- ☐ High medication cost/Co-Pays
- ☐ Medical costs
- ☐ Disabled family member that requires special services
- ☐ Significant debt directly related to severe mental illness
- ☐ Other (please specify)

_____ _____

Team Leader signature for Co-Pay adjustment **Date**

Years of Education completed:	Are you currently enrolled in any type of education: ☐ Yes ☐ No

What is your current living arrangement?

☐ Private residence - dependent ☐ Private residence - independent ☐ 24 - hour residential care ☐ Adult or child foster home

☐ Institutional setting ☐ Jail or correctional facility ☐ On the street/homeless shelter

What is your employment status?

☐ Disabled, not in labor force ☐ Employed full-time (35 hours or more) ☐ Employed part-time (35 or fewer hours) ☐ Homemaker ☐ Retired

☐ Student ☐ Supported/Transitional Employment ☐ Unemployed, NOT seeking work ☐ Unemployed, seeking work

Please select the option(s) that reflects your nicotine/tobacco use:

☐ Never Smoked/Vaped ☐ Former Smoker/E-Cig User ☐ Current Everyday Smoker/E-Cig User ☐ Current Some Day Smoker/E-Cig User

☐ Smokeless Nicotine User (i.e. chewing tobacco, snus, snuff, nicotine pouches, etc..) ☐ Other (Please _____

Age of first use:

What is your race?

☐ White ☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander

☐ Other single race ☐ Two or more races

What is your Ethnicity?

☐ Not of Hispanic Origin ☐ Cuban ☐ Mexican ☐ Other ☐ Puerto Rican

Have you been arrested in the past 30 days? ☐ Yes ☐ No

Please list prior mental health and/or substance use treatment and location(s) and date(s) and type(s):

Outpatient:

Inpatient:

Is this your first time being seen at Central Utah Counseling Center? ☐ Yes ☐ No

Previous mental health services anywhere: ☐ Yes ☐ No

Have you had any inpatient mental health services at the Utah State Hospital: ☐ Yes ☐ No

What language(s) do you speak?

Who referred you to CUCC:

☐ Alcohol/Drug Abuse Care Provider ☐ Clergy

☐ DCFS *Caseworker Name:_____

☐ Division of Workforce Services ☐ DSPD ☐ Employer/EAP ☐ Family or Friend ☐ Justice Referral ☐ Mental Health Provider

☐ Other Community Referral ☐ Other Healthcare Provider ☐ School ☐ Self

Are you currently involved with:

☐ Probation or parole ☐ DCFS ☐ Adult Drug Court Program ☐ Other_____

CLIENT'S HEALTH QUESTIONNAIRE

Please check any positive test(s) you have had for these illnesses: ☐ Tuberculosis (TB) ☐ Sexually Transmitted Disease ☐ Hepatitis ☐ AIDS/HIV

Has anyone told you that you have or are at risk for the diseases listed above and recommended testing or treatment? ☐ Yes ☐ No
If yes, which diseases?

History of suicide attempt(s)? ☐ Yes ☐ No
If yes, when/how?

Do you have any drug allergies/negative drug reactions? ☐ Yes ☐ No

How would you rate your current health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any needs that would require accommodation, please explain:

Please check any problems/symptoms you have had:

☐ Asthma/Lung problems	☐ Heart Problems	☐ Liver Problems	☐ Seizure/Neurological
☐ Blood Disorder	☐ Hearing Problems	☐ Muscle/Joint Problems	☐ Sleep Problems
☐ Cancer	☐ High Blood Pressure	☐ No Reported Biomedical	☐ Stomach/Intestinal Problems
☐ Chronic Pain	☐ High Cholesterol	Conditions/Complications	☐ Thyroid Problems
☐ Dental Problems	☐ Infections	☐ Other _____	☐ Vision Problems
☐ Diabetes	☐ Kidney Problems	_____	

Family members with a history of:

Alcohol Use:_____

Drug Use:_____

Mental health inpatient:_____

Jail/prison:_____

Completed suicide: _____

Do you have a history of: ☐ Sexual assault/abuse ☐ Physical abuse ☐ Emotional abuse ☐ Legal problems

Do you believe you may be pregnant: ☐ Yes ☐ No ☐ Not Applicable

Are you a single mother with dependent children: ☐ Yes ☐ No

How many dependent children do you have (ages 0-17)_____

CLIENT'S CURRENT MEDICATIONS

Prescription	Date began	Doses/Schedule	Prescriber

HERBAL OR OVER-THE-COUNTER MEDICATIONS

Medication	Dose	Schedule	Response

CONSENT TO PHOTOGRAPH

I give Central Utah Counseling Center permission to take my photo and use it in my electronic record for identification purposes.

_____
Patient Name (please print)

_____ _____
Signature of Patient or Guardian (if required) **Date**

If the client refused please document here by signing your name and date:

_____ _____
Signature **Date**

CENTRAL UTAH COUNSELING CENTER

Acknowledgment of Receipt of Notice of Privacy Practices

Central Utah Counseling Center reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Central Utah Counseling Center.

_____ _____
Patient Name (please print) **Date**

_____ _____
Signature of Patient or Guardian (if required) **Relationship of Patient Representative to Patient**

CENTRAL UTAH COUNSELING CENTER

Consent to Treat Form

I have come to Central Utah Counseling Center in hope of receiving treatment. I understand I have the right to receive details of my condition. This will also include the evaluation findings, challenges, and expected benefits of treatment. I understand I can also learn of any reasonable alternatives to treatment. I agree to receive treatment with a Central Utah Counseling Center provider.

I further give my consent to receive treatment. This consent is voluntary.

I agree to take part in the development of my plan of care and treatment following my initial evaluation. In this process, I agree to be involved in the development of my plan of care.

I understand that I have the right to ask questions and receive a reasonable response to my questions at any time during the course of my care. This includes the right to receive details of my condition. I can also ask about my evaluation findings, challenges and expected benefits of treatment, and any reasonable alternatives to treatment.

I understand that I can discuss ending treatment at any time I wish with my provider.

_____
Patient Name (please print)

_____ _____
Signature of Patient or Guardian (if required) **Date**

CENTRAL UTAH COUNSELING CENTER

Client's Rights Statement

I.The following is a listing of your rights as a client:

YOUR RIGHT TO QUALITY OF CARE

1. The right to individual mental health and/or substance abuse treatment by qualified professionals.
2. The right to have a say in making your goals for treatment.
3. The right to ask and know about different methods of treatment.
4. The right to services without being treated unfairly on the basis of race, color, nationality, age, sex, including gender identity or expression, sexual orientation, religion, handicap, or political affiliation.
5. The right to understand and review the information in your treatment record, unless this may cause harm.

YOUR RIGHT TO CONFIDENTIALITY

The Staff will not talk to anyone, other than staff members involved in your treatment, about you being a client. Information cannot be given without your written permission unless:

1. Child abuse is suspected.
2. There is a medical emergency and the information would help with your care.
3. A court orders the information.
4. There is a threat to your life or safety or you are a danger to the life or safety of others.
5. Agencies that conduct reviews may see your client information. They must respect the confidentiality of individual clients.
6. There is a crime or a threat of a crime in the premises or involving program personnel.
7. Information is needed for insurance reasons. We only need to share that you have received treatment and that treatment is reimbursed.

YOUR RIGHT TO FILE A GRIEVANCE

1. Each office has a suggestion box for your complaints, ideas or to recognize someone who served you well.
2. You have the right to file a grievance. Please discuss your concern with any staff member and ask for a Client Grievance Handout.
3. If you are aware of or have reason to believe that a staff member has acted in a manner that is unprofessional or illegal, please ask for the person's supervisor and report the information right away.

II.The following rights and protections are for clients receiving Medicaid Prepaid Mental Health Services

1. The right to receive information about your treatment provider.
2. The right to be treated with respect and dignity.
3. The right to get information on available and different treatment options in a way that you can understand them.
4. The right to be involved in decisions about your mental health care, including the right to say no to treatment.
5. The right to be free from any form of restraint or seclusion used as a means of bullying, punishment, convenience of the staff, or someone getting back at you.
6. When allowed by Federal Law, the right to request and receive a copy of your medical records, and to request that they be changed or fixed. You may be charged for the copies.
7. The right to be given health care services that meet access and quality standards.
8. Your treatment providers will not be stopped by Central Utah Counseling Center from giving you advice or supporting on your behalf the following information.
    a. Your health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
    b. Any information you need in order to choose among possible treatment options.
    c. The risks, benefits, and consequences of treatment or non-treatment.
    d. Your right to participate in decisions regarding your health care, including the right to refuse treatment, and to have a say in future treatment decisions.

III.Responsibilities

1. To respect the privacy of other clients.
2. To arrive on time for your appointments.
3. To provide the information we need so we can bill appropriately.
4. To forward all insurance or other third-party payments to us. To pay Co-Payments on time.
5. To inform us of changes in your financial situation, with your address or telephone number.
6. To discuss openly with your therapist any problems about your care.
7. To be involved in your treatment planning process.

I have read and understand the above rights and responsibilities. I authorize Central Utah Counseling Center to provide treatment.

Signature of Patient or Guardian (if required) **Relationship** **Date**

CLIENT'S SUBSTANCE USE HISTORY

Have you **ever** consumed alcoholic beverages, used an illegal drug, taken a prescription medication for a non-medical reason, or misused any substance (i.e., inhalants, over the counter medication, etc..) ? Yes ___ No___ **If yes**, please complete the questions below

Have you ever used IV street drugs? Yes ____ No ____	How many times in the past 30 days have you attended a social support meeting (i.e., AA or 12-step)? ____	How many times have you received counseling for substance use in the past? 0___ 1___ 2___ 3___ 4___ 5+___	Are you receiving Medication Assisted Treatment? Yes (specify) ___ No ___ Naltrexone/Vivitrol ___ Suboxone ___ Methadone ___ Other_____
Have you ever felt you ought to cut down on your drinking or drug use? Yes ___ No ___ (CAGE-AID Screen)	Have people annoyed you by criticizing your drinking or drug use? Yes ___ No ___	Have you felt bad or guilty about your drinking or drug use? Yes ___ No ___	Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? Yes ___ No ____

What substance(s) have you **ever** misused?	Age of first use	In the **past 30 days**, how often have you used the substance(s) you listed (please circle below)?	How did you use the substance(s) you listed(please circle below)? Oral (swallowing); Smoking; Inhalation (fumes); IV injection; Nasal (snorted);Other
⬜ Alcohol		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Cocaine/Crack		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Marijuana/Hashish		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Synthetic Marijuana (K2/Spice)		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Heroin		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Non-Prescription Methadone		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Morphine (Ms Contin)		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Hydrocodone (Vicodin, Lortab)		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Oxycodone (Oxycontin, Percocet)		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Synthetic Opioids (Fentanyl)		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Methamphetamine		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Other Amphetamines/Stimulants		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Methylphenidate (Ritalin)		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Over the Counter		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Alprazolam (Xanax)		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Diazepam (Valium)		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Lorazepam (Ativan)		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Clonazepam (Klonopin,Rivotril)		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Other Benzodiazepines		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Barbiturates		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Other Sedatives/Hypnotic		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ GHB/GBL		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Rohypnol		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ MDMA (Ecstasy)		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Ketamine (Special K)		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ PCP		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ LSD		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Inhalants		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other
⬜ Other _____		1-3 x past month 1-2 x per week 3-6 x per week Daily None	Oral Smoked Inhaled IV Nasal Other

ACE SCORE

The CDC's Adverse Childhood Experiences Study (SCE Study) uncovered a stunning link between childhood trauma and the chronic diseases people develop as adults, as well as social and emotional problems. This includes heart disease, lung cancer, diabetes, and many autoimmune diseases, as well as depression, violence, being a victim of violence, and suicide.

		SCORE 1 FOR YES AND 0 FOR NO
1	Before your 18th birthday, did a parent or other adult in the household often or very often swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?	
2	Before your 18th birthday, did a parent or other adult in the household often or very often push, grab, slap, or throw something at you? Or ever hit you so hard that you had marks or were injured?	
3	Before your 18th birthday, did an adult or person at least five years older than you ever touch or fondle you, or have you touched their body in a sexual way? Or attempt or actually have oral, anal, or vaginal intercourse with you?	
4	Before your 18th birthday, did you often or very often feel that no one in your family loved you or thought you were important or special? Or your family did not look out for each other, feel close to each other, or support each other?	
5	Before your 18th birthday, did you often or very often feel that you did not have enough to eat, had to wear dirty clothes, and had no one to protect you? Or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	
6	Before your 18th birthday, was a biological parent ever lost to you through divorce, abandonment, or other reasons?	
7	Before your 18th birthday, was your mother or stepmother: often or very often pushed, grabbed, slapped, or had something thrown at her? Or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or, ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	
8	Before your 18th birthday, did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	
9	Before your 18th birthday, was a household member depressed or mentally ill? Or, did a household member attempt suicide?	
10	Before your 18th birthday, did a household member go to prison?	
	TOTAL SCORE	

As your ACE score increases so does the risk of disease and social and emotional problems. With an ACE score of 4 or more, things start getting serious. The likelihood of chronic pulmonary lung disease increases 390%; hepatitis 240%; depression 460%; attempted suicide 1220%/ Talk to your provider about this score. You cannot change the past, but you can change and prevent further problems in the future.

Utah Dept of Health TB Screening Tool

Bureau of Epidemiology

(Adapted from the ACHA TB Screening Tool)

Part I: Tuberculosis (TB) Screening Questionnaire

Patient name_____ DOB_____ Today's Date_____

Have you ever had close contact with persons known or suspected to have active TB disease? ❑ Yes ❑ No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below) ❑ Yes ❑ No

Afghanistan	Congo	Iran (Islamic Republic of)	Namibia	Singapore
Algeria	Côte d'Ivoire	Iraq	Nauru	Solomon Islands
Angola	Democratic People's Republic of Korea	Kazakhstan	Nepal	Somalia South Africa
Anguilla	Democratic Republic of the Congo	Kenya	Nicaragua	South Sudan
Argentina	Djibouti	Kiribati	Niger	Sri Lanka
Armenia	Dominican Republic	Kuwait	Nigeria	Sudan
Azerbaijan	Ecuador	Kyrgyzstan	Northern Mariana Islands	Suriname
Bangladesh	El Salvador	Lao People's Democratic Republic	Pakistan	Swaziland
Belarus	Equatorial Guinea	Latvia	Palau	Tajikistan
Belize	Eritrea	Lesotho	Panama	Thailand
Benin	Estonia	Liberia	Papua New Guinea	Timor-Leste
Bhutan	Ethiopia	Libya	Paraguay	Togo
Bolivia (Plurinational State of)	Fiji	Lithuania	Peru	Trinidad and Tobago
Bosnia and Herzegovina	French Polynesia	Madagascar	Philippines	Tunisia
Botswana	Gabon	Malawi	Poland	Turkmenistan
Brazil	Gambia	Malaysia	Portugal	Tuvalu
Brunei Darussalam	Georgia	Maldives	Qatar	Uganda
Bulgaria	Ghana	Mali	Republic of Korea	Ukraine
Burkina Faso	Greenland	Marshall Islands	Republic of Moldova	United Republic of Tanzania
Burundi	Guam	Mauritania	Romania	Uruguay
Cabo Verde	Guatemala	Mauritius	Russian Federation	Uzbekistan
Cambodia	Guinea	Mexico	Rwanda	Vanuatu
Cameroon	Guinea-Bissau	Micronesia (Federated States of)	Saint Vincent and the Grenadines	Venezuela (Bolivarian Republic of)
Central African Republic	Guyana	Mongolia	Sao Tome and Principe	Viet Nam
Chad	Haiti	Montenegro	Senegal	Yemen
China	Honduras	Morocco	Serbia	Zambia
China, Hong Kong SAR	India	Mozambique	Seychelles	Zimbabwe
China, Macao SAR	Indonesia	Myanmar	Sierra Leone	
Colombia				
Comoros				

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to: http://www.who.int/tb/country/data/profiles/en/

Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease (or regular contact with people who are from one of these countries)? (If yes, CHECK the countries or territories, above) ❑ Yes ❑ No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facility or homeless shelter)? ❑ Yes ❑ No

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? ❑ Yes ❑ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? ❑ Yes ❑ No

Do you regularly use immunosuppressive medication, or have any of the following conditions: HIV, organ transplant recipient, diabetes, silicosis, cancer, end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, 10% or more below ideal body weight? ❑ Yes ❑ No

If the answer is YES to any of the above questions, screening with a PPD or IGRA is indicated.

*I understand that a TB (Tuberculosis) test is recommended if any answers above are marked YES and that testing is available through the Central Utah Health Department. "*Please talk to a case manager or your therapist for testing referral assistance.*"

_____

Patient, Parent, or Other Responsible Party Signature **Relationship to Patient**

CENTRAL UTAH COUNSELING CENTER

Notice of Privacy Practices

Central Utah Counseling Center is committed to protecting your medical information.

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

Effective April 14, 2003. Central Utah Counseling Center is required by law to maintain the privacy of your medical information, provide this notice to you, and abide by the terms of this notice.

HOW WE USE YOUR HEALTH INFORMATION

When you receive care from Central Utah Counseling Center, we may use your health information for treating you, billing for services, and conducting our normal business known as health care operations. Examples of how we use your information include

Treatment: We keep records of the care and services provided to you. Health care providers use these records to deliver quality care to meet your needs. For example, your therapist may share your health information with another practitioner who will assist in your treatment. Some health records, including confidential communications with other mental health professionals or substance abuse treatment records, may have additional restrictions for use and disclosure under state and federal laws.

Payment: We keep billing records that include payment information and documentation of the services provided to you. Your information may be used to obtain payment from you, your insurance company, or other third-party payers. We 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, we may disclose information about the services provided to you to claim and obtain payment from your insurance company. If you pay the full cash price for services, you may request a restriction of information to your insurance company.

Health Care Operations: We use health information to improve the quality of care, train staff, and students, provide customer service, manage costs, conduct required business duties, and make plans to better serve our communities. For example, we may use your health information to evaluate the quality of treatment and services provided by our therapists, psychiatrists, psychologists, case managers, and other health care workers.

OTHER SERVICES THAT WE PROVIDE

We may also use your health information to recommend treatment alternatives, tell you about health services and products that may benefit you, share information with family and friends involved in your care (authorized by you through a written release), share information with third parties who assist us with treatment, payment, and health care operation, and remind you of an appointment (optional, notify the therapist or secretary if you do not wish to be reminded). Also, CUCC utilizes electronic prescribing. One of the features of electronic prescribing systems is that it allows us to view medications that have been electronically prescribed to you by other physicians. This improves patient safety by helping us avoid prescribing medications that might interfere with what you are already taking. By signing the acknowledgement form that you received this form, you authorize us to view your medication history.

YOUR INDIVIDUAL RIGHTS

You have the right to

- Request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully but are not required to agree to any restriction.
- Request that we use a specific telephone number or address to communicate with you.
- Inspect and copy your health information, including billing records. There is a charge of $.25 per page copied. Under limited circumstances, we may deny you access to a portion of your health information and you may request a review of that denial.*****
- Request corrections or additions to your health information.*****
- Request an accounting of certain disclosures of your health information made by us. The 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 within the six years prior to your request and excludes dates prior to April 14, 2003. The first accounting is free, but a fee will apply if more than one request is made in a 12-month period.*****

Requests marked with a star (*) must be made in writing. Contact the Central Utah Counseling Center Privacy Officer for the appropriate form for your request.

SHARING YOUR HEALTH INFORMATION

There are limited situations when we are permitted or required to disclose health information without your signed authorization. These situations include activities necessary to administer the Medicaid program and the following:

- Emergency situation requiring immediate care. For public health purposes such as reporting communicable diseases (if such diseases have not been reported by the health department), or other diseases and injuries permitted by law.
- To protect victims of abuse, neglect, or domestic violence.
- For lawsuits and similar proceedings.
- When otherwise required by law.
- When requested by law enforcement as required by law or court order.
- For research approved by our review process under strict federal guidelines.
- To reduce or prevent a serious threat to public health and safety.
- For specialized government functions such as intelligence and national security.

All other uses and disclosures, not described in this notice, require your signed authorization. You may revoke your authorization at any time with the written statement. The following are examples.

- Most uses and disclosures of psychotherapy notes.
- Uses and disclosures of protected health information for marketing purposes, including subsidized treatment.
- Disclosures that constitute a sale of protected health information.

OUR PRIVACY RESPONSIBILITIES

Central Utah Counseling Center is required by law to:

- Maintain the privacy of your health information and notify you of any breach of your information.
- Provide this notice that describes the ways we may use and share your health information.
- Follow the terms of the notice currently in effect.

We reserve the right to make changes to this notice at any time and make the new privacy practices effective for all information we maintain. Current notices will be posted in all our offices. You may also request a copy of any notice from the secretary of the Central Utah Counseling Center Privacy officer listed below:

CONTACT US

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 we made about access to your health information, contact the Central Utah Counseling Center Privacy Officer- Jared Kummer at 34 East 100 North, Gunnison, UT 84627, 800-523-7412 or email: jaredk@cucc.us

We will investigate all complaints and will not retaliate against you for filing a complaint.

You may also file a written complaint with the Office of Civil Rights, 200 Independence Avenue, S.W. Room 509F HHH Bldg., Washington, D.C. 20201.

CENTRAL UTAH COUNSELING CENTER

Utah Department of Health & Human Services Client Rights

Clients have the right to:

- Be treated with dignity.
- Be free from potential harm or acts of violence.
- Be free from discrimination.
- Be free from abuse, neglect, mistreatment, exploitation and fraud.
- Communicate and visit with family, attorney, clergy, physician, counselor, or case manager, unless therapeutically contraindicated or court-restricted.
- Privacy of current and closed records.
- Be informed of agency policies and procedures that affect client or guardian's ability to make informed decisions regarding client care, to include:
    - Program expectations, requirements, mandatory or voluntary aspects of the program consequences for non-compliance.
    - Reasons for involuntary termination from the program and criteria for re-admission program service fees and billing.
    - Safety and characteristics of the physical environment where services will be provided.

Utah Department of Health & Human Services rights violation reporting:

- Call: 801-538-4242
- Email: licensingconcerns@utah.gov
- Mail: 195 N. 1950 W, Salt Lake City, UT 84116 (please include program name in the letter or email)