Client Information
Please Print

Doctor's Name	Referred By	Diagnosis

CLIENT INFORMATION – PLEASE COMPLETE ALL INFORMATION

Last Name	First Name	Initial	Date of Birth	Age	Sex	Marital Status	Social Security #

Mailing Address	Street	City	State	Zip	Home Phone	Cell Phone

Email Address	Name of Employer (Client)	Work Phone

Name of Spouse	Date of Birth	Age	Social Security #

Address	City	State	Zip

Employer	Address	Phone #

Name of Nearest Relative Not Living with You	Relationship	Phone #

Address of Nearest Relative	City	State	Zip

RESPONSIBLE PARTY INFORMATION (if not Client)

Last Name	First Name	Initial	Date of Birth	Age	Social Security #

Mailing Address	Street	City	State	Zip	Home Phone	Cell Phone

Name of Employer	Address	City	State	Zip	Work Phone

LIST ALL INSURANCE COVERAGE (if not insured write N/A)

Insurance Company or EAP	Phone #

Address of Insurance Company or EAP	City	State	Zip

Name of Insured Person	Date of Birth	Relationship to Client

Insurance ID #	Group Number	Phone # of Employer

Employer Name	Address	City	State	Zip

Secondary Insurance	Phone #

Address of Insurance Company	City	State	Zip

Name of Insured Person	Date of Birth	Relationship to Client

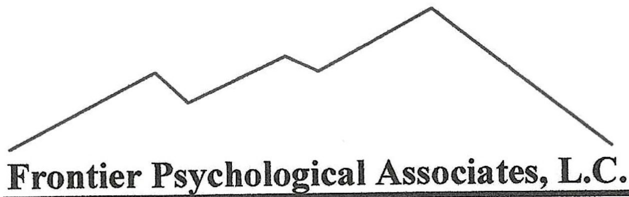
Insurance ID #	Group Number	Phone # of Employer

Employer Name	Address	City	State	Zip

I, the undersigned, give permission to release information to the third party carrier(s) and to assign all insurance benefits for treatment to be paid directly to the above named provider and request that this assignment remain on file with my insurance carrier. I certify that a copy of the assignment shall be as valid as the original. I understand that I am financially responsible for all charges whether or not paid for by insurance. I further agree to pay interest at the rate of 1½% per month (18% per year). I understand that if I do not pay on my account, my name and address may reluctantly be submitted to a collection agency to ensure payment. I understand that a one-time late payment fee for up to half of my account balance may be assessed before referring my account to a collection agency. I hereby authorize said assignee to release all information necessary to secure payment. My signature is consent for treatment for myself or dependent child.
I hereby certify and represent that I am a parent or guardian of the child/ward and have the authority to sign this document on my behalf and on my child's/ward's behalf.

A FEE WILL BE CHARGED FOR LATE CANCELLATIONS AND NO SHOWS.
TO AVOID A LATE CHARGE, PLEASE CANCEL YOUR APPOINTMENT 24 HOURS IN ADVANCE.

_______________________________ _______________________
Signature of responsible party *Date*



Frontier Psychological Associates, L.C. 724 Front Street, Suite 230, Evanston, WY 82930 (307) 789-6773 FAX (307) 789-3244

Associates:
Juliet L. Jett, Ph.D.
Julia Murray, LPC, LAT, SAP

Affiliates:
Cora Klotzbach, Psy.D.
Denise M. DeBarre, Ph.D.

PREVIOUS TREATMENT INFORMATION FORM

Client's Name:____

Were you referred by someone? _____yes _____no

If so, Who?____

Would you be willing to sign a Release for us to speak to them? _____yes _____no

Have you been in previous treatment? _____yes _____no

If so,

Provider	Date	Willing to Sign Release	
		_____yes	_____no
		_____yes	_____no
		_____yes	_____no
		_____yes	_____no
		_____yes	_____no
		_____yes	_____no
		_____yes	_____no

Thank you for completing this form.

INTAKE FORM

This information is kept confidential

Date:____________________
Name:____
Referral source:____

Marital Status:
_____never married _____married for first time _____separated
_____divorced _____widowed _____married for 2nd (or _____) time

Race/Ethnicity____

Years of formal education completed (circle one):

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 more

How religious are you?

Very				Average				Atheist	
1	2	3	4	5	6	7	8	9	10

Religion:____

CLINICAL INFORMATION:
State briefly the nature of your concerns:_______________________
____
____

When did the problems begin?_____________________________________

What solutions have been most helpful?___________________________
____
____

Have you received therapy, professional assistance or psychiatric hospitalization before? If so, please give names, professional titles, and dates of treatment:
____
____

Have you taken medication for emotional/mental problems? If so, when and what kind?
____
____

Have you ever attempted suicide?_________________________________

Do you use alcohol or other drugs? If so, how much and how often?_______________
____

Do you have a history of alcohol or drug use?____________________
____

-over-

List any physical ailments, diseases, complaints, disabilities and/or current medications:
____
____

PERSONAL AND SOCIAL HISTORY:

With whom are you now living?

Name	Relationship	Age

Has any relative attempted or committed suicide?______________________

Does any member of your family suffer from alcoholism or any mental/emotional disorder? Give details:______________________________
____
____

CURRENT BEHAVIORS:
Underline any of the following that apply to you:

Work too hard	Nervous tics	Aggression	Nightmares
Crying	Impulsive	Eating problems	Lazy
Legal problems	Loss of control	Sleep problems	Risk-taker
Odd behavior	Compulsions	Phobias/fears	Withdrawal
Temper	Smoke	Strange thoughts	Distracted easily

PHYSICAL SENSATIONS:
Underline any of the following that apply to you:

Headaches	Tingling	Back pain	Dry mouth
Dizziness	Numbness	Tremors	Burn, itch
Chest pains	Stomach trouble	Fainting spells	Tension
Muscle spasms	Tics	Hear things	Blackouts
Rapid heart beat	Fatigue	Watery eyes	See things
Sexual disturbances	Twitches	Flushes	Sweating

Please indicate any additional information you would like your therapist to know:
____
____
____
____
____
____

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____
Printed Name of Client

Welcome to Frontier Psychological Associates. It is our wish to be of service to you, and we have found that understanding the following information is helpful. If there is anything that you do not understand on this page, be sure to ask your provider, and they will be happy to discuss it.

Confidentiality: In general, any information you give to us during the course of our meetings with you is confidential and cannot be released to others without your written consent. However, there are several exceptions to this promise. First, if you state that you intend to hurt yourself or someone else, we will release that information to persons we believe appropriate in order to protect your safety or the safety of others. Second, if it comes to our attention that there are issues involving sexual or physical abuse of children or vulnerable adults, we are required by law to inform authorities of this situation. We also may share information among the Associates and Affiliates of this practice in order to gain new ideas and review the quality of services offered. For a complete statement of our policy, please see our Notice of Privacy Practices. The confidentiality of your records is protected by Federal Regulation 45 CFR Part 160 and 164. Confidentiality of records related to drug and alcohol assessment and/or treatment are regulated by Federal Regulation 42 CFR, Part 2.

Fees: The initial session when we meet to assess your situation is $185. After the initial session fees for a full therapy session are $160, and for a half session (defined as one-half hour or less) $90. Family therapy session $160. Group therapy sessions are priced as negotiated for the particular group. Community-based sessions are $185 for a full therapy session and $100 for a half session. For psychological evaluations we charge $185 per hour. Please note, insurance may not reimburse for all tasks associated with the evaluation. Substance abuse evaluations are $295. SAP (Substance Abuse Professional) evaluations for the DOT are $450. Fees for other services such as consultation vary and should be discussed before services are arranged. In addition, we ask for 24-hour notice of cancellation of session or we will charge you $70 for a missed Full session and $40 for a missed Half session. It is important that you realize that most insurance companies will not reimburse you for missed appointments. We are willing to discuss your case with you over the phone in case of emergencies, but will charge you for the time at the regular session rates after 10 minutes have elapsed.

We are happy to assist you in dealing with insurance companies, but it is important that you understand that the financial responsibility ultimately belongs to **you**. If your insurance company requires a co-payment, we ask that you pay this at the beginning or end of your session. If we are

______________________________ ____________________
Client or Guardian Date

notified by the insurance company that they have a limitation on the number of sessions they will pay for, the amount they will pay for session, or that your deductible is not yet met, we will bill you for the balance on your account. Please check with your insurance company on the status of your policy and deductible, particularly as it relates to mental health services. If your insurance company requires preauthorization, you are responsible for contacting them prior to your initial session. As part of the billing process insurance companies generally require a diagnostic code. This code describes the nature of the concerns that brought you to treatment. At times they will also require further information, such as specific symptoms or treatment goals. If you have questions regarding your diagnosis or other information given to your insurance company, please speak with your therapist.

If you have a billing difficulty, please speak to your provider. He or she will discuss an appropriate payment plan with you. An interest rate of 1½% per month (18% per year) will be assessed for unpaid balances. If you do not pay on your account, we may reluctantly submit our name and address to a collection agency to ensure payment. A one-time late payment fee may be assessed for up to half of your account balance before referring your account to collection.

Sometimes clients have emotional crises and need to speak with someone quickly. If you feel suicidal, or have any other kind of after-hours emergency, please go directly to the Emergency Room at the Evanston Regional Hospital or call **911** and ask for help.

The Mental Health Professions Licensing Act requires all professionals licensed under that act to provide a disclosure statement to all clients. Julia Murray is licensed under this act. The following information is provided for those who may receive services from her. In addition to information already provided, you need to be informed that sexual intimacy between a therapist and client is never appropriate. Also, information regarding the specific training, licensure and status of Julia Murray is to be provided as follows: Julia Murray received her Bachelor of Educational Studies from University of Missouri-Columbia with an emphasis in counseling and personnel services in May 1979 and Master of Education with an emphasis in agency and group counseling in May 1981. Current professional credentials include Wyoming Professional Counselor License # LPC-327, Wyoming Licensed Addictions Therapist #LAT-221, Utah Clinical Mental Health Counselor #12994328-6004, Missouri Professional Counselor License # CS000560 and National Certified Counselor # 20692. She is a member of the limited liability company Frontier Psychological Associates. Julia Murray will adhere to the codes of Ethics of the American Counseling Association and NAADAC. This disclosure statement is required by the Mental Health Professions Licensing Act and by the Mental Health Professions Licensing Board, 2001 Capitol Avenue, Room 127, Cheyenne, Wyoming 82002, (307) 777-7788. Substance abuse services are also governed by rules of the Wyoming Department of Health, Behavioral Health Division, 122 West 25th Street, Herschler Building 2 West, Suite B, Cheyenne, WY 82002, 800-535-4006.

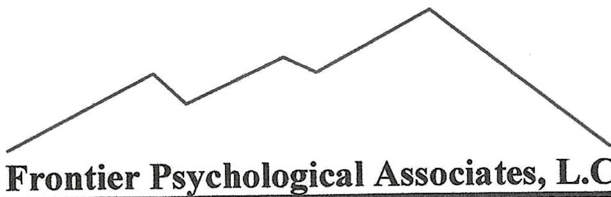
I authorize the release of any treatment information necessary to process Medicaid or other insurance claims.

I have read and understand the above information and have received a copy of this to keep.

I have received a copy of the Notice of Privacy Practices.

__________________________________ __________________

Client or Guardian Date



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____
Printed Name of Client

Frontier Psychological Associates, LC
Electronic Communications Policy

Frontier Psychological Associates, LC is concerned about your privacy, and the following is provided for your protection. Please be aware of possible breaches in confidentiality if you communicate with us electronically (i.e., by phone, email, video platform, etc.) It is possible others could hear you on the phone or video platform, or could read emails or faxes. This is a particular concern if you are using public access to the internet or if you are on a computer network. It is advisable to be aware of your employer's policies regarding use of work phones and/or computers before communicating with us from work. You should consider avoiding use of auto-remember services on your computer for passwords that access your email or other confidential accounts. There is also risk of technical failure with any electronic device. Other entities (i.e. schools, social service agencies, etc.) may use electronic communications to send us information about you or your child and we have no control over their security measures.

Telephone

We use an answering machine on which you can leave messages. Please remember there is always a risk of technical failure, and we might not receive your message. In addition, you should be aware that our therapists cannot guarantee how promptly phone messages will be received and responded to. It can take days for a response and issues may often be addressed during the next therapy session rather than through a lengthy phone conversation.
PLEASE INITIAL YES OR NO BELOW:

I agree to receive messages on my cell phone. *Yes*_____ *No*_____

I agree to receive messages on my home phone *Yes*_____ *No*_____

I agree to receive messages at another number *Yes*_____ *No*_____

*Name and other number where messages can be left*______________________________

______________________________ ______________________________
Client or Guardian Signature Date

Social Networking

FPA does not have a presence on any social networking sites (Facebook, LinkedIn, Twitter, blogs, etc.) We do have a website for informational purposes only. Some therapists may have personal social networking accounts. We do not accept friend or contact requests from current or former clients. We believe that adding clients as friends or contacts can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when you meet with your provider.

Location-Based Services

If you use location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. We do not place our practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at our office on a weekly basis. Please be aware of this risk if you are intentionally "checking in" or if you have a passive LBS app enabled on your phone.

Email

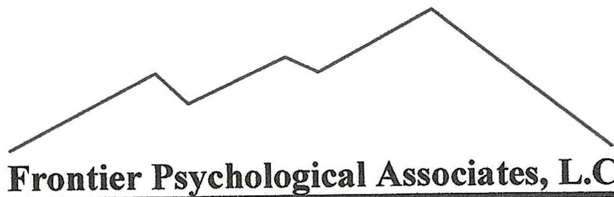
We use the Virtru person-to-person encrypted email program. Please be aware that this program only secures outgoing emails and does not protect incoming emails you or other entities may send us. In addition, you should be aware that our therapists cannot guarantee how promptly emails will be received and responded to. It can take days, or possibly weeks, for a response and issues may often be addressed during the next therapy session rather than through an email response. **PLEASE INITIAL YES OR NO BELOW**.

I waive my right to encryption of emails regarding myself or my dependent. Yes_____No_____

I have read and understand the above information and have received a copy of this to keep.

_____________________________________ _____________________________

Client or Guardian Signature Date



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CLIENT RIGHTS

You Have The Right:

*To be treated with respect and dignity

*To have your privacy protected

*To help develop a plan of care and services that meets your specific mental health needs

*To have family members and/or members of your support system participate in your assessment and ongoing treatment if requested

*To participate in decisions regarding your mental health care

*To receive services in a barrier-free location (accessible)

*To request information about names, location, phones and languages for local agencies

*The right to receive the amount & duration of services needed

*To understand available treatment options and alternatives

*To refuse any proposed treatment

*To receive care that does not discriminate against you (e.g. age, race, type of illness)

*To be free of any sexual exploitation or harassment

*To receive quality services that are medically necessary

*To have a second opinion from a mental health professional

*To choose a mental health care provider or choose one for your child

I have read these rights and understand them.

______________________________ __________________________

Client or Representative Date

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NOTICE OF PRIVACY PRACTICES

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

Effective Date of this Notice and Policy is February 4, 2014.

1. PURPOSE: Frontier Psychological Associates, LC (FPA) and its professional staff, employees, and trainees follow the privacy practices described in this Notice. FPA keeps your mental health information in records that will be maintained and protected in a confidential manner, as required by Federal Regulation 45 CFR Part 160 and 164 (HIPPA). Confidentiality of records related to drug and alcohol assessment and/or treatment are regulated by Federal Regulation 42 CFR, Part 2. Please note that in order to provide you with the best possible care and treatment, all professional staff involved in your treatment and employees involved in the health care operations of the agency may have access to your records.

2. HOW WILL FPA USE MY PROTECTED HEALTH INFORMATION **(PHI)**? Your PHI will be retained by FPA for approximately eight (8) years after your last clinical contact. After that time has elapsed, your PHI will be erased, shredded, burned or otherwise destroyed in a way that protects your privacy. Copies of mental health records that have been distributed to other entities may continue to exist and be managed by their policies. Until the records are destroyed, they may be used for the following purposes:

- Appointment reminders and notification when an appointment is cancelled or rescheduled;
- As may be required by law;
- Mental health oversight activities, e.g., Audits, inspections, investigations of administration and management of FPA;
- Lawsuits and disputes;
- Law enforcement (e.g., in response to a court order or other legal process) about a death that may be the result of criminal conduct; about criminal conduct that occurred against a person or property associated with FPA; when emergency circumstances occur relating to a crime;
- To prevent a serious threat to health or safety. For example, confidentiality may be waived to protect your safety or the safety of others. Additionally, if it comes to our attention that there are issues involving sexual or physical abuse of children or vulnerable adults, we are required by law to inform authorities of this situation;
- Obtaining authority and reimbursement for services from insurance companies;

- To carry out treatment and health care operations functions through transcription, billing services, accounting, taxes and collections;
- When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

3. YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES. Except as indicated in this privacy notice, we will not use or disclose your PHI unless you authorize (permit) FPA in writing or verbally to do so. You may revoke your permission, which will be effective only after the date of your written revocation. Psychotherapy notes, if and when utilized, will require a separate authorization prior to disclosure.

YOU HAVE RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION.

You have the following rights regarding your PHI, provided that you made a written request to invoke the right on the form provided by FPA.

- Right to request restriction. You may request limitations on your PHI we may disclose, but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

- Right to confidential communications. You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted.

- Right to inspect and copy. You may have the right to inspect and copy your PHI regarding decisions about your care; however, psychotherapy notes may not be inspected and copied. We may take up to thirty (30) days to respond to your request. We may charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied. If you are denied access to PHI, you may request that the denial be reviewed. Another licensed health care professional, other than the person who denied your request, will be chosen by the facility to review your request and denial. FPA will comply with the outcome of the review.

- Right to request clarification or amendment of your PHI. If you believe that the information we have about you is incorrect or incomplete you may ask to add clarifying information. You may ask for a form for that purpose and the form will

require certain specific information. We have up to sixty (60) days to provide a written response to your request. FPA is not required to accept the information that you propose, but will provide an explanation if it is denied.

- Right to accounting of disclosures. You may request a list of the disclosures of your PHI that have been made to persons or entities other than for treatment or health care operations in the last eight (8) years, but not prior to April 14, 2003.

- Right to restrict disclosures when you have paid for your care out-of-pocket. You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

- Right to be notified if there is a breach of your unsecured PHI. You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPPA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

- Right to a copy of this Notice. You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy.

REQUIREMENTS REGARDING THIS NOTICE

FPA is required to provide you with this Notice that governs our privacy practices. FPA may change its policies or procedures in regard to privacy practices. If and when changes occur, the changes will be effective for PHI we have about you as well as any information we receive in the future. Any time you come in to FPA for an appointment, you may ask for and receive a copy of the Privacy Notice that is in effect at the time.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with FPA or with the Health and Human Service Office of Civil Rights. You will not be penalized or retaliated against in any way for making a complaint.

Contact: Call FPA and ask to speak to the person/official responsible for privacy. The person responsible for privacy is Julia Murray, M.Ed., L.P.C.

Forms/privacypol