life stone™

Client Information

Client Name: First _____ Middle _____ Last_____ Gender: _____

SSN: _____ DOB: _____ Age: _____ How did you first hear about us: _____

Address: _____ City: _____State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Employer: _____ Phone: _____ Address: _____

Religion: _____ Single | Married | Separated | Divorced

Emergency Contact: _____ Relationship: _____ Phone: _____

Spouse/Partner/Parent Name:_____ Their DOB: _____

Divorced Spouse/Parent Name: _____ Their DOB: _____

Primary Insured Name: First _____ Middle _____ Last _____ Gender: ___

Insured Policy # _____ Group #: _____

Insured DOB: _____Insurance Company: _____

Secondary Insurance Company Name: _____

List all current **PRESCRIPTIONS and/or MEDICAL CONDITIONS**?

Prescription and/or Condition	Month/Year it Started/Stopped	Comments

_____ _____

Signature of Patient or Patient Representative* Date

*If client is a minor, signature of the legal guardian is required. ☐Parent ☐Foster ☐Guardian

**Proof of guardianship is required for all minors with guardians.

***If Guardian is different from parent: Name: _____ Phone: _____

Address: _____ City: _____State: _____ Zip: _____

life stone™

Client Authorization for Release of Protected Health Information

Client Name (First / Middle / Last): _____

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

Social Security Number*: _____ DOB: _____ Phone: _____

* Providing your Social Security Number is voluntary but necessary to accurately identify your medical records.

1. I authorize the following health care provider or facility **TO RECEIVE & DISCLOSE** my patient information:
   Life Stone Center, 7300 S. 300 West, Suite 101, Midvale, UT, 84047, phone: 801-984-1717
2. I authorize the following person or organization **TO RECEIVE & DISCLOSE** my patient information:
   [Court, Judge, Probation/Parole Officer, Attorney, Medical Provider, Therapist, Clergy, Family, Friend, Employer]
   ☐ Name/Organization/Phone# : _____
   ☐ Name/Organization/Phone# : _____
   ☐ Name/Organization/Phone# : _____
   ☐ Name/Organization/Phone# : _____
   ☐ Name/Organization/Phone# : _____
3. Please disclose the following information: Assessment, Treatment, Compliance, Completion and Referral.
4. Discloser may occur to: Obtain Information, Provide Updates, Facilitate Court Process, and Provide Referral.
5. I understand that sanctions may be applied if I revoke my consent.
6. If applicable, I understand that based on the information I have designated above, the disclosure Life Stone makes pursuant to this authorization may include information regarding my participation in a substance abuse treatment program. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 and 164.
7. I understand that Life Stone will not condition treatment, payment enrollment or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used under this authorization. Fees may apply.
8. I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to: Life Stone/Medical Records, 7300 S. 300 West, Suite 101, Midvale, UT, 84003. I understand my revocation is not effective to the extent that action has been taken in reliance on this authorization. This authorization expires 1 year from the date below.

I have read the above, understand it, and hereby give my consent to the above-mentioned receipt & disclosure.

_____ _____

Signature of Patient or Patient Representative* Date

*If client is a minor, signature of the legal guardian is required. ☐Parent ☐Foster ☐Guardian

life stone™

Rights & Notice of Privacy Practices

Client Name (First / Middle / Last): _____

Life Stone's written policy for consumer rights and privacy includes the following:

1. Clients have the right to be treated with dignity and equality without discrimination according to race, religion, gender, sexual orientation or physical handicap.
2. Clients have a right to privacy. It is the responsibility of everyone who is working for Life Stone to protect information in the records from being made available to anyone who is not specifically authorized to have access to that information.
3. Clients have the right to treatment in a safe treatment environment. Every effort will be made to have clients conform to program and treatment rules and expectations, including being warned regarding inappropriate behavior, asked to leave the setting if necessary, and including the use of law enforcement if further assistance is necessary. Clients may be involuntarily terminated for lack of compliance with treatment program expectations. Clients may be re-admitted upon re-application and re-evaluation by program staff.
4. Clients have the right and responsibility to participate in their treatment as determined by assessment and evaluation, which will be conducted on an ongoing basis during the course of treatment. Clients will have the opportunity to continue in treatment by following all the rules and program expectations.
5. Clients have a right to make complaints about their treatment. Clients are encouraged to take complaints first to their therapist, counselor, or case manager and thereafter to owners if the complaint is not addressed correctly.
6. Clients with a smoking addiction may continue to smoke at the center during designated breaks and in designated outdoor locations. Clients are not allowed to smoke during group, individual therapy or any indoor location at the Center. All applicable restrictions and guidelines of the Utah Clean Air Act must be followed.

HIPPA Authorization

I hereby authorize the use or disclosure of my protected health information as described below and understand and acknowledge the following:

I am not required to sign this authorization and may in fact refuse to sign this authorization. Life Stone Center will not condition my treatment or payment for my treatment on obtaining this authorization from me, unless permitted by law. If the organization or person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected. I may inspect or copy the protected health information sought to be used or disclosed in this authorization, as permitted by the federal privacy regulations. I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to Julie Pettit at Life Stone Center. If I do revoke this authorization, however, my revocation will not affect any prior actions taken in reliance on my authorization. If I have any questions about this authorization, I may contact Julie Pettit at Life Stone Center. She will provide me with more information about this authorization and/or about Life Stone's privacy practices. This authorization applies to **Treatment Recommendations and Notices of Compliance** to specific agencies. This authorization will expire automatically twelve months following the discharge date from **LIFE STONE GROUP.**

I certify I have READ, UNDERSTOOD and SIGNED this Notice of Privacy Practices. I may request a copy of this Notice.

_____ _____

Signature of Patient or Patient Representative* Date

*If client is a minor, signature of the legal guardian is required. ☐Parent ☐Foster ☐Guardian

life stone™

Client Expectations

Client Name (First / Middle / Last): _____

As a participant at Life Stone, I agree to the following:

- I agree to fully participate in treatment and will not be disruptive or threatening in any way.
- I agree to give 24 hours notice when cancelling an appointment. I understand that if prior notice is not given, Life Stone reserves the right to charge for time reserved.
- I agree to not engage in physical, sexual or other intimate behaviors with other Life Stone group members or staff. Fraternization with other Life Stone group members may be forbidden, as determined by the Treatment Team.
- I agree to refrain from any and all violent or threatening behavior while on the premises. This includes weapons and knifes. Such behavior may result in my being asked to leave the premises and/or being arrested.
- I agree that while I am at Life Stone, to demonstrate personal integrity and self-respect, I will dress in clothes that are modest, non-offensive and non-distracting to staff and other group members. Clothing cannot be revealing. Shorts and skirts must be mid-thigh when seated.
- If you are in a life and death emergency situation, dial 911 for assistance or go immediately to your local emergency medical facility.
- I agree to keep the names and information revealed by other clients confidential during group or family sessions.
- I agree to complete all assignments and bring them to the assigned session.
- Involuntary termination from my program may result if I fail to attend group sessions or contact Life Stone. Upon involuntary termination, my file may be closed and I may be required to be re-evaluated, at my own expense, and pay any outstanding balance before being readmitted to the program. I understand that, upon Involuntary Termination, I may be required to start my program over.
- I agree to never bring prescription drugs, illegal substances, alcohol or Spice/K2 to Life Stone. I understand I am expected to be free from the influences of any drugs and/or alcohol at the time of services. I agree to not take prescription and/or over-the-counter drugs without disclosing them to Life Stone. If I am under the influence of any substance, I am expected to report this to my instructor/therapist. If I am suspected of being under the influence, I agree to submit to a drug test, and that I may be asked to leave the facility and forgo my scheduled session. If I use any substance listed above during treatment, I may subject to a higher level of care as determined by the Treatment Team. Additional fees may apply.
- I understand Life Stone may disclose all knowledge of illegal behaviors not related to consented parties and/or law enforcement agency.
- I agree to arrive at least 10 minutes early in order to check in, pay any owed fees and be ready to receive services. I agree that, if I am more than 15 minutes late, I may not be permitted to attend the session. If I do not think I will be able to attend a session, I will contact Life Stone in advance and make arrangements for making up the session in order to prevent a non-compliance letter from being sent to consented parties.

I have read and understand the above expectations. I understand the failure to comply with any of these items listed above may result in termination of services.

_____	_____	_____
Signature of Patient or Patient Representative*	Date	Life Stone Witness

*If client is a minor, signature of the legal guardian is required. ☐Parent ☐Foster ☐Guardian

life stone™

Consent for Treatment & Financial Responsibility

Client Name (First / Middle / Last): _____

CONSENT FOR TREATMENT:
I acknowledge that I have received, have read (or have had read to me), and understand the information about the Life Stone services. I have had all my questions answered fully. I do hereby seek and consent to take part in the services provided by this organization. I agree to play an active role in my treatment. We reserve the rights to refuse and/or discontinue service at any time and for any reason.

I understand that no promises have been made to me as to the results of treatment or of any procedures or services provided by this agency and/or service providers at this agency. While psychotherapy cannot insure the successful resolution of issues you face, it is our experience that most people can gain benefit from the therapeutic process.

I understand that Life Stone is not a medical facility. Clients should have regular medical evaluations to identify any health or medical needs. Clients must inform Life Stone of any health or medical conditions that may be relevant to the services provided at Life Stone.

Although the client-therapist sessions will be intimate psychologically, it is important for you to understand that the client-therapist relationship is professional and not social. All contact will be limited to sessions you arrange with your therapist. Sessions are usually held in our offices. If I am participating in an electronic service, I understand that I must be in the state of Utah to receive these services. If you should encounter your therapist outside of the office, the therapist will speak with you only if you initiate the contact; this allows you to maintain your privacy.

FINANCIAL RESPONSIBILITY:
I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged the full self-pay rate for that appointment. Insurance will not pay for a non-cancelled/no show appointment.

I understand that I will be responsible for the cost of all services provided. Full payment is due at the time of service; I understand that I will be paying my bill at the time of service even if I have insurance coverage. I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), costs, date(s), & providers of any services or treatments I receive.

Insurance is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services it is ultimately your responsibility to pay that portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have with your insurer). It is the patient's responsibility to know your contract benefits, assure collection of insurance payments to us and to negotiate with your insurance company over any disputed claims. If your insurance company rejects your claim, you are responsible to pay the balance in full upon receipt of your statement. I understand that if payment is not received for my services, the therapist may discontinue my treatment. We do not charge for basic paperwork requests. We may charge for paperwork requests that we judge to be beyond basic.

RETURNED CHECKS: A $35.00 handling charge is applied to all returned checks.

DELINQUENT ACCOUNTS: Accounts that are more than 30 days delinquent are placed with our collection attorney for legal action. If your account goes to our collection attorney, a 30% balance increase will be added to the balance owed on the day your account is sent to our attorney. You will also be responsible for all attorney's fees and court costs. Interest will also start to accrue at the rate of 18% per year after your account becomes more than 30 days delinquent.

My signature below shows that I understand and agree with all of these statements.

_____ _____
Signature of Patient or Patient Representative* Date

*If client is a minor, signature of the legal guardian is required. ☐Parent ☐Foster ☐Guardian

life stone™

Arbitration Agreement

Client Name (First / Middle / Last): _____

Article 1. Dispute Resolution

By signing this agreement ("Agreement") we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or jury.

Article 2. Definitions

A. The terms "we," "parties" or "us" means you, (the Patient), and the Provider.
B. The term "Claim" means one or more Actions defined in the Utah Health care Malpractice Act (Utah Code 78-14-3 (15). Each party may use any legal process to resolve non-medical malpractice claims.
C. The term "Provider" means the physician, group or clinic and their employees, partners, associates, agents, successors and estates.
D. The term "Patient" or "you" means you and any person who makes a Claim for care given to you, such as your heirs, your spouse, children, parents or legal representatives.

Article 3. Dispute Resolution Options

A. Methods Available for Dispute Resolution. We agree to resolve any and all Claims by the following:
   a. Working directly with each other to try and find a solution that resolves the Claim; OR
   b. Using non-binding mediation (each of us will bear one-half of the costs); OR
   c. Using binding arbitration as described in this Agreement.
B. Legal Counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and cots of our own attorney.
C. Arbitration-Final Resolution. If working with the Provider or using non-binding mediation dos not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final.

Article 4. How to Arbitrate a Claim

A. Notice. To make a Claim under this Agreement, mail a written notice to the Provider by certified mail that briefly describes the nature of your Claim (the "Notice"). If the Notice is sent to the Provider by certified mail, it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement.
B. Arbitrators. Within 30 days of receiving this Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.
   a. Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.
   b. Jointly-Selected Arbitrator. You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly-Selected Arbitrator). If you and the Provider(s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly-Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal courts of Utah. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Utah court select an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly-Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Utah Uniform Arbitration Act.
C. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each of us will pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.
D. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Utah Uniform Arbitration Act.

Client Initials _____

E. All Claims May Be Joined. Any person or entity that could be appropriately named in a court proceeding ("Joined Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision ("Joinder"). Jointed may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A "Jointed Party" does not participate in the selection of the arbitrators but is considered a "Provider" for all other purposes of this Agreement.

Article 5. Liability and Damages May be Arbitrated Separately

At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel e selected for considering damages. However, if a second panel is selected, the Jointly –Selected Arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

Article 6. Venue/Governing Law

The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Salt Lake City, Utah. Arbitration proceedings are private and shall be kept confidential. The provisions of the Utah Uniform Arbitration Act and the Federal Arbitration Act govern this Agreement. We hereby waive the pre-litigation panel review requirements. The arbitrators will apportion fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

Article 7. Term/Rescission/Termination

A. Term. This Agreement is binding on both of us for one year form the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it.
B. Rescission. You may rescind this Agreement within 10 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date of the rescission is postmarked. If not rescinded, this Agreement will govern all medical services received by the Patient from Provider after the date of signing, except in the case of a Joined Party that provided care prior to the signing of this Agreement (see Article 4(E).
C. Termination. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to the Provider. This Agreement applies to any Claim that arises wile it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.

Article 8. Severability

If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

Article 9. Acknowledgement of Written Explanation of Arbitration

I have received a written explanation of the terms of this Agreement. I have had the right to ask questions and have my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration related costs. I understand that this Agreement renews each year unless cancelled before the renewal date. I understand that I can decline to enter into the Agreement and still receive health care. I understand that I can rescind this Agreement within 10 days of signing it.

Article 10. Receipt of Copy I have received a copy of this document.

_____ _____

Signature of Patient or Patient Representative* Date

*If client is a minor, signature of the legal guardian is required. ☐Parent ☐Foster ☐Guardian