APPLICATION/REGISTRATION FOR SERVICES

Client ID:_____

Client Information

Birthdate:_____

Client Legal Name: _____ Client Preferred Name: _____

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

Home Phone: _____ Cell Phone: _____ Email: _____

Primary Language: □ English □ Spanish □ Other_____ Religious preference: _____

Marital Status: □ Married □ Divorced □ Widowed □ Single □ Separated

Race: □ Alaska Native □ Asian □ Black/African-American □ Native American □ White
□ Pacific Islander or Native Hawaiian □ Other single race □ 2 or more races □ Decline to answer

Ethnicity: □ Dominican □ Hispanic or Latino □ Not Hispanic or Latino □ Decline to answer

Assigned Gender: □ Male □ Female

Gender Identity: □ Agender □ Female □ Male □ Genderqueer □ Non-binary □ Transgender □ Other
□ Don't know □ Decline to answer

Sexual Orientation: □ Gay/Homosexual □ Straight/Heterosexual □ Bisexual □ Don't know □ Other
□ Decline to answer

Pronouns: □ She/Her/Hers □ He/Him/His □ They/Them/Theirs □ Other □ Decline to answer

Are you homeless: □ Yes □ No

How Did You Hear About Us

Name/Clinic:_____ Phone:_____

Emergency Contact

Next of kin:

Name: _____ Phone: _____ Relationship to Client: _____

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

Other emergency contact:

Name: _____ Phone: _____ Relationship to Client: _____

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

Insurance Information

Do you have Insurance: □ Yes □ No

Name of Insurance: _____ Plan: _____

Policy or ID#:_____ Phone #: _____

Policy Holder Name: _____Phone #:_____ DOB: _____

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

Primary Care Physician

Do you have a Primary Care Physician: □ Yes □ No

Name/Clinic: _____Specialty: _____ Phone #: _____

Address:_____City:_____State:_____Zip:_____

Education/Employment

Education Status: □ Enrolled □ Not enrolled Education Level: _____

Employment Status: □ Employed □ Not employed Employment Information: _____

Military Status: *Currently in the U.S. Military:* □ Yes □ No *Prior experience in the U.S. Military:* □ Yes □ No

Tobacco Use: □ Yes □ No

Advanced Directive: □ I have an Advanced Care Directive □ I do not have an Advanced Care Directive

Acknowledgements

□ Yes □ No I have received a copy of Highland Springs Specialty Clinic's Notice of Privacy Practices

□ Yes □ No I have received a copy of Highland Springs Specialty Clinic's Client Rights & Responsibilities

_____ (initial) *Abuse or Violence:* I acknowledge and understand that Highland Springs Specialty Clinic may have a legal obligation to report or make referrals in instances of abuse of children and elderly or vulnerable adults to appropriate governmental or law enforcement agencies, and, further, that Highland Springs Specialty Clinic may have a legal obligation to report or make referrals in instances of family violence or threatened crimes to appropriate governmental or law enforcement agencies. I further consent to such reports and/or referrals by Valley.

Emergency Medical Care

□ Yes □ No I consent to receive first aid and emergency treatment. This would be if I have an accident, injury, illness or other medical emergency. I understand this applies only during treatment at Highland Springs Specialty Clinic.

Consent

□ Yes □ No I consent to treatment and testing / assessment at Highland Springs Specialty Clinic and with Telehealth. I understand testing includes, but is not limited to intellectual, cognitive, developmental and functional testing.

□ Yes □ No I hereby consent to have Highland Springs Specialty Clinic staff to communicate with me, where appropriate via e-mail and text messages regarding the following aspects of my medical care and treatment (*prescriptions, appointments and billing*). I understand that e-mail and text messages are not a confidential method of communication. I further understand that there is a risk with these means of communication between my treatment team, clinical office staff, my other physicians or nurse practitioners and myself regarding my medical care and treatment that may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail and/or text communications between my physician, clinical office staff, my other physicians or nurse practitioners and myself regarding my medical care and treatment may be printed out and made a part of my medical record.

I understand that in an urgent or emergency situation I should call my provider or go to the Emergency Room and not rely on email.

I understand that if I have a grievance, I have the right to file a complaint with Valley's Client Advocate 801-263-7135 and/or DHS Licensing 801-538-4242/dhslicensing@utah.gov.

I further consent to, and agree, that any electronic signatures by me are valid and enforceable as if I signed in person.

I certify that I understand the above information and that it is accurate and complete.

_____ _____

Signature of Client or Legal Representative Date

_____ _____

Printed Name of Legal Representative Relation to Client

_____ _____

HSSC Staff Signature Date

V4.2023

CLIENT FEE AGREEMENT-CANCELLATION & PAYMENT POLICIES

Client ID # _____

Name: _____ **DOB:** _____ **Effective Date:** _____

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

Phone #: _____ **Email:** _____ **SSN#:** _____

BY SIGNING THIS FORM, I AGREE TO THE FOLLOWING ASSIGNMENT OF BENEFITS:

- I accept financial responsibility for payments due for all services received. All co-payments and deductibles must be paid at the time of the service. This arrangement is part of your contract with your insurance company.
- I understand that my insurance may not cover all services provided, and that I will be expected to pay for non-covered services at the self-pay rates. Rates are available upon request. These rates are subject to change.
- _____**(initial) I acknowledge that Highland Springs Specialty Clinics are non-participating Medicaid providers and that I am not currently Medicaid eligible.**
- _____**(initial) I will notify Highland Springs Specialty Clinic if I become Medicaid eligible during my treatment at Highland Springs Specialty Clinic and understand a referral will be made to a Medicaid provider and that I will be discharged from treatment at Highland Springs Specialty Clinic.**
- I **further understand that Highland Springs Specialty Clinic cannot bill Medicaid for any services received at a Highland Springs Specialty Clinic if I were to become retroactively eligible for Medicaid.**
- I understand that Highland Springs Specialty Clinic will bill my health insurance or other payer the full cost of services for all covered treatment and services I receive.
- I understand that I must notify Highland Springs Specialty Clinic of any changes to my insurance or coverage and that by failing to do so I will be liable for the self-pay rates for all services provided.
- I understand that if my insurance is terminated and I am not covered on the date of service that I will be charged the self-pay rates for all services I have received after the insurance termination date.
- I agree to send Highland Springs Specialty Clinic all payments from insurance or third-party payers that I have received directly for services I have received from Highland Springs Specialty Clinic and that failure to do so will result in me being liable for such payments.
- I understand that Highland Springs Specialty Clinic does NOT accept checks
- I understand that Highland Springs Specialty Clinic has the right to refuse to provide additional services and send my account to a collection agency for resolution after 90 days of non-payment for services.
- If my account is sent to a collections agency, I understand that I am liable for all costs incurred by Highland Springs Specialty Clinic including court filings, constable fees, attorney fees, and interest accumulation at the legal rate on the unpaid balance until the balance is **paid in full**.
- I understand that there are fees associated with missed appointments that are not cancelled/rescheduled with 24 hours' notice. **The fee is $50.00 per missed appointment**.

Authorizations

- I authorize my insurance company or third-party payer to make payments, otherwise payable to me, directly to Highland Springs Specialty Clinic. In the event that the benefits paid exceed the total cost of services Highland Springs Specialty Clinic will be responsible for issuing a refund.
- I authorize Highland Springs Specialty Clinic to pre-authorize services with my insurance company and to appeal, on my behalf, any decision made by the insurance company regarding payment.
- I authorize Highland Springs Specialty Clinic to disclose protected health information to my insurance company or any other entity responsible for paying for my treatment in order to obtain reimbursement.

This fee agreement covers all services provided by Highland Springs Specialty Clinic including mental health and substance abuse treatment.

Client/Parent/Representative Signature	**Date**
Parent/Representative Printed Name	**Relationship to Client**
HSSC Staff Signature	**Date**