Utah Healing Center

5284 S. Commerce Dr., Suite C-134 ♦Murray, UT 84170♦Phone: 801-266-4643♦Fax: 801-266-4775

Patient Information

NAME		**DOB**		**AGE**		**SSN**	
HOME ADDRESS		**CITY**		**STATE**		**ZIP**	
PRIMARY PHONE		**E-MAIL**		**GENDER**		**RACE**	

SINGLE	**MARRIED**	**DIVORCED**	**WIDOWED**

(Please circle all that apply)

STUDENT	**EMPLOYED**	**RETIRED**	**DISABLED**

(Please circle all that apply)

HOW MAY WE REMIND YOU OF YOUR APPOINTMENT								
BY PHONE CALL	**Y**	**N**	**BY TEXT MESSAGE**	**Y**	**N**	**BY E-MAIL**	**Y**	**N**

School/Employment Information

PATIENT'S SCHOOL/EMPLOYER			**PATIENT'S OCCUPATION/GRADE**		
ADDRESS		**CITY**		**ZIP**	

(Please circle highest level completed)

GRADE SCHOOL	**HIGH SCHOOL**	**COLLEGE DEGREE**	**GRADUATE DEGREE**	**OTHER**

Insurance

PRIMARY INSURANCE POLICY HOLDER (Person who has the insurance)	**DOB**	**SSN**	**INSURANCE COMPANY**	**POLICY #**
ADDITIONAL INSURANCE POLICY HOLDER (Person who has the insurance)	**DOB**	**SSN**	**INSURANCE COMPANY**	**POLICY #**

Parent / Legal Guardian Information

(Complete if Patient is Under 18)

NAME		**DOB**		**AGE**		**SSN**	
HOME ADDRESS		**CITY**		**STATE**		**ZIP**	
HOME PHONE		**CELL PHONE**		**WORK PHONE**			

I GIVE PERMISSION TO TREAT THE ABOVE MENTIONED PATIENT.

CLIENT SIGNATURE (IF NOT A MINOR) _____ **DATE** _____

PARENT/LEGAL GUARDIAN SIGNATURE _____ **DATE** _____

WITNESS' SIGNATURE _____ **DATE** _____

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Notice of Privacy Practice Receipt and Acknowledgement of Notice

I hereby acknowledge that I have received and been given an opportunity to read, a copy of Utah Healing Center's *Notice of Privacy Practices*. I agree to allow my Protected Health Information (PHI) to be used to provide treatment, arrange for payment for services, or for other ways as outlined in the Notice. I understand that if I have questions regarding the Notice or my privacy rights, I can discuss them with my therapist.

Advanced Directive			
If at any time during your visits to Utah Healing Center should you become disoriented, confused, feel that you cannot drive home, or need special medical attention, what would you prefer the therapist do:			
Call a Family Member	Contact Mobile Crisis	Other	Assist you to the nearest ER
Contact information of Emergency Choice Listed Above			
Name		Phone #	

Payment Options

I give permission to bill insurance, an approved third party payer, or myself. Client will be responsible for extra time not covered by insurance.

MY COPAY IS: _____ **MY DEDUCTIBLE IS:** _____

I PREFER TO PAY:

CO-PAY AT SESSION		**CASH/DEBIT/CREDIT/MEDICAL CARD EACH SESSION**		**MONTHLY PAYMENT FROM INVOICE**	

I AGREE THAT ALL OF THE ABOVE MENTIONED INFORMATION IN THIS DOCUMENT IS LEGAL AND VALID AND I AGREE TO BE LIABLE FOR MY BILL.

CLIENT SIGNATURE (IF NOT A MINOR) _____ **DATE** _____

PARENT/LEGAL GUARDIAN SIGNATURE _____ **DATE** _____

WITNESS' SIGNATURE _____ **DATE** _____

Office Staff Only

CODE _____ **DIAGNOSIS** _____

CODE _____ **DIAGNOSIS** _____

CODE _____ **DIAGNOSIS** _____