2025 Yearly Updated Professional Services Agreement

Patient Last Name:_____First:_____Middle:_____
Birth Date: _____Social Security #: _____Sex: ☐ M ☐ F
Gender Identity: _____

❒ ***Demographic information is unchanged***

Primary Phone: _____Secondary Phone: _____
E-mail Address:_____

Address: _____ Apt. #:_____
City: _____State: _____Zip Code: _____
Responsible Party if patient not 18: _____Phone: _____
Address:_____❒ Same as above
City: _____State: _____Zip Code: _____

❒ ***Declined to give Emergency Contact Information***

Emergency Contact: _____Ph: _____
Address: _____Email:_____
City: _____State: _____Zip Code: _____

❒ ***Primary Insurance information is unchanged***

Insurance: Does your insurance require a "referral" or "pre-auth" PRIOR to first visit? ☐ Yes ☐ No
Insurance Company: _____ Copay Amount: _____
Insurance Phone #: _____Group #: _____ ID #: _____
Policy Holder Name: _____Social Security #: _____
Relation to Patient: _____ Date of Birth: _____Gender: ☐ M ☐ F
Address (if different from patient): _____
Effective Date: _____Policy Holder Employed by:_____

Secondary Insurance:
Do you have a second insurance that covers health care? ☐ Yes ☐ **N**o
Are your services to be paid by Worker's Comp or Auto Accident Insurance? ☐ Yes ☐ No
Are you using an EAP Employee Assistance Program to pay for services: ☐ Yes ☐ No
If YES to any of the above, request and complete additional insurance information form.

Medicare Information:
If insured with Medicare, how do you qualify? ❒ Retirement ❒ Long-term Disability ❒ ESRD
Do you currently have a spouse that is employed? ☐ Yes ☐ No
If you marked Yes above, are there more than 20 employees at their place of work? ☐ Yes ☐ No

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Acknowledgement. I understand that some of the clinicians providing services to me may be independent contractors and not CPS employees.

Insurance Benefits. I understand that it is my responsibility to check with my insurance company regarding my benefits before receiving services and that I should advise CPS of any required authorization procedures.

Cancellations and Payment. I agree to pay my copay, contracted rate, or the full fee if I am a self-pay client or if my insurance fails to pay. Appointments canceled less than **2 BUSINESS DAYS** in advance will result in a charge of **$80** for therapy or medication management or **$300** for an evaluation appointment, which cannot be billed to insurance (Example: Monday appointments need to be canceled on the previous Thursday). Additional fees may be billed for services such as written reports, completion of paperwork, etc. A Coinsurance payment is due on the day of service and a $10 billing fee will be charged when this is not paid accordingly. ***Collections Fee.*** A collection fee of 35% of my unpaid balance will be added to the unpaid amount overdue. Services may be denied if payments are not received on the day of service.

Authorization and Release of Information. Professional staff at CPS may exchange information relevant to my care with each other and with your Primary Care Physician, and your health care insurers. I understand that my health care provider is required by law to report any threat to human life or any suspicion of child abuse. I also understand that it may be necessary to furnish information to a court of law if a subpoena is issued (in cases of child custody, accidents, divorce, or otherwise).

Consent for Treatment. While most people benefit by participating in mental health services, in some cases symptoms or problems may worsen. In signing for services for a minor, I certify that I am the legal guardian, and I have the legal right to approve of the evaluation, treatment, and release of information. As the legal guardian, I understand that I (or another guardian) must be present for services to be rendered with an under aged child.

Emergencies. Please call 911 or go to a local emergency room. CPS provides services by appointment only. We do not offer after-hours services. The SAFE UTAH Crisis line (Test or Dial 988) is available 24/7 to offer help in these cases.

Program Rules and Grievances. I understand that weapons or pets, unless certified as support animals and vested are not allowed in the CPS facility. ***Grievance Policy. To file a grievance:*** contact the CPS staff representative and/or the CEO. Then the matter will be reviewed, and you will be notified of CPS' resolution. If you have concerns, you may contact the Office of Licensing: Phone: (801) 538-4242 or Email: DLBC@utah.gov.

Treatment and Services. I understand that CPS offers a variety of outpatient mental health services, including but not limited to psychotherapy, psychiatric medication management, and psychological testing. I understand that I can expect outpatient mental health services as outlined in our list of services; confidentiality and secure records keeping; professionalism and competency from providers and office staff; scheduling support; referrals to outside sources if necessary and in keeping with my treatment plan; and prescription refill support if CPS is given 5 days advance notice.

Telehealth Consent. I agree to participate in telehealth appointments when necessary. Telehealth can include text, emails, and phone calls and secure video calls. I understand that telehealth may (although unlikely) compromise privacy. Telehealth requires us to have your credit card on file.

I have been given information regarding behavioral health diagnosis and treatment and best practices as described by the American Psychiatric Association section on Patients and Families; information regarding local support groups, information about CPS privacy policies and client rights, and this Patient Services Agreement.

Psychological Evaluation: I have received and reviewed a copy of the Psychological Evaluation Client Information Form and understand the process and I understand that I am responsible for charges outside of insurance coverage. I understand that most psychological evaluations require between 8 and 10 hours of the evaluator's time. I have read the cancellation policy above and understand that I will be responsible for a late cancellation.

By virtue of my signature below, I understand the risks and responsibilities noted above and agree to the conditions implied or stated above.

Signature of Responsible Party: _____ **Date:** _____

Please Print Name of Responsible Party: _____

Please Print Name of Patient: _____ **DOB:** _____