Utah Healing Center
5284 S. Commerce Dr., Suite C-134 ♦ Murray, UT 84107 ♦ 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 _____

Notice of Privacy Practice Receipt and Acknowledgement of Notice

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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 anything not covered by insurance. Client is responsible for prior authorizations from insurance.

MY COPAY IS: _____ **MY DEDUCTIBLE IS:** _____ **MY AUTHORIZATION NUMBER IS:** _____

I PREFER TO PAY:

PERSONNALLY PAY AT EACH SESSION		**UHC AUTOMOATICALLY CHARGE CARD AT EACH SESSION**		**BISHOP PAY**		**EAP NUMBER OF SESSIONS**	

Parents and Guardians will be required to keep a credit card on file and will be charged at time of service if a minor is not accompanied by an adult to their appointments. If the debit/credit card on file declines, a valid card will be required to be put on file.

1. I hereby authorize Utah Healing Center to keep a responsible party debit/credit card on file and automatically charge the responsible parties' card for the patient's co-pay, co-insurance, or deductible amount for the patients' appointment if the responsible party does not give a different payment to the front desk during check-in for the patient's appointment.
   Type of Card (Circle): **Mastercard** **Visa** **American Express** **Discover**
   Credit card #: _____
   Expiration Date: _____ V-Code (3 or 4 digit) _____
   Billing Address Street: _____
   Billing Address City, State, Zip: _____

Patient or Guarantor Printed Name	Patient or Guarantor Signature	Date
UHC Employee Printed Name	UHC Employee Signature	Date Received

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** _____