GENERAL INFORMATION

Name: _____ SSN: _____

Address: _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Sex: __ M __ F

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

Spouse Name" _____ Spouse DOB _____ Spouse Phone _____

FINANCIALLY RESPONSIBLE (OR INSURED) PARTY

Name: _____ SSN: _____

Address: _____

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

Home Phone: _____ Work Phone _____ Cell Phone: _____

Date of Birth: _____ Relation to Patient: _____ Sex: __ M __ F

Employer: _____ City _____

Supervisor/Contact: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder Employer: _____ Phone: _____

Group: _____ Group Number: _____ ID Number: _____

Policy Holder Name: _____ DOB: _____

Relationship to Patient: __ Self __ Spouse __ Other

Secondary Insurance: _____

Policy Holder Employer: _____ Phone: _____

Group: _____ Group Number: _____ ID Number: _____

Policy Holder Name: _____ DOB: _____

Patient's Relationship to Policy Holder: __ Self __ Spouse __ Other

EMERGENCY CONTACT INFORMATION

Contact Person: _____ Relationship: _____

Address: _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Additional Contact Person (not living in your home): _____

Address: _____ Home: _____

INFORMATION AND AGREEMENT
Bruce R. Johns, Ph.D.

This document contains important information about my professional services and business policies. Please read it carefully and discuss with me any questions you might. Your signature certifies this document as a legally binding agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy can result in very positive outcomes, but usually requires significant effort on your part, both during sessions and between sessions. Since therapy may involve discussing difficult subjects, some sessions may be uncomfortable. And since many factors can affect the outcome of therapy, success cannot be guaranteed. What I offer is my best effort to help you achieve good results.

Therapy frequently involves a large commitment of time, money and energy. Within the first session or two, I'll be able to offer you my view of the problems and how we might best address them. If you have questions about treatment goals or procedures, please discuss them with me whenever they arise. If, after talking about your concerns, you're unsure of whether you want to proceed, I can help you set up an appointment with another therapist for a second opinion.

CONFIDENTIALITY

In general, law protects the privacy of all communications between a patient and a psychologist; I can only release information about our work to others with your permission, but there are a few exceptions, outlined below:

1. When a patient invites a spouse, family member or friend to attend therapy, he or she is redrawing the lines of confidentiality to include that person in the inner circle.
2. There are some situations in which I am legally obligated to take action to protect others from harm (such as reporting to appropriate agencies when someone has threatened serious bodily harm, a life is at risk, or when abuse or neglect is suspected). These actions may include notifying the potential victim, contacting family members or others that can help provide protection, contacting the police or seeking hospitalization for the patient. Such situations often require that I reveal some information about a patient's treatment.
3. When a child's welfare is involved, or where a patient's emotional condition is a critically important issue, a judge may order my testimony if he/she determines that the issues demand it. Such an order has been exceptionally rare in my experience.
4. I associate with and collaborate with other behavioral health providers, all of whom are members of Mt. Logan Clinic, LLC. We are each independent of one another, yet we share office space, certain expenses, and administrative functions. I am completely independent in providing you with clinical services and I am fully responsible for those services. My professional records are separately maintained and no member of the group can have access to your records without your specific, written permission. My support staff may have access to your medical chart and may be tasked with sending or receiving privileged information such as psychotherapy notes, evaluations, and other written and/or verbal communications and they are under the same limits of confidentiality I am.
5. Most insurance companies require you to authorize me to provide them with clinical information such as symptoms, clinical history, diagnoses, treatment plans, and clinical progress. I have no control over what your insurance company may do with information submitted to them. I can provide you with a copy of any report I submit, upon request. If you prefer, you always have the right to pay for services yourself to avoid insurance complexities.

I am willing to discuss any questions you may have about confidentiality. You may also want to obtain formal legal advice because the laws governing confidentiality are quite complex and I'm not an attorney.

CHILD CARE

Effective therapy requires your full attention. As such, please make arrangements for any needed childcare. It can be problematic, disturbing, or even harmful for children to be present during an adult's therapy session. Children cannot be left in the waiting room unsupervised. Should a problem arise due to inadequate supervision, the therapy session would be cut short that day.

APPOINTMENTS

Therapy sessions are typically 45 minutes long. This time is reserved for you. Because your therapy session is a substantial portion of my day, it is important that you keep track of your appointments. If you fail to show for an appointment, you will be charged full fee for the session. Your insurance will not pay for missed appointment fees.

Should it be necessary to cancel an appointment, please notify the receptionist at least one full working day in advance so she can offer that appointment time to other patients. Appointments canceled with less than a full working day's notice will be charged full fee. Mt. Logan Clinic is open Monday through Thursday. As such, Monday appointments cannot be cancelled any later than the previous Thursday by 5:00 p.m. Your insurance will not pay for late cancellation fees.

Patients who miss two consecutive appointments will be contacted to determine whether they want to continue therapy. To protect you from continued missed appointment fees, if no response is received within 3 business days, future appointments will be cancelled, until we hear from you. Additional appointments can only be rescheduled after any missed appointment fees have been paid in full.

APPOINTMENT REMINDERS

You can now receive appointment reminders via email, text message, or telephone voice message. Please note that appointment reminders are sent as a courtesy only. Missed appointment fees still apply if, for any reason, the reminders cannot be delivered.

How would you like to receive appointment reminders? (check one)
_____ via secure text message to this cell phone number: _____
_____ via secure email to this email address: _____
_____ via automated voice message to my home phone number: _____
_____ Do not send reminders. I'll remember my appointments on my own.
Appointment information may be classified as "Protected Health Information." By my signature, I am requesting that reminders be handled as I have noted above.

Signature _____ Date: _____

STATEMENTS

Monthly electronic statements will be delivered via secure email unless you elect to receive paper statements via U.S. Mail (Note: a $2 paper statement fee will be added to cover the additional costs associated with preparing and mailing paper statements).

How would you like to receive monthly statements? (check one)
_____ Send secure electronic statements to this email: _____

_____ Send paper statements to my home address. I accept the monthly $2 charge.

Appointment information may be classified as "Protected Health Information." By my signature, I am requesting that appointment reminders and statement be handled as I have noted above.

Patient's signature _____ Date: _____

YOUR PATIENT PORTAL

Patients can also view scheduled appointments, request additional appointments, request cancellations, view account balances, make payments, and send secure messages to myself or my staff in our secure patient portal. If you have no interest being able to do these things online, please skip to Billing and Payment.

To access your patient portal, go to **www.therapyappointment.com** and click on "find your therapist" at the top of the page. That will direct you to a screen where you can look up Bruce Johns, Ph.D. by name. Once you do, it will ask you for your temporary user name and password, which you will create below. To get started, please fill in the information below so we can set your temporary user name and password.

Patient name: _____
Your requested login name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| (letters and/or numbers only)
Temporary password: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| (must be at least 8 characters and contain both letters and numbers)

After you log in with your temporary user name and password, you'll be asked to change your temporary password to a permanent password**.** Please write down your user name and permanent password. Once established, you can access your patient portal by going directly to **www.schedule.care** at any time.

BILLING AND PAYMENT

1. **Co-pays:**
   If I am a paneled provider for your insurance company, I will accept the contracted maximum allowable fee (MAF) as payment in full for services. The MAF is comprised of a co-pay (a per-session fixed amount or percentage of the MAF for which the patient is responsible) plus an amount or percentage the insurance company agrees to pay on behalf of the patient. For example, a patient may pay a $25 co-pay at the time of a session and then insurance is billed for the remaining portion of the MAF. Or, a patient may pay a 20% co-pay at the time of service and the insurance is billed for the remaining 80% portion. Payment for services is ultimately the responsibility of the patient. If an insurance claim is not responded to or is denied, patients remain responsible for the cost of the service.

   Insurance company policies and my policy require that co-pays be submitted at the time of service (upon check-in). **There is a $10 service fee charge for non-payment of co-pay at the time of service**. Lack of co-pay for two successive sessions will prevent future appointments being made until the balance owed is paid. Future scheduled appointments may also be cancelled, if co-payments or co-insurance payments are not made within 30 days.

2. **Deductibles:**
   Most insurance plans have "deductibles" which renew at the beginning of the insurance contract year (usually January 1st or July 1st). A "deductible" is an amount that you are required to pay out of your own pocket before your insurance will begin paying its portion of the maximum allowable fee (MAF).

The deductible is "met" by you paying for any covered health services out of pocket until your required deductible amount has been reached (e.g., a $500 deductible may be met by paying $150 to a psychologist and $350 to a family physician). After the deductible has been met, you are only responsible for your co-pay for any qualified services, until the beginning of your next contract year. Consequently, at the beginning of your contract year, you will be responsible to pay the entire contracted MAF, at the time of service, until you have met your deductible.

3. **Qualified services:**
Insurance companies vary in what they consider qualified services. Some insurance companies exclude certain diagnoses or procedures. They may or may not pay for family sessions without the patient, 60-minute sessions, psychological testing, crisis intervention, and consultations. Miscellaneous services, such as writing letters on behalf of patients, telephone calls, travel time, time spent responding to insurance requests, or services for legal proceedings, are unlikely to be covered. If you have a question about whether a service or diagnosis is likely to be covered please ask me. Please note that you remain responsible to pay for my services, even if your insurance company does not qualify them.

4. **Service fees**
Unless I've agreed with your insurance company to accept their maximum allowable fees (MAF), the current cost of an initial assessment is $200. Subsequent 45-minute sessions are $131 and 60-minute sessions are $175. Other professional services you may need are $175 per hour or $43.75 per quarter hour for crisis intervention, psychological test administration, scoring and interpretation, report writing, telephone conversations lasting more than 10 minutes, consultations with doctors, hospital staff, school personnel, other providers, agencies, attorneys, or court officials, preparing for depositions, office visits lasting longer than 10 minutes, reading documents submitted regarding your case, preparation of treatment summaries or insurance reports, required travel, or time spent performing any other service you relative to your case. Billing is typically in 15-minute increments.

Fee increases do occur occasionally, to keep up with cost of living increases. Fee increases may occur without prior notice.

Due to the additional costs associated with working with insurance companies, patients who do not use insurance will be offered a 25% discount for psychotherapy services (initial assessment $150, 45-minute appointment $98, psychological assessment $131/hour). Services typically not covered by insurance will be charged full fee ($175 per hour, $43.75 per quarter hour).

Miscellaneous services requiring less than 10 min. are typically provided, without cost, as a courtesy.

Should you require special financial consideration, please talk with me about your situation. Any deviation to the fee schedule must be in writing and signed by me.

5. **Outstanding balances and returned checks:**
It is expected that you will pay any deductible and co-pay at the time of service. If, for some reason, there is a balance owed (other than a pending insurance payment), you are expected to pay off the balance at your next visit. Patients will be informed of their balance at each scheduled session.

Patients owing a balance will be sent monthly statements showing your charges, payments and insurance company payments. Insurance companies usually make payments within 30 - 60 days. Any insurance charges left unpaid after 60 days will become your responsibility to pay. You may then

settle with your insurance company. Payment is due within ten days of receipt of your statement. A finance charge of 1.5% per month (18% per annum, $5.00 minimum charge) is assessed on any unpaid balance over 60 days old. Returned checks result in a $20 service charge in addition to any bank service charges.

If your balance (excluding pending insurance payments) exceeds $300, you would be required to bring the balance under $300 prior to any future appointments being made, unless other arrangements are made, by written agreement, with me. Lack of doing so, within 30 days, could risk the loss of existing appointments and may result in the account being turned over to a collection agency.

6. **Statements**
Statements can be confusing. For example, our billing software system automatically applies payments to the oldest outstanding charge in order to reduce interest charges. It may therefore appear that a co-pay wasn't credited when it really was, but it was applied to an older charge. If there is an error on your statement, please bring it to our attention so we can promptly resolve the problem. If you have questions about your statement or balance owed, please contact my billing specialist at 435-750-6300 ext. 207.

7. **Changing Insurance:**
You are responsible for informing me, or my billing specialist, of any changes in your insurance coverage. I may consider applying for panel membership if your new insurance company's policies, procedures and maximum allowable fees (MAF) are acceptable. If you switch insurance coverage to a company with whom I am not paneled, you may want to contact your insurance company and request a single-case agreement (which might allow continued insurance coverage of my services) or you may elect to use the self-pay schedule (see "Service Fees" above). If necessary, I am also willing to facilitate a transfer to a therapist who is either paneled with your new insurance or who provides services on a sliding-fee scale.

Due to the recent instability of insurance fee schedules, I reserve the right to evaluate whether to maintain my relationship with insurance companies at my sole discretion. Such decisions may be determined by the insurance company's fee schedules, paperwork demands, or willingness to support what I consider quality treatment.

8. Outstanding Payment Authorization
To keep our therapeutic relationship free of any financial strains and to avoid the possibility of needing to turn an account over to a collection service (which is expensive and hurts clients' credit ratings), I require each financial guarantor to consent to an outstanding payment authorization agreement. Essentially, the guarantor assures payment for my professional services by authorizing us to charge a credit/debit card (identified below) for the total amount of any unpaid balance owed, after it is 60 days past due. At least two separate notices of any balance 60 days overdue would be attempted, prior to the card being charged. If there is a dispute regarding any charges billed, a written notice of the issue must be submitted a minimum of five business days prior to the 60-day limit. All reasonable and appropriate efforts will then be made to resolve the identified dispute before charging the card on file. However, I reserve the right to submit charges to the card for any services I've rendered consistent with the contracted rates and charges identified in this agreement, provided sufficient reasonable evidence exists that services were rendered for each applicable charge (e.g., patient signature on applied date of service). No other charges will be placed upon the card without your express consent. All credit card information will be stored using encryption consistent with both

HIPPA and Payment Card Industry Data Security Standards (PCI-DSS). If an attempt to charge the card/account on file is unsuccessful or denied for any reason, the financial guarantor will be assessed a service fee of $100 in addition to all other outstanding charges and the account may be submitted to collections as detailed in the signed contract.

With your signature below, you certify that you are an authorized user of the identified credit card/account and authorize use of the card by Bruce R. Johns, Ph.D., P.C., as detailed above. You also agree that you will not dispute these transactions with your bank or credit card company, so long as the transactions correspond to the terms indicated in this document. You further agree that if, at any time, you terminate the card on file, you will provide Bruce R. Johns, Ph.D., P.C. with a replacement card.

Name of Patient: _____
Name of Responsible Party (if different): _____
Signature of Responsible Party: _____ Date: _____

Type of Card: Visa _____ MasterCard _____ Discover _____
Cardholder Name: _____ Card Number: _____
Expiration Date: _____
Billing Address: _____ City, State, Zip: _____
Phone: _____ Email: _____
Cardholder Signature: _____ Date: _____

9. **Collections:**
If reasonable efforts to collect your bill fail, the account is turned over to a collection agency or a claim is made in small claims court. Collection agencies typically require that an amount equal to 50% of the outstanding balance be added to the bill as a "collection fee". This charge is included in the claim. In most collection situations, the only information I release is the name of the patient and responsible party, the dates and nature of services provided, and the amounts due. Negative credit reports may be submitted to a credit reporting agency, when contracted financial obligations are unfulfilled, which can damage your credit rating.

CONTACTING ME

I am usually in my office between 8:30 AM and 5:30 PM Monday through Thursday. However, I am usually with a patient. The most reliable way to contact me is through the receptionist (435-750-6300 ext. 100) or, if you prefer, you may leave me a confidential voice mail (435-750-6300 ext. 103) or leave me a message via the patient portal. I retrieve messages and try to return calls at the end of my day, Monday through Thursday (except for holidays and vacations). I do not guarantee my availability or how quickly I will be able to respond. **If you have an emergency, please call 911 or go directly to the emergency department of the nearest hospital.**

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I keep two sets of records–the medical record and my psychotherapy notes. The medical record includes the dates and times of sessions, the type of therapy provided, the results of any psychological testing, and any summaries of symptoms, diagnosis, treatment plan, and treatment progress. The medical record is available for your review upon request. Psychotherapy notes and my personal notes, on the other hand, are protected by HIPAA law and state law and are considered the property of the health care provider who created them.

FAMILY, AND FRIENDS

A spouse, family member, or friend may participate in and play an important part in treatment. A person participating in this way might attend only one session or might attend all of the patient's therapy sessions. In fact, the participant's relationship with the patient may be a major focus of the treatment. But a participant is not a patient and does not have a right to access the medical record nor does he or she have the same rights as the patient regarding confidentiality. My primary responsibility and allegiance remains with my patient.

At times I may recommend that a spouse, family member, or friend obtain his/her own therapy. I may refer the person to another clinician unless my patient and I agree that both my patient and the other person might be better served if I provide the therapy. But such situations carry risks. Providing therapy for two people that have a close relationship (e.g. spouses), can lead to complications such as one party believing that the therapist has taken sides with or shows preferential treatment toward the other party. Also, if a therapist were to see a parent and a child separately, the child might worry whether what is told the therapist in confidence will really remain confidential. This could interfere with the child's trust and reduce the effectiveness of therapy. Trust is a critical component to successful therapy.

Sometimes conjoint couple or family therapy can be most helpful in treating the individuals. Usually, in such cases, one person becomes the designated patient and the others become participants. When this occurs, everyone involved agrees that the normal limits of confidentiality are redrawn to include the partner or other participants. Not all information shared with me is shared with anyone else. Rather, I will use my judgment regarding what information is shared and with whom. My intent in sharing information is to promote the welfare of those involved. If you have any concerns about what information may or may not be shared under these circumstances, please talk to me.

In the event of a separation, divorce, or other legal situation, any request for a release of information to attorneys or others regarding notes or records regarding conjoint sessions would require the consent of those parties present during the session.

Summary of Agreement

I have read and reviewed the Information and Agreement above and resolved and questions or concerns that I had. I understand and agree to the expectations and conditions as detailed above.

Specifically (please initial each paragraph below):

_____I understand that I have rights to confidentiality but those rights to confidentiality have limits, as explained above. I understand that, by including other people in my therapy, I am redrawing the lines of confidentiality to include those persons in my inner circle.

_____ I understand that I am solely responsible for keeping track of my appointments with Dr. Johns.). I understand that failure to show up for appointments, or failure to cancel an appointment, with one full working day's notice, may result in a missed appointment or late cancel fee. I understand that after two no-shows, those fees must be paid in full in order to continue treatment.

_____I understand that I will be billed for Dr. Johns' services at the rates detailed above. I understand that insurance companies may not cover some charges or diagnoses. I accept that any charges left unpaid, by the insurance company after 60 days, will become my responsibility to pay. I agree to pay for all services provided me by Dr. Johns. I understand that fee rates may be increased without prior notice.

_____I understand that I am required to pay my co-pay at the time of service and agree to do so. I understand I will be charged a $10 fee for failure to do so. I understand that further sessions will not be held/scheduled after missing two consecutive co-pays until the co-pay balance is paid in full. I understand that insurance company refusal to pay does not relieve me of my responsibility for payment of services provided by Dr. Johns.

_____I understand that I am required to pay any deductible (out of pocket) amounts at the time of service. I also understand that unpaid deductible payments may result in an interruption of services until the deductible balance is paid in full. I understand it is my responsibility to educate myself about my insurance company's calendar year and deductible policies.

_____I understand that it is my responsibility to inform Dr. Johns and his staff of any changes to my insurance coverage or requirements. I accept financial responsibility for any denial of insurance payments that might result from my failure to inform. I accept that Dr. Johns has the right to choose to become a non-provider for my insurance.

_____I understand I am responsible to pay any outstanding balance within 60 days of the service date. I agree to authorize Dr. Johns to charge my designated credit or debit card for any unpaid charges past the 60 day period. I understand the identified form of payment (credit or debit account) will not be used for any other purpose without my express consent.

_____I understand that I will be charged interest, on any outstanding balance, at 18% per year. I understand that there is a returned check charge. I also understand and agree that lack of payment would result in my account being sent to collections, that 50% of the outstanding balance would be added as a collection fee, and that I would be fully responsible for all collection costs.

_____My mobile phone number is. (___)_____-_____. I authorize this number to receive scheduling and billing messages. I agree to update this office if my mobile number changes.

_____I understand that, in case of emergency, I am to call 911 or proceed to the hospital. I understand how that I can leave messages for Dr. Johns, but there is no guarantee of his availability or how quickly he may respond.

_____I understand that I have rights to access my treatment record but not Dr. Johns' psychotherapy notes.

_____I understand that people whom I include in my therapy do not automatically become patients of Dr. Johns. If I consent to Dr. Johns seeing a spouse, family member or friend as an individual client, I accept the possible complications and risks that could arise from such an arrangement. If others are included in my therapy, I accept that the normal limits of confidentiality are redrawn to permit communication with those persons or family members. I understand that in the case of separation or divorce, any request for a release of information would require the signed agreement of any parties involved.

My signature also confirms that I am authorizing Dr. Johns and his staff to contact my insurance company and release any medical or other information necessary for authorization of services, insurance payment, or processing of claims. I am authorizing payment of medical benefits directly to Dr. Johns. Additionally, I am authorizing Dr. Johns and his staff to contact me for billing or collection purposes.

Patient Name (printed)

Signature of Patient

Today's Date

QUESTIONNAIRE FOR ADULTS

Date: _____ Your Name: _____ Age:
Marital Status: ___Single ___ Married ___Co-habiting ___Divorced ___Separated ___Widowed
Race: ___White ___Black ___Asian ___Hispanic ___American Indian ___Other
Sex: ___Male ___Female
With whom do you live? _____
In what city and state do you live? _____
Your employer _____ Current position _____
Employment Status: ___ Full-time ___ Part-time ___ Homemaker ___Unemployed ___Retired ___Disabled
Other (specify) _____
Student Status: School _____ Year in School _____ Full-time ___ Part-time ___
Referred by:_____

REASONS FOR SEEKING HELP AT THIS TIME_____
_____
_____
_____
_____
_____

Please mark symptoms you are experiencing NOW with an "N" then mark symptoms you have had in the PAST, but are no longer experiencing with a "P".

___ Sadness
___ Feeling empty
___ Tearfulness
___ Irritability
___ Guilt
___ Headaches
___ Stomach aches
___ Fatigue/exhaustion
___ Restlessness
___ Social withdrawal
___ Indecisiveness
___ Low self-esteem
___ Feeling worthless
___ Self-blame
___ Restless sleep
___ Not sleeping enough
___ Waking too early
___ Sleeping too much
___ Difficulty concentrating
___ Difficulty thinking
___ I wish I didn't exist
___ Loss or reduction of energy
___ Weight loss (_____ lbs.)
___ Weight gain (_____ lbs.)
___ General aches/pains
___ Things aren't fun anymore
___ Loss of interest in things/life
___ Suicidal thoughts

___ Worrying/brooding
___ Decreased concentration
___ Intense or irrational fears
___ Feeling stressed out
___ Restless/on edge
___ Mind goes blank
___ Fear of leaving home
___ Unresolved trauma
___ Easily fatigued
___ Decreased concentration
___ Obsessive thoughts
___ Avoid social situations
___ Muscle tension
___ Irritability
___ Compulsions

___ Panic
___ Shortened breath
___ Nausea
___ Fear of dying
___ Palpitations
___ Hyperventilating
___ Dizziness
___ Tingling sensations
___ Sweating
___ Choking
___ Things seem unreal
___ Chills/hot flashes
___ Trembling
___ Chest pain
___ Fear of losing control
___ other

___ Lose temper easily
___ Deliberately annoying
___ Angry
___ Bullying others
___ Legal problems
___ Argumentative
___ Easily annoyed
___ Spiteful/vindictive
___ Initiate physical fights
___ Start fires
___ Defiant/noncompliant
___ Excessively "touchy"
___ Cruel to animals
___ Destroy property
___ Robbery
___ Blame others
___ Aggressive
___ Cruel to others
___ Theft/stealing

___ Highly inflated self-esteem
___ Very rapid, "pressured" talking
___ Excessive increase in productivity
___ Reckless or taking high risks
___ Decreased need for sleep
___ Ideas racing through mind
___ Hyper-sexuality
___ Excessive energy
___ Far more talkative than usual
___ Excessively distractible
___ Running away from home
___ Spending far too much

___ Sig. reduction of calories
___ Dissatisfaction with body
___ Sig. weight loss
___ Excessive exercise
___ Loss of menses
___ Obsession with food
___ Laxative abuse
___ Binging
___ Intense fear of weight
___ Purging

___ Poor attention to detail
___ Difficulty listening
___ Difficulty organizing things
___ Excessively fidgety
___ Frequent, careless mistakes
___ Difficulty following instructions
___ Hyperactive
___ Talk excessively
___ Difficulty paying attention
___ Difficulty finishing tasks
___ Impulsive
___ Forgetful

HISTORY OF THE PROBLEM:
When were your symptoms first noticed? _____
_____

Since then, have the symptoms been: ___getting worse ___unchanged ___intermittent ___improving
How much do they interfere with your life? ___minimal ___moderate ___significant ___extensive
Is there a prior history of mental health problems? ___No ___Yes (specify) _____
_____
_____

Previous Mental Health Treatment (therapy, hospitalizations, medications)? ___No ___Yes (if so, specify provider, length, when, hospitalizations, medications) _____
_____
_____

Is there a family history of mental health problems? ___No ___Don't know ___Yes (specify) _____
_____

Current Stresses: (circle all that apply)

marital conflicts	relationships with peers	problems related to	history of neglect
separation/divorce	school problems	substance abuse	emotional abuse
parent-child conflicts	recent move	legal problems	physical abuse
conflicts with siblings	work stresses	medical problems	sexual abuse
conflicts with extended	financial strains	recent death	Other _____
family	job loss or change	housing problems	

Is there a history of substance use/abuse? ___No ___ Yes If yes, please mark the following:

Experimentation: Mark **"E"** next to those substances you've **EXPERIMENTED** with but don't currently use.
Use: Mark **"U"** next to those substances which you currently **USE** but not to the point of getting drunk or high
Abuse: Mark **"I"** next to those substances you occasionally or regularly use to get **INTOXICATED**.
Dependency: Mark "**A**" next to those substances you are now **ADDICTED** to or dependent on.

___ caffeine	___ marijuana	___ cocaine, crack or	___ PCP / angel dust
___ tobacco	___ diet pills or	crank	___ LSD/hallucinogens
___ alcohol	amphetamines	___ methamphetamine	___ opiates/heroin

___ inhalants ___ prescription meds ___ Other: _____

Any previous substance abuse treatment? No ___ Yes ___ (if yes, specify) _____
_____

Any history of legal problems? No___ Yes___ (if yes, specify _____
_____

Current Charges? No___ Yes___ (if yes, specify) _____
_____

Any history of medical problems? No___ Yes___ (circle any you've had)

seizure	hypoglycemia	high blood pressure
extreme fever	diabetes	low blood pressure
loss of consciousness	hypothyroidism	head injury
due to _____	hyperthyroidism	memory problems

Other Medical Problems: _____
_____
_____

Current Medications: _____
_____
_____

BACKGROUND INFORMATION

Where were you born? (City/State) _____ **Where did you grow up?** _____
Your birth order? (e.g. 2nd of 4 children) _____ of _____ children
Describe your father, his occupation, and your relationship with him growing up ____
_____
_____
Describe your mother, her occupation, and your relationship with her growing up ____
_____
_____
Describe your relationship with siblings as you grew up. _____
_____
_____

Areas of Conflict or Concern in Your Family of Origin: (circle all that apply)

family finances	alcohol or drugs	legal problems	sexual abuse
medical problems	friendships	roles and expectations	Other: _____
religious conflicts	frequent moves	physical abuse	

Developmental Problems: (circle all that apply)

pre-natal problems	toilet training	tantrums	fighting
birth complications	thumb sucking	attention problems	destructiveness
early illness or injury	bed-wetting	learning disabilities	fire-setting
delayed development	soiling	hyperactivity	cruelty to animals
sitting up	Other: _____	difficulties with peers	vandalism
crawling	nail biting	truancy	drug abuse
walking	nightmares	lying	running away
talking	stuttering	stealing	Other: _____

Mark "C" or "A" next to those characteristics that described you as a Child or Adolescent

__ easy going	__ perfectionistic	__ anxious	__ rigid or	__ reckless
__ organized	__ shy	__ disorganized	stubborn	__ aggressive
__ confident	__ sensitive	__ confused	__ distrustful	__ easily bored
__ talkative	__ insecure	__ a loner	__ impulsive	__ Other_____
__ adventurous	__ awkward	__ moody	__ irritable	
__ popular	__ submissive		__ rebellious	

In your youth did you have ___many friends ___some friends ___few friends ___no close friends

Did you make and maintain friends ___easily ___as easily as most ___with some difficulty ___with great difficulty e) Other _____

Did you date ___a lot ___an average amount ___seldom ___almost never

How satisfying was your dating experience? ___enjoyable ___satisfactory ___frustrating ___traumatic ___other _____

Years of education completed _____ High School Grade Point Average _____
College GPA _____

School was (Mark all that apply)**:** ___easy ___interesting ___ok ___challenging ___difficult ___boring ___Other (explain) _____

MARRIAGE AND FAMILY

Details regarding any previous marriage(s) or cohabitations (names, dates, why ended, children): _____
_____
_____
_____

Current (most recent) spouse/partner's name _____ How long have you:
co-habited____ been married _____ been separated_____ been divorced_____ been widowed ____
_____

Describe the quality of the relationship ___excellent ___good ___average ___poor
What are the strengths and weaknesses of your relationship? _____
_____
_____
_____
_____

Mark below any areas of conflict or concern within your relationship.

finances	religion	friends	roles and	physical abuse
communication	in-laws	work or career	expectations	sexual abuse
affection	alcohol or drugs	time together	power & control	
sex	discipline of kids	interests/leisure	emotional abuse	

Other areas of concern or conflict: _____
_____
_____
_____
_____

Names of Children Age Sex Living at Home? Describe your relationship
_____
_____
_____
_____
_____
_____

EMPLOYMENT

At what age were you first employed full-time? _____
What jobs have you worked in the past and for how long? _____
_____
_____

How satisfying is your current employment or position? _____
_____

YOUR INTERESTS & ACTIVITIES: _____
_____
_____

Thank You

PATIENT E-MAIL CONSENT FORM

I, _____ (Patient Name) would like to be able to use e-mail to communicate with Dr. Johns and his staff. I understand that e-mail is to be used *solely* for ***non*-emergency** questions and requests in the ordinary course of business. I understand that, if necessary, the Dr. Johns' staff may have access to some e-mails related to their work:

Name/Position	Purpose
Dr. Bruce Johns	Treatment
Receptionist	Scheduling /dispersal of information
Billing secretary	Billing and Collections

I understand that my confidential and sensitive information will never be shared with a third party without my written authorization. I also understand that there are certain situations in which Dr. Johns and his staff may share my e-mail messages without written authorization (e.g., disclosures required by state or federal law). I understand that if law requires a disclosure, Dr. Johns will attempt to provide only the amount of information he judges necessary to achieve the purpose of the request and I will receive notice that the disclosure was made.

RESPONSE TIME

I understand Dr. Johns will try to respond to my e-mail within 2-3 business days, unless he considers it counter-therapeutic to do so. If, for any reason (such as vacation, illness, emergency), Dr. Johns is unavailable to answer my e-mail request within that time frame, I understand he will respond as soon as he is available.

PERMISSIBLE USES

Permissible email use includes:

1. Communication about client status.
2. Communication about third-party involvement (meetings with other providers, school professionals, etc.).
3. Confirmation of currently scheduled appointments.
4. Request to schedule additional appointments; this request will be followed up by a phone call to schedule for specific dates and times.

NON-PERMISSIBLE USES

Prohibited uses of e-mail include but are not limited to:

1. Urgent or time-sensitive communications
2. Appointment scheduling, cancelling, or changing.
3. Highly sensitive or sensitive information. Email is *not* compliant with HIPPA standards; therefore, the privacy of the information you provide and/or receive cannot be guaranteed or maintained. Highly confidential or sensitive information (e.g., discussion of HIV status, mental illness, chemical dependency and workers compensation claims) should not be transmitted.

4. Using e-mail to attach large database files or files containing inappropriate materials unrelated to the permissible uses defined above.
5. If Dr. Johns feels the content or subject matter of an e-mail is inappropriate for an electronic response, I understand he has the right to refuse communication via e-mail and may suggest an alternate means to discuss the question or request. I understand that at no time should I expect a diagnosis, a recommendation of treatment or a prognosis via e-mail regarding a complaint or symptom for which the doctor did not see me personally, regardless of whether the doctor has seen me personally on prior occasions.
6. I understand that at any time Dr. Johns may terminate e-mail communications with me and that I will be notified of such termination in writing. I understand that termination of online communication does not necessarily mean termination of the patient-doctor relationship.

PATIENT RESPONSIBILITIES

I understand that e-mail should be used only for appropriate messages and non-urgent situations. I agree to call the practice immediately if the situation escalates to a point where a phone call or visit is necessary. I also agree to do the following when making an e-mail request:

1. Clarify the nature of the information or service requested.
2. Place my full name in the first line of the body of the message.
3. Configure automatic reply to acknowledge receipt of the message, if possible.

I also understand that all messages, will become part of my medical record. I understand it is my duty to maintain my own copies of e-mail communications.

SECURITY

Dr. Johns has the following security mechanisms in place to secure confidential and sensitive information:

1. I understand that after receipt, emails will be deleted from email account and will be placed into my file. I understand, the transmission of email cannot be secured and is not, therefore, compliant with HIPPA.
2. Back-ups of data will be performed *weekly, into long-term storage*.
3. Password protection allows access only staff authorized to access and handle office e-mail communications.
4. Password protected screen savers will be used on computers, including keeping all screens out of public view.
5. Information sent in a group mailing will maintain the confidentiality of the patient by using a blind copy to keep recipients invisible to each other.

INDEMNIFICATION

I agree to indemnify, defend, and hold harmless **Bruce R. Johns, Ph.D., P.C.**, its officers, directors, employees, agents and independent contractors from and against any and all losses, expenses, damages and costs arising out of my use of Patient e-mail, any activity

related to my patient account information and any information lost due to technical failures.

CONSENT

I have read this consent, have been given the opportunity to discuss the issues with Dr. Johns, and understand that by signing this consent I agree to the above policy and conditions. I understand that I may also withdraw consent for the use of e-mail interactions at any time without affecting my right or access to future treatment.

_____

Printed Name

_____ _____

Signature **Date**

_____ _____

Parent's or Guardian's Signature **Date**

BRUCE R. JOHNS, PHD, PC

SUMMARY OF PRIVACY PRACTICES

I am required by law to follow the guidelines described in this summary. All associates with whom I share on-call emergency services are also bound by the same principles and conditions. This is a summary of privacy practices, but does not replace the full—a copy of which you may also receive upon request or may review at my office at any time. This notice describes how medical information about you may be used and disclosed and how you can access that information. This notice applies to personal health information that is kept in or by the practices in Mt. Logan Clinic. Neither this summary nor the full Notice of Privacy Practices covers every possible use or disclosure. If you have any questions, please contact the Privacy Officer for the specific practice providing your treatment.

We may use your personal health information to:

- Plan your treatment and services
- Submit bills to your insurance, Medicaid, Medicare, or other third party payer.
- Obtain approval in advance from your insurance company to determine whether payment for the treatment is covered by your plan or to facilitate payment of a referring physician.
- Perform healthcare operations such as sharing your information with business associates who need to use or disclose your information to provide a service for our medical practice (e.g., our billing company).
- Exchange information with other state agencies as required by law.
- Treat you in an emergency
- Treat you when there is something that prevents us from communicating with you.
- Send you appointment reminders.
- For certain types of research.
- When there is a serious public health or safety threat to you or others.
- To agencies involved in a disaster situation
- As required by state, federal, or local law; this includes investigations, audits, inspections, and licensure.
- To law enforcement if you are a victim of a crime, if you are involved in a crime at our facility, if you have threatened to commit a crime, or if abuse of a minor is reported or suspected.
- To a parent or guardian when a minor reports a life-threatening concern (e.g., threat of suicide or homicide).
- To coroners, medical examiners, and funeral homes when necessary for them to fulfill their professional obligations.
- When ordered to do so by a court or judge.
- To federal officials involved in security activities authorized by law.
- To a correctional facility if you are an inmate within that facility.

As a patient in our clinic, you have the right:

- To ask that we communicate with you about medical matters in a certain manner or at a certain location; this request must be made in writing.
- To inspect and obtain a copy of your record; however, there are several exceptions provided by federal legislation—some of which are specific to mental health records
- To appeal our decision if we decide not to allow you to see all or some parts of your record
- To ask for the record to be changed if you believe you see a mistake or something that is incomplete; you must make this request in writing.
    - We may deny your request if: 1) we did not create the incorrect or inaccurate entry; 2) the information is not part of the file that we keep permanently; 3) the information is not part of the file that we would ordinarily permit you to see; or 4) if we believe that the record is accurate and complete.
- To require that we limit how we use or disclose information you. For example, a request that we *not* release information to your spouse or to a particular healthcare provider or agency; this request must be made in writing and we are not obligated to comply with this request.
- To know to whom we have sent information about you for up to the last six years. The first request in a 12-month period is free of charge, but we may charge you for additional requests.
- To have a paper copy of the Notice of Privacy Practices.
- To file a complaint if you believe that any of your rights have been violated; all complaints must be made in writing. You will *not* be penalized in any fashion for filing a complaint.
- To authorize and/or direct us to release any of your personal information (including anything not described above). You may change your mind and remove this authorization at any time in writing.
- If you wish to exercise any of these rights or to file a complaint, you should contact the Privacy Officer of the individual practice involved.

Acknowledgement of Privacy Practices

I, _____, acknowledge that I have read the Notice of Privacy Practices.

_____ _____

Signature Date

RELEASE OF INFORMATION

I, _____, authorize (check all that apply):

_____ Dr. Johns to send my medical and psychological information to:
_____ Dr. Johns to receive my medical and psychological information from:
_____ Dr. Johns to exchange medical and psychological information and consult with:

Professionals/Organizations/Persons	Address	Telephone	Fax
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient name (Print)_____ Birthdate _____
Maiden or former name _____ Telephone _____
Address: _____

I specifically authorize the following information to be released:

__ initial evaluation (includes presenting problem, history of problem, previous treatment, personal & family background, diagnosis, prognosis, treatment plan)
__ treatment plan
__ treatment progress
__ diagnosis
__ medications
__ other (specify) _____

Reason for release of Information (e.g. coordinating care, transfer of care, application/insurance requirement, etc.): _____

_____ _____
Signature of Patient Date

Important:

- You may revoke this authorization at any time by written request. Obviously, the revocation can't apply to information already released.
- There may be charges associated with the time required to fulfill this release of information.
- Your treatment is not conditional on signing this authorization.
- You are entitled to a copy of this authorization upon request.
- This authorization will expire one year from the date of your signature above.

Bruce R. Johns, Ph.D., P.C. 246 E. 1260 N. Logan, UT 84341 P.O. Box 6244,
Ph. 435-750-6300 Fax 435-753-8995