NEW PATIENT 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: ________
Parents Names (if minor patient): ______________________________

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: ______________
Patient's Relationship to Policy Holder: __ Self __ Spouse __ Child __ Other
Secondary Insurance: ______________________________________
Policy Holder Employer: ____________________ Phone: ______________
Group: __________ Group Number: __________ ID Number: __________
Policy Holder Name: ____________________ DOB: ______________
Patient's Relationship to Policy Holder: __ Self __ Spouse __ Child __ 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 & Agreement Verification Form

______ (initial) By initialing, I verify an understanding that I am required to pay my co-pay/co-insurance payment at the time of service and agree to do so. I understand I will be charged a fee (subject to change) 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.

______ (initial) By initialing, I verify an understanding that I am required to pay my deductible payments in a timely manner, preferably 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 deductible time of year and policies and agree to do so.

______ (initial) By initialing, I verify an understanding that I will be billed for miscellaneous (non-session or out-of-office services at the above rate provided by Dr. Boghosian that he deems clinically indicated or that I request. I understand that insurance companies do not usually cover such charges. I agree to pay for miscellaneous services received as part of my therapy.

______ (initial) By initialing, I verify that I am responsible for notifying Dr. Boghosian's office at least 24 hours in advance of cancellations (except in cases of illness/ emergency). I understand that failure to do so will result in a fee. I understand that after two no-shows, those fees must be paid in full in order to continue treatment.

______ (initial) By initialing, I verify that I am responsible to maintain my outstanding payment balance under $300. I agree to pay down the payment balance when it exceeds $300 within one month from the statement date indicating said balance. I understand that failure to do so will result in an interruption of treatment and that I may not schedule/retain further appointments until the balance is maintained under $300. I understand refusal to pay will result in being sent to collections.

______ (initial) By initialing, I verify that if my insurance coverage changes, if I no longer have insurance covering behavioral health services, or if Dr. Boghosian elects to discontinue his professional relationship with my insurance provider, I will either have to contact my insurance about negotiating a single-case agreement, switch to self-pay rates, or be referred to a provider who is paneled with my insurance or who provides services on a sliding fee basis.

______ (initial) By initialing, I verify that I authorize Sara Boghosian, PhD, PC and/or its affiliates to contact my insurance company and/or myself to fulfill the completion of my claims process as identified and explained in the agreement.

______ (initial) By initialing, I acknowledge that I have received the Notice of Privacy Practices in either electronic and/or printed format. I acknowledge that my privacy rights have been explained to me in a manner that I can understand them. I also acknowledge that Dr. Boghosian has given me an opportunity to discuss any questions or concerns associated with my privacy rights.

______ (initial) By initialing, I acknowledge that my mobile phone number is: (_____) ______ - ________. I authorize the use of my mobile phone number (listed above) to receive scheduling and billing messages. I agree to update this office if my mobile number changes.

With my signature, I verify that I have read, understand, and agree to this information and agreement policy effective 17 April 2017. I understand this policy supersedes any and all former policies/statements. My signature also verifies that I was provided a full and complete copy of the information and agreement policy, including billing and contact information, and an opportunity to discuss any questions or concerns with Dr. Boghosian.

Patient's Name (printed)	Signature of Patient (or Parent/Guardian if minor)
Parent/Guardian Name (if patient is a minor)	Name of Person accepting financial responsibility
Signature of Person accepting financial responsibility	Today's Date

Appointment Reminders & Patient Portal

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a voice message) before your scheduled appointments.

You can also enjoy the convenience of viewing your scheduled appointments, account balance, and other tools located in our secure patient portal. Simply visit www.therapyappointment.com to find your healthcare provider and set up your patient portal. Once established, you can access your patient portal by going to www.schedule.care.

Your name: ____

Requested login name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(letters and/or numbers only)

Requested temporary password: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(must contain both letters and numbers)

(After you log in, you will be asked to change this to a permanent password)

Your email address: ____

Your home phone number: _______________________________________

Your cell phone number: ____

How would you like to receive appointment reminders? (initial one)

_____ via a text message to my cell phone (normal text message rates will apply)

_____ via an email message to the email address listed above

_____ via an automated voice message to my home phone number listed above

_____ Do not send reminders. I'll remember my appointments on my own.

NOTES: (1) If requested, appointment reminders are sent as a courtesy. Missed appointment fees still apply if, for any reason, the reminders cannot be delivered. (2) 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 ____________________

Acknowledgement of Receipt

Notice of Privacy Practices

I, ________________________________, acknowledge that I have received the Notice of Privacy Practices.

________________________________ ________________________________
Signature Date

I, the undersigned, hereby authorize the release of medical/health/psychological information:

To: _______ (initial) From: _______ (initial)
Sara Boghosian, PhD, PC
246 East 1260 North, P.O. Box 6244
Logan, Utah 84341
Phone: 435-750-6300
Fax: 435-753-8995

To: _______ (initial) From: _______ (initial)
Professional/Clinic/Person:
Address:
City, State Zip:
Phone:
Fax:

I authorize: □Verbal Communication □Written Letters □Copies of Medical Records
regarding the psychological status/condition/treatment of the patient(s) named below.
Reason for release of Information (e.g. coordinating care, transfer of care, application requirement, etc.):
____

PATIENT INFORMATION
Name (print): ______________________ **Birthdate:** ______________
Address: ______________________ **City, State, Zip:** ______________
Home Phone: ______________________

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 services rendered to fulfill this release of information request.
- 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 below.

Name of Person Authorized to Consent: ______________________ **Date:** __________

Signature of Authorized Person: ______________________ **Date:** __________

SYMPTOM CHECKLIST

To be completed by the parents/caregivers:
Please mark all of the following symptoms your child is **now** experiencing with an **N**.
Please mark past (not current) symptoms with a **P**. Thank you.

__ 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

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

__ Lose temper easily
__ Deliberately annoying
__ Angry
__ Bullies others
__ Legal problems
__ Argumentative
__ Easily annoyed
__ Spiteful/vindictive
__ Initiates physical fights
__ Starts fires
__ Defiant/noncompliant
__ Excessively "touchy"
__ Cruel to animals
__ Destroys property
__ Robbery
__ Blames others
__ Aggressive
__ Cruel to others
__ Theft/stealing

__ Grossly inflated self-esteem
__ Very rapid, "pressured" talking
__ Excessive increase in productivity
__ Reckless decision making
__ Decreased need for sleep
__ Ideas racing through mind
__ High risk or hypersexual
__ 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 eye contact
__ Minimal use of gestures
__ Social difficulties
__ Problems with toileting
__ Speech/language delays
__ Odd/unusual interests
__ Odd/unusual behaviors
__ Tics

Please complete these questions as fully and accurately as possible to help me provide the best possible care for your child. If you need more space to write, please write on the back of these pages. Thank you!

IDENTIFYING INFORMATION

Child's Name: ______________________ DOB: ____________________ Age: ____________

Child's Gender: ______________________ Race/Ethnicity: ______________________________

Referred by? ____

PRESENTING CONCERNS

What is the primary reason you are bringing your child to see me? ________________________________
____

When did this problem begin? ____
____

When did you first notice symptoms? ____
____

How much do these concerns interfere with daily functioning? Extensively Moderately Minimally

Since they began, have the symptoms become worse __ unchanged __ intermittent __ improved __

FAMILY HISTORY

Please specify if the child's parents are single married cohabitating divorced widowed

Parents' names: ____

If parents are divorced or separated, what are the custody arrangements? ______________________
____

If divorced, please bring divorce decree to the initial interview

Length of time parents married/living together? ____

Describe the child's relationship with his/her mother: ______________________________________

Describe the child's relationship with his/her father: _______________________________________

Describe the relationship between the child's mother and father: ____________________

____

Has child protective services ever been involved in this child's life? If yes, please explain: ____________________

____

Has there been any history of trauma or abuse of any kind within this child's life? If yes, please explain: ______

____

Has either parent been married before? If so, when? ____________________

____

Is there a family history of mental health conditions? If so, please describe: ____________________

____

What spiritual, cultural, and/or religious practices are important to you? ____________________

____

Please list the following information for everyone currently living in your child's home:

Name	Age	Gender	Relationship to you

Please mark all that currently apply or have ever applied to your child's life (**N = now, P = past**)

__ Marital conflict
__ Extended family conflict
__ Work-related stress
__ Substance abuse
__ Trauma/abuse history
__ Separation/divorce
__ Peer relationships
__ Financial stressors
__ Medical problems
__ Spiritual or religious conflict
__ Parent/child conflicts
__ School problems
__ Job loss or change
__ Housing problems
__ Sibling conflict
__ Recent move
__ Legal problems
__ Recent death
Other (specify)

MEDICAL/DEVELOPMENTAL HISTORY

How would you describe your child's current physical health? excellent good fair poor

Please list all medications your child currently takes (including dosages): ____________________

____

Please list all medications your child was previously prescribed (including dosages): ____________________

____

Has your child had significant side effects from medications? If yes, please explain: ____________________

____

Please rate the effectiveness of the medications your child has taken (1 – 10): ____________________

Please check any of the following that are part of your child's medical history:

__ Seizure __ Neurological disorder __ Traumatic brain injury __ Loss of consciousness
__ Stroke __ Blood pressure problems __ Thyroid problems __ High Fever

Were there any complications during the mom's pregnancy with this child? If yes, please explain: ___________

Were there any complications with the labor or delivery of this child? If yes, please explain: ___________

After how many months or weeks of pregnancy was your child delivered? ___________

How much did this child weigh at birth? ___________

Did your child require any unusual medical care following birth? If yes, please explain: ___________

Please describe your child's progress on developmental milestones (D = delayed, T = typical, E = early)

Task	Typical Development	Your Child's Development		
Lifts head	1 – 3 Months	___ D	___ T	___ E
Smiles	1 – 3 months	___ D	___ T	___ E
Babbles	4 – 11 months	___ D	___ T	___ E
Sits alone	5 – 8 months	___ D	___ T	___ E
Stands	6 – 10 months	___ D	___ T	___ E
Walks	11 – 14 months	___ D	___ T	___ E
First words	11 – 15 months	___ D	___ T	___ E
Pretend play	12 – 24 months	___ D	___ T	___ E
Toilet trained	20 – 48 months	___ D	___ T	___ E
Speaking in sentences	2 – 3 years	___ D	___ T	___ E
Riding tricycle	2 – 3 years	___ D	___ T	___ E
Playing cooperatively	4 – 6 years	___ D	___ T	___ E
Writing letters/numbers	4 – 6 years	___ D	___ T	___ E

Please describe/explain anything that was exceptional, unusual, or unexpected about your child's development:

SOCIAL HISTORY:

Does your child have a history of legal problems? (If yes, please explain) ______________________________

____

How well does your child make or maintain friends? ______________________________

____

Has your child frequently been bullied by or bullied others? If yes, please explain: ______________________________

____

How well does your child get along with teachers or other adults? ______________________________

____

ACADEMIC HISTORY

Where does your child attend school? ____________________ What is his/her current grade? __________
Has he/she ever skipped a grade? Has he/she ever been held back? __________
Has he/she ever received special education services in school? ______________________________
What is your child's typical grade range in school? ______________________________
Has your child ever been suspended or expelled from school? If yes, please explain: ____________________

____

SUBSTANCE USE AND ABUSE

For the following substances, please:
Write "E" if your child has experimented with, but does not currently use any of these substances
Write "U" if your child currently uses any of these substances, but not to the point of getting drunk or high
Write "A" next to those substances your child occasionally or regularly uses to get drunk or high.
Write "D" next to those substances your child *has ever been* or *is now addicted* to or *dependent* upon.

__ Caffeine __ PCP/Angel Dust __ Alcohol __ Marijuana __ Amphetamines
__ Inhalants __ LSD/Hallucinogens __ Cocaine or crack __ Opiates __ Heroin
__ Tobacco __ Prescription drugs __ Ecstasy __ Acid

Has your child ever been treated for substance abuse? If yes, please specify: ______________________________

____

Prior Behavioral Healthcare

Has your child previously received mental health services? ______________________________
If yes, please answer the following questions:
When did therapy begin and end? ______________________________
Where did therapy take place? ______________________________
With whom did you work? ______________________________
What happened as a result? ______________________________

What would you like to see accomplished through therapy? ______________________________
____
____
____

Sara Boghosian, 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.

246 E. 1260 N.
Logan, UT 84341
Phone: (435) 750-6300
Fax: (435) 753-8995

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

- To ask that we communicate with you about eh 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 requires 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.

INFORMATION AND AGREEMENT

This document contains important information about the professional services and business policies of Sara Boghosian, PhD, PC. Please read it carefully and note any questions you might have so we can discuss them. Your signature verifies this document as a legal and binding agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy requires significant effort on your part, both during sessions and between sessions. Since therapy may involve discussing difficult aspects of your life, some sessions may be uncomfortable. Therapy can result in very positive outcomes. However, since many factors can affect the outcome of your therapy, success can't 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, she/he is extending the limits of confidentiality to include that person while that person is in session.
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 five 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. It is important that you understand that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no member of the group can have access to them without your specific, written permission. My support staff may have access to your medical chart and may have occasion to send or receive privileged information such as psychotherapy notes. They are the only ones, beside myself, who will have access to your medical records and they are under the same limits of confidentiality I am.
5. My support staff may have access to your medical chart and may occasionally send or receive privileged information such as psychotherapy notes, evaluations, and other written and/or verbal communications. All persons affiliated with Sara Boghosian, PhD, PC abide by the same limits and laws of confidentiality.

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.

BILLING AND PAYMENT

1. If I am a paneled provider for a patient's insurance company, I will accept the contracted maximum fee (MAF) as payment in full for services. The MAF is comprised of a co-pay (a per-session fixed amount for which the patient is responsible), or a co-insurance (a 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. As a courtesy service, my billing specialist, Joanie, will bill the patients' insurance. Please note, however, that payment for services received is ultimately the responsibility of the patient and if an insurance claim is not responded to or denied, patients are responsible for the cost of the service.

2. Co-pays and co-insurance payments: *both insurance companies and my policy require that co-pays and co-insurance payments be paid at the time of service (at check-in).*The co-pay/co-insurance amount due will be written on the super-bill slip patients sign at check-in. Patients' total outstanding balance will also be noted on the super-bill with a brief description of charges. There is a $10 service fee charged if patients choose to not pay the co-pay/co-insurance at the time of service. I will waive this fee if a patient brings in the co-pay/co-insurance payment within the same business day of the session. If a patient does not pay his/her co-pay/co-insurance for two successive sessions, no further appointments will be scheduled until the payment is made. Future sessions already scheduled may be cancelled until the payment is made.

3. Deductible: many patients have deductibles at the beginning of their new insurance year (usually in January, but July for some insurance companies). This means that the patient is entirely responsible for paying for the service until their deductible is met. Deductible amounts vary from plan to plan and are met by paying for any covered health services out of pocket (e.g., a $500 deductible may be met by paying $150 to a psychologist and $350 to a family physician). After the deductible for the insurance year has been met, insurance companies are required to pay their portion of remaining health services received that insurance year. *When the new insurance year begins and deductibles are being met, co- payments/co-insurance payments are still due at the time of service. Patients will be informed at check-in of the estimated amount of the deductible charge and asked to pay at the time of service. If patients choose not to pay at the time of service, the amount will be billed in their monthly statement. Balances must be paid in a timely manner and not exceed a $300 limit in order for treatment to continue uninterrupted. Patients are encouraged to educate themselves as to how their deductible works and plan ahead for this time of year when their out of pocket expenses will increase.*

4. Services and charges:

CPT	Purpose	Cost	Explanation
90791	Initial evaluation	$200	This is a 45 min. initial appointment where paperwork is collected and a comprehensive diagnostic interview is conducted in order to form initial diagnostic impressions and begin treatment planning.
90832	Therapy	$88	A 16-37 min. psychotherapy session.
90834	Therapy	$131	A 38-52 min therapy session.
90837	Therapy	$175	A 53-67 min. weekly therapy session length. If, for any reason, the insurance company does not cover this service, patients may still chose it, but will then be responsible for the 15 min. of additional service (e.g., we will bill for a 45-minute session and the patient pays and additional $43.75 for the additional 15-minute service).

	Therapy	$175 per hour	As of 2013, there is no longer a covered insurance code for sessions that exceed one hour. These longer sessions (exceeding 67 min.), most often used for complex or highly emotional work (e.g., trauma work or urgent or crisis management sessions where a safety plan must be put in place), may still be selected, but patients are then responsible to pay for the additional service provided. For example, if the patient selects/receives a 90-minute session service, we will bill insurance for a 60-minute session (or a 45-minute session in cases where 60-minute sessions are not a covered service) and the patient pays out-of-pocket for the additional 30-minutes of service ($87.50).
90846	Family therapy without patient present	$131	A 45 min. session with the family member(s) of a patient when the focus of the session is the primary patient.
90847	Family therapy with patient present	$131	A 45 min. session with the primary patient and any family member(s) when the focus of the session is the primary patient. Patients and their families may choose longer sessions (exceeding 45 min.), but are then responsible to pay for the additional service provided. For example, if the patient selects/receives a 75-minute session service, we will bill insurance for a 45-minute session and the patient pays out-of-pocket for the additional 30-minutes of service ($87.50).
96100, 96101, 96103	Psychological testing	$175 per hour	Includes diagnostic, intelligence/achievement, memory and personality testing (e.g., depression inventories, personality inventories, trauma assessments, eating disorder symptom severity assessments). Time charged includes administration, scoring, interpretation, and written and/or verbal feedback of results—including all time required to create a written report and/or obtain collaborative information from any sources.
90899a	Legal proceedings and agency meetings	$175 per hour	This charge will be assessed for my involvement and participation in any legal proceedings of any kind and my involvement with any agency of any kind (excluding my practice). Services include, but are not limited to, involvement in court proceedings (including testifying), consulting with legal professionals, IEP meetings, 504 meetings, report creation for another agency, and any other meeting that takes place with another professional. If you become involved in legal proceedings that require my participation, you will be expected to pay for my time even if I am called to testify by another party. The amount of time required for court appearances and agency meetings tends to be unpredictable and often requires setting aside extra time. Thus, any and all preparation time for court and/or agency meetings is also charged to you as an expense. You will be responsible to pay for all of my time associated with my involvement in your care. If cumulative travel of more than 50 miles from my office is required, additional fees will apply.
90899b	Miscellaneous Charges (excluding	$150 per hour	These are any services provided by me that do not fit in the above-mentioned categories (e.g., writing letters, crisis calls, facilitating hospital or residential admissions, consulting with

legal proceedings and agency meetings)	other providers, consulting with teachers/schools). Miscellaneous services less than 10 min. may be provided as a courtesy; billing will typically occur in 10-minute increments. Often, these services are not covered by insurance plans, in which case the patient will be billed directly. If insurance does offer coverage, the billing manager will send in a claim and the patient will be responsible for his/her portion.

5. Self-Pay Patient Rates: patients who do not have insurance or do not use their insurance will be offered a courtesy discount of 25% outlined below:

CPT	Purpose	Cost	Self-Pay Rate
90791	Initial evaluation	$200	$150
90832	Therapy	$88	$66
90834	Therapy	$131	$98
90837	Therapy	$175	$131
	Therapy	$175 per hour	$131 per hour
90846	Family therapy without patient present	$131	$98
90847	Family therapy with patient present	$131	$98
96100, 96101, 96103	Psychological testing	$175 per hour	$131 per hour
90899a	Legal proceedings and agency meetings	$175 per hour	$131 per hour
90899b	Miscellaneous Charges (excluding legal proceedings and agency meetings)	$150 per hour	$112.50 per hour

6. No-Show Fees: when patients fail to present for an appointment without calling to cancel a minimum of 24 hours prior to their scheduled appointment (unless in cases of sudden illness or emergency), they will be charged a fee of $85. Patients may speak with me if they feel circumstances warrant a discount or waiving of the fee. Number and frequency of no-shows, ratio of no-shows to shows, as well as unique circumstances may be taken into consideration. Patients who fail to present for two consecutive sessions will be contacted to determine whether they want to continue therapy. If no response is received within 3 business days, all future appointments will be cancelled. To resume the option to schedule further therapy all no-show fees must be paid in full.

7. Outstanding balances: interest is charged on outstanding balances at a rate of 1.5% per month, 18% per year. Patients will be informed of their total balance at each scheduled session; each person will also have the opportunity make payments toward their balance. Patients owing a balance will also be sent monthly statements reflecting the portion they owe for services provided. Statements can be confusing to read (e.g., our billing software system automatically applies payments to the oldest outstanding charge in order to reduce patients' interest charges; it may therefore appear that a co-pay paid wasn't credited to the account when it was, but it was applied to an older charge). If patients have questions about their statement or amount owed, they are encouraged to contact Joanie or speak with me. *Patients whose balances (patient portion) exceed $300 will be given one month from the statement date indicating an outstanding payment balance exceeding $300 to return their balances under $300. If that does not occur, patients will be contacted to make a payment or payment arrangements. Payment arrangements must be made (and followed) in order to schedule further appointments and/or to retain existing appointments.* Patients will be sent a letter indicating the amount of their outstanding bills. Patients will be sent a second letter of outstanding balance with an appraisal that payments are necessary to avoid having the balance sent to collections. Although I will make every effort to work with patients on payment plans in cases of financial hardship, patients who refuse to make payment arrangements or adhere to them will be sent to collections. Thus, when reasonable efforts

to collect an outstanding balance have failed, the account will be turned over to a collections agency or a claim will be made in small claims court. Should your account be submitted to a collections agency, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, all associated attorney's fees, all associated court fees, and all associated collection fees in the amount of 40% of the initial balance. The obligation to pay all collection fees shall be imposed at the time of the assignment of the debt to a third party debt collection agency. State law requires us to inform you that a negative credit report is submitted to a credit-reporting agency if you fail to fulfill your financial oblations.

8. If a patient's insurance changes, patients are responsible for informing me and/or Joanie of said changes in plan, policy, and/or provider. If a patient's insurance changes to a company with whom I am not paneled, but the patient prefers to continue treatment with me, there are options:
    a. I will consider applying for panel membership if the company is within an acceptable range in their fee schedule, paperwork demands, and rules and regulations;
    b. Patients can contact their insurance company to request a single-case agreement. If they are willing to negotiate such an agreement and will meet the requirements specified above, efforts to make those arrangements will be made
    c. The patient may elect to use the self-pay schedule (see #5 above). If self-pay costs are prohibitive, I can facilitate a transfer to a therapist who is paneled with the patient's new insurance or provides services on a sliding-fee scale.
    d. If a patient loses his/her insurance—patients who begin treatment insured and then lose their insurance will have the options of continuing services at self-pay rates (see #5 above) or if self-pay rates are prohibitive, have me facilitate a transfer to a therapist at a community mental health center or sliding fee scale-based treatment center.
    e. Due to chronic and recurrent changes in insurance company's fee schedules, I reserve the right to evaluate whether or not to maintain my professional relationship with any and all insurance companies. These decisions are at my sole discretion; decisions may be determined by the insurance company's fee schedules, paperwork demands, and level of support offered toward providing quality treatment of patients. If I discontinue panel membership with a patient's insurance and the patient wishes to continue treatment with me, patients may call their insurance provider and request a single-case agreement, which can be negotiated. If the insurance companies are unwilling to do so or their terms are not within reasonable limits, patients may elect to pay for service according to the self-pay schedule (see #5 above). If no single-case agreement can be negotiated and self-pay costs are prohibitive, I will facilitate a transfer to a therapist who is paneled with the patient's insurance.

9. Monthly statements will be sent to you showing charges, your payments and your insurance company's payments. If there is an error on your statement, please bring it to our attention so we can promptly resolve the problem. 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.

10. When reasonable efforts to collect an amount owed fail, the account is turned over to a collection agency or a claim is made in small claims court. If such action is necessary, 40% of the outstanding amount is 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. State law requires me to inform you that a negative credit report is submitted to a credit reporting agency when a person fails to fulfill contracted financial obligations.

11. Any and all agreed-upon changes to the above billing policy must be made and maintained in writing.

12. With your signature, you are authorizing Sara Boghosian, PhD, PC and/or its affiliated office and billing personnel to release any medical or other information necessary to your insurance company and its affiliates for the purposes of billing, receiving authorization for services, and/or to process any claims for payment of services. You are authorizing payment of medical benefits to Sara Boghosian, PhD, PC. Additionally, you are authorizing Sara Boghosian, PhD, PC and/or its affiliated office and billing personnel to contact you for billing purposes.

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's schedule, it is important that you keep track of your appointments. Reminder calls are a courtesy only, are not guaranteed, and should not be relied upon as a way of keeping track of your appointments. Do not leave appointment cancellations on my voice mail.

Effective therapy commonly requires full attention. As such, please make arrangements for childcare because we cannot provide it. Children should not be left in the waiting room unsupervised. Should a problem arise due to inadequate supervision, your therapy session would be cut short that day.

INSURANCE REIMBURSEMENT

Insurance companies usually provide coverage for specific mental health diagnoses. My staff and I will do what we can to help you receive the full benefits to which you are entitled (including filing your insurance claim for you). However, you are ultimately responsible for payment of my fees. It is important that you find out exactly what coverage you have. You should read carefully the section in your insurance coverage booklet that describes mental health coverage, paying particular attention to deductibles, co-payments, number of sessions allowed, and authorization requirements. Sometimes, after a certain number of sessions, it is necessary to seek approval from your insurance for more therapy. If you have questions, please call your plan administrator.

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 try to provide the requested information while being sensitive to my patient's desires for confidentiality. The submitted information becomes part of the insurance company files and will probably be stored in a computer. I have no control over what your insurance company may do with information submitted to them. I will provide you with a copy of any report I submit upon your request. If you prefer, you always have the right to pay for services yourself to avoid insurance complexities.

CONTACTING ME

I am usually in my office between 8:30 AM and 6:00 PM Monday through Thursday. However, I am usually with a patient. The most reliable way to contact me is through voice mail (435-750-6300) or by leaving a message with the receptionist. I try to return calls at the end of my day, Monday through Thursday (exceptions being holidays and vacations). When I am unavailable and in the case of emergency, 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. Psychotherapy notes and 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.

SPOUSE, FAMILY, AND FRIENDS (OTHER PARTICIPANTS)

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 primary focus of the treatment. But a participant is not a patient and does not have a right to access the medical record nor does she/he have the same rights as the patient regarding confidentiality. My primary responsibility and allegiance remains with my patient. A handout with more information on this topic is available from the receptionist.

When the patient is a child or adolescent, I usually also meet with the parents. In order for children and teenagers to speak openly, parents must surrender some of their rights to information obtained in therapy. This allows the child to have confidence that whatever she/he wants kept confidential will be. Parents continue to have rights to general information about their child's therapy (how the therapy is going, treatment goals, level of the child's cooperation). Additionally, if I believe there is a high risk that a child or teen is about to seriously harm someone or himself/herself, I will notify the parents of my concern. I am also willing to provide parents a summary of treatment when it is complete.

At times I may recommend that a spouse, family member, or friend seek his/her own therapy. I will likely refer the person to another clinician unless my current patient and I agree that both persons' might be better served if I provided the therapy myself. 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.

Sometimes conjoint therapy for couples or family therapy can be most effective in treating the individual. In such an instance, one person becomes my patient and the others are participants. If this is done, everyone involved agrees that I would have permission to use my judgment in how information revealed to me may be shared with others involved in the therapy. My intent in sharing information is always to promote the welfare of those involved. If you have any concerns about what information may be shared under these circumstances, please ask me.

AGREEMENT

I have read and reviewed the above and have discussed with Dr. Boghosian those items which were unclear or of concern to me. I understand and agree to the above as written as verified by initials and signature (as indicated). My signature also verifies that I have been provided a printed and/or electronic copy of the information and agreement.

______________________________	______________________________
Patient's Name (printed)	Parent/Guardian Name (if patient is a minor)
Signature of Patient (or Parent/Guardian if minor)	Today's Date
Signature of Financially Responsible Person	Name of Financial Guarantor