SANCTUARY

COUNSELING & PSYCHOLOGICAL TESTING

Thank you for choosing Sanctuary!

Please fill out these forms to the best of your ability and return them to our office.
We will need a copy of your insurance card and a photo ID.
Please arrive 5-10 minutes before your appointment.
If you must cancel, please give 24 hours notice.
Copays will be collected at the time of service.

Office Hours:
M-F 9am-5pm

Address:
4737 S. Afton Place, Suite A
Chubbuck, ID 83202
(Right behind Wilks Funeral Home)

Phone: (208) 417-0623
Fax: (208) 417-0641
After Hours Crisis Phone
(for Current Clients):
(208) 339-3163

Office Email:
frontdesk@sanctuaryntc.com

Testing Email:
a.hughes@sanctuaryntc.com

SANCTUARY
COUNSELING & PSYCHOLOGICAL TESTING

Member Contact Information

PATIENT INFORMATION Date: _____

Client Legal Name _____ (pref. name)_____ Social Security #_____

Address_____City_____State_____ Zip_____

Date of birth _____ Age_____ Legal Sex: ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female ☐ Unspecified

Preferred Phone _____ Call okay? ☐ Yes ☐ No Text Okay? ☐ Yes* ☐ No

Secondary Phone _____ Call okay? ☐ Yes ☐ No Text Okay? ☐ Yes* ☐ No

Email: _____ May we contact you by email? ☐ Yes ☐ No

Emergency contact? Name_____ Phone _____Relationship_____

Who referred you to our practice? _____

(If applicable:)
Name of QIDP/Case Manager/TCC/other _____Phone#_____

Agency name _____ Agency Phone#_____

*Note: By checking this box you agree to any charge or fee associated with receiving text messages according to your phone carrier agreement.

IF PATIENT IS A MINOR / OR HAS A GUARDIAN**:

Mother/Guardian

Name_____Address_____

Employer_____ Occupation_____ Social Security #_____

Home phone _____ Work phone _____ Cell phone_____

Date of birth_____ Does patient live with this parent? ☐ Yes ☐ No ☐ Part Time** _____%

Father/Guardian

Name_____ Address (if diff from above)_____

Employer_____ Occupation_____ Social Security #_____

Home phone _____ Work phone _____ Cell phone_____

Date of birth_____ Does patient live with this parent? ☐ Yes ☐ No ☐ Part Time** _____%

(If Applicable) **Do both parents/guardians have legal and/or physical custody? ____/____% Physical ____/____% Legal

****Note: We may require Guardianship/Custody papers, and/or need our intake forms signed by both custodial parents to have on file for our records.**

SANCTUARY
COUNSELING & PSYCHOLOGICAL TESTING

Consent for Assessment and Treatment

This document/agreement contains important information about
1) our professional services, 2) our business practices.

Purpose and Mission of Sanctuary Counseling

Our mission is to foster the success of our members and their families through innovative, evidence-based treatment for people of all walks of life, resulting in recovery and improved resiliency. Members will participate in assessment and treatment which builds on the individual's strengths and can expect to be treated with both dignity and respect. Sanctuary Counseling will be recognized as a leader in clinical services, training, research, and advancing evidence based clinical treatment.

Neuropsychological & Psychological Services

Effective treatment depends upon the particular problems you are experiencing, as well as personality factors and establishing a good clinician-client alliance. Psychotherapy may call for more active disclosure and effort on your part. For therapy to be most successful, we recommend you work on the things we talk about during the session and at home. Psychological treatment includes potential for some risk as well as benefits. Since therapy involves discussing unpleasant aspects of your life, you may experience feelings, which may be temporarily uncomfortable. On the other hand, psychological treatment has been known to produce many benefits such as reduction in distress, solutions to specific problems, and better relationships. There can be no guarantees of what you will experience. Sanctuary Counseling attempts to minimize risks by employing well-trained clinicians and by frequent conversations with you about your progress.
The first few sessions will involve evaluation of your needs. By the end of this evaluation period, your clinician will be able to offer you an initial impression of your needs and a plan for what treatment might include, if you decide to continue with therapy. If you ever have any questions about procedures, you should discuss them whenever they arise.
Office hours at Sanctuary Counseling vary during the week. Sanctuary provides full time voice mail, but you may not be able to reach your clinician who may be out of the office or seeing other clients. Your clinician will make every effort to return your call as soon as possible. If you are difficult to reach, please inform your clinician of times you might be available. Sanctuary Counseling does not currently provide emergency services (see Emergency Care and Crisis Situations).

Forensic (Legal) Services:

Sanctuary Counseling provides a variety of forensic services including evaluations and court testimony. If you know you may need these services, please let us know at the beginning or during services. We will be happy to provide what help we can. Importantly, presenting your clinician with an unexpected subpoena to testify or produce records for the courts rarely benefits you. Unfortunately, it is often interpreted by the legal system as deception or manipulation and typically damages the therapeutic relationship between you and your clinician.

Research & Training:

Sanctuary Counseling has secondary goals of training the next generation of mental health professionals and advancing psychological science. To this end, we are affiliated with Idaho State University. While the confidentiality of every member receiving services through the clinic is strictly maintained, your case may be discussed within the confines of the clinic for training and quality service improvement purposes. Further, if you are participating in services, you may be asked if you are willing to have a session recorded. However, prior to this occurring, you will be asked to specifically sign a form consenting to recording.
In addition, at times, research opportunities may arise for a family or individual in your situation. When these occur, you may be contacted to see if the opportunity is of interest to you. Of note, unless you specifically request otherwise, if you participate in neuropsychological or psychological testing your anonymous data will be kept in our secure database for potential future research on individuals with your condition. To reiterate, in this situation your personal information will in no way be connected to your test data.

Emergency Care and Crisis Situations

Sanctuary Counseling is not able to provide emergency services or psychiatric medications. Individuals who need emergency clinical access should contact 911 or access an emergency room or emergency provider such as the State of Idaho Department of Health and Welfare.

Member's Rights And Responsibilities

Member's Rights

Members have the right to:

- Receive information about services and member's rights and responsibilities.
- Be treated with respect and recognition of his/her dignity and right to privacy.
- Participate with practitioners in making decisions about his/her mental health care.
- A candid discussion of appropriate or medically necessary treatment options for his/her condition.
- Voice complaints or appeals about Sanctuary Counseling for the services provided by Sanctuary Counseling.
    - When concerns or complaints arise, a member can discuss it with any staff, volunteer, or student working for Sanctuary Counseling, with whom they feel comfortable. The concern will try to be resolved informally initially to the satisfaction of the member. If that is insufficient, the staff member can help the member participate in the formal grievance process.
- Make recommendations regarding Sanctuary Counseling members' rights and responsibilities policies.
- Care that is considerate and that respects his/her personal values and belief system.
- Personal privacy and confidentiality of information.
- Reasonable access to care regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.
- Have family members participate in treatment planning. Members over 12-years-old have the right to participate in such planning
- Individualized treatment, including:
    - Adequate and humane services regardless of the source(s) of financial support.
    - Provision of services within the least restrictive environment possible.
    - An individualized treatment or program plan.
    - Periodic review of the treatment or program plan.
    - An adequate number of competent, qualified and experienced professional clinicians to supervise and carry out the treatment or program plan.

- Participate in the consideration of ethical issues that may arise in the provision of care and services, including:
    - Resolving conflict.
    - Participating in research, investigational studies, or clinical trials.
    - Designate a surrogate decision-maker if he/she is incapable of understanding a proposed treatment or procedure or is unable to communicate his/her wishes regarding care.
    - Be informed, along with his/her family, of his/her rights at Sanctuary Counseling in a language they understand.
    - Choose not to comply with recommended care, treatment, or procedures and be informed of the potential consequences of not complying with the treatment recommendations.
    - Be informed of rules and regulations concerning his/her own conduct
    - Be informed of the reason for any non-coverage determination, including the specific criteria or benefits provisions used in the determination.

- Inspect and copy their protected health information (PHI) and in addition:
    - Request to amend their PHI.
    - Request an accounting of non-routine disclosures of PHI.
    - Request limitations on the use or disclosure of PHI.
    - Request confidential communications of PHI to be sent to an alternate address or by alternate means.
    - Make a complaint regarding use or disclosure of PHI.
    - Receive a Privacy Notice regarding their PHI.

Member Responsibilities:

Members have the responsibility to:

- Supply information (to the extent possible) required by practitioners at Sanctuary Counseling in order to provide and/or coordinate care.
- Follow plans and instructions for care that they have agreed on with his/her network practitioner.
- Understand his/her health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Keep scheduled appointments and actively participate in treatment.

Assessment Referral List

Speech Language Pathology

Portneuf Hospital- Physical Medicine

515 E. Benton Street

Pocatello, ID 83201

Ph 208-239-1490

Ph 208-239-1000

Occupational Therapy

Portneuf Hospital- Physical Medicine

515 E. Benton Street

Pocatello, ID 83201

Ph 208-239-1490

Ph 208-239-1000

Physical Therapy

Portneuf Hospital- Physical Medicine

515 E. Benton Street

Pocatello, ID 83201

Ph 208-239-1490

Ph 208-239-1000

Hearing

Portneuf Hospital- Physical Medicine

515 E. Benton Street

Pocatello, ID 83201

Ph 208-239-1490

Ph 208-239-1000

Current Developmental Disability Agencies in Southeast Idaho recognized by the Idaho Department of Health and Welfare:

A New Hope

Access Point Family Services, Inc.

Adolescent and Child Development Center, LLC

Allies Family Solutions

Center Case Management and DD Services, LLC

Community Connections of Pocatello

Dawn Enterprises, Inc.

Franklin County Development Services

Grace Educational Opportunities, Inc.

Southeastern Idaho Developmental Center

Swift dba New Day Products and Resources, Inc.

Contact information for these agencies are available on request or by visiting the Idaho Department of Health and Welfare website.
Http://www.healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=sxQW30i645k%3d&tabid=398&mid=2068

SANCTUARY
COUNSELING & PSYCHOLOGICAL TESTING

Informed Consent

By signing below, I certify that I am aware of these agencies and choose to be a customer of Sanctuary Counseling of my own volition.

Your signature below indicates that you have read this agreement and agree to its terms.

These matters have been explained to you and you fully and freely give consent to receive Sanctuary Counseling evaluation and/or treatment services.

_____
Name of Client (**please print**)

_____ _____
Signature of Client (or Representative for Minor Client) Date

_____ _____
(If applicable) **Printed** name of Representative for Minor Client Relationship to client

_____ _____
Sanctuary: NTC Clinician/Witness Date

SANCTUARY
COUNSELING & PSYCHOLOGICAL TESTING

Fees, Billing, and Payment Policy

Please initial each space below to acknowledge that you have been informed.

_____ The fees for therapy sessions are listed as follows, but may be subject to change in special circumstances:

Service:	Out of Pocket Cost	CPT Code****	Criteria
Intake (CDA, Intake Paperwork, Treatment Plan)	$240.00 p/evaluation	90791	Up to 2hrs
Case Consultation - Family/Individual	$180.00 p/session	90839	Up to 1hr
Family Therapy:			
Family with Client Present	$180.00 p/session	90847	Up to 1hr
Family without Client Present	$180.00 p/session	90846	Up to 1hr
Individual Therapy:			
30 Minute Session	$80.00 p/session	90832	16-37 min
45 Minute Session	$105.00 p/session	90834	38-52 min
60 Minute Session	$120.00 p/session	90837	53 min +
Peer Support	$15.00 p/unit**	H0038	15 min
Family Support	$15.00 p/unit**	H0046	15 min
Group Therapy / Skills Training Class	$40.00 p/session*	90853	Up to 1hr
Misc. letter writing	$25 per unit***		
Neuropsychological/Psychological:			
Full Evaluation and Report Cash Pay total	$1400.00 due upon receipt of report		
Testing & Report Writing	$110.00 p/hour		
Neuro-Testing Feedback	$180.00 p/session*		
Forensic Services:			
Psychological/Neuropsychological Eval	$150.00 p/hour		
Expert Testimony	$150.00 p/hour		
Therapy/skills training	$150.00 p/session*		
Designated Examination/Testimony	$150.00 p/hour		
Competency Evaluation	$150.00 p/hour		
Misc Report/Letters	$25 p/unit***		

Session (approximately 45-60 minutes)
Unit (approximately 15 minutes)
Any letter pertaining to your legal case, school, Health & Welfare, employment, service animal etc. Not billable to insurance
****For Billing to Insurance, amounts are subject to contracts between provider and insurance company
Different amounts may be reflected on your EOB when it goes towards your deductible or Out Of Pocket limit.****

_____ Individuals requesting any services which require Sanctuary Counseling to hire a lawyer, are responsible for any and all legal fees acquired by Sanctuary's lawyers.

_____ **Private Insurance Coverage**: As a courtesy Sanctuary Counseling will bill your insurance claim for you. If your insurance company does not respond or pay within a reasonable time period (60 days), you will be responsible for the remaining balance. Sanctuary Counseling requires all co-pays to be paid on the day that services are rendered.

Sanctuary Counseling will work with your insurance company as long as your clinician is a contracted provider covered by your policy. It is very important that you understand what your insurance covers and does not cover. Sometimes prior authorization is required for mental health services or the services are limited to a specific number of sessions, certain types of therapy, or assessment services, or approved providers. Ultimately, you (not your insurance company) are responsible for full payment of Sanctuary Counseling fees.

_____ If you are more than **15 minutes late for your appointment**, you will be charged a $25.00 cancelation fee and may be asked to reschedule your appointment at that time. This will not be billed to your insurance.

_____ **Delinquent Accounts**: If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, your bill will be subject to a 5% Interest Rate per every 30 day billing cycle. Sanctuary Counseling has the option of using legal means to secure payment. This may involve contracting with a collection agency which requires us to disclose otherwise confidential information. In most collection situations, the only information Sanctuary Counseling releases are the client's name, contact information, such as address, the nature of the services provided, and the amount due.

_____ **Returned Checks**: All returned checks will be subject to an additional processing fee of $25.00.

_____ **Court Ordered Services**: Often court-ordered services are not covered by insurance companies. If necessary, please call your plan administrator to have your questions about covered services answered.

_____ **Missed or Late Appointments**: Should it be necessary to miss an appointment, please notify our office a minimum of 24 hours in advance. We understand that life can be unpredictable, but our clinicians strive to keep a punctual schedule and we expect our patients to follow the same guidelines. If you are more than 15 minutes late for an appointment, you may be asked to reschedule your appointment. If the issue of 2 or more un-kept appointments arise the clients regularly scheduled appointment will be discontinued and it will be the responsibility of the client to reschedule with the clinician another time in their schedule.

_____ **Patient Conduct**: Sanctuary Counseling promotes a positive working environment and our clients, staff, and visitors have the right to feel safe and protected in our care. We reserve the right to ask anyone that may jeopardize or compromise the health and wellbeing of our clients, staff, and visitors to leave our premises immediately. No pets are allowed except trained and certified service dogs as recognized by the ADA. Emotional support animals are not the same and are not permitted inside the building.

SANCTUARY
COUNSELING & PSYCHOLOGICAL TESTING

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PURPOSE OF THIS NOTICE

This notice of Privacy practices describes how Sanctuary: Neuropsychology & Treatment Consultants handles confidential information, following state and federal requirements. All programs in Sanctuary: Neuropsychology & Treatment Consultants may share your confidential information with each other as needed to provide you with benefits of services, and for normal business purposes. Sanctuary: Neuropsychology & Treatment Consultants might also share your confidential information with others outside of Sanctuary: Neuropsychology & Treatment Consultants as needed to provide benefits or services.
We are dedicated to protecting your confidential information. We create records of the benefits or services you receive from Sanctuary: Neuropsychology & Treatment Consultants. We need these records to give you quality of care and services. We also need these records to follow various local and federal laws.
We are required to:

- Use and disclose confidential information as required by law.
- Maintain the privacy of your information
- Give you this notice of our legal duties and privacy practices for your information, and
- Follow the terms of the notice that is currently in effect.

Health Insurance Portability and Accountability Act (HIPAA)

A federal law, HIPAA, provides privacy protections for medical records and new client rights with regards to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. This notice explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that Sanctuary: Neuropsychology & Treatment Consultants has provided you with this information at the end of this session.

Confidentiality

Federal and state law protects the privacy of communication between a client and a psychologist/clinician. Every effort will be made to keep your evaluation and treatment strictly confidential. In most situations, Sanctuary: Neuropsychology & Treatment Consultants will only release information about your treatment to others if you sign a written authorization that meets certain legal requirements. In the following situations, no authorization is required:

a) Clinical information about your case may be shared fully within Sanctuary: Neuropsychology & Treatment Consultants by the staff for the purposes of supervision were applicable.
b) Personal information is also shared for Sanctuary: Neuropsychology & Treatment Consultants' administrative purposes such as scheduling, billing, and quality assurance. Sanctuary: Neuropsychology & Treatment Consultants' files are also available to insurance company auditors. Data contained in your file is available for archival research (i.e., reviews of records to describe Sanctuary: Neuropsychology & Treatment Consultants' referrals, outcomes, and trends) as long as your identity cannot be linked to the data used. All staff members have been given training about protecting your privacy and have agreed not to disclose any information without authorization or approval of the Sanctuary: Neuropsychology & Treatment Consultants Clinic Director in mandated reporting situations (see Limits to Confidentiality).
c) On occasion Sanctuary: Neuropsychology & Treatment Consultants may find it helpful to consult with another health or mental health professional. During such a consultation, every effort is made to avoid revealing the identity of the client. If you do not object, it is our policy to tell you about such consultations only if it is important to you and your clinician working together. All consultations are noted in the client's records.
d) Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.

Consultation

For your information, the clinical providers of Sanctuary: Neuropsychology & Treatment Consultants function as a team and routinely consult regarding each member's case in order to provide the most effective and comprehensive care possible. In addition, some providers may consult with supervisors or other professionals outside of this clinic. In these situations, all professionals involved are bound by the confidentiality policies outlined in this document and have been required to sign a confidentiality agreement if they have access to the personal health information of a member.

Emails, Cell Phones, Computers, & Faxes

It is important to be aware that computers and un-encrypted emails, texts, and faxed communications can be relatively easily accessed by unauthorized people and, hence, can compromise the privacy/confidentiality of the information contained therein. Emails, texts, and faxes are vulnerable in that server/communication companies have access to the information sent through them. Further, they can be accidentally sent to an incorrect address or computer.

To combat these risks, the computers of Sanctuary: Neuropsychology & Treatment Consultants are equipped with firewalls, virus protection, and passwords. Further all information is routinely "backed-up" on encrypted hard-drives. Sanctuary: Neuropsychology & Treatment Consultants will not utilize emails, texts, or faxes without your direction to do so. Please notify the staff of Sanctuary: Neuropsychology & Treatment Consultants if you would like to specifically avoid or limit the use of emails, texts, cell phone calls, phone messages, or faxes when conveying your personal health information. If you communicate confidential or private information via un-encrypted e-mail, text, fax, or phone message, Sanctuary: Neuropsychology & Treatment Consultants will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate with those modalities. Please do not use texts, emails, voicemail, or faxes for emergencies.

Limits to Confidentiality

There are situations where Sanctuary: Neuropsychology & Treatment Consultants may be required or permitted to disclose information without your authorization. These situations are unusual at Sanctuary: Neuropsychology & Treatment Consultants, but include:

a) If Sanctuary has knowledge, evidence, or reasonable concern regarding the abuse or neglect of a child, elderly person, or disabled person, it is required to file a report with the appropriate agency, usually the Department of Health and Human Services. Once such a report is filed, we may be required to provide additional information.
b) If a client communicates an explicit threat of serious physical harm and has the apparent intent and ability to carry out such a threat, Sanctuary: Neuropsychology & Treatment Consultants may be required to take protective actions. These actions may include contacting the police and/or seeking hospitalization for the client.
c) If we believe that there is an imminent or even, in our judgment, high risk that the client will physically harm himself or herself, we will also take protective actions.
d) Although courts have recognized clinician-client confidentiality, there may be circumstances in which a court would order Sanctuary: Neuropsychology & Treatment Consultants to disclose personal health or treatment information. We also may be required to provide information about court ordered evaluations or treatments. If you are involved in, or contemplating litigation, you could consult with an attorney to determine whether a court would be likely to order Sanctuary: Neuropsychology & Treatment Consultants to disclose information.
e) Sanctuary: Neuropsychology & Treatment Consultants is required to provide information to a legal guardian of a minor child, including a non-custodial parent.
f) If a government agency is requesting information for health oversight activities or to prevent terrorism (patriot Act), Sanctuary: Neuropsychology & Treatment Consultants may be required to provide it.
g) If a client files a worker's compensation case, Sanctuary: Neuropsychology & Treatment Consultants may be required, upon appropriate request, to provide all clinical information relevant or bearing upon the injury for which the claim was filed.

h) If a client files a complaint or lawsuit against Sanctuary: Neuropsychology & Treatment Consultants or professional staff, Sanctuary: Neuropsychology & Treatment Consultants may disclose relevant information regarding the client in order to defend itself.

If any of these situations were to arise, Sanctuary: Neuropsychology & Treatment Consultants would make every effort to fully discuss it with you before taking action, and would limit disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions you have with us now or in the future. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

Professional Records and Clients Rights

The laws and standards of the mental health profession require that Sanctuary: Neuropsychology & Treatment Consultants keep Protected Health Information (PHI) about you in your clinical record for 7 years. Generally, you may examine and/or receive a copy of your clinical record, if you request it in writing. There are a few exceptions to this access:

1) some of the unusual circumstances described above,

2) when the record makes reference to another person (other than a health care provider) and we believe that access is reasonably likely to cause substantial harm to that other person or

3) where information has been supplied confidentially by others. Also, the clinic will not release copyrighted test information or raw data.

Because these are professional records, they can be misinterpreted. For this reason, Sanctuary: Neuropsychology & Treatment Consultants recommends that you initially review them in the presence of your clinician, or have them forwarded to another mental health professional so you can discuss the contents. Sanctuary: Neuropsychology & Treatment Consultants keeps no additional notes (sometimes called psychotherapy or process notes) beyond that which is in the clinical record. In most circumstances, Sanctuary: Neuropsychology & Treatment Consultants is allowed to charge a copying fee for re-producing your records. If Sanctuary: Neuropsychology & Treatment Consultants refuses your request for access to your records, you have the right of a review of this decision (except for information supplied confidentially by others), which the Sanctuary: Neuropsychology & Treatment Consultants Clinic Director will discuss with you upon request.

Minors and Parents

Please be informed that according to state and federal law, any person with legal rights pertaining to a child (e.g., legal guardian or non-custodial parent) may have the legal right to terminate the child's services unless that person has given his/her signed, informed consent. As stated earlier, Sanctuary: Neuropsychology & Treatment Consultants will honor requests for information by a legal guardian of a minor child.

Clients under 18 years of age who are not emancipated from their parents should be aware that the law allows parents to examine their clinical records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is Sanctuary: Neuropsychology & Treatment Consultants prerogative to request an agreement from parents that they consent to give up access to their child's records. If the parents agree, Sanctuary: Neuropsychology & Treatment Consultants will provide them only with general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Parents may be provided with a summary of their child's treatment when it is complete. Other communications will require the teenager's assent, unless Sanctuary: Neuropsychology & Treatment Consultants feels it is a crisis situation including personal risk or physical danger to the minor. If possible, such disclosures would be discussed beforehand with the teenager to minimize his/her objections and concerns.

***This Notice of Privacy Practices does not affect your eligibility for benefits or services.**

YOUR RIGHTS ABOUT YOUR CONFIDENTIAL INFORMATION

1. **Right to Review and Copy**
   You have the right to ask to review and copy your information as allowed by law.

   If you would like to ask to review and copy your information a "Request Regarding Records Form" is available at the Sanctuary: Neuropsychology & Treatment Consultants office. You must complete this form and return it to a Sanctuary: Neuropsychology & Treatment Consultants office staff member for processing.
   If you ask to receive a copy of the information, we may charge a fee. If you request 100 pages or more from our files, the fee will be 25 cents per page.
   You will be told if there is information we are legally prevented from disclosing to you.

2. **Right to Amend**
   You have the right to ask us to make changes to your information if you feel that the information we have about you is wrong or not complete.
   If you would like to ask Sanctuary: NTC to change your information a "Request Regarding Records Form" is available at the Sanctuary: Neuropsychology & Treatment Consultants office. You must complete this form and return it to the Sanctuary: Neuropsychology & Treatment Consultants office staff member for processing.

   We may deny your request if you ask us to change information that:
   - Was not created by Sanctuary: Neuropsychology & Treatment Consultants
   - Is not part of the information kept by or for Sanctuary: Neuropsychology & Treatment Consultants
   - Is not part of the information which you would be allowed to review and copy; or
   - We determine is correct and complete.

3. **Right to Restrict Health Information Disclosures**
   You have the right to ask us not to share your health information for your treatment or services, or normal business purposes. You must tell us what information you do not want us to share and who we should not share it with.

   If you would like to ask Sanctuary: Neuropsychology & Treatment Consultants to not share your information, a "Request Regarding Records Form" is available at the Sanctuary: Neuropsychology & Treatment Consultants office. You must complete this form and return it to a Sanctuary: Neuropsychology & Treatment Consultants office staff member for processing. If we agree to your request, we will comply unless the information is needed to give you emergency treatment, or until you end the restriction.

4. **Right to an Alternate Means of Delivery**
   You have the right to ask that we deliver your information to you at a different mailing address. For example, you can ask that we send your information from one program to a different mailing address from other programs that you receive services or benefits from.
   If you would like to ask for an alternate means of delivery of your information, a "Request Regarding Records Form" is available at the Sanctuary: Neuropsychology & Treatment Consultants office. You must complete this form and return it to a Sanctuary: Neuropsychology & Treatment Consultants office staff member for processing. Reasonable requests will be approved.

5. **Right to a Report of Health Information Disclosures**
   You have the right to ask for a report of the disclosures of your health information. This report for disclosures will not include when we have shared your health information for treatment, payment for your treatment, or normal business purposes, or the times you authorized us to share your information.
   If you would like to ask for a report of your health information disclosures, a "Request Regarding Records Form" is available at the Sanctuary: Neuropsychology & Treatment Consultants office. You must complete this form and return it to a Sanctuary: Neuropsychology & Treatment Consultants office staff member for processing.

   The first report you ask for and receive within a calendar year will be free of charge. For additional reports within the same calendar year, we may charge for the costs for providing the report. We will tell you the cost and you may choose to remove or change your request at the time before any costs are charged to you.
   Processing required by HIPAA is 30days,

SANCTUARY
COUNSELING & PSYCHOLOGICAL TESTING

Acknowledgment Of Receipt Of Rights & HIPAA Compliant Privacy Practices

By signing below, I acknowledge that I received and understand my Sanctuary: Neuropsychology & Treatment Consultants Rights, Responsibilities, and Privacy Practices form.

_____
Name of Client (please print)

_____ _____
Signature of Client / Minor Child 14+ Date

_____ _____
Name of Representative of Minor Child (please print) Relationship to Client

_____ _____
Signature of Representative of Minor Patient Date

_____ _____
Sanctuary: NTC Clinician/Witness Date

SANCTUARY
COUNSELING & PSYCHOLOGICAL TESTING

Insurance Information and Authorization Form

Patient's <u>Primary</u> Insurance*: Patient Name:_____ DOB: _____

Insurance Company Name _____ID #_____Group #_____

Policy Holder's Name_____ Date of Birth_____ SSN_____

Address (if different from patient) _____City_____ State_____ Zip _____

Preferred Phone#_____ Other Phone# or Email address _____

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Effective Date _____ (If not known put the 1st of the month right before your first appointment)

Patient's <u>Secondary</u> Insurance* (If applicable)**:**

Insurance Company Name _____ID #_____Group #_____

Policy Holder's Name_____ Date of Birth_____ SSN_____

Address (if different from patient) _____City_____ State_____ Zip _____

Preferred Phone#_____ Other Phone# or Email address _____

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Effective Date _____ (If not known put the 1st of the month right before your first appointment)

***WE WILL NEED A COPY OF YOUR CURRENT INSURANCE CARD, FRONT AND BACK.**

All **co-payments will be collected** at the time of service. **If you do not have insurance, payment is expected the time of service.** It is up to you to provide us with all information necessary to bill your insurance company, and to report any changes in coverage immediately. We do not guarantee payment. You will be responsible for payment of all services not covered by your insurance company. We will not bill your insurance company if you are seeing an out-of-network provider; you will be responsible for payment at the time of service. We can however, provide you with an invoice which contains all the necessary information for you to submit a claim to your insurance company for reimbursement. If you know your deductible has not been satisfied for the year, please pay at the time of service. We will bill your insurance company and give you credit for the allowable amount toward your deductible. **WE HAVE A 24 HOUR CANCELLATION POLICY. IF YOU MUST CANCEL YOUR APPOINTMENT, PLEASE GIVE US 24 HOURS NOTICE. IF YOU CANCEL YOUR APPOINTMENT LATE OR DO NOT SHOW UP, YOU MAY BE CHARGED IN FULL FOR THE APPOINTMENT. YOUR INSURANCE COMPANY CANNOT BE BILLED FOR THE CHARGE.**

AUTHORIZATION TO PAY BENEFITS TO THE PROVIDER: I hereby authorize payment from my insurance company directly to my individual provider or Sanctuary NTC as a whole. I also give Sanctuary NTC permission to appeal any denied claims on my behalf.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Sanctuary NTC, and/or my individual provider to release to my insurance company any and all information they may require concerning my care.

ACKNOWLEDGEMENT: I have read the above policy statement and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account in a timely manner. I agree that I will pay all such charges including but not limited to deductibles, co-pays, coinsurances, as well as collection costs, attorney fees and all court costs incurred in connection with collection of my account.
If the patient is a minor: I, the undersigned, am the guarantor for the above individual, whom I give Sanctuary NTC permission to treat, and I accept responsibility for payment as explained above.

_____ _____
Patient's Signature (or Guarantor's for Minor Patient) Date Signed

_____ _____
Witness Date Signed

SANCTUARY
COUNSELING & PSYCHOLOGICAL TESTING

AUTHORIZATION TO RELEASE OR EXCHANGE CONFIDENTIAL INFORMATION

4737 AFTON PLACE Ste. A, CHUBBUCK, IDAHO 83202 PHONE: 208-417-0623 FAX: 208-417-0641

TODAYS DATE: ____/____/_____ *(THIS RELEASE EXPIRES ONE YEAR FROM THIS DATE)*

PATIENT LEGAL NAME: _____ **DOB:** _____

MEDICAL CLINIC / AGENCY: _____

PCP/CLINICIAN/WORKER NAME: _____ PHONE: _____

ADDRESS: _____ FAX: _____

(Please ask for another form for multiple providers/contacts)

PERSONAL CONTACT NAME: _____ PHONE: _____

RELATIONSHIP: _____

Please **INITIAL** each category of specific information that you are allowing to be released or exchanged.

_____ **6 MONTH MEDICAL HISTORY & RECORDS** _____ **VERBAL COMMUNICATION AS NEEDED**

_____ **PSYCHOLOGICAL EVALUATION** _____ **CDA/ TREATMENT PLAN(S)**

_____ **OTHER:** _____

(CHECK BOXES) THIS INFORMATION IS BEING RELEASED OR EXCHANGED FOR THE FOLLOWING PURPOSE(S):

☐ COORDINATION OF TREATMENT/ CARE ☐ FAMILY CONSULTATION ☐ OTHER_____

☐ I DECLINE GIVING SANCTUARY COUNSELING MY MEDICAL INFORMATION.

SIGNATURE OF CLIENT (or GUARDIAN for Minor) _____

(If applicable) PRINTED NAME OF GUARDIAN for Minor _____(relationship)_____

CLINIC WITNESS: _____ TITLE: _____ DATE FAXED: _____

(REVISED 05-25-2025)

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical, or other information is not sufficient for this purpose.

SANCTUARY
COUNSELING & PSYCHOLOGICAL TESTING

Authorization For Text Messaging

Due to the changing world of technology and healthcare, Sanctuary can provide our clients with text messaging appointment reminders. Sanctuary believes strongly in protecting the privacy of our clients. When you provide this information to us, it is only used as a way to communicate with you. In order to protect your privacy, no confidential or personal information will be sent from Sanctuary via text messaging. Sanctuary does not share the names, addresses, and/or phone numbers of clients with any other company, or with any other client.

"I, _____(print name of phone owner), hereby authorize Sanctuary Counseling to send automatic appointment reminder messages and other pertinent communications by text to the cell phone number provided below. By signing I acknowledge and accept the risks of communicating through text messaging, and any associated carrier/plan fees."

If you have questions about risks, please talk to a Sanctuary representative by calling (208)417-0623.

Or you may decline by marking the box below:

☐ "I decline receiving text messages from Sanctuary Counseling."

_____ _____

Signature of Phone Owner Cell Phone Number

_____ _____

Printed name of client (if different from above). Today's Date

SANCTUARY
COUNSELING & PSYCHOLOGICAL TESTING

ACEs Assessment

Name: **Date:**

Instructions:
Answer the following questions to the best of your ability based on your experiences **during your first 18 years of life**. For each question, select the answer that best describes your experience. (A caregiver may answer on behalf of a child.)

#	Experience	Yes	No	Not sure
1.	Did a parent or other adult in the household often swear at you, insult you, put you down, or threaten you with physical harm?	☐	☐	☐
2.	Did a parent or other adult in the household often push, grab, slap, throw something at you, or hit you so hard that it made a mark?	☐	☐	☐
3.	Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way?	☐	☐	☐
4.	Did you often feel that no one in your family loved you or thought you were important or special?	☐	☐	☐
5.	Did you often feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect you?	☐	☐	☐
6.	Were you separated from a biological parent through divorce, abandonment or any other reason?	☐	☐	☐
7.	Was a parent or caregiver often pushed grabbed slapped or had something thrown at them?	☐	☐	☐
8.	Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	☐	☐	☐
9.	Was a household member depressed or mentally ill, or did a household member ever attempt suicide?	☐	☐	☐
10.	Did a household member ever go to prison or was constantly in and out of jail?	☐	☐	☐

*For office use

ACE SCORE (Total "Yes" Answers): _____

Scoring:
Once the client has answered all the questions, add up the 'yes' answers to get their ACE score. Their ACE score can range from 0 to 10, with higher scores indicating a higher likelihood of experiencing negative outcomes later in life.

Notes:

SANCTUARY
COUNSELING & PSYCHOLOGICAL TESTING

PTSD Checklist – Civilian Version (PCL-C)

Client's Name:_____**Date:**_____

Instruction to patient (or caregiver if filling out on behalf of a minor): Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, mark one circle per question to indicate how much you have been bothered by that problem **in the last month**.

No.	Response	Not at all	A little bit	Moderately	Quite a bit	Extremely	
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?	①	②	③	④	⑤	
2.	Repeated, disturbing *dreams* of a stressful experience from the past?	①	②	③	④	⑤	
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?	①	②	③	④	⑤	
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?	①	②	③	④	⑤	
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?	①	②	③	④	⑤	
(Shaded areas for office use only)	Total circles marked: Q's 1-5						___ >1 =S_x
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?	①	②	③	④	⑤	
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?	①	②	③	④	⑤	
8.	Trouble *remembering important parts* of a stressful experience from the past?	①	②	③	④	⑤	
9.	Loss of *interest in things that you used to enjoy?*	①	②	③	④	⑤	
10.	Feeling *distant* or *cut* off from other people?	①	②	③	④	⑤	
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	①	②	③	④	⑤	
	Total circles marked: Q's 6-12						___ >3 =S_x
12.	Feeling as if your *future* will somehow be *cut short*?	①	②	③	④	⑤	
13.	Trouble *falling* or *staying asleep*?	①	②	③	④	⑤	
14.	Feeling *irritable* or having *angry outbursts*?	①	②	③	④	⑤	
15.	Having *difficulty concentrating*?	①	②	③	④	⑤	
16.	Being *"super alert"* or watchful on guard?	①	②	③	④	⑤	
17.	Feeling *jumpy* or easily startled?	①	②	③	④	⑤	
	Total circles marked: Q's 12-17						___ >2 =S_x
Total severity score: (add up numbers in marked circles)		___ + ___ + ___ + ___ + ___ = ___>44 =S_x					

SANCTUARY
COUNSELING & PSYCHOLOGICAL TESTING

Patient Health Questionnaire – PHQ-9

Name: **Date:**

Over the last **two weeks**, how often have you been bothered by any of the following problems? (Mark one circle per question.)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	⓪	①	②	③
2. Feeling down, depressed, irritable, or hopeless?	⓪	①	②	③
3. Trouble falling or staying asleep, or sleeping too much?	⓪	①	②	③
4. Feeling tired or having little energy?	⓪	①	②	③
5. Poor appetite/weight loss or overeating/weight gain?	⓪	①	②	③
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down?	⓪	①	②	③
7. Trouble concentrating on things, such as reading, or watching TV?	⓪	①	②	③
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you move around more than usual?	⓪	①	②	③
9. Thoughts that you would be better off dead, or thoughts of hurting yourself in some way?	⓪	①	②	③
*For office use	____	+ ____	+ ____	+ ____
Severity Score				**Total=____/27**

Depression Severity: 0-4 none; 5-9 mild; 0-14 moderate; 15-19 mod. severe; 20-27 severe

SANCTUARY
COUNSELING & PSYCHOLOGICAL TESTING

Psychological & Medical History

Part I: Demographic Information

Today's Date: ____/____/____

Client Name: _____ Age _____ Date of Birth: _____

Current Occupation_____ Employer/School_____
How long at this occupation? _____ How long at this present job? _____ Highest grade completed _____
Birthplace_____ Religion_____ Military service? y/n -if yes what branch_____
Race/Ethnicity _____

Social Support: (where applicable) **Is the relationship good, bad, or other?**

Spouse/Significant Other Name: _____ _____

Former Spouse's/Significant Other's Names: _____ _____

Children's Names & Ages: _____ _____

_____ _____

Mother's Name: _____ _____

Father's Name: _____ _____

Step-Mother's Name: _____ _____

Step-Father's Name: _____ _____

Siblings Names & Ages: _____ _____

_____ _____

_____ _____

Treatment Providers **Do you want us to coordinate care with this professional?** **Contact information:**

Medical Provider: _____ ☐ Yes ☐ No _____

Psychiatric Medication Provider:_____ ☐ Yes ☐ No _____

Psychotherapist/Counselor: _____ ☐ Yes ☐ No _____

Other: _____ ☐ Yes ☐ No _____

Part II: Reason for Referral

Please describe the primary reason for seeking assistance at this time:

_____
_____
_____
_____
_____

Part III: Current & Past Treatment:

Have you participated in treatment for any of these problems?

Counseling/psychotherapy: When? _____ With whom? _____ Was it helpful? _____
_____ _____ _____

Behavioral Health Unit Inpatient Stay: When? _____ Where? _____ Was it helpful? _____

Other Treatment (Please describe):_____
_____

Previous Psychological/Neuropsychological Testing and Diagnoses?: _____
_____
_____

Medications:

Current:

Type & Dosage? _____ Time period?_____ Is it helpful?_____
Type & Dosage? _____ Time period?_____ Is it helpful?_____
Type & Dosage? _____ Time period?_____ Is it helpful?_____

Past:

Helpful Medications: _____
Ineffective Medications: _____

Part IV: Symptom Screening:

Please indicate the following **symptoms** or **problems** you have experienced now or in the past, **when they first occurred**, and also describe **how long** they were or have been present:

Symptom/Problem:	What age did it start?	Is it a (C) Current or (P) Past problem? How long did it last?	Did/does a family member have this problem? Who?
Mental Health Symptoms:			
Anxiety			
Depression			
Rapid Mood Changes			
High Levels of Stress			
Panic Attacks			
Chronic Worry			
Relationship Problems			
Suicidal Thoughts			
Trauma			
Drug Problems			
Alcohol Problems			
Chronic Anger			
Grief			
Visual Hallucinations			
Auditory Hallucinations (voices)			
Chronic Irritability			
Sexual Problems			
Sleep Problems			
Intrusive Thoughts			
Obsessive Thoughts			
Paranoia			
Thoughts of Harming Others			
Other:			

Behavioral Problems:			
Self-Injurious Behavior			
Suicide Attempts			
Impulsivity			
Hyperactivity			
Fighting			
Destruction of Property			
Deception			
Theft			
Pornography			
Verbal Aggression			
Socially Inappropriate			
Problems Making Friends			
Property Destruction:			
Threatening Behavior:			
Other:			

Cognitive Problems:			
Attention Problems			
Short-term memory problems			
Long-term memory problems			
Poor Judgement			
Racing Thoughts			
Reading Problems			
Spelling/Writing Problems			
Learning Problems			
Migraines			
Concussions			
Loss of Consciousness			
Stroke			
Black-outs			
Seizures			
Head Injuries			
Other:			

Developmental Problems:			
Prenatal Exposure to Alcohol:			
Prenatal Exposure to Drugs:			
Prenatal Exposure to Accutane:			
Parental Exposure to Chemicals:			
Prenatal Medical Problems:			
Birth Complications:			
Serious Newborn Illnesses:			
Late Walking:			
Late Talking:			
Speech & Language Problems:			
Problems Making Eye Contact:			
Overly Sensitive to Sound:			
Overly Sensitive to Textures:			
Poor Sensitivity to Sound:			
Poor Sensitivity to Pain:			
Late Reading:			
Late Toileting:			
Toileting Problems:			
Late Developing Humor:			
Unusual Sense of Humor:			
Overly Literal:			
Late Understanding Sarcasm:			
Late Social Development:			
Late Cognitive Abilities:			
Other:			