Giles & Associates
FAMILY PSYCHOLOGY

233 South Pleasant Grove Boulevard Suite 203 Pleasant Grove, UT 84062
Phone: (801) 785-4622 | Fax: (801) 785-4623

Patient Information CODE (office use only):__________________

Patient Full Name: ____________________________________ Patient Preferred Name: ___________________________
Referred By:_________________________________ Date of Birth:_________________ Gender: Male Female
Address:____ City:____________________ State:_____ Zip:________
Email Address:____ *(required for email receipts & online billing)*
Phone Number:__________________________ Type:___________
Appointment Reminder Preferences (circle two): Home Cell Cell (text) Email
Marital Status:__________________________
Highest Level of Education:____

Members of the Household	Age	Gender	Relationship

Medications currently being taken:
____
Prescribed By: ____
Previous Counseling: Yes No If yes, with whom?____

Gender Identity and Name Changes: Our team at Giles & Associates (G&A) recognizes the right of individuals to change their name and gender identity. However, G&A is legally bound by state and federal statute to only recognize the legal name and gender of individuals on their account - including billing statements and other legal communications.

Confidentiality: Federal guidelines require us to provide notice to you about how your Protected Health Information (PHI), both psychological and medical, may be used and disclosed by our office. Signature below authorizes GAFP to release any information required by your medical insurance company/third party payer for payment of services. GAFP is also legally required to share information in certain cases if we have reason to believe that you are in imminent danger of harming yourself or someone else, or if we become aware of a case of child abuse or the abuse of a vulnerable adult. You have been given a summary of PHI information upon your first visit, and a more complete explanation of the federal guidelines is available upon request. ________________

By signing below, I state that all information listed above is correct and current:

Name (Please Print)	Responsible Party Signature	Date

Updated 8.10.2022

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Enforced Policies of Giles and Associates Family Psychology:

Please read and initial each office policy below to indicate your understanding and acceptance of policy.

Canceled or Missed Appointments: If you need to change or miss an appointment, please provide 24 hours' notice by calling the office at (801) 785-4622. Canceled or missed appointments without 24 hours' notice are subject to **cancellation fee of $75.00. Please be aware that if you miss two or more appointments in a row without any notice all remaining scheduled appointments may be canceled.** Appointments are scheduled for either 45 or 55 minutes. Occasionally, these sessions may extend beyond the set time, however they may also end before the set time when deemed appropriate by the therapist. _______________

Payment Policies: Payment of fees is ultimately the responsibility of the client. Giles & Associates will bill third parties as a service to our clients, but it is the client's responsibility to know and understand the mental health benefits, monitor the outstanding balance, and ensure that the balance is paid.

Out of Pocket Discount: An Out-of-Pocket Discount is available for clients who wish to pay for the service in full at the time of the service. If you choose to pay Out of Pocket instead of billing through insurance, the initial appointment rate of $225 will also be reduced to a rate of $175. The regular appointment rate of $190 will be reduce to $150 per appointment.

Payment on File: I authorize Giles & Associate to keep and charge my card on file in their secure online system. _____________

Late Payment Fee: A $10.00 Late Fee will be added to any account balance after 45 days of the scheduled service.

Returned Check Fee: Any check returned unpaid is subject to a $30.00 returned check fee.

Cancellation Fee: Appointments canceled without 24 hours notice or missed are subject to a **$75 cancellation fee**.

Testing Results: Test results and other correspondence will not be released until account balance is paid in full.

Collections: A 40% collection fee plus reasonable attorney(s) fees will be added to any account turned over to a collection agency. _____________

Reminder Calls: Giles & Associates Family Psychology has partnered with a company to send reminder notifications to our clients for their appointments. However, these are a **COURTESY. If you do not receive a call or other form of reminder and miss your appointment, you are still required to pay the $75.00 cancellation fee.** _____________

By signing below, I agree to all of the policies listed above:

Name (Please Print)	Responsible Party Signature	Date

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Cancellation Policy Agreement:

Twenty-four hours' notice is required to cancel an appointment without penalty. Cancelled or missed appointments with less than 24 hours' notice are subject to a cancellation fee of $75.00. **If two or more appointments are cancelled or missed without sufficient notice, any or all remaining scheduled appointments for that client may be cancelled at the discretion of GAFP.** If a client arrives late to an appointment, the practitioner may decide to meet with the client for the time remaining or to count the appointment as missed. If the appointment is counted as missed, the cancellation fee will be assessed. ______________

Appeals to GAFP's decision to assess a cancellation fee must be submitted in writing to the Appeals Committee via the following email address: appeals@gilesfp.com. Overturning the assessment of the cancellation fee may only be made by the Appeals Committee. No single practitioner nor staff member may waive a cancellation fee.

Payment Policy:

I understand that if I have insurance, my co –payments is due at the time of service. Insurance co-pays vary significantly and I understand that my co-pay amount may change after claims are submitted. If my insurance company requires me to meet a deductible before they pay for services, I will pay the contract amount for services in full until my deductible is met. I understand that Giles & Associates Family Psychology will bill my insurance as a service, but that I am ultimately financially responsible for all services rendered.

If I do not have insurance or if my provider is not contracted with my health plan, I agree to pay in full at the time of service.

By signing below I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein.

I agree that interest will accrue on all past-due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principal amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

I understand that it is my responsibility to be familiar with the **mental health benefits** of my insurance plan. It is my responsibility to get preauthorization for services as required by my insurance company. If my insurance company denies payment because I did not obtain the proper pre-authorization, I understand that I am responsible for payment of services.

By signing below, I acknowledge that I have received this information and accept the terms of this contract. I further agree to assign my insurance benefits to Giles & Associates Family Psychology for services rendered.

Printed Name ____________________________________

Signature ____

Date____

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