

**A Southern Utah Counseling Experience**

1071 East 100 South, Ste B-5  
St. George, Ut 84770  
Phone (435) 688-1111 Fax (435) 688-8488  
UTAH DHS License # 8736  
[Mftmatt@infowest.com](mailto:Mftmatt@infowest.com)

**CLIENT INFORMATION AND AGREEMENT**

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ WorkPhone: \_\_\_\_\_  
Address: \_\_\_\_\_ City and State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Sex: Male \_\_\_ Female \_\_\_ Date of Birth: \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Employer: \_\_\_\_\_ Years there: \_\_\_\_\_ Position: \_\_\_\_\_  
Education (list high school, trade school, college, etc.) \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
List any significant health problems: \_\_\_\_\_

\_\_\_\_\_

List any medications you are presently taking and the dosage: \_\_\_\_\_

\_\_\_\_\_

Have you been in therapy or counseling before? YES \_\_\_ NO \_\_\_ If yes, when? \_\_\_\_\_  
Name of therapist or counselor: \_\_\_\_\_  
Give brief description of issues worked on: \_\_\_\_\_

\_\_\_\_\_

Referred by (therapist, physician, yellow pages, friend, etc.) \_\_\_\_\_  
Who to contact in case of an emergency: \_\_\_\_\_  
Phone: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

**FAMILY INFORMATION**

| <u>Name</u> | <u>Birth date</u> |
|-------------|-------------------|
| _____       | _____             |
| _____       | _____             |
| _____       | _____             |
| _____       | _____             |
| _____       | _____             |
| _____       | _____             |
| _____       | _____             |
| _____       | _____             |
| _____       | _____             |
| _____       | _____             |

**CONFIDENTIALITY STATEMENT:**  
All information shared during counseling sessions is completely confidential except in certain circumstances governed by the laws of the State of Utah including the mandatory reporting of threat of harm to self or harm to others, particularly in the case of sexual abuse of a child, handicapped person, or elder abuse.

**FINANCIALLY RESPONSIBLE PERSON'S INFORMATION**

Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_  
Address: \_\_\_\_\_ City and State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_  
Employer: \_\_\_\_\_

**FINACIAL AGREEMENT:**

|   |  |
|---|--|
| Matt Eschler will charge                | <b>\$95.00</b> per session paid at time of service |
| Licensed Clinical therapist will charge | <b>\$90.00</b> per session paid at time of service |
| Interns will Charge                     | <b>\$75.00</b> per session paid at time of service |
| Psychoeducational group                 | <b>\$45.00</b> Per 2 hour Group Meeting            |

**GENERAL TERMS:**

**Payment and Interest**

- A. I understand and agree that I am responsible for the payment of any and All charges associated with my counseling session(s).
- B. I further understand and agree to pay eighteen percent (18%) per annum interest on any unpaid balance once that balance becomes thirty days (30) outstanding.

**Payment of Legal Fees**

- C. I agree to pay all attorneys' fees, court costs, filing fees, including charges or commissions that are incurred in enforcing the terms of this Agreement or that may be assessed to me by any collection agency retained to pursue this matter, which may be more than the principal balance owed.
- D. Furthermore, I understand and agree that if this office or any therapist or intern is required to quash an improper subpoena, I will be responsible for any and all attorney's fees, expenses and costs incurred or expended in quashing that subpoena, including any and attorneys fees and costs and any and all time spent by this office or any therapist or intern in quashing the subpoena at the standard hourly billing rates set forth above.
- E. I understand and agree that the prevailing party to any action brought to enforce the terms of this Agreement shall be entitled to recover against the other party the costs, expenses and attorney's fees incurred in such action.

### **Compensation for Witness Testimony**

- F. I understand and agree that the value of the time of the therapist or intern is the same regardless of whether the therapist or intern is in a counseling session or testifying in court, arbitration, mediation or in any other venue designated for dispute resolution.
- G. Accordingly, I agree to pay the therapist or intern for any and all testimony he/she provides whether it be in court, in arbitration, in mediation or in any other venue designed for dispute resolution at the standard hourly rate set forth above.

### **Confidentiality of Testimony**

- H. I agree and understand that any and all testimony provided by a therapist or intern will be provided in accordance with his/her ethical obligations.
- I. In addition, I understand and agree that Matt Eschler will not disclose any confidential information, regarding our counseling sessions, during his testimony unless I have specifically waived my right to have that information kept confidential, or such testimony is required by the Court.

### **Additional Terms**

- J. I understand that the headings in this Agreement are for ready reference only and shall not be used to limit or expand the terms of this Agreement.
- K. I agree that any action to enforce the terms of this Agreement shall be brought in the Fifth Judicial District Court in and for Washington County, Utah.
- L. I understand and agree that this Agreement shall be construed in accordance with the substantive and procedural laws, including the applicable statute of limitations, of the State of Utah.
- M. I understand and agree that if a court of competent jurisdiction shall find any provision of this Agreement unenforceable under Utah law, such provision shall be stricken and the remainder of the Agreement shall remain in full force and effect.
- N. I understand and agree that this Agreement shall inure to the benefit of and be binding upon me, my heirs, successors, agents and assigns.
- O. I understand and agree that this Agreement is intended to be the final expression of the agreement with respect to the subject matter hereof, and is intended as the complete and exclusive statement of the terms of the

Agreement. As such, this Agreement constitutes the entire agreement, whether oral or written, with respect to the subject matter hereof, and may only be modified by subsequent writing duly executed by all parties involved.

P. I understand and agree that facsimile signatures shall be considered the same as original signatures.

**I have read and understanding each and every provision contained within this agreement and voluntarily signs this agreement agreeing to the provision and terms established herein.**

CLIENT \_\_\_\_\_

DATE \_\_\_\_\_

THERAPIST \_\_\_\_\_

DATE \_\_\_\_\_

### **GUARANTY**

I, as the Responsible Party or Custodial Parent, approve of and consent to the terms of this Agreement and, in consideration of this office providing counseling to the client, and for other good and valuable consideration, I irrevocably and unconditionally guarantee payment when due and to become due to and guarantees the performance of the client with respect to all the covenants and conditions contained herein, together with all interest thereon and all attorneys' fees, costs and expenses of collection incurred in enforcing any such obligations and liabilities.

Responsible Party \_\_\_\_\_

Date \_\_\_\_\_

Custodial Parent \_\_\_\_\_

Date \_\_\_\_\_

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License # 340219-3902

DHS# 10074

## A Southern Utah Counseling Experience

Therapy Guidelines Please read and initial:

- 1- \_\_\_\_\_ Payment is collected at time of service unless otherwise agreed upon in writing at the first session.
- 2- \_\_\_\_\_ As a courtesy we can allow consumers to miss one session's payment and make this payment at the next scheduled session. It will not be possible to be two sessions behind in fees for service.
- 3- \_\_\_\_\_ A Southern Utah Counseling Experience counselors or office management does not do third party billing. We will provide a HCFA form to you as a receipt. This receipt can be turned in to your insurance for reimbursement if the coverage allows.
- 4- \_\_\_\_\_ If you miss a scheduled session without canceling with 24 hour notice you will be billed for this session in full. If you call we can fill this time with others that need session times and there is no consequence.
- 5- \_\_\_\_\_ If you have needs of documentation of your sessions for personal, court, or other reasons please be specific at the intake session. Give us all documentation schedules, types of documentation needed and for whom.
- 6- \_\_\_\_\_ Any letters or documentation that takes longer than 10 minutes will be billed the same as your therapists' session fee.
- 7- \_\_\_\_\_ We do not allow animals in our facility unless it is a special needs licensed Seeing Eye dog.
- 8- \_\_\_\_\_ We do not allow guns to be brought into our premises.

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**Matt Eschler, MA, LMFT**

**Date**