



**FOOTHILLS COUNSELING & WELLNESS LLC
MINOR CLIENT INTAKE PACKET**

MINOR CLIENT PERSONAL INFORMATION

Name _____ Date _____
Address _____ Apt _____
City _____ State _____ Zip Code _____
Date of Birth ____/____/____ Age _____ Birth Sex ___ Male ___ Female
Gender Identity _____ Preferred Gender Pronouns _____
___ Male _____ Female ___ He/Him/His
___ Transgender Male ___ Transgender Female ___ She/Her/Hers
___ Additional Gender Category _____
Name of School Attending _____

PARENT/GUARDIAN INFORMATION

Name _____ Relationship _____
Cell Phone _____ Work Phone _____
OK to contact? YES NO OK to contact? YES NO
OK to leave voicemail? YES NO OK to leave voicemail? YES NO
OK to text appointment reminders? YES NO
E-mail _____
OK to contact? YES NO
OK to email appointment reminders? YES NO

PERMISSION TO LEAVE MESSAGES

By signing below, I give the staff at Foothills Counseling & Wellness LLC, permission to leave detailed appointment information verbally on my answering machine at the phone numbers that I have indicated above. I also give them permission to send an appointment reminder email, or text, if indicated above. I understand that I have the right to revoke this authorization at any time.

Parent/Guardian Signature _____ Date _____

EMERGENCY CONTACT INFORMATION (PLEASE PROVIDE TWO CONTACTS)

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

CONSENT TO TREAT A MINOR CLIENT

Parent(s)/Guardian(s) Information:

Client’s parents are currently: ___ Married ___ Separated** ___ Divorced**

If the parents are separated/divorced, how much time does the client spend with each parent?

Parent/Guardian Name _____ % of the time

Parent/Guardian Name _____ % of the time

****If the client’s parents or legal guardians are not married or are legally separated, please provide the court custody order or custody agreement that outlines the custody arrangement of the client. In the state of Idaho, Foothills Counseling & Wellness LLC cannot provide mental health services until both parents grant consent and custody order/custody agreement is provided to Foothills Counseling.**

Consent is given to Foothills Counseling & Wellness LLC, and rendering provider to provide necessary services including; assessment procedures, mental health counseling, treatment planning, and summoning emergency services if needed. In case of emergency, I authorized providers of Foothills Counseling & Wellness LLC, staff or their designees, to make a professional judgment if necessary, with and/or without me being present. I/we voluntarily consent that Foothills Counseling & Wellness LLC, being the holder of confidential privilege, – the right to withhold disclosure of private information about my child within the limits set by the ICA and ACA Code of Ethics. However, in the interest of developing a trust relationship between the provider and my/our child, I/we give Foothills Counseling & Wellness LLC permission to reveal or withhold information that in his/her clinical judgment is necessary to best help and protect my/our child.

The only exception to this discretion would be in the following:

In cases where there are legal custody arrangements: If parents have joint custody, both parents have a legal right to access their child’s medical records. If there is a divorce or separation arrangement/agreement, Foothills Counseling & Wellness LLC needs to obtain a copy of the arrangement/agreement and will use that to decide which parent(s) will have legal authority to participate in the client’s treatment and/or have access to their child’s medical records. Medical records are confidential, and copies of medical records will not be released unless it is in the minor client’s best interest to do so, or if there is a court order mandating that copies of medical records be made and released to a designated parent, guardian, or officer of the court.

I hereby acknowledge that no guarantees have been made to me as to the effect of such treatment on my child's condition.

I understand that at least one parent/guardian must be involved in the counseling of my minor child and will need to be on premises during counseling.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____
(if custody is shared)



INFORMED CHOICE AND CONSENT FOR SERVICES

As a client of Foothills Counseling & Wellness LLC, I am aware that I have a choice of providers for counseling services, and I have chosen Foothills Counseling & Wellness LLC to provide these services. I have read and signed the enclosed intake paperwork and understand that Foothills Counseling & Wellness LLC is available to provide services consistent with psychological concerns. These services include preventative, diagnostic, therapeutic, rehabilitative, and palliative care. As a client of Foothills Counseling & Wellness LLC I understand that I may choose to refuse or discontinue services at any time without any judgement or negative repercussions.

Financial Information and Agreement

INSURANCE PROVIDER

PRIMARY INSURANCE Do You Have Insurance? YES NO

Insurance Provider _____ Employer _____

Minor Client's Relationship to Policy Holder ___ CHILD ___ OTHER _____

Policy Holder's Name _____ Date of Birth ___/___/___ Sex ___ M ___ F

Policy Holder's Address _____ Phone # _____

Member ID _____ Group # _____

FINANCIAL AGREEMENT AND RELEASE OF INFORMATION FOR BILLING

Counseling fees are \$150-\$250, depending on the type and duration of the session: intake, crisis, 45-minute, 60-minute, etc.

All fees are due at the time of service. If you are utilizing your insurance benefits, Foothills Counseling & Wellness LLC will bill your insurance company. Please take the time to inform yourself of what services your individual insurance plan provides. **Please note that in the event that your insurance provider does not pay for services, you are responsible for all fees.** For questions involving payments and insurance, please contact the office.

Many insurance plans are managed care plans. Under a managed care plan, the insurance company periodically requires your counselor to submit your diagnosis, progress, and treatment plan to their reviewer, who then determines if further treatment is medically necessary. We want you to know that if you have a managed care insurance plan; this information will be released to the reviewers. If you don't want to release this information, you can choose not to use your insurance coverage and pay for services yourself at the time of each visit.

Your signature below authorizes Foothills Counseling & Wellness LLC to release your confidential information to your insurance carrier for the purposes of verifying benefits, billing, and other requests for information requested by your insurance carrier. It also indicates that you understand that you are responsible for all fees that are not reimbursed by the insurance carrier.

Parent/Guardian Signature _____ Date _____

Minor Client Medical Information

MINOR CLIENT PRIMARY CARE INFORMATION

Primary Care Physician/Pediatrician _____ Office Phone # _____

Office Address _____ City _____ State _____ Zip _____

Current medications (other than for mood/mental health?) ___ YES ___ NO

Name of Medication _____	Purpose _____
_____	_____
_____	_____

MINOR CLIENT PSYCHIATRIC HEALTH and HISTORY

Has the client ever been hospitalized for psychiatric reasons? ___ YES ___ NO If YES, when: _____

Reason for hospitalization

___ Psychiatric ___ Danger to Self ___ Danger to Others ___ Drug/Alcohol ___ Other _____

Is the client currently a patient with any Mental Health Providers?

Psychiatrist	YES	NO	Psychologist	YES	NO	Developmental Therapy	YES	NO
OTHER	_____							

Name of Provider _____ Office Address _____
Office Phone # _____

Current mood/mental health/psychiatric medications? YES NO

Name of Medication _____	Purpose _____
_____	_____
_____	_____

MINOR CLIENT MEDICAL HISTORY

Minor Client Medical Conditions (please list current and past surgeries, major illness, allergies):

What _____ When _____ Doctor's Name _____

What _____ When _____ Doctor's Name _____

What _____ When _____ Doctor's Name _____

MINOR CLIENT FAMILY HISTORY

Family History Medical Conditions (Mental Illnesses)

Maternal Side _____

Paternal Side _____

Siblings _____



Information Disclosure and Informed Consent

Purpose of This Form:

- 1. It tells you what to expect from counseling:** Your first visit will help us get a general understanding of your situation in order to determine how we might best help you. Because we want you to participate actively in planning your counseling, do not hesitate to ask questions.
- 2. This form serves as an Agreement between you and the counselors of Foothills Counseling & Wellness LLC.** All counselors at Foothills Counseling & Wellness LLC are independent contractors, with their own private practice; not employees of Foothills Counseling & Wellness LLC. Foothills Counseling & Wellness LLC contracts with counselors for office space, scheduling, billing, insurance verification and file storage. All business associates who are contracted by Foothills Counseling & Wellness LLC have signed a confidentiality waiver and are required to keep all information confidential. All counselors keep their files separate from each other. You may revoke (cancel) this Agreement in writing at any time. That revocation will be binding on the counselor listed in writing of Foothills Counseling & Wellness LLC unless we have already relied on this agreement to take action, or if your health insurer requires a counselor of Foothills Counseling & Wellness LLC to send information needed in order to process claims made for your services, or if you have not paid your bill in full.
- 3. This form also contains information about a federal law that affects your privacy rights.** HIPAA (Health Insurance Portability and Accountability Act) regulates the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. HIPAA requires that we give you a Notice of Privacy Practices. The Notice, included in this Agreement, explains HIPAA's application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. We will give you a copy of this Agreement, including the Notice.
- 4. This form explains our policies.** Please let your counselor know if you have concerns or questions about these policies.

COUNSELING PURPOSE

Counseling is a way of talking through your problems in order to begin resolving them. The counseling process is a collaboration between the counselor and the client, working as a team towards implementing healthy goals. You will need to take an active part in counseling by working on, and thinking about the things you talk about with your counselor. Counseling has been shown to have many benefits. However, there are no guaranteed results, and at times, a counseling session may leave you with unhappy feelings. When it is effective, counseling often leads to better relationships, solutions to specific problems, and feeling much less distressed. Not every counselor will be a good fit for every client. If there is a desire to end counseling before goals are met, an appropriate referral to another counselor can be made.

APPOINTMENT, CREDIT/DEBIT CARD AND CANCELLATION POLICY

Individual and family sessions last 45 to 60 minutes and can be scheduled through your counselor, the Foothills Counseling & Wellness LLC office staff, or on TherapyPortal.com. Our preference is that you place a credit/debit card on file for costs not paid by your insurance and potential missed appointment fees.

Once the appointment is made, the time is set aside for you. **If you cancel an appointment, we require you to provide notice at least 24 hours before the session. If a 24-hour notice is not given, or there is a "no show", there will be a \$100-\$130 missed appointment fee charged to the credit/debit card on file. Insurance does not cover charges for reserved time; you are personally responsible for any such charges.** If you are over 15 minutes late, your counselor may cancel your appointment, and missed appointment fees will apply.

If you demonstrate a pattern of arriving late (even if you are less than 15 minutes late) and your therapist has to change to a billing code with a lower compensation rate, you may be responsible for the difference between what your therapist would have been paid for a 60-minute session versus what they will now be paid for a 45-minute session.

There are times when your counselor may be unable to start your session on time. If your counselor is late, you will be given your full session time, if possible. If it is not possible, your counselor will add the same amount of time to a future session.

BILLING INSURANCE

Medical insurance that provides mental health and counseling benefits do so based on a medical model. This means your counselor will be required to provide your insurance with a medical diagnosis. Benefits are limited to those that are “medically necessary.” Many social, family and marriage problems are not deemed medically necessary and are therefore NOT covered by many insurance plans. Please talk with your counselor if you have questions regarding diagnosis and medical necessity.

PROFESSIONAL STANDARDS

Counselors are required to adhere to the professional code of ethics adopted by the Idaho Counselor Licensing Board. If you have reason to believe your counselor has acted in an unethical manner, you have the right to file a complaint in writing to the Idaho Bureau of Occupational Licenses located at 1109 Main Street, Suite 220, Boise, ID 83702, or by phone at (208) 334-3233.

You may, at any time, seek a second opinion or request to see another counselor. If you are dissatisfied with your counselor, it is your right and responsibility to seek another counselor, or to terminate treatment (unless treatment has been court-ordered). A referral to another counselor will be given upon request.

TELEHEALTH

To use telehealth, you need an internet connection and a device with a camera for video. When your Provider provides telehealth, they will meet you on the FOOTHILLS COUNSELING & WELLNESS LLC client portal (Therapy Portal: <https://www.therapyportal.com/p/foothills83702/>) for a secure and HIPAA-compliant video session. If telehealth is not a good fit for you, your Provider will recommend a different option. There are some risks and benefits to using telehealth:

- Risks
- Privacy and Confidentiality. You may be asked to share personal information with the telehealth platform to create an account, such as your name, date of birth, location, and contact information. Your Provider carefully vets any telehealth platform to ensure your information is secured to the appropriate standards.
- Limitations. Your Provider cannot see you, your body language, or your non-verbal reactions to what you are discussing. Due to technology limitations, your Provider may not hear all of what you are saying and may need to ask you to repeat things. To reduce the effect of these limitations, your Provider may ask you to describe how you are feeling, thinking, and/or acting in more detail than I would during a face-to-face session.
- Technology. At times, you could have problems with your internet, video, or sound. If you have issues during a session, your Provider will follow the backup plan that you agreed to prior to sessions.
- Crisis Management. It may be difficult for your Provider to provide immediate support during an emergency or crisis. You and your Provider will develop a plan for emergencies or crises, such as choosing a local emergency contact, creating a communication plan, and making a list of local support, emergency, and crisis services.
- Benefits
- Flexibility. You can attend therapy wherever is convenient for you.
- Ease of Access. You can attend telehealth sessions without worrying about traveling, meaning you can schedule less time per session and can attend therapy during inclement weather or illness.
- Recommendations
- Make sure that other people cannot hear your conversation or see your screen during sessions.
- Do not use video or audio to record your session unless you ask your Provider for their permission in advance.
- Make sure to let your Provider know if you are not in your usual location before starting any telehealth session.

CONFIDENTIALITY AND CLIENT RECORDS: NOTICE OF PRIVACY POLICIES AND PRACTICES

Federal and State laws governing confidentiality can be quite complex. This Notice explains some specific Patient Rights that you have under these laws.

CLIENT RECORDS—All counselors at Foothills Counseling & Wellness LLC maintain a Clinical Medical Record file on your case, which is the property of Foothills Counseling & Wellness LLC, and your provider. Foothills Counseling & Wellness LLC utilizes electronic medical records files. Check with your counselor to discuss how they are keeping their files secure. These files contain a copy of this intake paperwork, insurance/billing information, a medical record documenting your session with your counselor, medical records received by other providers, and any medical releases you have signed. Counselors and Staff at Foothills Counseling & Wellness LLC respect the confidentiality of other provider's client files and do not access files other than their own.

You may examine and/or receive a copy of your file *if* you request it in writing *and* the request is signed by you *and* dated not more than 60 days from the date it is submitted. There may be a charge for writing reports or for copying materials. All requests to release medical records will need to be approved by your provider.

PLEASE NOTE: If you are being seen in couples, group, or family therapy, Idaho laws concerning confidentiality are not clear. Foothills Counseling & Wellness LLC will not release information to other parties without the written permission of all individuals involved in the therapy session, except when allowed or required to do so by State or Federal law, unless a court order requires us to release information about your case.

CONFIDENTIALITY— Information provided by and to a client during therapy sessions is legally confidential if the counselor is a licensed counselor, or reasonably believed by the client to be so. If the information is legally confidential, the counselor cannot be forced to disclose the information without the client's consent with the following exceptions: Information may be released to parents of a minor child (under 18 years old) who have the legal right to access their child's medical information; When authorized by other state laws; If the counselor is a defendant to a civil, criminal, or disciplinary action arising from therapy; The client is a defendant in a criminal proceeding, and the use of confidential information would violate the defendant's rights to a compulsory process.

You may choose to engage in electronic communications (including but not limited to email, text, and telehealth) with Foothills Counseling & Wellness LLC. If you and Foothills Counseling & Wellness LLC choose to do so, it is important for you to understand that confidentiality may be difficult to guarantee in that format. However, we will follow guidelines as outlined in the ACA (American Counseling Association) Code of Ethics, as well as HIPAA security requirements.

COURT INVOLVEMENT POLICY AND FEES

At times, a client may ask a counselor to appear in court on their behalf or on behalf of their children. Counseling is primarily a therapeutic relationship with the goals focused on personal growth and healing, with all the information shared in session being confidential. **Therefore, it is the policy of counselors at Foothills Counseling & Wellness to refuse all requests to appear in court on behalf of any client. If the counselor is legally compelled to participate in court processes, the following fees will apply.**

Court Appearance Fee

- \$1,400 per court appearance (half-day minimum and then billed hourly)
- Due 7 days before the scheduled court date
- Non-refundable, even if the clinician is not called to testify
- A new fee applies for each rescheduled court date

Hourly Legal Rate

- \$150/hour for preparation, documentation review, attorney communication, travel, and waiting time
 - Billed in 15-minute increments
- \$350/hour for depositions or sworn testimony by phone or video
 - Minimum of 4 hours

Document Preparation

- \$150/hour for letters, summaries, treatment records, or other written materials
- Minimum charge: 30 minutes

Attorney Costs

- Any legal fees incurred by the clinician (such as consulting with their own attorney) will be billed to the client at cost.

Role Limitations

- Clinicians do not provide custody evaluations or parenting assessments.
- Clinicians testify only to factual information such as attendance, treatment progress, or diagnoses.
- Clinicians do not voluntarily participate in court unless legally compelled.

Subpoenas & Records Requests

- Subpoenas must be delivered to the office.
- Standard record-request fees apply.
- Clinicians may need time to review records before release to ensure legal and ethical compliance.

Responsibility for Fees

- The client or the requesting attorney is responsible for all court-related fees.
- If multiple parties are involved, the party requesting the clinician's involvement is responsible for payment.

ACCESS TO CARE AND AFTER-HOURS CRISIS

Foothills Counseling & Wellness LLC does not offer after-hours crisis services. If you experience a life-threatening mental health emergency, call 9-1-1 or go to the nearest Emergency Room.

HIPAA and Your Protected Health Information (PHI) - Notice of Privacy Practices

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

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Foothills Counseling & Wellness LLC may *use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes* with your *consent*. To help clarify these terms, here are some definitions: “PHI” refers to information in your health record that could identify you. “Treatment, Payment and Health Care Operations”:

- *Treatment* is when Foothills Counseling & Wellness LLC provides, coordinates, and manages your health care and other services related to your health care.
- *Payment* is when Foothills Counseling & Wellness LLC obtains reimbursement for your healthcare. Foothills Counseling & Wellness LLC may use collections agencies, an accountant, a billing manager, and technical support service for our billing software. As required by HIPAA, these businesses have signed contracts with us in which they promise to maintain the confidentiality of protected health information except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and a blank copy of the contract.
- *Health Care Operations* are activities that relate to the performance and operation of Foothills Counseling & Wellness LLC.
- “*Use*” means activities within Foothills Counseling & Wellness LLC’s practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. Your counselor practices with other mental health professionals and also employs support staff. In most cases, your counselor needs to share information with support staff for purposes such as billing, scheduling, and quality assurance. Also, Foothills Counseling & Wellness LLC and clinical staff routinely consult with each other concerning our clients. Please let your counselor know if you would prefer that other clinical staff not be consulted about your case. During consultations, your therapist makes every effort to avoid revealing the identity of patients. The other professionals are also legally bound to keep the information confidential. All of the professional staff members are bound by the same rules of confidentiality, and all support staff have training in privacy rules and have agreed not to release any information outside of the practice without permission of a professional staff member. The therapist will note all consultations in your Clinical Record.
- “*Disclosure*” means activities outside of our office, such as releasing, transferring, or providing access to information about you to other parties. Your therapist may find it helpful to share information with your primary care physician or other health and mental health professionals who are currently treating you.

Redisclosure: if you disclose your information pursuant to the Privacy Rule, it will no longer be protected by the Privacy Rule.

USES AND DISCLOSURES REQUIRING AUTHORIZATION

Your counselor may use or disclose PHI for purposes outside of treatment, payment, and health care operations when authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when your therapist is asked for information for purposes outside of treatment, payment, and health care operations, he/she will obtain a written authorization from you before releasing this information. Your therapist will also need to obtain a separate authorization before releasing your psychotherapy notes.

“*Therapeutic notes*” are notes your counselor has made about your conversations during a private, group, joint, or family counseling session, which your counselor has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time. Foothills Counseling & Wellness LLC reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that is maintained. Foothills Counseling & Wellness LLC will provide you with a revised notice by posting the revisions in the waiting room for your inspection. You may not revoke an authorization to the extent that (1) your counselor has relied

on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

USES AND DISCLOSURES WITH NEITHER CONSENT OR AUTHORIZATION

In all cases, including those listed below, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

Your therapist may use or disclose PHI without your consent or authorization in the following circumstances.

- **Child or Vulnerable Adult Abuse, Abandonment, or Neglect:** If your therapist knows or suspects that children or vulnerable adults are being or has been abused, abandoned, or neglected, they are required by law to report the known or suspected instances of abuse, abandonment, or neglect to the proper (adult or child) law enforcement agency or the Idaho Department of Health and Welfare (IDHW) within 24 hours of discovery.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by the psychologist-client (or counselor-client) privilege law. Foothills Counseling & Wellness LLC cannot provide any information without your (or your personal or legal representative's) written authorization. However, if a court orders Foothills Counseling & Wellness LLC to disclose information, we are required to provide it. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- **Serious Threat to Health or Safety:** If your counselor believes that you pose a clear and substantial risk of imminent serious harm to yourself or another person, they may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to your counselor an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and your therapist believes you have the intent and ability to carry out the threat, then they are required by law to take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s).
- **Worker's Compensation:** If you file a worker's compensation claim, your counselor may be required to give your mental health information to relevant parties and officials.
- **If the client is a minor under 18 years old:** Both parents have access to the minor client's complete medical record, including counseling notes, unless there is a court order prohibiting one of the parents from access.
- **If a government agency** (such as Medicaid/Medicare) is requesting the information for health oversight activities, Foothills Counseling & Wellness LLC may be required to provide it to them.
- **If a client files a complaint** or lawsuit against Foothills Counseling & Wellness LLC or any of its counselors or staff, Foothills Counseling & Wellness LLC may disclose relevant information regarding that patient in order to defend itself.
- **Foothills Counseling & Wellness LLC and staff may present** disguised case material in seminars, classes, or scientific writings; in this situation, all identifying information and Protected Health Information is removed, and client anonymity is maintained.
- **Your health insurance plan** has the right to review your clinical records for any services you have asked them to pay for. Unless your treatment is being paid for by a workers' compensation plan, a health insurance company is *not* entitled to see counseling notes, which are detailed notes your counselor may make concerning what you have talked about in therapy. However, they *are* entitled to see PHI in your clinical record, including information about dates of therapy, symptoms, your diagnosis, your overall progress towards those goals, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

CLIENT'S RIGHTS

- **Right to Request Restrictions** –You have the right to request restrictions on certain uses and disclosures of protected

health information about you. However, your counselor is not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, if you don't want family members to know you are seeing a counselor, you can have your bills sent to an alternate address.
- *Right to Inspect and Copy* – You have the right to inspect and/or obtain a copy of your, or your minor child's, PHI and counseling notes in your counselor's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. There will be a charge for copies made.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your counselor may deny your request.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the Privacy Notice from your counselor upon request, even if you have agreed to receive the Notice electronically.

COUNSELOR'S DUTIES

- Your counselor is required by law to maintain the privacy of PHI and to provide you with a notice of their legal duties and privacy practices with respect to PHI.
- Foothills Counseling & Wellness LLC reserves the right to change the privacy policies and practices described in this notice. Unless your counselor notifies you of such changes, however, the counselor is required to abide by the terms currently in effect.
- If Foothills Counseling & Wellness LLC revises their policies and procedures, they will be posted in the waiting room for your inspection, at your convenience.

COMPLAINTS

Initial complaints should be addressed with your counselor. However, if you are concerned that your counselor has violated your privacy rights, or you disagree with a decision your counselor made about access to your records, you may contact the Idaho Department of Occupational Licenses. If you have any questions about this Notice, please contact:

Privacy Officer: Laura Siney
Phone: 208-429-3854
Address: 1919 W State St
Boise, ID 83702
Email: Admin@FoothillsBoise.com

EFFECTIVE DATE

This notice is effective February 16th, 2026



Agreements

Please sign below after you have read the previous pages and keep pages 7-13 for your records.

The full text of this agreement is also available in the waiting area/front desk at the address below and is available for download from our website: www.FoothillsBoise.com.

FOOTHILLS COUNSELING & WELLNESS LLC
1919 W State St
Boise, ID 83702

If you have questions regarding these forms, please ask your counselor or contact Foothills Counseling & Wellness LLC at 208-429-3854.

INFORMATION DISCLOSURE, INFORMED CONSENT, CLIENT RIGHTS, AND HIPAA AND YOUR PROTECTED HEALTH INFORMATION (PHI)

_____ *I have read and reviewed this informed consent. I understand and agree to all the terms as they are written. In addition, I have been offered a copy of this form for my own records.*

_____ *I have read, understand, and accept my rights as a client of Foothills Counseling & Wellness LLC regarding both privacy practices, and the scope of services available.*

_____ *My signature below indicates that I have read the attached agreement and agree to its terms, and serves as an acknowledgement that I have received the HIPAA notice of privacy practices.*

Parent/Guardian Signature _____ Date _____