Notice of Privacy Policies

Utah Family Institute • 1471 North 1200 West • Orem, Utah 84057 • (801) 802-9464

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.

If you have any questions about this Notice, please contact our Privacy Officer.

This Notice of Privacy Policies describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Policies. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Policies by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by your therapist to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your therapist will use or disclose your protected health information as described in this Privacy Policies Section. Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the therapist's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the therapist's office is permitted to make once you have signed our consent for. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another mental health agency that provides care to you. We will also disclose protected health information to other therapists who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a therapist to whom you have been referred to ensure that the therapist has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another therapist or health care provider (e.g., a specialist or laboratory) who, at the request of your therapist, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your therapist.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists, licensing, and other administrative tasks to monitor the quality of care that we provide.

For example, we may disclose your protected health information to other therapists, clinical director and/or treatment coordinator, that see patients at our office, to insure that the treatment you are receiving is the best suited to your needs. In addition, we may use a sign-in sheet at the reception desk where you will be asked to sign your name and indicate your therapist. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services, etc.) for the practice. Whenever an arrangement between our office and a business associate involves the use of disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other permitted and Required Uses and Disclosures that May be Made with Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your therapist may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your therapist shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your therapist or another therapist in the practice is required by law to treat you and the therapist has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your therapists or another therapist in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the therapist determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosure that May be Made without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your therapist created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosure to you and when required by the Secretary of the Department of Health and Human Service to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

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Please sign indicating receipt of our Practice and Therapist's Notice of Privacy Policies or denial to receive Privacy Policies:

_____ I have read and understand the Notice of Privacy Policies.

_____ I chose not to receive a copy of the Notice of Privacy Policies.

Name of Patient: _____

Signature of Patient: _____

Date: _____

Authorized Representative: _____

Authority of Representative: _____

Patient Consent Agreement

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Consent for Purposes of Treatment, Payment and Healthcare Operations

Client Rules & Requirements of Outpatient Psychotherapy: Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems brought forward. I acknowledge that there are a variety of clinical treatment methods Utah Family Institute (UFI) may utilize to deal with my problems. I understand that Psychotherapy calls for a very active effort on my part. In order for the therapy to be most successful, I will have to work on things talked about both during the session(s) and at home. I further recognize that psychotherapy is a personal and collaborative effort between myself and my psychotherapist. I further understand that active weekly participation in psychotherapy, unless otherwise directed by my psychotherapist, is paramount to positive treatment outcome. Ultimately, I am responsible for what positive gains I may achieve as a result of outpatient psychotherapy.

Client, Couple and Family Treatment Expectations: Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects, I may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees to the outcome. In signing this form, I consent to receive treatment and/or have a minor in which I have legal guardianship over receive treatment at Utah Family Institute.

Types of Outpatient Services and Cost of Services: I understand that outpatient psychotherapy at Utah Family Institute may include any single or combination of treatment milieus. I may choose to engage in Individual, Family or Group psychotherapy. I understand that those treatment modalities may take place once-per-week or more often as indicated by my personal treatment needs. I recognize that as part of my outpatient treatment my therapist may utilize emotional and behavior check lists which will guide treatment and provide feedback for psychotherapy.

I understand that outpatient psychotherapy at Utah Family Institute is a fee for service. I acknowledge that any fee for service collected by UFI from my insurance carrier was billed by UFI as a courtesy on my behalf. I understand that the actual fee collected is governed by my insurance company. I further understand that any co-pay I pay for services is also governed by my insurance carrier. I was informed of those costs prior to receiving services. I understand that any fee paid to Utah Family Institute in my behalf for outpatient services under contract with the Department of Human Services (DHS), that that fee schedule is determined solely by DHS. I acknowledge that I may independently contact my insurance carrier or my DHS service worker to determine the cost for services at UFI. In the event that I have elected an out-of-pocket-pay for outpatient psychotherapy services at UFI, those costs have been disclosed to me in their entirety. I am responsible to make all co-pays for services at the time of service. I understand that any appointment I fail to keep and do not cancel twenty-four (24) hours prior to the scheduled time, that I will be billed for the full amount allowed under contract. In any case where I or my insurance carrier have not paid for services, I understand that services at UFI may be indefinitely suspended until my account is brought current. I may contact a UFI administrative authority to discuss my bill at any time.

Client Rights to Obtain Emergency Care & Authorization: I acknowledge that Utah Family Institute is an outpatient psychotherapy facility. I understand that UFI's regular business hours are Monday through Friday from 8:00 am. until 5:00 p.m.. I may obtain emergency after hour care by calling UFI's main number (801-802-9464), and following instructions for after hour emergency care. I understand that I may be directed for emergency care to an appropriate facility, such as an Hospital Emergency Care Center. I authorize any after hour emergency needs to be related by UFI's "on call" psychotherapist to my psychotherapist and that he/she will be notified of my emergency. I understand that I may call my psychotherapist directly during regular business hours, to discuss any emergency requirements I may have. I acknowledge that this may result in the scheduling of a psychotherapy appointment according to my emergency mental health needs.

Client Arrangements for Missed or Cancelled Appointments: I understand that it is my responsibility to keep psychotherapy appointments. In the event that I cancel an appointment, I agree to reschedule the missed appointment with my psychotherapist or his/her representative, within the week if possible. I acknowledge that any appointment I fail will be my responsibility to reschedule. I may reschedule any appointment by calling my

psychotherapist directly or speaking to one of his/her representative. I agree to reschedule the failed appointment within the week if possible.

Client Consequences for Missed or Cancelled Appointments: Ultimately, I understand that I am responsible for my own treatment success or failure. I recognize that psychotherapy is a complex process and that in order for me to benefit from that experience, I will commit to on-going treatment as identified by my personal treatment needs. I acknowledge that I may voluntarily withdraw from treatment at any time, unless otherwise directed by the Court or any other Legal Authority. In the event of missed or cancelled appointments, I acknowledge that this may adversely affect my expectations for positive outcome. I further acknowledge that any missed or cancelled appointment(s), unless otherwise arranged between myself and my psychotherapist may result in the necessity to reschedule a different time for psychotherapy. I understand that upon any voluntary withdrawal from outpatient psychotherapy my case may be closed at the discretion of my psychotherapist. I also understand that I may voluntarily resume outpatient psychotherapy by contacting my psychotherapist.

Client Use or Disclosure of Protected Health Information: I consent to the use or disclosure of my protected health information by Utah Family Institute for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Utah Family Institute. I consent to the exchange of information between Utah Family Institute and the referring agency. I understand that diagnosis or treatment of me by Utah Family Institute may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Utah Family Institute is not required to agree to the restrictions that I may request. However, if Utah Family Institute agrees to a restriction that I request, the restriction is binding on Utah Family Institute, therapist and staff.

I have the right to revoke this consent, in writing, at any time, except to the extent that Utah Family Institute has taken action in reliance on this consent.

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Utah Family Institutes Notice of Privacy Practices prior to signing this document. The Utah Family Institute's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Utah Family Institute. This Notice of Privacy Practices also includes and describes my rights, the therapists and Utah Family Institute's duties with respect to my protected health information.

Utah Family Institute reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I may request a copy of this Patient Consent Agreement in its entirety.

May we leave messages on your home or work voice mail or answering machine: ___Yes ___No

Signature of Patient or Personal Representative	Date
Name of Patient or Personal Representative	Description of Personal Representative's Authority

PATIENT RECORD OF DISCLOSURES
WITH Non-UFI Staff

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I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ O.K. to fax to this number _____

☐ Work Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other _____

_____ _____

Patient Signature Date

_____ _____

Print Name Birthdate

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or fax number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)

(1) Check this box if the disclosure is authorized

(2) Enter how the disclosure was made: F=Fax; P=Phone; E=E-mail; O-Other

Patient's Rights Notification

The following is a statement of your personal rights, the rights of others, your responsibilities, your rules of conduct and your rights regarding your protected health information. Those rights are explained within the context of your psychotherapy experience and treatment at Utah Family Institute (UFI). A brief description of how you may exercise these rights is explained. If you do not understand these rights you may request a verbal explanation.

You have the right to treatment With freedom from discrimination and to be treated with dignity and respect. You have the right to receive treatment in a safe environment, free from potential harm or acts of violence. In the event that you feel threatened by any individual at the UFI office you may immediately report this to any UFI office staff and/or your psychotherapist. You have the right to humane and reasonable treatment by a therapist that will best meet your needs. Much consideration is taken to meet that criterion but if there is a concern, you may request a change in therapist. If it is not possible to meet your needs in our office, Utah Family Institute shall provide you with the names of other qualified psychotherapists. You have the right to ask questions about the procedures used during therapy. You have the right to prevent the use of therapeutic techniques.

Client Responsibilities and Rules of Conduct Consistent with your right to treatment, you have the responsibility to treat others at UFI's office with dignity and respect. You have the responsibility not to discriminate against any client receiving services at UFI. Any acts of harm or potential harm to another at UFI will not be tolerated and may result in your termination from treatment at UFI. You will be expected to comply with all "Patient Rights" and "Patient Agreements" as contained within this and other documents given to at the initiation of outpatient treatment at Utah Family Institute.

Utah Family Institute Smoke Free Environment All Utah Family Institute Clients have the right to "clean air." Utah family Institute supports the Utah Clean Air Act and does not allow smoking on its premises or within 25 feet of the building. You have the right to report any violation of this policy to any UFI office staff and/or your psychotherapist.

Involuntary Termination To ensure that your personal rights and the rights of others are upheld, we request that you do not impose on the rights of others in our facility. If found violating another's rights, you will be requested to stop the violation. If the violation persists you will be asked to leave the premises. The police will be called if the violation threatens to harm another or well being of anyone at the UFI office. Your rights to treatment may be terminated for any violation of another's dignity, violent acts toward another, disrespectful treatment, threats to another, or any other major violation of UFI policy as outlined within this or the Patient Consent Agreement. With or without the assistance of your psychotherapist you may petition UFI's Privacy Officer and Clinical Director for reinstatement into psychotherapy services at UFI. Re-admission is upon a case-by-case basis and is weighted heavily upon the specific act of violation, any remuneration plan in place, safety plan required and is at the sole discretion of UFI's Privacy Officer and Clinical Director. If not otherwise under Court ordered, or some other Legal Authority, you have the right to voluntarily terminate treatment at any time without any moral or legal obligation, and without incurring future financial obligations. If treatment is involuntarily terminated, you will need to speak with the Privacy Officer and Clinical Director before being re-admitted.

Psychotherapy is a fee for services treatment You have the right to know the service fees if you are paying for treatment or the funding source for your treatment. Upon your request, your psychotherapist can report to you what your insurance carrier has indicated your deductibles, fees and co-pays are. You may also request disclosure of those fees from the Privacy Officer and Clinical Director of UFI. If you are an out-of-pocket-pay client those fees were previously agreed by you prior to your accepting treatment. You may speak to the Privacy Officer and Clinical Director of UFI concerning fees you have paid.

You have the right to inspect and copy your protected health information. You have the right to confidentiality except for the reasons explained in the Notice of Privacy Policy. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your therapist and the practice use for making decisions about your treatment. You may request access by completing an Access Request Form (Patients Authorization for Use or Disclosure of Protected Health Information) available from any staff member. Your request will be reviewed by our Privacy Officer and Clinical Director. Access for "closed records" is also available. Closed case

records are kept at a secure storage facility for ten (10) years. Under limited circumstances, we may deny your access to a portion of your records. If your request is denied, you will receive a written response. If you request copies or a summary of your record, we may charge a fee for the cost of copying, mailing and other services. The fee will be determined at the time your request is processed.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, raw psychological testing data, psychological evaluations, mental health evaluations; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Policies. Your request must state the specific restriction requested and to whom you want the restriction to apply.

If you choose to restrict the disclosure of your protected health information for the purpose of payment, you will be expected to pay for services in full at time of service.

Your therapist is not required to agree to a restriction that you may request. If the therapist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your therapist does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your therapist. You may request a restriction by completing a Request for Restriction of use of Disclosure of Protected Health information form available from any staff member.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your therapist amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. Please ask for a Medical Record Amendment Request Form available from any staff member. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Policies. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2004. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. You may request an accounting by completing a Request for Accounting of Use or Disclosure of Protected health information form available from any staff member.

You have the right to obtain a paper copy of this notice from us Upon request you may receive a paper copy of your Patients Rights Notification. You have a right to receive any verbal explanation regarding your rights and may discuss those with your psychotherapist or by calling our Privacy Officer and Clinical Director.

Grievance & Complaint Procedures You may file any complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us

by notifying our Privacy Officer and Clinical Director of your complaint. You may present a grievance for: denial of services; exclusion from services; or inadequacies/inequities in services provided. *We will not* retaliate against you for filing a complaint. You may contact our Privacy Office and Clinical Director at (801) 802-9464 for further information about the complaint process or to file a complaint.

This notice was initially published and became effective on August 21, 2008. A revised notice was published and became effective on August 18, 2011.

Patient's Name: _____

Patient's Signature: _____

Authorized Representative: _____

Representative's Signature: _____

Description of Representatives Authority: _____