



Client Information

Have you ever been a client of Vitality Unlimited at any of our facilities? Yes No

Date: _____ How did you hear about Vitality? _____

Name: _____ DOB: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Are you homeless? Yes No If yes, for how long? _____ (months/years)

Email: _____ Phone: _____ Cell Home

Sex: Male Female Gender Identity: Male Female Other

Sexual Orientation: Bisexual Heterosexual Homosexual Questioning Undisclosed

Race: American Indian or Alaskan Native Asian Black/African American White

Hawaiian/Pacific Islander Middle Eastern/N. African Other Two or more Undisclosed

Ethnicity: Hispanic Not Hispanic Other

Marital Status: Single Married Widowed Divorced Separated

Emergency Contact: _____ Relationship: _____ Phone: _____

Are you employed? Yes No If no: Retired On Disability

Type of employment? Full-time Part-time Homemaker Other

Employer: _____ Occupation: _____

Student? Yes No (If yes) School: _____

Current or Prior Military? Yes No Related to prior military? Parent Spouse Child

PARENT/GUARDIAN INFORMATION: (Custody documents are required for split households)

Parent/Guardian Status: Biological parents Married Divorced Separated

Custody Status: Guardian Full Custody Shared Custody

Name: _____ DOB: _____ Phone: _____

Name: _____ DOB: _____ Phone: _____

Medical

Height: _____ Weight: _____ Allergies: _____

Please list any medical concerns or conditions: _____

Current Medications

Please include all prescriptions and over-the-counter medications. Use an additional piece of paper if needed.

Medication	Dosage and frequency	Reason	Physician

Client Name: _____

Billing Information

Primary Insurance: _____ Member ID: _____ Group: _____

Name of policyholder: _____ DOB: _____ Employer: _____

Relationship to Client: Self Child Spouse Parent/Guardian

Secondary Insurance: _____ Member ID: _____ Group: _____

Name of policyholder: _____ DOB: _____ Employer: _____

Relationship to Client: Self Child Spouse Parent/Guardian

Client Financial Agreement

Client Name: _____ Responsible Party: _____

Address: _____ City: _____ State: _____ Zip: _____
Responsible Party information

SSN: _____ DOB: _____ Phone: _____ Cell: _____

How would you like to receive your statement? (choose one) Email Mail In person

Payment is due at the time of service, this includes all co-pays, deductibles, or co-insurance. Please notify the office of any changes to your insurance plan. You are responsible for obtaining any required referrals prior to your first visit. No individual will be denied services due to their ability to pay, however we encourage you to speak with our office regarding setting up a sliding fee scale or payment arrangements.

You may pay at the time of service, or you may store a credit or debit card that will be charged for any amount due. Please indicate your choice.

I will pay at the time of service.

I authorize Vitality Unlimited to securely store my credit or debit card information through its electronic processing system. I authorize my credit or debit card to be charged at the time of service for any amounts due. I further authorize Vitality Unlimited to charge my credit or debit card for any future services.

Name on card: _____ Credit card No.: _____

Expiration date: _____ Security code: _____ Zip code: _____

Cardholder's signature: _____ Date: _____

This authorization is valid for one year. You can opt out of auto payments by contacting our office at 775-738-4158.

I accept the terms of this agreement.

Client/responsible party's signature: _____ Date: _____

Base Fee Schedule			
<i>This fee schedule is not inclusive and does not represent those fees negotiated with individual and separate private party insurances. *A 20% discount for payments made at the time of service is available.</i>			
Biopsychosocial Assessment	\$200.00	Peer Support - 15 minutes	\$25.00
Individual Therapy – One hour	\$150.00	Medical Appointments	\$80.00 - \$180.00
Individual Therapy – 45 minutes	\$115.00	Detoxification – per day	\$750.00
Individual Therapy – 30 minutes	\$70.00	Residential SUD Program 30 days +	\$7,500.00
Group Session	\$70.00	IOP – per day	\$300.00
Targeted Case Management 15 minutes	\$25.00		

Are you interested in applying for a sliding fee scale? Yes No

Good Faith Estimate: You are entitled to a good faith estimate. Fees may be determined by in and out of network schedules and preferred providers contractual obligations. If you would like to receive a Good Faith Estimate, please speak with the office coordinator.

Client Name: _____

Mental Health History

Mental health concerns: _____
 Have you ever seen a counselor/therapist before? Yes No
 List all previous/current mental health diagnoses: _____
 Have you ever intentionally hurt yourself or made a suicide attempt? Yes No
 If yes, how, and when? _____

 Currently having suicidal thoughts? Yes No Homicidal thoughts? Yes No

Substance Use Information

Are you currently using substances? Yes No
 Primary drug of choice: _____ Secondary drug of choice: _____
 Additional substances used: _____
 Date of last use: _____ Are you an IV drug user? Yes No
 List withdrawal symptoms: _____
 Do you smoke? Yes No If yes, how much? 5-10/day 11-20/day 21 or more/day
 Do you use any other nicotine products? Yes No If yes, what? Vape Gum Chew/snuff

Legal History

Have you ever been arrested for, charged with, committed, or convicted of a sexual crime?
 Yes No If yes, explain: _____
 Have you ever been arrested for, charged with, committed, or convicted of a violent crime?
 Yes No If yes, explain: _____
 Have you been ordered/referred into treatment by any of the following?
 Counselor Court CPS Physician Probation/Parole Social Worker
 Will reporting or communication with your referral source be needed during treatment? Yes No
 Referral Source: _____ Phone: _____

****If yes, you will need to complete a release of information form and provide relevant court orders or stipulations.***

CONTRACT FOR SERVICES AND CONSENT TO TREATMENT: Please review all the information and policies below.

CONFIDENTIALITY POLICY: Client records are protected by federal laws, including HIPAA, 42 C.F.R. Part 2, and 45 C.F.R. parts 160, 162 and 164. This program may not confirm a client's participation or disclose information identifying them as having a substance use disorder or behavioral health condition unless: (1) the client provides written consent, (2) a court orders the disclosure, (3) information is needed by medical personnel in an emergency or by qualified staff for research, audits, or evaluations, or (4) state-mandated reporting requires disclosure of suspected abuse or neglect. Violations of these laws are crimes and may be reported to the appropriate authorities. Clients may file privacy complaints with Vitality Unlimited at 775-389-5832 or the U.S. Department of Health and Human Services without fear of retaliation. These protections do not apply to information about crimes committed at the program, against staff, or threats to commit such crimes.

CONFIDENTIALITY AMONG, BY, FOR, AND WITH THOSE PARTICIPATING IN TREATMENT: I understand that treatment for substance use or behavioral health issues is private, and I am responsible for protecting that privacy. I will keep confidential the identity of any Vitality Unlimited client and any information shared in group sessions. I will not disclose anyone's personal or protected health information, and this obligation continues even if I am no longer a Vitality Unlimited client.

Client Name: _____

CONSENT FOR RELEASE OF CONFIDENTIALITY FOR BILLING PURPOSES: I understand that billing for my treatment requires sharing my protected health information (PHI). I authorize Vitality Unlimited to release the PHI necessary for billing, including treatment details, treatment plans, labs, prescriptions, and progress notes, to my insurance provider or other approved payors. I understand I may request copies of my billing records for insurance purposes.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION FOR COLLECTION PURPOSES: I understand that if I fail to meet my financial obligations, Vitality Unlimited may share my demographic and financial information with its chosen collection agency for collection purposes.

MEDICAL RECORD RETENTION POLICY: In accordance with SB17 (2009 Session), health care records for clients under 23 years old may not be destroyed. Records may be destroyed only after they have been retained for at least seven years beyond the client's 23rd birthday.

RESEARCH POLICY: I authorize Vitality Unlimited to provide or send me questionnaires for research and follow-up. I understand the information collected will be used for research and to evaluate treatment outcomes, and that my identity will not be linked to the results. This consent remains in effect until the research project is complete.

NO SHOW POLICY: I understand that keeping my scheduled appointments is part of my treatment plan, and that missing appointments or canceling with less than 24 hours' notice is detrimental to my progress and reflects a lack of commitment. I understand that if I miss two scheduled appointments within a two-month period, all future appointments will be removed from Vitality Unlimited's schedule, and I will be placed on a same-day call-in basis. This means I may not book appointments in advance and must call the clinic daily to check for same-day availability. If an appointment is available, I may schedule it; if not, I must continue calling on subsequent days. I understand that if I am placed on a same-day call-in basis and fail to attend a same-day appointment, I may be discharged from my program for 90 days, after which I may re-establish services. I also understand that if I have difficulty keeping scheduled appointments, I should discuss this with Vitality Unlimited staff before being placed on same-day call-in status. I acknowledge that violating this policy may be considered my choice to leave treatment.

SUPERVISION NOTIFICATION POLICY: Vitality Unlimited reserves the right to provide treatment through supervised interns and I must be informed of the name and contact information of their Clinical Supervisor.

Clinical Supervisor Name: _____ Phone: _____

RECORDING POLICY: Occasionally, individual or group sessions may be recorded for quality assurance and for supervision of intern counselors or therapists. A Vitality Unlimited supervisor may review these recordings with the counselor or therapist. I understand that some Vitality Unlimited facilities use video surveillance for security purposes, that my image may be captured, and that these images are protected by state and federal confidentiality laws. I also understand that I may not record any services or communications without written permission.

AUTHORIZATION FOR PHARMACEUTICAL, MEDICAL AND DENTAL TREATMENT AND FINANCIAL

RESPONSIBILITY: I authorize Vitality Unlimited to seek and refer me for medical or dental treatment as deemed necessary by its staff. I understand that Vitality Unlimited uses third-party laboratories, pharmacies, and other medical services, and that I am responsible for any related costs. If I require emergency services during treatment, I am responsible for all charges from third-party providers. I understand that Vitality Unlimited is not responsible for the actions or decisions of these providers.

CONSENT TO TELEHEALTH SERVICES: I consent to receive treatment and services through telehealth, including interactive video or audio platforms. I understand that some platforms may not be fully secure but are permitted under emergency rules. I acknowledge that telehealth carries risks, including unsecure or unencrypted transmission, audio or video interruptions, unauthorized access, and technical failures. Although unlikely, I understand my protected health information could be breached if the technology is compromised. This consent remains in effect until I revoke it, and I may revoke it at any time by notifying my provider. I understand that any technology or data charges incurred while using telehealth services are my responsibility. I also understand that I may not record any telehealth services or communications without written permission.

