Life Changing Services

Programs and Services

Please mark which program or service you want to participate in.

☐ **Individual or Marital Therapy Session -** One-on-One counseling to help you overcome life's obstacles. We work in a collaborative manner with our clients to establish goals and develop insight to make real-life changes. Using a number of therapeutic techniques including client centered, cognitive and cognitive-behavioral strategies, we empower clients to build upon existing strengths and develop new coping skills. **[Cost is dependent on individual therapist]**

☐ **Sons of Helaman Program** - The Sons of Helaman is face-to-face group therapy meetings held in person or in online classroom, directed by a certified, licensed professional clinician. The groups consist of young men who have dedicated themselves to helping each other overcome unwanted pornography and/or masturbation addictions. Group participants practice and develop the warrior instincts that are required to conquer these addictions for the rest of their lives. They learn the strategies that the adversary will use against them. For young men ages 12-28. This program is ideal for helping a young man prepare for his mission and/or temple marriage. Graduation from the group includes having successfully conquered the addiction for 12 consecutive weeks and kept 6 goals for 28 perfect days. Client is financially responsible for missed groups. Please call with a twenty-four hour advanced notice for missed groups. By signing this contract, you are agreeing to be financially responsible for the program until you graduate or call 1-877-HERO-877 to cancel.
[$50 a week, $125 intake fee includes "Like Dragons Did They Fight" & Sons of Helaman Journal, $55 Transfer from Private Therapy Fee] ***Initial Here:*** **____**

☐ **Sons of Mosiah Program** - The Sons of Mosiah program is for missionaries in-field. The Participants work with a daily journal to develop skills to fight the adversary and overcome unwanted behaviors. Participants strengthen one another through online confidential email groups. The training and program is the same as the Sons of Helaman program. A certified on-line coach, overseen by a licensed clinician, leads participants through discussions to improve or increase their warrior chemistry. Client is financially responsible for missed weeks. By signing this contract, you are agreeing to be financially responsible for the program until you graduate or call 1-877-HERO-877 to cancel.
[$20 a week, $50 for participant kit] ***Initial Here:*** **____**

☐ **Text Coaching** - Sometimes the skills and/or determination needed to succeed for a long time is insufficient. Text Coaching addresses this problem. "T-Coaching" takes advantage of text messaging . The client is sent several texts/prompts each day. In these texts/prompts the client is asked carefully structured questions designed to train their brains to overcome addictive and/or compulsive behaviors. The answers that the client returns go directly to a trained and certified coach who then helps the client "win their battles" until they get the next text. By winning for shorter periods of time the client gains the momentum needed to help them succeed for a life time. Try it out for a few weeks and see how it goes. . Client is financially responsible even if they don't respond to the text messages. By signing this contract, you are agreeing to be financially responsible for the program until you call 1-877-HERO-877 to cancel. **[$20 per week]** ***Initial Here:*** **____**

☐ **Men of Moroni** – This program is for grown men, married or single, who want to fight like dragons against the Adversary's tools of pornography and sexual addiction. Online and in person groups are held throughout the week. Completion from the program includes having successfully conquered the addiction for 12 consecutive weeks and kept six goals for 28 consecutive perfect days at the end of the twelve weeks. Upon completion men will no longer be charged for Men of Moroni program unless they have two lost battles within a three-month period. At that point they will restart the program. All groups meet for two hours. Client is financially responsible for missed groups. Please call with a twenty-four hour advanced notice for missed groups. By signing this contract, you are agreeing to be financially responsible for the program until you graduate or call 1-877-HERO-877 to cancel. ***Initial Here:*** **____**
Please check one.
[$30 per class for mentor led in person/online groups and daily messaging. One time $50 fee includes orientation, registration, and kit. ☐]
[$50 per class led by Professional Clinical Level Therapists. One time $145 fee includes professional intake session, registration, and kit. ☐]

☐ **Daughters of Light** – The Daughters of Light is a group for adolescent girls, ages 12 to 17, who are struggling with finding their voice in the chaotic world around them. Hope, empowerment and the skills to navigate through the trials, including addictions, surrounding them are offered. Graduation from Daughters of Light includes successfully overcoming fears or addictions and implementing skills to obtain personal goals for 12 consecutive weeks.
[$120 intake fee includes Girl Power Journal, $50 per week]

☐ **Worth** – W-O-R-T-H Group: Women of Rebirth, Therapeutic Healing: For Women who are going through unfortunate painful experiences due to their current or previous significant other's misbehaviors, sexual addictions (pornography, infidelity, etc.), physical and/or emotional abuse. **[Free for all women in need]**

☐ **Personal Warrior Training** - Sometimes group or individual therapy isn't enough, and the warrior wants/needs more personalized training. LCS Warrior Trainers coach your loved one in the same self-mastery principles and tools taught by the other Life Changing Services programs, like Sons of Helaman, Men of Moroni. Eternal Warriors, and Daughters of Light. The synergy of Eternal Principles with cutting edge science has been found to greatly impact many lives.
[1hr = $50, 1/2hr = $25, 1/4hr = $12.50, $25 Participant Kit, if needed

Personal information:

First name: _____Last Name: _____Date: ____/____/____

Street address: _____City:_____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell: _____

Email: _____ Birth date: ____/____/____ Sex: [M] [F]

List present health problems or diagnosis: _____

_____

List medication currently taking: _____

_____

Parent or Spouse Information:

(Father or Husband) First Name: _____ Last Name: _____

Street address: _____ City: _____ State: ___ Zip: _____

Home Phone: _____ Business Phone: _____ Cell: _____

Email: _____ Employer: _____

(Mother or Wife) First Name: _____ Last Name: _____

Street address: _____City: _____State: ____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell: _____

Email: _____ Employer: _____

How did you hear about Life Changing Services? _____

Bishop's name: _____Ward:_____

Bishop's Address: _____ City _____ Zip _____

Ph. #_____ Email: _____

Stake President's name: _____ Stake: _____

(If applicable)Mission: _____ President's Name: _____

Ph. #_____ Email: _____

Do we have permission to contact President: No Yes Sign: _____

Do we have permission to contact Bishop: No Yes Sign: _____

Do we have permission to contact Parents (if applicable): No Yes Sign: _____

Do we have permission to contact Wife about WORTH Group (if applicable): No Yes Sign: _____

(Revised: 1/30/2016)

PAYMENT OF SERVICES- CHECK ONE

☐ **Option A**: Cash or Check

☐ **Option B:** Check/Bishop Pay

If indicated that a bishop will be paying any portion of your bill, the Authorization for Release of Confidential Information on the following page will need to be signed so we can contact that bishop and verify the information regarding your billing/payment arrangements. If there is a change in bishops during the course of treatment, and you want the new bishop to continue payment for services, you must notify the new bishop and our office at 877-HERO-877or 877-437-6877. The new bishop will need to be added to this Authorization for Release of Confidential Information form. If you will be receiving Bishop's assistance, please complete the following information:

Ward: _____

Bishop Name: _____ Bishop Ph. # _____

Bishop Complete Address: _____

☐ **Option C:** Credit Card

If you would like your credit card billed automatically each week:

Circle: Visa/MasterCard/Discover

Name as appears on card: _____

#_____/_____/_____/_____ Exp.____/____ Security Code _____

Signature: _____

Billing Zip Code: _____

Any payment questions contact the office at 877-HERO-877or 877-437-6877 or email sofhoutreach@gmail.com.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Life Changing Services

Name (print) _____

I authorize *Life Changing Services* and persons or entities listed below, or their representatives, to mutually release and disclose my health information.

I have received and reviewed *Life Changing Services* Notice of Privacy Practices.
I understand that only employees of Life Changing Services may ask me to sign this authorization.

I understand that by signing this General Authorization I am authorizing *Life Changing Services* to disclose my health information to the persons and entities listed below and that any health information of other confidential information in the possession of the persons and entities listed below may be disclosed to *Life Changing Services.* My health information includes, without limitation, any records, reports, test results, opinions, assessments and any other information relating to medical, emotional, educational or psychological condition. Disclosure may also be made to describe my condition and progress and to discuss treatment.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to the agency director at the *Life Changing Services* office where I am receiving counseling. I understand that my revocation of this General Authorization will not affect a disclosure that *Life Changing Services* has already made under this authorization.

I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by *Life Changing Services* confidentiality rules.

I waive any right of privacy that I may have in connection with the disclosure hereby authorized.

This authorization is only valid until three months after my file is closed at *Life Changing Services.*

Bishop	Phone	Client's Initials
Name	Phone	Client's Initials
Name	Phone	Client's Initials

Signatures	
Client's signature	Date
Name of parent or guardian(if client is under 18)	Date
Witness	Date

COUNSELING DESCRIPTION OF SERVICES- *Life Changing Services*

We welcome you to Life Changing Services, and hope that your visit will be worthwhile. The following information is important for your consideration; your goals are more likely to be met when you understand the nature and limitations of counseling.

Goals and Outcomes

Generally, counseling is most useful in helping individuals help themselves or improve their relationships by changing feelings, thoughts, or behaviors. You determine the nature and amount of change you wish to make.

Benefits and Risk

Most people experience improvement or resolution to concerns that brought them to counseling, but, of course, there are no guarantees; and there are some risks. For example, counseling could open up new levels of awareness that may cause discomfort.

Length of Therapy

Length of Therapy is determined by the client. If you are attending an addiction recovery group, it is a twelve week graduation program. You must obtain 12 weeks of sobriety, after which you are invited to attend at no charge. Daughters of Light is not a graduation program but is a 12 week rotating program. If you are coming for individual therapy, the Clinicians will make suggestions as to the length of therapy. Ultimately, the client decides how often and how many visits to make. Some clients feel their needs have been met after one visit, others continue for years. If you hope for insurance to compensate, you will need to check with your insurance company to learn how many visits they are willing to cover.

Cancellation of Appointment or Group Attendance

On occasion, a situation may arise which prevents you from keeping a scheduled appointment with your therapist or attending your group session. As a courtesy to your therapist and the agency, please notify us 24 hours in advance of your appointment if you cannot keep the appointment or attend group. **You** will be personally billed for no shows and for appointments not cancelled 24 hours in advance. We will not bill your bishop, insurance or other party.

Confidentiality

We understand the information you share can be very personal and that you may not want us to disclose this information to the others without your authorization. The Life Changing Services Notice of Privacy Practices informs you of your rights and obligations regarding the use and disclosure of health information. All clients will be asked to sign a Counseling Services General Authorization. Agency personnel will not release confidential information without this written authorization, unless such a release is otherwise authorized or required by the law. For example, the law may require us to disclose confidential information if there is a reason to believe that a child has been abused or neglected, or that you may be in danger of harming yourself or others. You may ask your clinician about other laws.

Grievance

You have every right to be treated with respect and dignity in a safe environment. Discrimination by our staff is not tolerated, if you have concerns about the services you receive, talk to your counselor or make an appointment with the agency director who will assist you.

Time

We would like to remind you that each one hour therapy session is split into three sections. The session begins with 5 minutes when your clinician prepares for the visit with you, followed by 50 minutes of direct face-to-face therapy, concluding with 5 minutes for your clinician to update your paper work. Your clinician will work to bring your visit to a close 50 minutes from the time you enter the office. Group therapy sessions are designed to last one hour and 45 minutes. Due to the inexact nature of therapy, it is unlikely that the sessions will begin and end exactly as described above, but it is what your clinician is working toward. Thank you for your patience and support.

Money

For individual, marriage or group therapy, payments for services are expected at the time of your visit unless we are billing an ecclesiastical leader. If you cannot pay on the day of your visit, an invoice will be sent to you within two weeks. If you are receiving ecclesiastical assistance, it is your responsibility to see that payment is sent to our office within two weeks of your visit. It is expected that you will make contact with your ecclesiastical leader at least every two weeks in order to thank them for their assistance, and offer service in exchange for their financial contribution. Ecclesiastical leaders also like to hear about the value you are getting from your visits on a regular basis. For text coaching and online services you will be billed weekly. You will be given 30 days to pay for services before you are assessed a $25 no payment fee. Please note that pricing for services may periodically change. You will be notified in advance of such changes.

Terms and Conditions

All delinquent accounts will be charged and interest rate of 1.5% per month (18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay all collection costs, which according to state law can be up to 40% of the amount collected. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney fees.

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account. We may also contact you by sending text messages or e-mails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree to terms listed above.

_____ _____

Client or Responsible Party if under 18 Signature Date

Other Areas of Discussion for the Clinician

We encourage you to ask your clinician about areas of concern. Following are questions that you may want to consider asking.

- What is your clinician's background?
- What does your clinician feel most qualified to treat?
- Following the assessment interview, you may ask how your therapist intends to help you, or what methods will be used, and how long that may take.
- You may ask about alternative forms of treatment such as support groups, marriage counseling, etc.
- If a referral is recommended, how will it be handled?

Please arrange for small children to remain at home unless specifically asked to bring them as part of family therapy. Children may not be left unattended in the waiting area.

I have read the above information, and understand that I am encouraged to ask questions, and give input regarding the counseling process at any time. If there is anything in this form that I do not understand, it is my responsibility to seek clarification.

NOTICE OF PRIVACY PRACTICE - HIPAA

(This and the following page are to be separated from the application and **given to the client** or the guardians of the client for their own records.)

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.

We are providing you with this notice:
We are required by a federal law known as the Health Insurance Portability and Accountability Act (HIPAA) to give you this Notice. This notice will tell you about the ways in which we may disclose health information about you and will describe your rights and our obligations regarding the use and disclosure of that information.

Your Health Information:
This notice applies to the information and records we have about your health, health status, and the health care services you receive from *Life Changing Services,* this information and these records relate primarily to counseling services you have received from us.

How We May Use and Disclose Health Information about You

For Treatment:
We may use and disclose health information about you so that we can be paid by you, an insurance company, or another party, including current or future bishops if they are paying any portion of the fee for the services we provide to you. For example, we may need to give your insurance company information about our services to you so the company will pay us for these services.

For Agency Operations:
We may use and disclose health information about you in order to run our office and make sure that you and our other clients receive quality care. For example, we may use your health information to evaluate the performance of our staff or to contact you to remind you of your appointments.

Please notify us in writing if you do not want us to contact you to remind you of your appointments.

Special Situations:
We may use or disclose your health information without your permission for several reasons. These reasons include:

- Disclosing your health information when we believe that disclosure is necessary to prevent a serious threat to your health and safety or the health and safety of another person.
- Disclosing your health information as required by federal, state or local law.
- Disclosing your health information as required by law to prevent injury or suspected abuse or neglect.
- Disclosing your health information in response to a court order, subpoena, warrant, summons or similar process.

Other Uses and Disclosures of Health Information

Except where otherwise required or authorized by law, we will not use or disclose your health information for any purpose without your written authorization. If you authorize us to use or disclose health information about you, you may revoke your authorization, in writing at any time. If you revoke your authorization, we will no longer use or disclose your health information for the reasons covered by your written authorization, but we cannot take back any uses or disclosures we have already made with your permission.

Your Rights Regarding Your Health Information

You have the following rights with regard to your health information:

- You may inspect or copy your health information, with certain exceptions.
- If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information.
- You may obtain an accounting of our disclosures of your health information. This is a list of all of our disclosures of your health information for purposes other than treatment, payment and health care operations.
- You have the right to request that we restrict or limit our use or disclosure of your health information to only treatment, payment or health care operations. We are not required to comply with your request.
- You may request that we communicate with you about your health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work.
- You have the right to receive a paper copy of this notice.

If you want to exercise any of these rights, please contact the agency director, in writing, at the office where you are receiving counseling.

Changes to This Notice:

We have the right to change this notice. If we do so, the new notice will apply to the health information we may already have about you and to the health information that we receive in the future. We are required to abide by the most current notice that is in effect. We will post a summary of the most current information in our office. You are entitled to receive a copy of the most current notice.

Complaints:

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

_____ _____

Signature Date

If you are a Sons of Helaman, Sons of Mosiah, Men of Moroni, or Daughters of Light participant, for your use in setting goals, please print only this page (page 9) and complete the following privately. Then give it to your clinician.

History of Lost Battles

Your name: _____ Your age now: _____

M = Masturbation
P = Pornography

1) Which of the two have you struggled with the most? _____
2) At what age were you first introduced to M? _____
3) Did you (A) discover it on your own, or (B) did someone teach you? If (B), who was it? _____.
4) At what age did M visits become regular? _____
5) At what age was M the worst? _____
6) At that time, how often (on average) was it? Per day____ per week ____ Per month ____
7) What is the longest you have gone without it since that age? _____
8) What has been your pattern for the last 3 months? Clusters or Steady?
   -Clusters - How many days in a cluster of lost battles? ____
   How many good days in between? ___
   -Steady – How often (on average) per day_____ per week ____ per month ____
9) At what age were you first introduced to P? _____
10) Did you ☐ discover it on your own, or ☐ did someone teach you? If (B), who was it? _____.
11) At what age did P visits become regular? _____
12) At what age was P the worst? _____
13) At that time, how often (on average) was it? Per day____ per week ____ per month ____
14) What is the longest you have gone without it since that age? _____
15) What has been your pattern for the last 3 months? Clusters or Steady?
16) Clusters - How many days in a cluster of lost battles? ____
    How many good days in between? ___
17) Steady – How often (on average) per day_____ per week ____ per month ____
18) What is the primary source of P? _____
19) What type of P do you view? _____