

INTAKE INFORMATION

Parent/Guardian Name: _____ Today's Date _____

Address _____ Date of Birth _____

City, State, & Zip _____ Religion _____

Home Phone _____ Cell Phone _____ Race ____ Marital Status ____

Employer _____ Phone _____

Emergency Contact _____
(Name) (Phone) (Relationship to you)

| Children at Home: (Include first, middle, and last name) | Age: | Birthdate: |
|---|------|------------|
|---|------|------------|

| | | | |
|--|--|--|---|
| | | | Please circle the child/children for whom treatment is being requested. |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

What is the highest grade completed in school by the individual for whom treatment is being requested? _____

Who referred you here? _____
(Person's name) (Name of agency/position)

Insurance Information

Do you have Medicaid/Medicare? Yes ___ No ___

Do you have health insurance? Yes ___ No ___

Do you have mental health benefits? Yes ___ No ___

Insurance Company Name _____

Phone Number of Insurance Company _____

Name of Insured _____

Address (if different from above) _____

Policy # _____ Social Security # _____

Employer _____ Insured Date of Birth _____

CONFIDENTIAL INTAKE QUESTIONNAIRE

CHILD'S NAME _____
TODAY'S DATE _____
BIRTH DATE _____

What type of therapy are you seeking for your child? Circle all that apply.

- 1. Individual therapy
- 2. Couple therapy
- 3. Family therapy
- 4. Group therapy

Has he/she been in therapy before?

No _____

Is he/she currently taking

medications? No____Yes _____ Yes

With whom? _____

List _____

When? _____

For what? _____

Why are you seeking counseling for your child?

Please use the scale to indicate your level of concern with that problem. **(Only rate those that apply).**

SCALE: 1 2 3 4
 small concern some concern much concern high concern

- 1) drugs/alcohol _____
- 2) anxiety _____
- 3) death/grief/loss _____
- 4) depression _____
- 5) eating problems _____
- 6) emotional abuse _____
- 7) family relationships _____
- 8) marital issues _____
- 9) past family problems _____
- 10) physical abuse _____
- 11) romantic relationships _____
- 12) self esteem _____
- 13) sexual abuse _____
- 14) sexuality _____
- 15) stress _____
- 16) other _____

PLEASE MARK ALL POSSIBLE TIMES YOU ARE AVAILABLE FOR AN APPOINTMENT.

| TIME | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |
|----------|--------|---------|-----------|----------|--------|
| 8:00 AM | | | | | |
| 9:00 AM | | | | | |
| 10:00 AM | | | | | |
| 11:00 AM | | | | | |
| 12:00 PM | | | | | |
| 1:00 PM | | | | | |
| 2:00 PM | | | | | |
| 3:00 PM | | | | | |
| 4:00 PM | | | | | |
| 5:00 PM | | | | | |

Note: Late afternoon and evening appointments have a longer waiting list, (3+ months), than the morning and daytime appointments. For expedited scheduling, please mark as many time slots as possible.

MESSAGE PERMISSION FORM

I _____, give the Family Support & Treatment Center permission to leave messages:

| | | |
|-------------------------|-----|----|
| on my answering machine | yes | no |
| with my spouse | yes | no |
| with whomever answers | yes | no |
| at work | yes | no |

_____ **YES** I want a weekly reminder call

_____ **NO** I do not want a weekly reminder call

Signature

Date

DEMOGRAPHIC INFORMATION

Name: _____

Housing Composition (List each person who lives in dwelling)

| | Family Member Name | Age | Sex | Relationship | Adopted/Foster |
|----|--------------------|-------|-------|--------------|----------------|
| 1) | _____ | _____ | _____ | _____ | _____ |
| 2) | _____ | _____ | _____ | _____ | _____ |
| 3) | _____ | _____ | _____ | _____ | _____ |
| 4) | _____ | _____ | _____ | _____ | _____ |
| 5) | _____ | _____ | _____ | _____ | _____ |
| 6) | _____ | _____ | _____ | _____ | _____ |
| 7) | _____ | _____ | _____ | _____ | _____ |

(list additional members on back of form)

- 1) Name of individual in program: _____
- 2) Is anyone in the household age 65 or older? _____

- 3) Is anyone in the household of a minority ethnic origin?
- | | |
|---|---------------------------------|
| _____ American Indian/Alaska Native & Black/African American | _____ Asian |
| _____ American Indian/ Alaska Native & White | _____ Asian & White |
| _____ American Indian/Alaska Native | _____ Hispanic |
| _____ Native Hawaiian/Other Pacific Islander | _____ Black/African American |
| _____ Black/African American & White Islander | _____ Asian /Pacific |
| _____ Other Multi-Racial | _____ White |

- 4) Is a single female head of the household? _____
- 5) Is anyone in the household physically or mentally handicapped, or is anyone learning disabled? _____

Please circle the income range that most reflects your total family income based on family size:

| Total PERSONS | 1 person | 2 persons | 3 persons | 4 persons | 5 persons | 6 persons | 7 persons | 8 persons | 9 persons | 10 persons |
|---------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| | \$12,600 <i>or less</i> | \$14,400 <i>or less</i> | \$16,200 <i>or less</i> | \$18,000 <i>or less</i> | \$19,450 <i>or less</i> | \$20,900 <i>or less</i> | \$22,300 <i>or less</i> | \$23,750 <i>or less</i> | \$25,200 <i>or less</i> | \$26,640 <i>or less</i> |
| | \$21,000 <i>or less</i> | \$24,000 <i>or less</i> | \$27,000 <i>or less</i> | \$30,000 <i>or less</i> | \$32,400 <i>or less</i> | \$34,800 <i>or less</i> | \$37,200 <i>or less</i> | \$39,600 <i>or less</i> | \$42,000 <i>or less</i> | \$44,400 <i>or less</i> |
| | \$33,600 <i>or less</i> | \$38,400 <i>or less</i> | \$43,200 <i>or less</i> | \$48,000 <i>or less</i> | \$51,850 <i>or less</i> | \$55,700 <i>or less</i> | \$59,500 <i>or less</i> | \$63,350 <i>or less</i> | \$67,200 <i>or less</i> | \$71,040 <i>or less</i> |
| | \$33,601 <i>or above</i> | \$38,401 <i>or above</i> | \$43,201 <i>or above</i> | \$48,001 <i>or above</i> | \$51,851 <i>or above</i> | \$55,701 <i>or above</i> | \$59,501 <i>or above</i> | \$63,351 <i>or above</i> | \$67,201 <i>or above</i> | \$71,041 <i>or above</i> |

FAMILY SUPPORT & TREATMENT CENTER
BILLING & PROCEDURE POLICY

The Family Support & Treatment Center appreciates the opportunity to serve you in a therapeutic setting. We hope you feel the services provided are beneficial to you. In order to provide quality therapeutic services, please note the following necessary business policies.

Individual and/or Family Therapy at the Family Support & Treatment Center is billed per session. The cost of a session varies depending upon the funding source. The rates are as follows:

Self-Pay: \$80.00

Insurances: \$90.00 (client portion of this amount is determined by specific insurance plan).

Bishop Pay: \$70.00 (client portion of this amount is determined by the client's Bishop).

If you have a funding source that is not mentioned above, it is your responsibility to determine session cost by contacting Ruth Mitsuda in the billing department. Under limited circumstances, the client may be eligible for a discounted fee. This is determined by household size, income, and extenuating circumstances as determined by the Business Manager and the Clinical Director.

Requested written reports/letters will be billed at \$17.50 per quarter hour; fee for service is due at time of receipt. We will not bill secondary parties for this service.

All clients must do a business intake with the business office prior to their first therapy and/or group session. During this time the client will furnish the business office with financial information. Proof of income and other data may be requested. Withholding or providing misinformation pertinent to funding will result in the full responsibility of payment being deferred to the client. The client is responsible to notify the business office of any financial or funding changes. **The client is responsible for any portion of the fees which the funding source does not cover.** We are unable to assign you to a therapist until a funding source is in place.

If the client is funded through an insurance company, it is the client's responsibility to verify and understand their outpatient mental health benefits. Please be aware that these benefits may vary from your standard medical benefits.

The client's portion of payment, e.g., self-pay or co-payments, is due at time of service. **If a client's balance becomes outstanding, they are required to make payment arrangements with the business office. If the client fails to do so, treatment will be discontinued.** For those individuals desiring to return to therapy, treatment may be delayed until arrangements have been made to pay prior delinquent bills. This is also true for those individuals for whom the client is financially responsible.

If it is not possible to keep a scheduled therapy appointment, you are required to contact us to cancel the appointment. If circumstances and schedules allow, you may reschedule your appointment with the receptionist. After two missed appointments where we were not contacted to cancel and/or failure to maintain a 75% monthly attendance rate, we reserve the right to reassign your time slot. You will be notified prior to this happening. If desired, your name will return to the waiting list until another time slot becomes available.

We hope you find the Family Support & Treatment Center a supportive environment. We look forward to working with you. Please contact Ruth Mitsuda or Tatiana Lewis at (801)229-1181 with any questions you may have.

Billing Policy Certification

I have read and been provided a personal copy of the *Billing & Procedure* policy. I understand the expectations outlined in the policy and agree to comply with the provisions therein. Any questions or clarifications of the *Billing & Procedure* policy have been presented and satisfactorily responded to.

Signature of client/guardian

Date

FAMILY SUPPORT & TREATMENT CENTER
REQUEST FOR TREATMENT, CONFIDENTIALITY,
AND HOLD HARMLESS FORM

I request services at the Family Support & Treatment Center. I understand that all information obtained concerning me and/or my children or anything I tell the staff, orally or in writing, will be kept confidential within the Center with these exceptions:

- 1) I sign a release request specifying to whom the information is to go, what information I want released and for what time period information may be released.
- 2) Upon a proper court order.
- 3) In emergencies when it appears I may be a danger to myself or to others.
- 4) In child abuse cases as the law requires.5) As required by funding sources for Family Support & Treatment Center to receive payment.
- 6) As outlined in the Notice of Privacy Practices.

I indemnify and hold harmless the Family Support & Treatment Center for the fulfillment of its legal responsibilities stated above. All of the information of this sheet has been clearly explained to me by a staff member and I acknowledge that I understand it and am willing to abide by it.

Signature

Date

Witness

FAMILY SUPPORT & TREATMENT CENTER

CONSENT TO TREATMENT

I hereby give my consent for my son/daughter _____ to receive individual, family, and/or group treatment for personal/family issues.

I understand that my relationship with the Family Support & Treatment Center is confidential and that **NO INFORMATION WILL BE RELEASED WITHOUT MY WRITTEN PERMISSION** except as outlined in the **Hold Harmless form**. I am aware that if my child participates in group therapy, the group will be led by a licensed therapist and/or graduate student under supervision of a licensed therapist. In addition, there may be a co-leader in the group who is a student in the counseling field. If I am concerned about my child's treatment I may consult with his/her therapist and/or the clinical director. I agree to answer a confidential follow-up questionnaire regarding the quality of my child's therapy at the end of my treatment.

In the rare event that any recording equipment or observation of treatment is to be utilized, this will be described to me **IN ADVANCE** and my permission obtained. I will also be notified about any proposed change of my child's therapist.

I understand that treatment at the Family Support & Treatment Center shall be free from discrimination by race, religion, sex, ethnicity, age, or handicap.

Signature of Parent/Guardian

Date

Witness

Behavior Checklist

Child's Name _____

Date:

Please rate the following items that occur for your child.

0 = None, 1 = Mild, 2 = Moderate, 3 = Severe

- _____ Has a hard time giving close attention to details (A)
- _____ Makes careless mistakes in schoolwork or work
- _____ Doesn't seem to listen when spoken to
- _____ Doesn't follow through on instructions
- _____ Fails to finish school work or chores
- _____ Has difficulty organizing tasks and activities
- _____ Avoids or doesn't like homework
- _____ Loses things often
- _____ Is easily distracted
- _____ Forgetful in daily activities
- _____ Fidgets with hands or feet or squirms in seat
- _____ Difficulty staying seated
- _____ Often talks excessively
- _____ Easily distracted
- _____ Often shows feelings of restlessness
- _____ Often "on the go" with excessive energy
- _____ Often blurts out answers
- _____ Has difficulty awaiting turns
- _____ Often interrupts or intrudes on others.

- _____ Often loses temper (B)
- _____ Often argues with adults
- _____ Often actively defies or refuses to comply with adults' requests or rules
- _____ Often deliberately annoys people
- _____ Often blames others for his/her mistakes or misbehavior
- _____ Often touchy or easily annoyed by others
- _____ Often angry and resentful
- _____ Often spiteful or vindictive

- _____ Repeated passage of feces into inappropriate places (clothing or floor) (C)

- _____ Repeated voiding of urine into bed or clothes (whether involuntary or intentional) (D)

- _____ Overly upset when separated (or thinks about being separated) from home or parent(s) (E)
- _____ Worries about losing or about possible harm coming to parent(s)

- _____ Worries about getting lost or kidnapped
- _____ Refuses to go to school or elsewhere because of fear of separation
- _____ Is afraid to be alone or without parent(s)
- _____ Often refuses to go to sleep with out being near parent(s)
- _____ Repeated nightmares involving the theme of separation
- _____ Repeated complaints of physical symptoms (such as headaches, stomach aches, or nausea) when separation from parent(s) occurs or is anticipated

- _____ Sad, depressed, unhappy (F)
- _____ Decreased enjoyment, pleasure, interest
- _____ Change in weight
- _____ Failure to make expected weight gains
- _____ Sleep problems
- _____ Irritable, agitated
- _____ Fatigue, loss of energy
- _____ Hopelessness
- _____ Guilt feelings
- _____ Difficulty concentrating, indecisiveness
- _____ Suicidal verbalizations, thoughts
- _____ Social withdrawal _____ Physically _____ Verbally
- _____ Anxious, nervous, edgy
- _____ Poor appetite or overeating
- _____ Low self-esteem
- _____ Often in an irritable mood
- _____ Often whining or crying
- _____ Few friends, losing friends
- _____ Negative self statements
- _____ Negative statements or thoughts
- _____ Vegetate in front of the TV

- _____ Inflated self-esteem or grandiosity (G)
- _____ Decreased need for sleep.
- _____ More talkative than usual.
- _____ Racing thoughts
- _____ Distract able
- _____ Psychomotor agitation
- _____ Mood swings
- _____ Irritable mood
- _____ Overactive, too happy, too busy, elevated mood
- _____ Excessive involvement in pleasurable activities

- _____ Child has been a victim or has witnessed events that involve events that are outside of normal human experiences (abuse, domestic violence, natural disaster, death, etc.) (H)
- _____ Child has responded to such event(s) with intense fear, helplessness, or horror
- _____ Disorganized or agitated behavior
- _____ Fears, Specify: _____
- _____ Repetitive play with themes or aspects in trauma is expressed

- _____ Recurrent nightmares, Theme _____
- _____ Somatic complaints such as body complaints, stomach pains or headaches
- _____ Overly dependent
- _____ Worries of separation
- _____ Excessive need for reassurance
- _____ Tense/unable to relax
- _____ Feelings of detachment or estrangement from others (like experience are not real)
- _____ Restricted range of emotions (either sad or angry)
- _____ A general distrust of people
- _____ Avoidance of certain people, places or activities

- _____ Excessive worry about a number of events (I)
- _____ The child finds it difficult to control the worrying
- _____ Feelings of being keyed up or on edge
- _____ Easily fatigued
- _____ Difficulty concentrating or mind going blank
- _____ Irritability
- _____ Muscle tension
- _____ Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

- _____ Obsessional thought, impulses or images that are a product of the child's mind (J)
- _____ Repetitive behaviors (hand washing, ordering, checking) or mental acts (praying, counting, repeating words silently) that the child feels driven to perform with the aim to prevent or reduce some dreaded event or situation.

- _____ Persistent fear of one or more social or performance situations where the child is afraid that he or she will act in a way that will be humiliating or embarrassing. (The fear would include peers as well as adults) (K)
- _____ Anxiety expressed in such situations by crying, tantrums, freezing or shrinking from social situations with unfamiliar people.
- _____ The feared social or performance situations are avoided or else are endured with intense anxiety or distress

- _____ Excessive fear linked to a specific thing (flying, heights, animals, receiving a shot, seeing blood, etc.) (L)
- _____ Exposure to the thing the child is afraid of provokes immediate anxiety such as crying, tantrum, freezing, or clinging
- _____ Child avoids the thing they are afraid

- _____ Experiencing periods of time of intense fear with some of the following symptoms (circle all that apply) pounding heart, sweating, trembling or shaking, sensations of shortness of breath, feelings of choking, chest pain, nausea, feeling dizzy, fear of losing control, fear of dying, numbness of tingling sensations, or chills (M)
- _____ Fear is so great the child doesn't want to leave home or being in social situations

- _____ Has experienced a serious emotional stressor within the last 3 months (divorce, witnessing abuse, abuse, separation from a loved one, moving, problems at school, etc.) (N)