

INTAKE INFORMATION

Name _____ Today's Date _____
(First) (M.I.) (Last) mo/da/yr

Address _____ Date of Birth _____

City, State, & Zip _____ Religion _____

Phone _____ Race _____ Marital Status _____

Employer _____ Phone _____

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

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

Spouse's Name _____
(First) (M.I.) (Last)

Address _____ Date of Birth _____

City, State, & Zip _____ Religion _____

Phone _____ Race _____ Marital Status _____

Employer _____ Phone _____

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

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 _____

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

FAMILY SUPPORT & TREATMENT CENTER

CONSENT TO TREATMENT

I _____ hereby give my consent 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 I participate in group therapy, the group will be led by a licensed therapist and/or a 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 treatment I may consult with my therapist and/or the clinical director. I agree to answer a confidential follow-up questionnaire regarding the quality of my 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 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 client

Date

Witness

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 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 (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

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 _____ Asian
& Black/African American

_____ American Indian/ Alaska Native _____ Asian & White
& White

_____ American Indian/Alaska Native _____ Hispanic

_____ Native Hawaiian/Other Pacific _____ Black/African
Islander American

_____ Black/African American & White _____ Asian /Pacific
Islander

_____ 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>

