Family Support & Treatment Center

Child Intake Form

Parent/Guardian Name: ______________________________ Today's Date: ______________

Home Phone: ______________ Cell Phone: ______________ Date of Birth: ______________

Address: ____
Street City State Zip

Email: ______________________ Religion: __________ Marital Status: ____________

Employer: ________________________________ Phone: ______________

Emergency Contact: ____
(Name) (Phone) (Relationship to you)

<u>Children at Home:</u>

Name: *(Include first, middle, and last name)	Gender	Age	Birth Date

➢ If divorced, please provide a copy of your divorce decree.

Highest school grade completed by individual for whom treatment is being requested: ______________

Were you referred here? Y / N By whom? ________________________________
(Person's Name) (Name of agency/position)

<u>Insurance Information</u>

Do you have Medicaid/Medicare? Yes___ No___ (If yes, please contact staff)

Do you have health insurance? Yes___ No___

Do you have mental health benefits? Yes___ No___

Insurance Company: ______________________ Insurance Phone: ______________

Name of Insured: ______________________ Insured Date of Birth:______________

Address (if different from above): ________________________________

Policy #: ______________________ Social Security #: ______________

Employer: ________________________________

Confidential Intake Information

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

Has he/she been in therapy before?

No___ Yes___

With whom? ______________

When? ________________

Is he/she currently taking medication?

No___ Yes___

List ______________________

For what? __________________

Why are you seeking counseling for your child?

____

____

____

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

SCALE:	1 small concern	2 some concern	3 much concern	4 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) suicidal _____
17) other (please list) _____

____

PLEASE MARK ALL POSSIBLE TIMES YOU ARE AVAILABLE FOR A WEEKLY APPOINTMENT

TIME	Mon	Tue	Wed	Thu	Fri
8:00 AM					
9:00 AM					
10:00 AM					
11:00 AM			NA		
12:00 PM			NA		
1:00 PM					
2:00 PM					
3:00 PM					
4:00 PM					
5:00 PM					

These times are in high demand. (See Note)

NOTE:

Higher demand appointment times may have a longer waiting period (possibly up to 3 months).
5PM time slots have a wait time of over 3 months.

The more times you mark available the sooner we will be able to schedule you.
Please feel free to ask if you have questions regarding scheduling.

APPOINTMENT REMINDERS:

- ☐ I would like a weekly reminder CALL.
- ☐ I would like a weekly reminder TEXT
- ☐ I do NOT want a weekly reminder

ATTENDANCE POLICY

(Please read and initial next to each statement)

______ I understand that if it is not possible to keep a scheduled therapy appointment, I am required to contact the agency to cancel the appointment. If circumstances and schedules allow, I may reschedule my appointment with the receptionist.

______ I understand that texts are for reminders only. Any cancellations or schedule changes must be called in.

______ I understand that after two missed appointments without prior notification and/or failure to maintain a 75% monthly attendance rate, the agency reserves the right to reassign my timeslot. If I wish to continue services, I may request to be returned to the waiting list until another timeslot becomes available.

______ I understand that parents/legal guardians are required to check their children in for each appointment.

MESSAGE PERMISSIONS

I, ______________________________, give the Family Support & Treatment Center permission to contact me regarding appointments and services as follows:

	Preference:	May we leave a message:	
Home:	1st 2nd 3rd 4th	Voicemail Y / N	With whomever answers Y / N
Cell:	1st 2nd 3rd 4th	Voicemail Y / N	With whomever answers Y / N
Work:	1st 2nd 3rd 4th	Voicemail Y / N	
Spouse: (If applicable)	1st 2nd 3rd 4th	Name:	Number:

______________________________ ______________________________

Signature Date

Family Support & Treatment Center

REQUEST FOR TREATMENT, CONFIDENTIALITY AND HOLD HARMLESS

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 in 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.

______________________________ ______________
Parent/Guardian Signature Date

______________________________ ______________
Witness Date

Family Support & Treatment Center

CONSENT TO TREAT

I, hereby give my consent for my son/daughter, ______________________________, to receive individual and/or family 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 therapy will be provided by a licensed therapist and/or graduate student under supervision of a licensed therapist. 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 his/her 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.

________________________________ ________________

Parent/Guardian Signature Date

________________________________ ________________

Witness Date

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.

- Therapy is billed per session and cost of a session varies depending upon the funding source. The client's portion of payment (e.g., self-pay or co-payment) is generally due at time of service. If the client is a child, please plan to come in with him/her, or call ahead of time to make the payment. The rates are as follows:
    - Self-Pay: $90.00
    - Insurance: $120.79 (client portion of this amount is determined by specific insurance plan.)
    - Bishop Pay: $80.00 (client portion of this amount is determined by the client's Bishop.)
- If the client is funded through an insurance company, it is the client's responsibility to verify and understand their outpatient mental health benefits that may vary from standard medical benefits.
- If you have a funding source not mentioned above, it is your responsibility to determine session cost by contacting the Business Manager.
- **The client is responsible for any portion of the fees which the funding source does not cover**, including denials from insurance based on their diagnostic policies.
- Under limited circumstances, the client may be eligible for a discounted fee determined by household size, income, and extenuating circumstances through the Business Manager and Treatment Coordinator. 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.
- If a balance of more than three missed payments accrues, services will be suspended until the balance is paid in full or arrangements are made with the Business Manager.
- For 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.
- **The client is responsible to notify the business office of any financial or funding changes** (i.e. change of job and/or insurance plan, loss or gain of insurance, change of family gross income for grant clients). We are unable to assign you to a therapist until a funding source is in place.
- If payment is made via Venmo, it is client's responsibility to determine privacy settings.

Additional fees are as follows:

- If you are unable to attend your appointment, please call to reschedule/cancel as soon as possible. A 48-hour notice of cancellation is preferred; however, we understand that is not always possible. If you do not call to cancel, it will be considered a "no show." If you have more than one "no show" annually, there will be a $20 charge for each "no show" thereafter.
- The billing department sends monthly invoices, either through postal mail or eStatements via email. Payment is due within 30 days of the billing statement date. In the event that the balance is not paid in full by 30 days, you will begin to accrue interest at the rate of 2% per month on the remainder.
- 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.

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

Family Support & Treatment Center

NOTICE OF PRIVACY PRACTICES and
BILLING POLICY CERTIFICATION

On behalf of myself and/or my children I, ______________________________, certify that I have received a copy of the "Notice of Privacy Practices" from Family Support & Treatment Center.

I have also 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 in regards to the policy have been presented and satisfactorily responded to.

☐ I would like to receive my monthly statements via email to the following email address:

____

☐ I would like to receive a physical copy of my monthly statement in the postal mail.

By signing the Consent Agreement to electronically deliver your Family Support & Treatment Center eStatements below, you authorize us to transmit your account eStatements to your "electronic address."

Electronic Delivery Transmission

We will transmit your eStatement to the electronic address you have provided. These electronic deliveries will be attached to an e-mail message transmitted to you on the first business day following your statement date.

Electronic Address

You agree to provide us a current electronic address for transmission of your eStatements and to promptly notify us of any changes to your electronic address.

____
Client/Guardian Signature

____
Date

Family Support & Treatment Center

1255 North 1200 West, Orem, Utah 84057
Phone: (801)229-1181 Fax: (801)229-2787

CLIENT RIGHTS

You have a right to:

1. **Privacy of Your Information:** You have a right to have your records, both current and closed, kept confidential within the Center. Client information, whether received orally or in writing, will not be disclosed without your written permission except as outlined in the Hold Harmless Form.

2. **Reasons for Involuntary Termination and Criteria for Re-Admission:** Should the agency determine your termination from the program, you have a right to be notified, either verbally or in writing, of the reasons for the termination. You also have a right to receive information, either verbally or in writing, for the criteria for re-admission into the program.

3. **Freedom of Potential Harm:** You have a right to freedom from potential harm or acts of violence to you, your family member(s), and others who may accompany you to the Center.

4. **Consumer Responsibilities:** You have a right to be informed of your responsibilities as a client of the agency as provided to you in the *Billing Policy & Procedure* form. In addition to your financial obligations, you also have a right to be informed of other responsibilities including 75% attendance to maintain your treatment appointment, treating others with dignity and respect, and refraining from carrying weapons on the premises. Any other responsibilities will be provided verbally or in writing.

5. **Service Fees and Other Costs:** You are entitled to information regarding your payment responsibilities, in writing or orally. Co-pays are due at the time of service. You have a right to request duplicate invoices for payment services; however, if you request more than one duplicate in a 12-month period, you may be charged a fee. You will be notified of the fee at the time your request is processed and will be given an opportunity to withdraw or modify your request.

6. **Grievance and Complaints:** You have a right to file a grievance with the Family Support & Treatment Center (your service provider or supervisor) should you be dissatisfied with services or feel that your rights have been violated. You may also complain to the Director of the Office of Civil Rights of the U.S. Department of Health and Human Services. The Treatment Coordinator will provide you with the Director's address. If you desire further information about your privacy rights, contact the Treatment Coordinator. If you wish to file a complaint or are concerned that your privacy rights have been violated, contact the Treatment Coordinator at the address or phone number listed in the HIPPAA pamphlet. No retaliation or reduction in services will result if you file a complaint.

7. **Freedom from Discrimination:** You have a right to freedom from discrimination regarding race, color, national origin, sex, age, disability, or religion.

8. **Dignity:** You have a right to be treated with dignity and respect in accordance with the agency's mission statement.

9. **Smoking:** In accordance with the Utah Clean Air Act, 28-32-2, you have a right to receive services in a clean air environment. Smoking by employees, you, or others, should they choose to do so, is required to be done at least 25 feet from any "entranceway, exit, open window, or air vent to the building."

10. **Request Confidential Communication:** You have a right to request confidential communications from us by alternative means or at alternative locations, such as receive mail at an address other than your home.

11. **Individualized Service Plan:** You have a right to an individualized treatment plan developed with your cooperation and completed within 30 days of beginning treatment. You have a right to inspect and obtain a copy of the information contained in your health record that is used to make decisions about your treatment. You may request access by completing and Access Request Form available from the Treatment Coordinator. 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 limited circumstances, we may deny access to a portion of your records. If your request is denied, you will receive written response and may request that the denial be reviewed. It should be noted that your therapist's progress notes are a protected mental health record set and are released at your therapist's discretion.

12. **Amendment of Health Record:** You have a right to request that information about you that we created and use for decision making be corrected. The request must be made using the Amendment Request Form available from the Treatment Coordinator. We will comply with your request unless we believe that the information is already complete and accurate.

13. **Request a Restriction on Certain Uses of Information:** You have a right to request a restriction on certain uses and disclosures of your information for treatment, payment, or health care options. The Family Support & Treatment Center will consider all requests, but we are not required to grant a restriction. To request a restriction, ask any staff member for a Request for Restriction Form, and return it to the Treatment Coordinator.

14. **Accounting of Disclosures made without your consent:** You have a right to receive an accounting of disclosures of your health information that were made without your consent or authorization. You may request an accounting by completing the Accounting Request Form available from the Treatment Coordinator. Your request must specify the period time desired for the accounting. It may not include any time prior to April 14, 2003 or more than six years prior to completion of request. If you request more than accounting in any twelve-month period, you may be charged a fee for the additional accounting. You will be notified of the fee at the time your request is processed and will be given an opportunity to withdraw or modify your request.

____________________________ ________________

Client/Guardian Signature Date

____________________________ ________________

Witness Date

Family Support & Treatment Center

DEMOGRAPHIC INFORMATION

(Used for statistical purposes only.)

Housing Composition: (List each person who lives in dwelling)

Name	Age	Sex	Relationship	Adopted/Foster
____			SELF	
____				
____				
____				
____				
____				
____				
____				

(List additional members on back of form)

1.) Name of individual in program: ______________________

2.) Total Number living in household: ________

3.) Is anyone in the household age 65 or older? Y / N

4.) Please indicate ethnicity:

____ White

____ Hispanic

____ Black/African American

____ Asian

____ Asian/Pacific Islander

____ Asian & White

____ American Indian/Alaska Native

____ American Indian/Alaska Native & White

____ American Indian/Alaska Native & Black/African American

____ Black/African American & White

____ Native Hawaiian/Other Pacific Islander

____ Other Multi-Racial

5.) Is a single female the head of household? Y / N

6.) Is anyone in the household physically or mentally handicapped, or learning disable? Y / N

7.) Gross Annual Household Income (include all adults' income): __________________

** As a non-profit agency, we rely heavily on grants for funding. As part of their application process, they do require statistical information. Once the data is compiled and ensured accurate, all names are removed. The primary statistic asked for is the income levels of our clientele. We thank you for your help in this regards.

CLIENT BEHAVIOR INDICATOR

Child's Name: ______________________________ Date: ________________

Please rate the following items in regards to your child.

SCALE: 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 hand 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 other for his/her mistakes or misbehavior
____ Often touchy or easily annoyed by other
____ Often angry and resentful
____ Often spiteful or vindictive

****

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

****

____ Repeatedly urinating into bed or clothes (whether involuntary or intentional) (D)

****

____ Overly upset when separated (or thinks about being separated) from home or parents(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 without being near parent(s)
____ Repeated nightmares involving the theme of separation
____ Repeated complaints of physical symptoms (such as headaches, stomachaches, or nausea) when separation from parent(s) occurs or is anticipated.

****

(F)

____ Sad, depressed, unhappy
____ 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

****

(G)

____ Inflated self-esteem or grandiosity
____ Decreased need for sleep
____ More talkative than usual
____ Racing thoughts
____ Distractible
____ Psychomotor agitation
____ Mood swings
____ Irritable Mood
____ Overactive, too happy, too busy, elevated mood
____ Excessive involvement in pleasurable activities

****

(H)

____ Child has been a victim or has witnessed events that are outside of normal human experiences (abuse, domestic violence, natural disaster, death, etc.)
____ Child has responded to event(s) with intense fear, helplessness, or horror
____ Disorganized or agitated behavior
____ Fears; Specify: ____
____ Repetitive play where 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 experiences 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)
_____ He/she 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, restless or unsatisfying sleep)

****

_____ Obsessive thoughts, 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 is 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 of

****

_____ Fear is so great the child doesn't want to leave home or be in social situations (M)
_____ Experiencing periods of time of intense fear with some of the following symptoms:

-- circle all that apply --

pounding heart	sweating	sensations of shortness of breath	trembling or shaking
feelings of choking	chest pain	fear of losing control	feeling dizzy
fear of dying	nausea	numbness or tingling sensations	chills

****

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