Family Support & Treatment Center

Adult Intake Form

Client Name: ______________________________ Gender: M/F 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)

Children at Home:

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

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)

Insurance Information

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

Client Name: ____

Today's Date: ____

Birth Date: ____

What type of therapy are you seeking? (Circle all that apply)

1. Individual Therapy   2. Couple Therapy   3. Family Therapy

Have you been in therapy before?

No___ Yes___

With whom? _______________

When? ____________________

Are you currently taking medication?

No___ Yes___

List ________________________

For what? ___________________

Why are you seeking counseling?

____

____

____

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

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

Childhood Sexual Abuse (A)	_____	Anxiety	_____
Physical Assault (B)	_____	Depression	_____
Adult Sexual Assault (C)	_____	Emotional Abuse	_____
Domestic/Family Violence (J)	_____	Divorce	_____
Hate Crime (M)	_____	Marital Issues	_____
Human Trafficking (N)	_____	Relationships	_____
Custodial Kidnapping (Q)	_____	Self Esteem	_____
Stalking/Harassment (U)	_____	LGBTQ	_____
Survivor of Homicide Victims (V)	_____	Stress	_____
Death/Grief/Loss	_____	Self-Harm/Suicidal	_____

Other Traumatic Event/Concern _____ (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.

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.

______________________________ ____________________

Client Signature Date

______________________________ ____________________

Witness Date

Family Support & Treatment Center

CONSENT TO TREAT

I, ________________________________, hereby give my consent 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 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.

________________________________ ____________________

Client 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.
- In circumstances of divorce, one bill will be generated and sent to whomever is designated as the responsible party. If you would like us to split your bill, please contact the Business Manager for applicable fees.
- 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.

____
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.

Family Support & Treatment Center
ACE Study Questions

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often…Swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?
NO YES

2. Did a parent or other adult in the household often or very often…Push, grab, slap, or throw something at you? Or ever hit you so hard that you had marks or were injured?
NO YES

3. Did an adult person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way? Or Attempt or actually have oral, anal, or vaginal intercourse with you?
NO YES

4. Did you often or very often feel that …No one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other?
NO YES

5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
NO YES

6. Were your parents ever separated or divorced?
NO YES

7. Was your parent/caregiver: Often or very often pushed, grabbed, slapped, or had something thrown at him/her? Or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit at least a few minutes or threatened with a gun or knife?
NO YES

8. Did you live with anyone who was a problem drinker or alcoholic or who used drugs?
NO YES

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
NO YES

10. Did a household member go to prison or jail?
NO YES

Trauma Symptom Checklist—40

(Briere & Runtz, 1989)

How often have you experienced each of the following in the last month? Please mark one number, 0-3.

Symptom	*Never----------------Often*			
	0	*1*	*2*	*3*
1. Headaches				
2. Insomnia				
3. Weight loss (without dieting)				
4. Stomach problems				
5. Sexual problems				
6. Feeling isolated from others				
7. “Flashbacks” (sudden, vivid, distracting memories				
8. Restless sleep				
9. Low sex drive				
10. Anxiety attacks				
11. Sexual over activity				
12. Loneliness				
13. Nightmares				
14. “Spacing out” (going away in your mind)				
15. Sadness				
16. Dizziness				
17. Not feeling satisfied with your sex life				
18. Trouble controlling your temper				
19. Waking up early in the morning				
20. Uncontrollable crying				
21. Fear of men				
22. Not feeling rested in the morning				
23. Having sex that you didn’t enjoy				
24. Trouble getting along with others				
25. Memory problems				
26. Desire to physically hurt oneself				
27. Fear of women				
28. Waking up in the middle of the night				
29. Bad thoughts or feelings during sex				
30. Passing out				
31. Feeling that things are “unreal”				
32. Unnecessary or over-frequent washing				
33. Feelings of inferiority				
34. Feeling tense all the time				
35. Being confused about your sexual feelings				
36. Desire to physically hurt others				
37. Feelings of guilt				
38. Feeling that you are not always in your body				
39. Having trouble breathing				
40. Sexual feelings when you shouldn’t have them				