Family Counseling Service of Northern Utah
A United Way agency serving Weber, Morgan, Box Elder & Davis counties

(Revised November 2015)

FCS Intake Packet

CLIENT COVER SHEET

CLIENT INFORMATION		
Name:	Age:	Birth Date:
Home Address, City, State, Zip Code:		County:
Home Telephone Phone:		Cell Phone:
Employer Name:	Occupation:	Work Phone:
PERSON RESPONSIBLE FOR PAYMENT AND/OR LEGAL GUARDIAN (if different)		
Name:	Age:	Birth Date:
Relationship to Client (check): ❒ Spouse ❒ Parent/Guardian ❒ Other:		
Home Address, City, State, Zip Code:		County:
Home Telephone Phone:		Cell Phone:
Employer Name:	Occupation:	Work Phone:
Insurance ❒ Yes ❒ No	Name of Insurance Company:	
Emergency Contact Name (not a household member):		**Telephone Number:**

I, the undersigned, give my consent for me or other individual as legal guardian (as noted in the Intake Packet) to be treated at Family Counseling Service.

_____ _____

Client or Responsible Party Signature Date

……...Office Use Only Below This Line……..……

Assigned Counselor: _____ Co-Pay: _____

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FINANCIAL AGREEMENT

Family Counseling Service Fees

Counseling fees of Family Counseling Service (FCS) are based on your **TOTAL MONTHLY GROSS INCOME**. Your income is then applied to our sliding scale to determine your fee. In order to receive the benefit of being charged according to our sliding fee scale, it will be necessary to bring in **verification of all income and complete a Request for Financial Assistance Form.**

Report or Letter Fees

Any letters or reports to be written on your behalf by a therapist will be provided for a fee *in addition* to the regular charge for counseling sessions. Such fees are generally $50.00.

Fee Payments

Payment is expected at the time of service unless prior arrangements are made with the Executive Director. Appointments will not be scheduled if the client is behind in payments without prior authorization from the Executive Director.

In Lieu of Insurance Payment Commitment

I agree to pay FCS the charge determined by the agency's current fee scale for each counseling session as previously stated. If I am an insurance benefit recipient and my insurance company refuses payment, I will pay the fee as determined by the agency's sliding scale with the co-payment considered as partial payment. I understand that FCS will not extend credit without prior approval from the Executive Director. If my bill becomes delinquent, FCS may take appropriate legal action.

Cancellations and No-Shows

Due to the high demand for our counseling services, we request that you keep all appointments you schedule. FCS requires 24-hour notification to cancel or a $25 LATE CANCELLATION fee will be assessed. If you do not call to cancel your appointment and then fail to attend your appointment, a $25.00 NO SHOW fee will be assessed. These fees will need to be pre-paid before another appointment can be made. If you have any questions about these fees or policies above, please ask the Administrative Staff.

More than two "no shows' or "late cancellations" may void your assignment of a sliding scale fee and if that happens, you will be responsible for the standard fee of $125 per hour.

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RELEASE FOR INSURANCE PAYMENT AND ASSIGNMENT

I the undersigned have read, understand, and agree to the above policies regarding fees and appointments. Furthermore, I give permission to release information to third party carrier(s) and do assign all insurance benefits for treatment to be paid directly to Family Counseling Service of Northern Utah and request that this assignment remain on file with my insurance carrier. I certify that a copy of this assignment shall be as valid as the original. I also understand my insurance may have a deductible. A deductible is an amount I must pay before the insurance will cover any charges. I will be responsible to pay FCS any amount not covered by my insurance, due to my deductible, within 30 days of notification by this agency. I, the undersigned, recognize that the provider cannot accept responsibility for collecting any insurance claims or negotiating any settlement on a disputed claim. I also agree that in the event of my failure to pay the amount due on my account, I will be responsible for any and all fees associated with the collection of this account. (For example, court costs, attorney fees, filing fees, etc.)

_____ _____

Client or Responsible Party Signature Date

_____ _____

Administrative Review Date

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-KEEP THIS PAGE FOR YOUR RECORDS-

PRIVACY RIGHTS NOTICE

Family Counseling Service is committed to maintain the privacy of your personal information in compliance with the federal law known as the "Health Insurance Portability and Accountability Act of 1996." As part of this commitment, this Notice informs you of your rights and our legal duties and practices that protect this information from unauthorized persons, agencies, and businesses, FCS promises to adhere to the following legal duties and to ensure that your legal rights are upheld as described in this Privacy Rights Notice.

"This notice describes how medical (personal) Information about you may be used and disclosed and how you can get access to this information. Please review it carefully"

OUR USES AND DISCLOSURES OF YOUR PERSONAL INFORMATION

In working with you as a client, FCS may use and disclose your personal information (except your psychotherapy notes) *without* your specific authorization in the following ways as "permitted" by federal regulation or other applicable law:

1. for treatment services to you, for example, by describing and explaining your test results or making information available to you upon your request. FCS may contact you using the telephone information you provided to remind you about appointments or missed appointments, unless you indicate otherwise.
2. for FCS use among and between other FCS therapists and staff in providing you with our services that includes treatment, financial activities, and other health care operations or to market other products and services to you in person which may include giving you inexpensive promotional samples;
3. for use among the various health care agencies that FCS directly work with in order to provide services to you;
4. to obtain payment, for example, by sharing *limited personal* information with an insurance company, court system, or collection agency to assist me in obtaining any payment owed to FCS;
5. by sharing your personal information with other health care agencies that you have been involved with or with representatives of the U.S. Department of Health and Human Services in order to conduct health care operations, such as for example, quality assessments, competence and qualification reviews of staff and fraud or abuse monitoring;
6. by providing your personal information to such agencies as public health authorities authorized by law to protect the public health, such as for example, when a person contracts a communicable disease or to report food poisoning obtained from a retail establishment;
7. by providing your personal information to government agencies to report *child physical or sexual abuse or neglect or the physical or sexual abuse or neglect (within certain time limits) of a person who is disabled, elderly, or vulnerable* as required by state law.

-KEEP THIS PAGE FOR YOUR RECORDS-

8. by providing your personal information to your employer *when services are being rendered on behalf of your employer,*
9. by providing your personal information to a court *when services are being provided due to a court referral or in response to a court order or as part of a judicial or administrative proceeding;*
10. by providing your personal information to authorized individuals as required by law conducting governmental compliance monitoring, audit, legal activities or proceedings, *except for investigations pertaining to specific clients which are confidential records that require your authorization unless ordered by a court of law,*
11. by providing *limited* information to law enforcement or persons who can reasonably lessen *a serious and imminent threat to the health and safety of yourself or another "identifiable" individual*.
12. by providing your personal information to authorized individuals for the safety of governmental leaders or for purposes of national security;
13. by informing an "emergency contact" that you indicate or an authorized disaster relief agency about your whereabouts or directly relevant, general health condition when in the judgment of FCS believes that such disclosure would be in your best interest or health care in cases of disaster relief efforts or in cases of an emergency.

Any *other use* or disclosure will only be made with your written authorization (which you may revoke in writing as provided by applicable federal law or regulation).

YOUR PRIVACY RIGHTS

You have the following rights upon submitting a written request from FCS:

1. **to access, inspect, request to amend, obtain a copy of and an accounting of your personal information** in our possession and to know what personal information has been provided to other people who are not normally part of the health care process providing treatment and administrative support to you or as normally permitted by law. This personal information does *not* extend to psychotherapy notes, information dealing with a legal proceeding, protecting a confidential source, where you have consented (on a temporary basis) to be a part of a research project, or information that is restricted by other applicable laws and regulations. If FCS does *not* provide access, inspection, or copying of your personal information because FCS feels there may be a risk to you or another person, you may appeal in writing to FCS and receive a response from the Executive Director in writing within 30 days.
2. you have a right to *reasonably request without explanation* and FCS must accommodate such requests to provide you with your personal information or records through "alternative" means or to "alternative" locations to make such communications **confidential.**

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-KEEP THIS PAGE FOR YOUR RECORDS-

3. you have the right to request that FCS **restrict the uses or disclosures** of your personal information (including restricting marketing product and services to you and providing you with inexpensive promotional gifts).
4. Finally, you also have the right to a **copy of any release of information** that FCS authorizes.

Changes. Changes to these Privacy Rights and my obligations are subject to change and FCS reserves the right to amend these rights and obligations subject to applicable laws and regulations. FCS will post any new changes and you may request orally or in writing at no charge a written copy of these changes from FCS.

Complaints and Questions. You have a right to complain to FCS and to the U.S. Secretary of Health and Human Services, if you think that we have violated your Privacy Rights. You also have FCS's assurance as required by law that we will not retaliate against you for filing a complaint. To complain or to ask further questions regarding this notice, submit your complaints or questions in writing addressed to:

U.S. Dept. of Health & Human Services
Civil Rights
1961 Stout St. Room 1428
Denver CO 80294-3538
Telephone: (303) 844-2024

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ACKNOWLEDGEMENT OF THE RECEIPT OF PRIVACY RIGHTS NOTICE

I, _____, hereby, acknowledge that I have received a copy of the Privacy Right Notice as required by 45 CFR 164.520.

_____ _____

Client or Responsible Person Signature Date

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CLIENT PROBLEM SHEET

Client Name:
Instructions - In order to provide the best counseling possible to you, please describe in detail the problem(s) which have caused you to seek treatment. (Anything you can tell us about the problem is helpful, for example, what the problem is, how long you have been experiencing it, how has/is it affecting you, what you have done to cope with it in the past, etc.).

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PERSONAL HISTORY FORM

CLIENT DEMOGRAPHIC INFORMATION	
Client Name:	❒ Male ❒ Female
Age (Yrs.): ❒ 0-5 ❒ 6-11 ❒ 12-17 ❒ 18-23 ❒24-44 ❒45-54 ❒55-69 ❒ 70 or over	
Ethnicity : ❒ White ❒ Hispanic ❒African American ❒ Asian ❒ Pacific Islander ❒ Native American ❒ Other	
County of Residence:	❒ Weber ❒Davis ❒Morgan ❒ Box Elder ❒ Other _____
Are you a refugee:	❒ Yes ❒ No
Yearly Gross Family Income:	❒ $0 - $9,999 ❒ $10,000 – $14,999 ❒$15,000 - $24,999 ❒ $25,000 - $34,999 ❒ $35,000+

OTHER HOUSEHOLD INFORMATION			
Amount of Other Yearly Household Income (Alimony, Child Support, SSI, Public Assistance, Pensions, etc.)		Enter Amount: $	
Other People Living in the Household			
Name	Sex	Date of Birth	Age
	❒ M ❒ F		
	❒ M ❒ F		
	❒ M ❒ F		
	❒ M ❒ F		

COUNSELING INFORMATION

Presenting Problems

- ❒ **1. Depression**
- ❒ **2. Bereavement/Loss**
- ❒ **3. Communication**
- ❒ **4. Domestic Violence**
- ❒ **5. Hopelessness**
- ❒ **6. Work Problems**
- ❒ **7. Parent Problems**
- ❒ **8. Substance Abuse**
- ❒ **9. Problems w/ School**
- ❒ **10. Marriage/Relationship/Family**
- ❒ **11. Thoughts of Hurting Yourself**
- ❒ **12. Angry Feelings**
- ❒ **13. Sexual Abuse**
- ❒ **14. Emotional Abuse**
- ❒ **15. Physical abuse**
- ❒ **16. Problems with the Law**
- ❒ **17. Unhappy with your Life**
- ❒ **18. Anxiety**
- ❒ **19. Other**_____

How Many People To Receive Counseling? ☐	Counseling Primarily For: ❒ Individual ❒ Couple ❒ Family
Have you received counseling at Family Counseling Service before? ❒ No ❒ Yes If so, Year _____	
How were you referred? ❒ Yellow Pages ❒ Walk-In ❒ Hospital ❒ Other _____ ❒ Family Member ❒ Self ❒ **Court or DCFS Referral** ❒ Internet	

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Have you ever tried to purposely take your life? ❒ Yes ❒ No
If Yes, how many times: _____ Date of most recent attempt: _____

Are you currently thinking of taking your life? **❒ Yes ❒ No**
Initials _____

Have you ever been hospitalized for psychological reasons? ❒ Yes ❒ No
If Yes, how many times? _____ Date of most recent hospitalization: _____

Have you ever or do you currently have a substance abuse problem? ❒ Yes ❒ No
If Yes, What type of substances?

Type of Substance	Have you used in this substance in last 30 days?
	❒ Yes ❒ No
	❒ Yes ❒ No
	❒ Yes ❒ No
	❒ Yes ❒ No

Have you ever attended counseling before? ❒ Yes ❒ No
If Yes, how many times have you started counseling? _____
If Yes, how successful has past counseling been for you?
❒ Mostly Unsuccessful ❒ Somewhat Unsuccessful ❒ Somewhat Successful ❒ Mostly Successful
If Yes, please list briefly why you stopped attending counseling in the past:

HEALTH INFORMATION

How would you rate your current health? ❒ Poor ❒ Fair ❒ Good ❒ Excellent

Have you been hospitalized for other than psychological reasons for more than 24 hours in the past five years?
❒ Yes ❒ No
If Yes, what was the reason? _____

Other than normal childhood illnesses, any serious illnesses while growing up? ❒ Yes ❒ No
If yes, what were they? _____
_____

Are you currently taking prescribed medication? ❒ Yes ❒ No
If Yes, list the medication, purpose, dosage if known, and when started.

Medication Name	Purpose	Dosage, if known	When Started

Are you currently experiencing any changes in your eating habits? ❒ Yes ❒ No
If Yes, Explain: _____

Are you currently experiencing any changes in your sleeping patterns? ❒ Yes ❒ No
If Yes, Explain: _____

Have you ever deliberately cut or injured your body? ❒ Yes ❒ No
Please discuss this with your counselor.

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Have you ever suffered a serious head injury? ❒ Yes ❒ No

Are you currently experiencing serious after effects of any illness or injury? ❒ Yes ❒ No
If Yes, describe the symptoms: _____
_____

Do you have any special health concerns that you think your counselor should know? ❒ Yes ❒ No
If Yes, describe the concerns: _____
_____

MENTAL HEALTH INFORMATION

Have you ever been diagnosed as clinically depressed? ❒ Yes ❒ No
If Yes, what year was the diagnosis made? _____
Do you think you are currently depressed? ❒ Yes ❒ No
If Yes, please rate in your estimation how depressed you currently feel?
(Mild) ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10 (Severe)
If Yes, How long have you felt this way? _____
If Yes, list all the depression symptoms you are currently experiencing.
_____
_____
_____

If Yes, if you are taking medication(s), have they relieved your symptoms? ❒ Yes ❒ No
If No or if you have discontinued taking the medication, explain the reason:
_____
_____

Has a specific event or incident caused your depression? ❒ Yes ❒ No

Have you ever been diagnosed as Bi-Polar? ❒ Yes ❒ No
If Yes, have you ever taken medication for having Bi-Polar condition? ❒ Yes ❒ No
If Yes, list the medication(s)? _____
Have you ever been clinically diagnosed with a Borderline Personality condition? ❒ Yes ❒ No
If Yes, what year was the diagnosis made? _____.

SOCIAL HISTORY

How many times have you been married? _____
How many significant relationships, not including marriage have you had? _____
Are you currently married or in a significant relationship? ❒ Yes ❒ No
If Yes, how long have you been married or in a significant relationship? _____

Did any of the adults that raised you have a substance or alcohol problem? ❒ Yes ❒ No
When growing up did you move from place to place a lot? ❒ Yes ❒ No
Where were you primarily raised? _____
How do you get along with your siblings?

❒ Very Distant Relationship ❒Somewhat Distant Relationship
❒Somewhat Close Relationship ❒Close Relationship

Do you currently have a good support system? ❒ Yes ❒ No
Has it generally been easy for you to make friends? ❒ Yes ❒ No

When you were growing up did anything particularly upsetting happen to you? ❒ **Yes** ❒ **No**
BEFORE the age of 18 were you a victim of:
Sexual Abuse ❒ **Yes** ❒ **No**
Physical Abuse ❒ **Yes** ❒ **No**
Emotional Abuse ❒ **Yes** ❒ **No**
If Yes, what was the relationship of the perpetrator to you? _____
Was the abuse reported? ❒ **Yes** ❒ **No**

AFTER the age of 18 were you a victim of:
Sexual Abuse ❒ **Yes** ❒ **No**
Physical Abuse ❒ **Yes** ❒ **No**
Emotional Abuse ❒ **Yes** ❒ **No**
If Yes, what was the relationship of the perpetrator to you? _____
Was the abuse reported? ❒ **Yes** ❒ **No**

EDUCATION INFORMATION

Did you complete high school? ❒ Yes ❒ No
If Yes, what year did you complete high school _____
If No, did you earn a GED? ❒ Yes ❒ No
If Yes, what year did you earn a GED? _____
What is the highest educational grade you have completed? _____
Do you have difficulties reading or writing? ❒ Yes ❒ No
Were you ever suspended or expelled from school? ❒ Yes ❒ No
If Yes, How many times? _____
If Yes, for what reasons were you suspended / expelled?
_____
_____

Did you receive any awards in school? ❒ Yes ❒ No
If Yes, list what awards you received:
_____
_____

What did/do you feel about school?

❒ Disliked it very much ❒ Disliked it ❒ Liked it ❒ Liked it very much

LEGAL INFORMATION

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Do you currently have a civil or criminal case pending? ❒ **Yes** ❒ **No**
Is counseling here at FCS part of a court, probation or parole requirement? ❒ **Yes** ❒ **No**
If Yes, provide basic details and contact information (name, phone #) _____
_____
Note: there is an additional fee for counselor reports or letters

As an adult or juvenile, have you ever been arrested for reasons other than traffic tickets?
❒ Yes ❒ No
If No, *SKIP THE REST OF THIS LEGAL SECTION!!*
If Yes, How many total arrests as a juvenile? _____
If Yes, How many total arrests as an adult? _____
Have you ever spent more than 24 hours in jail or prison? ❒ Yes ❒ No
If Yes, How many times were you incarcerated for more than 24 hours? _____
If Yes, Indicate the length of the longest period of time you were incarcerated. _____
Have you ever been on probation or parole? ❒ Yes ❒ No
If Yes, are you currently on probation or parole? ❒ **Yes** ❒ **No**
If Yes, list your probation officer's name and telephone number:

_____ _____
Probation/Parole Officer's Name Telephone Number

VETERAN STATUS

Are you a veteran of the Armed Forces? ❒ Yes ❒ No
If Yes, What branch of service: ❒ Air Force ❒ Army ❒ Navy ❒ Marine
If Yes, Date of Service: _____
Have you ever served in a theater of conflict as a combat veteran? ❒ Yes ❒ No
If Yes, What theater? _____. When: _____

EMPLOYMENT INFORMATION

Are you currently employed full-time? ❒ Yes ❒ No
Are you currently employed part-time? ❒ Yes ❒ No
If not currently employed, how long have you been unemployed? _____
How many jobs have you held in the last five years? _____
What is the longest period of time you have worked at one job in the last 5 years? _____
Have you been terminated from any job in the last three years? ❒ Yes ❒ No
If Yes, How many times were you terminated? _____
If Yes, What were the reasons you were terminated from employment:
_____
_____

CLIENT'S PERSONAL ASSESSMENT AND GOALS

In your estimation, how serious do you feel or believe your current problems(s) are?

(Mild) ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ (10 Severe)

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In your estimation, what is your level of motivation to work out your current problems(s)? (Weak) ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ (10 Strong)
How many counseling sessions do you think will be necessary to work through your problems successfully? ❒ 1-3 Sessions ❒ 4-7 Sessions ❒8-11 Sessions ❒12+ Sessions
Do you understand that there are no "magical, quick fixes" for most counseling problems? ❒ Yes ❒ No
What are you specific goals for treatment?
Client Comments: Is there anything else about you that you believe we should know about that has not been covered in this form? Are there any additional comments you wish to make? If so, you many use the space below to describe them:

Client or Client's Guardian Signature **Date**

Therapist: **Date**

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CLIENT RIGHTS AND RESPONSIBILITIES

As clients in treatment here at FCS, it is important that you know your rights and responsibilities. After reading, please sign this document to acknowledge that you have read it and understand your rights as a client.

1. The records and information of both current and former clients will not be disclosed to parties outside FCS without written permission of the client. The exceptions to release of confidential information are explained in the Privacy Rights Notice that all clients must sign at time of Intake.

2. As a private agency, FCS reserves the right to deny or terminate services to any individual applying for services or a client receiving services. In all cases, only the Executive Director has the authority to permanently deny or terminate services.

3. Any denial of services will not be based on discrimination due to creed, ethnicity, gender, age or sexual orientation.

4. Reasons for termination or denial of treatment include, but are not limited to: (1) foul or abusive language or behavior that is rude, demeaning or threatening to FCS staff, FCS Trustees, clients, or FCS associates (2) destruction of FCS property (3) a systematic pattern of canceling appointments, late cancellation of appointments or not showing for scheduled appointments. Generally, **two such incidents in a three month period are grounds for termination of services** (4) the treatment needs of the individual exceed the ability FCS to provide (5) it is reasonably believed by the Executive Director the client poses a potentially significant risk to FCS staff, FCS Trustees, clients, or FCS associates (6) The client is actively psychotic (7) the client has reached the maximum benefit of treatment (8) failure to retire an outstanding account.

5. Currently, FCS receives support from a private foundation which requires that funding be discontinued if a client does not show up for an appointment or late cancels more than once. Such clients must wait 60 days before reapplying for funding. A client who has demonstrated little motivation in treatment, or who indicates minimal benefit from the treatment process, may be denied readmission to the foundation's treatment coverage.

6. While on FCS premises, clients are in a safe, therapeutic environment where they are free from potential harm or acts of violence.

7. Clients are expected to arrive on time for their scheduled appointments, to be appropriately dressed for the season and not under the influence of alcohol or illegal drugs.

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8. Payment is expected at the time of service unless prior arrangements have been made. Appointments cannot be scheduled if the client is behind in payments without prior authorization from the Executive Director.

9. Clients with complaints about FCS office personnel or policies are encouraged to inform the Executive Director of their concerns. The Executive Director is responsible for investigating client complaints, taking corrective action when warranted and informing the client of the results of the Executive Director's investigation.

10. Clients with complaints about their therapist are encouraged to inform the Executive Director of their concerns. The Executive Director is responsible for investigating such client complaints, taking corrective action when warranted and informing the client of the results of the Clinical Director's investigation.

11. At all times, FCS clients will be treated with dignity and free from any form of discrimination.

12. Consistent with the Utah Clean Air Act, smoking is not permitted anytime, or for any reason in FCS offices.

13. **I, the undersigned, have read and understand my rights and responsibilities and I agree with Family Counseling Service terms and conditions**.

_____ _____

Client or Responsible Party Signature Date